



# California Hospital Association

## Center for Behavioral Health

Lanterman-Petris-Short Act  
Involuntary Commitment Laws  
LPS Modernization

Welfare & Institutions Code  
Section 5150 et al.

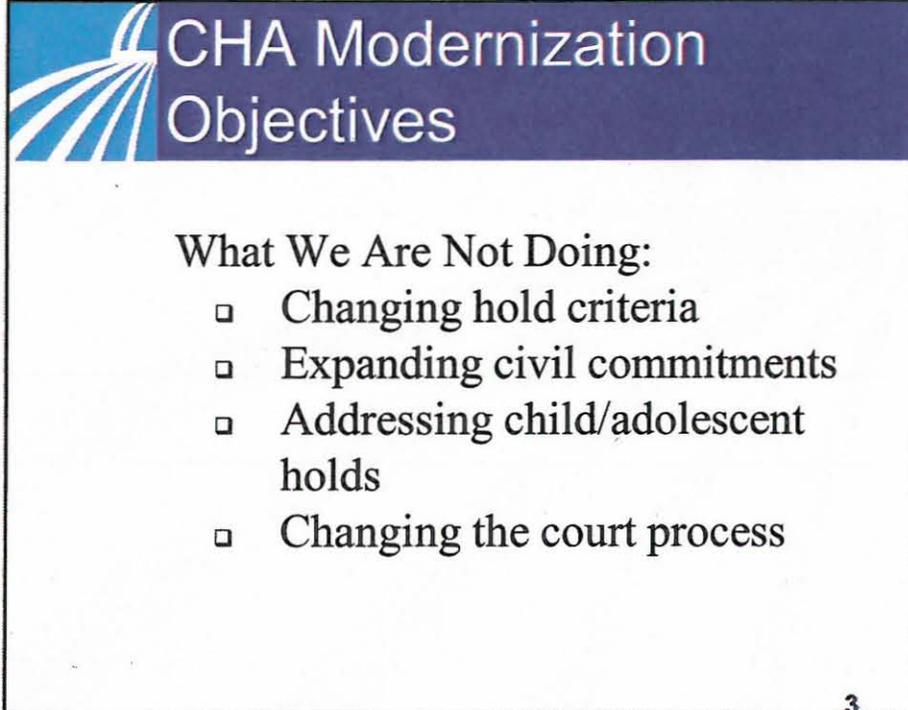


## CHA Modernization Objectives

What We Want To Do:

- Improve timely mental health assessment and treatment for involuntary patients
- Improve access to the least restrictive level of care
- Reduce wait times in Emergency Departments (EDs)
- Reduce non-emergent mental health care visits to EDs
- Improve the safety level in EDs for all patients and staff
- Improve the coordination of services between counties, mental health plans, law enforcement, transportation providers, and providers of mental health treatment
- Standardize who can generate, release, or continue holds
- Improve uniformity in the law's application across county lines

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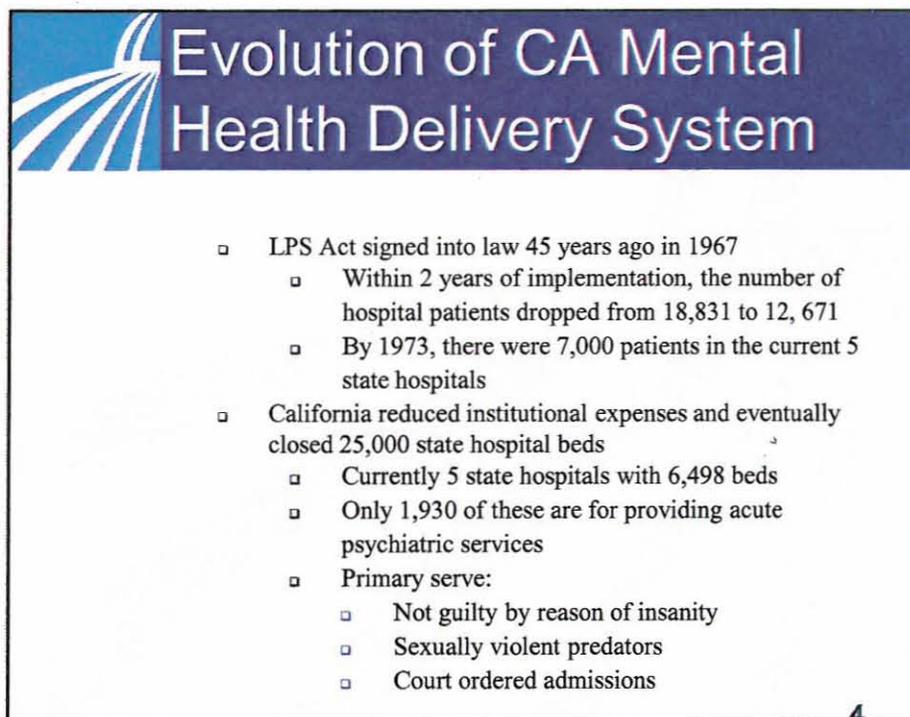


