INTRODUCTION

Significant state budget cuts to public mental health programs, county health departments, and law enforcement agencies has negatively impacted the availability of mental health, homeless, inebriate and substance abuse services. As county health and mental health programs and law enforcement services are eliminated or downsized, there is an increased dependence on hospital emergency departments (EDs) and acute psychiatric inpatient hospitals (APHs) to provide care to the county mental health population without corresponding resources and funding. This increased unfunded dependence on EDs and APHs has many adverse consequences, including: reduced availability of inpatient psychiatric beds for the private market; increasing ED crowding causing delays in treatment to those requiring both physical/medical emergent care and emergency psychiatric care; delays in obtaining psychiatric evaluations in EDs; placing staff and patients in potentially dangerous situations; EDs and APHs are more frequently on diversion; and causing hospitals to be the default provider for mental health care for county mental health Medi-Cal and indigent populations.

This strain on EDs and APHs is occurring when hospitals and EDs are already in the midst of a public health crisis dealing with the H1N1 virus and preparing for an influx of early release prisoners, many of whom have both physical and mental health problems and no established medical home in the community.

Over the past twenty years, the number of individuals released from California prisons has increased nearly threefold. As of August 2009, the statewide parolee population with mental health needs was 22,608. Parolees with mental illness account for approximately 20% of the overall prison population. The health care needs of California’s prisoner reentry population are high, and mental health care and substance abuse needs are even higher. California prison inmates bear a high burden of chronic diseases, such as asthma and hypertension, and infectious diseases, such as hepatitis and tuberculosis – conditions that require regular care for effective management. More than half of California inmates reported a recent mental health problem, and about half of them received treatment in prison. Given the high prevalence of mental health problems among the prison population, the need for services in communities is particularly high.

Certain counties and communities are disproportionately affected by parolee reentry. The distribution of parolees indicates that they are concentrated in the 11 most populated counties, around the Bay Area and in the southern part of the state.

When a parolee requires mental health treatment above the level of care available from prison-funded Parole Outpatient Clinics (POC) – medication management and individual/group therapy – the California Department of Corrections and Rehabilitation (CDCR) relies on the counties and other community health facilities to obtain necessary mental health services. CDCR has
established a recidivism reduction program requiring, upon parole, inmates to receive between 4 and 8 consecutive appointments at a POC.

Although these issues are experienced statewide, they manifest very differently in each county, depending upon local governments’ commitment to mental health, local health and law enforcement resources and the varying interpretations of the Welfare and Institutions Code, Lanterman-Petris-Short (LPS - 5150) involuntary commitment statutes as well as Health and Safety Code section 1799.111 non-designated hospital hold provisions.

COUNTY MENTAL HEALTH FUNDING HISTORY

In 1957, California passed legislation creating the Short-Doyle Program, whereby counties are required to ensure delivery of mental health services utilizing a system of county operated and contract providers.

In 1965, the United States Congress passed Title XVIII, the Medicare legislation that provides healthcare for some disabled individuals and persons 65 years of age and over, and Title XIX, the Medicaid legislation that provides federal matching funds to states that implement a comprehensive health care system for the poor under the administration of a single state agency.

After the enactment of Medicaid in 1966, California implemented the Medi-Cal program, based on the provisions of Title XIX. As first enacted, mental health services with federal reimbursement included psychiatric inpatient hospital services, nursing facility care and professional services provided by psychiatrists and psychologists. Services were provided under a fee for service reimbursement arrangement with rates set by the California Department of Health Services (DHS). This system came to be known as Fee for Service Medi-Cal (FFS/MC)

In 1971, California added Short-Doyle community mental health services into the Medi-Cal scope of benefits, enabling counties to obtain federal matching funds for their costs of providing certain additional mental health services to persons eligible for Medi-Cal. These new Short-Doyle Medi-Cal (SD/MC) services included inpatient hospital services delivered in acute care hospitals; individual, group, or family therapy delivered in outpatient or clinic settings; and various partial day or day treatment programs. In subsequent years, several more service components were added to the SD/MC array of mental health services via a state plan amendment (SPA). Reimbursement under the SD/MC program is primarily based on allowable costs or negotiated rates approved by DMH, up to a statewide maximum allowance.

Thus, prior to the advent of Managed Care, California’s Medi-Cal program consisted of two mental health delivery systems, the original program (FFS/MC) and the county based SD/MC system.
Realignment

In 1991, as a result of a state budget crisis, mental health, public health and social services funding were “realigned” with the enactment of the Bronzan-McCorquodale Act, (Chapter 89, Statutes of 1991). Realignment transferred financial responsibility for most of the state’s mental health and public health programs from the state to local governments, and provided counties with a dedicated revenue source to pay for these changes.

In order to fund the county portion of the realignment program, the Legislature enacted two tax increases in 1991:

- Sales Tax - The statewide sales tax rate was increased by a half-cent.
- Vehicle License Fee - The VLF, an annual fee on the ownership of registered vehicles based on the estimated current value of the vehicle

The revenue generated by the tax increases is distributed to counties, which in turn distribute the funds across three program accounts, one each for mental health, social services, and health. Each year realignment revenues are distributed to counties at levels equal to the previous year’s total. Funds received by the state prior to distribution to the counties above that amount are placed into a growth account. The distribution of growth funds is complex and mental health services are not prioritized. For example, the first claim on the Sales Tax Growth Account goes to caseload-driven social service programs. Due to continued caseload expansion in child welfare, foster care, and the In Home Health Support (IHSS) program, and the downturn in the economy, growth funds have not been and are not projected to be available for mental health.

Consolidation

The two separate Medi-Cal mental health systems – FFS/MC (the original Medi-Cal mental health system) and SD/MC – continued as separate programs until 1995. In January 1995, Medi-Cal mental health consolidation began with the Medi-Cal Specialty Mental Health Services Consolidation program, which operates under a federal 1915(b) Freedom of Choice waiver. Under consolidation, mental health services were “carved out” from the rest of Medi-Cal managed care, and county mental health departments were given the “first right of refusal” in choosing whether to be the Medi-Cal “Mental Health Plan” (MHP) for their respective counties. Each MHP contracts with the Department of Mental Health (DMH) and is responsible for providing medically necessary specialty mental health services to county Medi-Cal beneficiaries.

Prior to consolidation, county mental health departments had managed psychiatric inpatient hospital services only at county hospitals or hospitals under contract to the county. All other psychiatric inpatient hospital services were managed by DHS through the regular Medi-Cal program. After consolidation, MHPs assumed responsibility for inpatient hospitals and outpatient specialty mental health professional services in addition to providing rehabilitative mental health and targeted case management services.
MHPs are governed by state regulations in Title 9, California Code of Regulations, Division 1, Chapter 11. MHPs select and credential their provider network, negotiate rates, authorize services and provide payment for services rendered by specialty mental health providers in accordance with statewide criteria. Medi-Cal beneficiaries must receive Medi-Cal reimbursed specialty mental health services through the MHPs.

MHPs receive a fixed annual allocation of state general funds (SGFs) based on the historical cost of services formerly provided through the FFS/MC system. Under the current realignment funding structure, funds appropriated to the counties have not kept pace with 1991-92 levels when population changes and medical inflation are taken into account. Generally, the percentage increase in medical inflation and client growth combined, along with increased acuity of clients, has been substantially greater than the increase in realignment revenues. Counties have not received a cost of living increase for the Medi-Cal program since 2000 and have been subject to numerous Medi-Cal budget reductions.

California’s County Medical Services Program (CMSP)

The County Medical Services Program (CMSP) was established in January 1983, when California law transferred responsibility for providing health care services to indigent adults from the State of California to California counties. This law recognized that many smaller, rural counties were not in the position to assume this new responsibility. As a result, the law also provided counties with a population of 300,000 or fewer with the option of contracting back with the California Department of Health Services (DHS) to provide health care services to indigent adults. DHS utilized the administrative infrastructure of Medi-Cal's fee-for-service program to establish and administer the CMSP program.

In April 1995, California law was amended to establish the County Medical Services Program Governing Board (Governing Board). The Governing Board, composed of ten county officials and one ex-officio representative of the Secretary of the California Heath and Human Services Agency, is authorized to set overall program and fiscal policy for the CMSP program. This law also authorized the Governing Board to contract with DHS or an alternative contractor to administer the program. Between April 1995 and September 2005, the Governing Board contracted with DHS to administer the CMSP program. Beginning October 1, 2005, Blue Cross Life & Health (BC L&H) assumed administrative responsibility for CMSP.

Currently, thirty-four counties throughout California participate in CMSP including: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Kings, Lake, Lassen, Madera, Marin, Mariposa, Mendocino, Modoc, Mono, Napa, Nevada, Plumas, San Benito, Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, Tuolumne, and Yuba counties.

CMSP is funded exclusively by participating counties through county contributions from Program Realignment (motor vehicle license fee and sales tax revenue) and county general-purpose revenue.
CMSP members are medically indigent adults, ages 21 through 64, who meet all of CMSP’s eligibility criteria and are not eligible for Medi-Cal.

Since its inception in 1983, CMSP’s benefit coverage for mental health and substance abuse treatment had been limited and in 2007, the CMSP Governing Board designed a new behavioral health pilot project to test the effectiveness of short-term mental health and substance abuse treatment, integrated into the primary care delivery system. The pilot offers new CMSP reimbursement of individual and group counseling services for mental health (up to 10 sessions per year) and substance abuse conditions (up to 20 sessions per year). The pilot projects officially began in March 2008 and are scheduled to run through 2011.

Inpatient hospital mental health services are also covered by the CMSP program and as of January 1, 2009 the three-day limit per mental health inpatient hospital admission was increased to a maximum of six days per episode. The ten-day per fiscal year, per CMSP member maximum remains unchanged.

Medi-Cal Hospital/Uninsured Care Demonstration Project Section 1115 Waiver

The State of California currently operates its Medi-Cal program under a number of federal waivers. The current California section 1115 waiver for hospital financing and uninsured care will expire on August 31, 2010. This timing presents California with an opportunity to seek a new section 1115 waiver to transform the Medi-Cal program to deliver health care in a more efficient manner that achieves long-term cost savings and to lay the ground work for what will be needed to successfully implement national health care reforms, if pending reforms are ultimately enacted.

The California Medicaid program is poised for change. As part of the 2009-10 budget, ABx4 6 was enacted to slow the long-term Medi-Cal expenditure growth rate through significant restructuring of the Medi-Cal program. This legislation commits the Department of Health Care Services (DHCS) to pursuing a section 1115 waiver that will restructure the organization and delivery of health care for the most medically vulnerable, high cost Medi-Cal beneficiaries with complex chronic conditions, co-morbidities, and the highest needs for on-going health care.

The Governor and Legislature took this action because Medi-Cal expenditures have been increasing at a rate that is much faster than the growth in available revenue due to the greater use of services, increased costs in the health care system, and more individuals becoming eligible for services. ABx4 6 calls for structural reforms to enable Medi-Cal to reduce its growth rate in expenditures and continue serving low-income, vulnerable Californians, while increasing program efficiency.

Approximately 30 percent of Medi-Cal beneficiaries with disabilities have received treatment throughout the year for a mental health condition. In the waiver concept paper issued by the Department of Health Care Services, one of the initiatives to promote a more organized delivery system of care include the goal of ensuring that the systems meet the needs of persons with severe mental illness. The goal will be to establish systems that facilitate integration of
behavioral and physical health to create more effective and efficient systems that improve health care quality and outcomes.

These systems should allow for a medical home, which provides mental health services in the primary care setting or primary care services in the mental health setting. Phasing in of adults with severe mental illness into organized systems of care will build upon the State and nationally recommended framework for service development, which identifies patient need based on their physical and behavioral health risk, acuity and complexity.

Based on this profile, a physical health or behavioral health provider will be assigned as the individual’s medical home and mechanisms will be employed to ensure that a wide range of health, behavioral health, and social supports are available to address the patient’s needs. This approach could also be a pathway towards the integration of physical and mental health financial systems and reimbursement mechanisms.

**Mental Health Services Act (Proposition 63)**

In November, 2004, the passage of Proposition 63, the Mental Health Services Act (MHSA), increased funding, personnel and other resources to support county mental health programs and monitor progress toward statewide goals for serving children, transition age youth, adults, older adults and families with mental health needs by imposing a 1 percent income tax on annual personal income in excess of $1 million. Since its inception, the MHSA has generated more than $4.1 billion in additional revenues for mental health services through the end of Fiscal Year (FY) 2007-08 and is anticipated to generate an additional $1 billion in FY 2008-09.

The MHSA addresses a broad continuum of prevention, early intervention and service needs and provides funding for the necessary infrastructure, technology and training elements that will effectively support the local mental health system.

The MHSA also specifies the percentage of funds to be devoted to each of these components and requires the Department of Mental Health (DMH) to establish the requirements for use of the funds. Because of the complexity of each component, implementation of the five components was staggered. An overview of the five components is listed below:

- **Community Services and Supports (CSS)** — “System of Care Services” described in the MHSA are now called “Community Services and Supports.” The CSS are the programs, services, and strategies identified by each County Mental Health Department (County) through its stakeholder process to serve unserved and underserved populations, with an emphasis on eliminating disparity in access and improving mental health outcomes for racial/ethnic populations and other unserved and underserved populations.

- **Workforce Education and Training** — This component targets workforce development programs to remedy the shortage of qualified individuals to provide services to address severe mental illnesses.
- **Capital Facilities and Technological Needs** — This component addresses the capital infrastructure needed to support implementation of the Community Services and Supports and Prevention and Early Intervention programs. It includes funding to improve or replace existing technology systems and for capital projects to meet program infrastructure needs.

- **Prevention and Early Intervention (PEI)** — This component supports the design of programs to prevent mental illnesses from becoming severe and disabling, with an emphasis on improving timely access to services for unserved and underserved populations.

- **Innovation (5 percent of CSS and 5 percent of PEI)** — The goal of this component is to develop and implement promising practices designed to increase access to services by underserved groups, increase the quality of services, improve outcomes, and promote interagency collaboration.

In addition to funding the components listed above, MHSA allows for up to five percent of the total revenues allowable in each fiscal year to be used to support DMH, the Mental Health Oversight and Accountability Commission (MHSOAC), and the California Mental Health Planning Council (CMHPC). Several other state entities are also allocated limited MHSA funding. These include the Department of Aging, the Department of Education, the Department of Alcohol and Drug Programs, the Department of Consumer Affairs Regulatory Boards, the Department of Developmental Services, the Department of Health Care Services, the Department of Rehabilitation, the Department of Social Services, the Department of Veterans Affairs, the Administrative Office of the Courts (Judicial Branch), the Board of Governors of the California Community Colleges, the California State Library, the Managed Risk Medical Insurance Board, and the Office of Statewide Health Planning and Development.

While these new MHSA revenues are an addition to California’s public mental health system, it is important to note that funds must be used to expand, not supplant, existing services. This means while counties struggle to keep their existing Medi-Cal and realignment-funded programs running with a declining revenue source, they are looking to build new programs. This has resulted in service reductions on the one hand and limited service expansion on the other. Counties will face increasing challenges as they attempt to make sense of this dynamic while trying to manage their consumers’ high expectations for systems improvements through the MHSA.

It is also worth noting that according to the Act, no funds may be provided from the state to the counties unless such spending is in accordance with a detailed plan developed by each county with significant local stakeholder input and involvement. In their MHSA Plans, counties are required to submit a listing of all work plans for which MHSA funding is being requested that identifies the proposed expenditures for each type of funding (Full Service Partnership, System Development, and Outreach and Engagement) and for each target age group (Adult, Children and Youth, Older Adult, and Transition Aged Youth).
The local plans must be approved by the State Department of Mental Health, after review and comment by the Oversight and Accountability Commission. Each plan is a three-year plan that must be updated annually, and each update must also be submitted to the state for review.

**MHSA and Involuntary Care**

Payment for involuntary inpatient care for some individuals is covered by the MHSA. Attachment A provides a thorough review of relevant regulations pertaining to this coverage. Specific authority can be found in the California Code of Regulations, Title 9, Section 3620 (k) and (l) which states:

(k) Notwithstanding Section 3400 (b)(2), the County may pay for short-term acute inpatient treatment for clients in Full Service Partnerships when the client is uninsured for this service or there are no other funds available for this purpose.

(l) Long-term hospital and/or long-term institutional care cannot be paid for with MHSA funds.

**Current and Future Budget Years**

County mental health services have experienced severe reductions in this budget year. These include but are not limited to the following:

- Reduction of state support for non-inpatient mental health services under Medi-Cal Managed Care – a reduction from $225 million to $113 million.
- Deferral of cost settlement payments to county MHPs for FY 2006-07 services in the amount of $16 million, until FY 2010-11.
- Deferral of $52 million in AB 3632 (Mental Health Special Education) mandate payments to counties.
- $350 million decline in county funds due to less sales tax (declined 13% in FY 2008-09) and VLF revenue (declined 8.5% in FY 2008-09) sources.

The County Mental Health Directors Association (CMHDA) has made the following projections on the impact to realignment funds for fiscal year 2009-10:

Sales tax revenues – Estimate decline 5% to 6%
Vehicle license fees – Estimate overall decline 1% to 2%
Based on estimates included in the Governor’s Proposed FY 2009-10
Budget the MHSA tax is expected to generate $914 million in FY 2009-10.

**IMD EXCLUSION**

The Medicaid financing process is highly complex, and much of the complexity is rooted in the federal government’s longstanding (1965) policy that inpatient psychiatric care – primarily for adults – is the responsibility of the states. Consequently, federal law does not generally allow Medicaid reimbursement for care provided to individuals older than 21 years or younger than 65.
years if the care is delivered in a health care facility classified as an institute for mental diseases (IMDs).

An IMD is defined as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care, and related services. Other facilities may fall under the IMD exclusion if more than 50% of the population served has a psychiatric primary diagnosis.

Thus, the IMD exclusion generally prohibits Medicaid reimbursement for services obtained in acute psychiatric hospitals by Medicaid-eligible adults from 22 to 64 years of age. However, Medicaid funds may be available for the same services rendered in a non-IMD environment.

CHA and many other state and federal organizations have for decades advocated for the abolishment of this discriminatory practice. The Senate Finance Committee has recently amended its version of health reform legislation to partially roll back current Medicaid policy prohibiting reimbursement for IMD services.

The amendment provides $75 million for three-year demonstration projects in up to eight states that would allow federal Medicaid matching payments for emergency psychiatric treatment in psychiatric hospitals that provide services to Medicaid beneficiaries between the ages of 21 and 64. Only non-publicly owned and operated psychiatric hospitals would be eligible to participate in the demonstration projects. The services eligible for federal payments under the demonstration projects are limited to emergency psychiatric treatment and stabilization.

The intent of the demonstration projects, as described by the Finance Committee, is to “demonstrate that covering patients in these hospitals will improve timely access to emergency psychiatric care, reduce the burden on overcrowded emergency rooms, and improve the efficiency and cost-effectiveness of inpatient psychiatric care.” A similar demonstration project was included in the House version of health reform legislation.

EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA)

The Emergency Medical Treatment and Active Labor Act (EMTALA) requires that hospitals participating in the Medicare program provide a medical screening examination to each patient who “comes to the emergency department” seeking or needing examination or treatment for a medical condition, including a psychiatric condition.

If, after the medical screening examination has been completed, the physician (or other qualified practitioner) determines that the patient does not have an “emergency medical condition,” the patient may be released.

If the patient has an emergency medical condition, the patient must be (1) admitted, (2) “stabilized” and then released or transferred appropriately, or (3) transferred appropriately in an unstabilized condition, but only if the transferring physician certifies that the medical benefits
reasonably expected from treatment at the receiving facility outweigh the increased risks to the patient from the transfer.

An unstabilized patient may also be discharged or transferred if the patient requests the discharge or transfer in writing after being given specified information. However, if the patient is a danger to self or others or gravely disabled, the patient may be held without his or her consent pursuant to Welfare and Institutions Code Section 5150 et seq. (designated facility, 72 hours) or Health and Safety Code Section 1799.111 (non-designated facility, 24 hours).

Federal EMTALA rules are very complex and continuously evolve as CMS creates additional requirements or “clarifies” existing requirements. This has led to significant confusions among law enforcement and community mental/physical health providers. This, coupled with the fact that some Acute Psychiatric Hospitals may not be bound by EMTALA mandates, causes significant confusion even within the hospital community.

See Attachment B for a list of pertinent EMTALA definitions.

IN VOLUNTARY HOLDS/DETENTIONS

California involuntary treatment laws result from a nexus between political, legal and social ideas. The civil commitment of the mentally ill is one of the most contentious areas of mental health law attempting to encompass a dual policy of protecting the public from the dangerously mentally ill and providing treatment for those who are unable to care for themselves.

California led the way into what was supposed to be an enlightened era with the 1967 passage of the Lanterman-Petris-Short (LPS) Act. The Act was designed to move most of the severely mentally disabled from institutions to community settings. The laws were tightened, as a matter of civil rights, to make it far more difficult to force someone with a serious mental illness into involuntary treatment.

However, much has changed the LPS Act was enacted 42 years ago. The mental health delivery system is no longer dominated by large state mental hospitals but rather by a fragmented and largely unfunded community delivery system where individuals are forced to be criminalized before they can receive mental health care.

In 2001, the California legislature took steps to rectify our laws so that the community mental health system can legally provide treatment to individuals who are gravely ill before they became a danger. Known as “Laura’s Law,” this treatment modality allows a court to verify that an individual meets the criteria and order that they accept and comply with mental health treatment in the community. Moreover, it mandates that the mental health system will provide the individual with their needed services and supervise that the person is taking their medication, has a place to live and is otherwise receiving the services required under the court-approved treatment plan. Laura’s Law requires that each county Board of Supervisors must pass a resolution that no voluntary programs be reduced in order to establish it. Currently, only two counties – Nevada and Los Angeles – have such a program.
California law permits courts to order patients to participate in outpatient mental health treatment [Welfare and Institutions Code Sections 5345-5349.5]. This law is operative only in those counties in which the county board of supervisors, by resolution, authorizes its application and makes a finding that no voluntary mental health program serving adults, and no children’s mental health program, will be reduced as a result of the implementation of this law. A county choosing to implement this law is required to provide a wide range of outpatient services to both voluntary and involuntary patients of every cultural and linguistic background, age, gender, physical disability, etc. A county implementing this law is also required to undertake detailed data collection, evaluation and reporting.

For the past two years, CHA has been an active participant in a statewide LPS Reform Task Force. The task force is made up of individuals from a wide range of professions all interested in improving the care for individuals suffering with serious and persistent mental illnesses. Participants include Psychiatrists, District Attorneys, Medical Directors, Probate Judges, County Counsel, Public Guardians, law professors and law enforcement organizations.

The mission statement for this Task Force is as follows:

The LPS Reform Task Force II has as its mission the reform of the LPS laws where they reflect inappropriate and punitive attitudes toward mental disorders and antiquated notions of how society should manage them. We propose to utilize current scientific understanding of the causes of such disorders, the advances that have been made in treatment, and best management and treatment principles. Our proposed reform will provide guidelines for the optimum treatment for those who have mental disorders, but who have, through society’s neglect, languished on our city streets and in jails and prisons, and who are so ill that they do not recognize the need for treatment. These new laws will balance society’s need for protection from people whose illnesses are out of control with the individual’s need for protection of his or her civil rights. A basic principle that guides us is the recognition that access to treatment for mental disorders is a civil right as well as an obligation of society to provide it.

Voluntarily or Involuntarily Detained

There exists substantial confusion about the rights and procedural protections afforded under California law to persons who are voluntarily or involuntarily detained for mental health services, including evaluation and treatment of a mental disorder, inebriation or drug use. These rights and protections are codified primarily in the Lanterman-Petris-Short (LPS) Act [Welfare and Institutions Code Section 5000 et seq.]. Other relevant principles applicable to these patients are found in Welfare and Institutions Code Section 6000 et seq., Health and Safety Code Section 1799.111 and in state and federal court decisions. See Attachment C for a one-page snapshot of involuntary holds.
Voluntary Admission of Adult Patients

Adults, including persons under conservatorship, may be voluntarily admitted for treatment of mental disorders, alcoholism or drug abuse. The patient or, if applicable, the patient’s conservator, may request admission. Welfare and Institutions Code Section 5350 provides for the appointment of a conservator of the estate, or of the person and the estate, for a person who is gravely disabled as a result of a mental disorder or impairment by chronic alcoholism.

Lanterman-Petris-Short Act (LPS)

The Lanterman-Petris-Short Act [Welfare and Institutions Code Section 5000 et seq.] provides procedural protections for any person who is involuntarily committed and evaluated because that person – as a result of a mental disorder, inebriation, the use of narcotics or restricted drugs – is a danger to self or others, or is gravely disabled. The LPS Act specifies periods for evaluation and treatment, which include:

- An initial 72-hour hold for evaluation and treatment;
- An additional 14-day intensive treatment
- An additional 30-day period of intensive treatment after the 14-day period of treatment (where the county board of supervisors authorizes such a procedure); and
- Further confinement depending on the person’s condition.

Mental Disorder

According to the California Attorney General, the reference to “mental disorder” in Welfare and Institutions Code Section 5150 draws no distinction between disorders of inorganic or organic origin and therefore includes, together with inorganic mental disorders, Alzheimer’s disease, brain injuries and other organic brain disorders [72 Ops.Cal.Atty.Gen. 41 (1989)].

Gravely Disabled

“Gravely disabled” means either of the following:

- A condition in which a person, as a result of a mental disorder or, in some cases, chronic alcoholism, is unable to provide for his or her basic personal needs for food, clothing or shelter [Welfare and Institutions Code Section 5008(h)(1)(A)]; or
- A condition in which a person has been found mentally incompetent under Penal Code Section 1370 (mentally incompetent to stand trial).

Mental retardation, by itself, does not constitute a grave disability [Welfare and Institutions Code Section 5008(h)].

Notwithstanding Welfare and Institutions Code Section 5008(h), a person is not gravely disabled if that person can survive safely without involuntary detention with the help of responsible family,
friends, or others who are willing and able to help provide for the person’s basic personal needs for food, clothing, or shelter. However, unless family, friends, or others specifically indicate in writing their willingness and ability to help, they must not be considered willing or able to provide this help [Welfare and Institutions Code Sections 5250(d) and 5350(e)]. This exception does not apply to patients who are considered gravely disabled pursuant to Welfare and Institutions Code Section 5008(h)(1)(B).

**Conditions for Detention**

Welfare and Institutions Code Section 5150 states that when a person, as a result of a mental disorder, is a danger to self or others or is gravely disabled, any of the following persons may, upon probable cause, take the person into custody, or cause the person to be taken into custody, and place the person in a facility designated by the county and approved by CDMH as a facility for 72-hour evaluation and treatment. The persons who may take such actions include:

- A peace officer (including park peace officers and regional park peace officers);
- A member of the attending staff of an evaluation facility (so designated by the county) who is authorized to admit a patient involuntarily. “Attending staff” is defined as a person who has responsibility for the care and treatment of the patient, as designated by the local mental health director, and who is on the staff of an evaluation facility designated by the county [Title 9, California Code of Regulations, Section 823]. “A member of the attending staff who is authorized to admit a person to a designated facility” is defined as a physician who is on the psychiatric attending staff of either a public or private designated facility to which the patient will be admitted; or
- Any other professional person designated by the county.

**Non-Interference with Peace Officers**

Welfare and Institutions Code Sections 5150.1 and 5150.2 restrict mental health professionals from interfering with peace officers who may be transporting a person to a designated facility for assessment under Welfare and Institutions Code Section 5150.

Welfare and Institutions Code Section 5150.1 provides:

No peace officer seeking to transport, or having transported, a person to a designated facility for assessment under Welfare and Institutions Code Section 5150, may be instructed by mental health personnel to take the person to, or keep the person at, a jail solely because of the unavailability of an acute bed, nor may the peace officer be forbidden to transport the person directly to the designated facility. No mental health employee from any county, state, city, or any private agency providing Short Doyle psychiatric emergency services may interfere with a peace officer performing duties under Welfare and Institutions Code Section 5150 by preventing the peace officer from entering a designated facility with the person to be assessed, nor may any employee of such an agency require the peace officer to remove the person without assessment as a condition of allowing the peace officer to depart.
Welfare and Institutions Code Section 5150.2 provides:

In each county whenever a peace officer has transported a person to a designated facility for assessment under Welfare and Institutions Code Section 5150, that officer shall be detained no longer than the time necessary to complete documentation of the factual basis of the detention under Welfare and Institutions Code Section 5150 and a safe and orderly transfer of physical custody of the person. The documentation must include detailed information regarding the factual circumstances and observations constituting probable cause for the peace officer to believe that the individual required psychiatric evaluation under the standards of Welfare and Institutions Code Section 5150.

Each county must establish disposition procedures and guidelines with local law enforcement agencies as necessary to relate to persons not admitted for evaluation and treatment and who decline alternative mental health services and to relate to the safe and orderly transfer of physical custody of persons under Welfare and Institutions Code Section 5150, including those who have a criminal detention pending.

**Preadmission Assessment**

Prior to admitting a person to a facility for a 72-hour treatment and evaluation pursuant to Welfare and Institutions Code Section 5150, the professional person in charge of the facility, or a designee, must assess the individual in person to determine the appropriateness of the involuntary detention [Welfare and Institutions Code Section 5151].

This preadmission assessment requirement must not be interpreted to prevent a peace officer from delivering an individual to a designated facility for assessment under Welfare and Institutions Code Section 5150.

When a patient is subject to detention pursuant to Welfare and Institutions Code Section 5150, the treating facility must acquire the patient’s medication history, if possible [Welfare and Institutions Code Section 5332].

**Period of Detention**

Welfare and Institutions Code Section 5151 provides that if a facility for 72-hour treatment and evaluation admits a person, it may detain the person for evaluation and treatment for a period not to exceed 72 hours, including Saturdays, Sundays and holidays. If evaluation and treatment services are not available on Saturdays, Sundays and holidays, and if CDMH certifies for the facility that evaluation and treatment services cannot reasonably be made available on those days, they should not be counted in the 72 hours. The certification by CDMH must be renewed every two years.

The 72 hours is counted from the time the person is admitted to the treating facility responsible for the evaluation and treatment. The time of admission runs from the time the person is first detained in the facility and is not dependent upon completion of admissions procedures or
paperwork. The time is not extended by a preadmission evaluation period at the facility (the 72 hours is designed to permit the facility to make an appropriate evaluation).

The 72 hours does not include time spent transporting the patient to the treatment and evaluation facility by peace officers or other persons designated to take a person into custody under Welfare and Institutions Code Section 5150, who are listed above.

**Termination of Detention**

If the professional person in charge of the facility providing evaluation and treatment, or a designee, determines that an individual may be properly served without being involuntarily detained, then evaluation, crisis intervention, or other inpatient or outpatient services must be provided on a voluntary basis [Welfare and Institutions Code Section 5151].

If detained, the patient may be released before 72 hours have elapsed only if the psychiatrist directly responsible for the person’s treatment believes, as a result of his or her personal observations, that the person no longer requires evaluation or treatment. However, in those situations in which both a psychiatrist and psychologist have personally evaluated or examined a person who is placed under a 72-hour hold and there is a collaborative treatment relationship between the psychiatrist and psychologist, either the psychiatrist or psychologist may authorize the release of the person from the hold, but only after they have consulted with one another. In the event of a clinical or professional disagreement regarding the early release, the hold shall be maintained unless the facility’s medical director overrules the decision of the psychiatrist or psychologist opposing the release. Both the psychiatrist and psychologist must enter their findings, concerns, or objections in to the patient’s medical record.

If a professional authorized to release the person believes the person should be released before 72 hours have elapsed, and the psychiatrist directly responsible for the person’s treatment objects, the matter must be referred to the medical director of the facility for the final decision. However, if the medical director is not a psychiatrist, he or she must appoint a designee who is a psychiatrist to make these decisions. If the matter is referred, the person must be released before 72 hours have elapsed only if the psychiatrist who makes the final decision believes, as a result of his or her personal observations, that the person no longer requires evaluation or treatment. [Welfare and Institutions Code Section 5152] A psychologist may not order an early release without potential liability [Ford v. Norton, 89 Cal. App. 4th 974 (2001)], except in the narrow instance outlined in the previous paragraph.

A patient who has been detained for evaluation and treatment must be released at the end of the 72 hour period unless any of the following applies:

- The patient is referred for further care and treatment on a voluntary basis;
- The patient has been certified for intensive treatment; or
- A conservator or temporary conservator has been appointed for the patient pursuant to Welfare and Institutions Code Section 5350 et seq.
Patient Impaired by Inebriation

Conditions for Detention

When a person is a danger to self or others, or is gravely disabled as a result of inebriation, a peace officer, member of the attending staff, as defined by regulations, of an evaluation facility designated by the county, or a person designated by the county may, upon reasonable cause, take the person into civil protective custody, or cause the person to be taken into such custody, and place the person in a facility designated by the county and approved by the California Department of Alcohol and Drug Programs as a facility for 72-hour treatment and evaluation of inebriates [Welfare and Institutions Code Section 5170].

Detention of Patient Awaiting Transfer

Health and Safety Code Section 1799.111 provides that a licensed general acute care hospital (that is not a county-designated facility pursuant to Welfare and Institutions Code Section 5150), licensed acute psychiatric hospital (that is not a county-designated facility pursuant to Welfare and Institutions Code Section 5150), licensed professional staff of these hospitals, or any physician and surgeon, providing emergency medical services in any department of these hospitals to a patient at the hospital, shall not be civilly or criminally liable for detaining the patient, if all of the following conditions exist during the detention:

- The patient is subject to detention pursuant to Welfare and Institutions Code Section 5150; that is, an adult who cannot be safely released from the hospital because, in the opinion of the treating physician and surgeon (or a clinical psychologist with the medical staff privileges, clinical privileges, or professional responsibilities provided in Health and Safety Code Section 1316.5, described below), the patient, as a result of a mental disorder, presents a danger to himself or herself, or others, or is gravely disabled. “Gravely disabled” is defined, for the purpose of this law, as the inability to provide for basic personal needs for food, clothing, or shelter.

Note: Health and Safety Code Section 1316.5 states that state owned and operated health facilities that offer services within the scope of practice of a psychologist must establish rules and procedures for consideration of an application for medical staff membership and clinical privileges submitted by a clinical psychologist. Private health facilities may enable the appointment of clinical psychologists on such terms and conditions as the facility may establish. If a particular service is offered by a health facility that permits clinical psychologists on its medical staff which both physicians and clinical psychologists are authorized by law to perform, such service may be performed by either, without discrimination.

- The hospital staff, treating physician and surgeon, or appropriate licensed mental health professional has made, and documented, repeated unsuccessful efforts to find appropriate mental health treatment for the patient.
- The patient is not detained beyond 24 hours.
- There is probable cause for the detention.
If the patient is detained beyond eight hours, but less than 24 hours, the following additional conditions must be met:

- Transfer for appropriate mental health treatment has been delayed because of the need for continuous and ongoing care, observation, or treatment that the hospital is providing.
- In the opinion of the treating physician, or a clinical psychologist with the medical staff privileges or professional responsibilities provided for in Section 1316.5, the patient, as a result of a mental disorder, is still a danger to himself or herself or others, or is gravely disabled (as defined above).

In addition, the facilities and professionals listed above are not civilly or criminally liable for the actions of the patient after release if the following conditions exist during the detention:

- The patient has not been admitted to a hospital for evaluation and treatment pursuant to Welfare and Institutions Code Section 5150.
- The release from the hospital is authorized by a physician or a clinical psychologist with the medical staff privileges or professional responsibilities provided for in Health and Safety Code Section 1316.5, who determines – based on a face-to-face examination of the patient – that the patient does not present a danger to self or others and is not gravely disabled. The clinical psychologist may authorize the release only after consulting with the physician. If there is a disagreement, the patient must be detained unless the hospital’s medical director overrules the decision of the physician opposing the release. The physician and psychologist must both enter their findings, concerns or objections in the patient’s medical record.

The hospital does not need to be designated by the county to hold patients pursuant to this law. In fact, hospitals that are designated by the county pursuant to Welfare and Institutions Code Section 5150 do not enjoy these immunities.

This law does not affect the responsibility of a hospital to comply with all state laws and regulations pertaining to the use of seclusion and restraint and psychiatric medications for psychiatric patients. In addition, patients detained under this law retain their legal rights regarding consent for medical treatment (i.e., the hospital cannot treat the patient without his or her consent, or the consent of the legal representative if the patient has been determined by a physician to lack capacity to consent to treatment).

A patient detained pursuant to Health and Safety Code Section 1799.111 must be credited for the time detained if he or she subsequently is placed on a 72-hour hold pursuant to Welfare and Institutions Code Section 5150. A transferring hospital should provide to the receiving hospital documentation regarding the length of time the person was detained, so that the receiving hospital can comply with this requirement. SB 743 expands the circumstances under which a hospital would be legally immune from liability, effective Jan. 1, 2010.
LEGISLATION

In response to member concerns regarding the lack of psychiatric evaluation teams and the length of time it takes for EDs to obtain psychiatric evaluations, CHA sponsored SB 916 to extend the amount of time an individual with behavioral health issues could be detained in a non-designated (non-LPS) hospital from 8 hours up to 24. SB 916 became effective in 2007. SB 743, effective in 2010, provides technical clarification to the current law allowing non-designated 5150 hospitals to detain, for up to 24 hours, individuals who present themselves at hospitals and are a danger to themselves or others or gravely disabled are immune from civil or criminal liability for the actions of these individuals after their release from the hospital.

DATA – CLOSURES AND DOWNSIZING

In California, the disjointed policies and reforms of the past have converged to create a severe under-funding of the State’s public mental health system and have caused, in part, a significant reduction in the number of hospitals providing behavioral health services. See Attachment D. California has suffered a loss of more than 30 percent of acute psychiatric inpatient hospital beds during the last decade. Currently, 49 of 58 counties have no acute psychiatric hospital beds to meet the unique needs of our growing geriatric population, 46 counties have no acute inpatient psychiatric hospital beds for children, 48 counties lack chemical /substance use disorder beds and 30 of 58 counties do not have any adult acute inpatient psychiatric hospital beds at all. Statewide, there are approximately 6,500 inpatient psychiatric beds supporting a population in excess of 37 million people.

Hospitals and their emergency departments are increasingly being forced to function as the only providers of mental health services in their local communities on a 24-hour, 7-day a week basis. This translates into consumers inappropriately accessing the most expensive level of care with non-emergent needs, frequently resulting in ED crowding and an increase in ED diversions. An increasing reliance on emergency care as the only treatment option left for patients with unmet mental health needs has important policy implications for the entire health system. As costs of hospital services and administrative and regulatory demands steadily rise, and revenues do not keep up with the costs of providing services, fewer hospitals are willing to continue providing mental health inpatient care.

Compounding the problem are the following:

- a dearth of mental health crisis stabilization services
- significant unavailability of step-down community-based mental health treatment options for patients ready for discharge
- fragmented interface with other components of healthcare including primary care, law enforcement and social services systems
- limited access to maintenance programs designed to prevent relapse and provide rehabilitation support
The financial pressures being experienced by hospitals come in many forms: reduced reimbursement from public, private and managed care payers; increased numbers of individuals who are uninsured or underinsured; workforce shortages; unrealistic mandated nurse-staffing ratios; costly seismic retrofitting requirements; increased state and federal regulatory pressures; federal EMTALA and IMD exclusion standards; county contracting mandates; administrative complexities and patient backlogs. These factors individually and collectively are influencing the viability of continued availability of existing psychiatric inpatient beds.