## CHA Modernization Objectives

What We Are Not Doing:

- Changing hold criteria
- Expanding civil commitments
- Addressing child/adolescent holds
- Changing the court process

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## Evolution of CA Mental Health Delivery System

- LPS Act signed into law 45 years ago in 1967
  - Within 2 years of implementation, the number of hospital patients dropped from 18,831 to 12,671
  - By 1973, there were 7,000 patients in the current 5 state hospitals
- California reduced institutional expenses and eventually closed 25,000 state hospital beds
  - Currently 5 state hospitals with 6,498 beds
  - Only 1,930 of these are for providing acute psychiatric services
  - Primary serve:
    - Not guilty by reason of insanity
    - Sexually violent predators
    - Court ordered admissions

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## Evolution of CA Mental Health Delivery System

- Federal government promised 1000 community clinics, known as State Clinics
- Federal government provided funding for 400 clinics
- Funding for clinics withdrawn; clinics close
- Feds no longer paid for adult (21-64) IMD
- Exclusion inpatient psychiatric care in dedicated psychiatric settings with more than 16 beds
- Radical shift in the delivery system and funding

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## Unanticipated Consequences

By 1972:

- Individuals with a mental illness started showing up in jails and prisons in increasing numbers
- The number of persons with serious mental illness who are homeless and living on the streets increased dramatically
- Others remain untreated or inadequately treated, often living with their families

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## Unanticipated Consequences

- In 1991, the State realigned mental health treatment from the state to the counties' specialty Medi-Cal Mental Health Plan (MHP)
- Between 1995 and 2010, California has lost 40 (22%) of its inpatient psychiatric facilities and more than 2700 (almost 30%) of its inpatient beds
- State funding has not kept pace with mental health needs
- If you've seen one county delivery system, you've seen one county delivery system

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## Just the Facts

- People with SMI die 25 years younger than the general population
- Victimization: People with SMI are 3 times more likely to be assaulted or raped
- Approximately 33% of the homeless are people with SMI
- At least 16% of the prison population have SMI (more than double the percentage of 30 years ago)
- Suicide is a consequence for 15% of people with SMI
- 25 attempts for every death by suicide
- 10% of homicides are committed by someone with SMI

Source: *Separate and Not Equal: The Case for Updating California's Mental Health Treatment Law*, LPS Task Force II, 2012

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## Hospital Facts

- 400+ hospitals in California, not including state hospitals and developmental centers
- 339 Emergency Departments (hospitals are *not* required to have an ED) with almost 14 million visits per year
- 70 EDs have closed from 2000 to 2010
- About 130 hospitals provide inpatient psychiatric care
- About 6500 inpatient psychiatric beds to serve nearly 38 million people
- 25 of California's 58 counties have no inpatient psychiatric services

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## Hospital Concerns

- Significant increase in EDs becoming the only treatment provider available 24/7
- EDs do not always have the capacity or capability to serve individuals with SMI
- Federal EMTALA law requires a medical screening for all who present at a hospital. EMTALA has been the law for 25 years and trumps part of the LPS Act.
- Increasing numbers of individuals are taken to EDs who do not have an emergency physical or psychiatric condition
- Increasingly, EDs are unable to locate appropriate resources to assist those with mental illness and substance use disorder

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## Original Intent of LPS Act

Must be preserved:

1. End inappropriate, indefinite, involuntary commitments
2. Provide prompt evaluation and treatment
3. Guarantee and protect public safety
4. Safeguard individual rights through judicial review

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## Original Intent of LPS Act

5. Protect persons with a mental illness from criminal acts
6. Provide individualized treatment, supervision, and placement for gravely disabled persons
7. Encourage the full use of existing agencies, professional personnel, and public funds
8. Prevent duplication of services and unnecessary expenditures

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## Civil Commitment - Involuntary

- Who qualifies?
  - Danger to self – suicidal
  - Danger to others – homicidal
  - Gravely disabled due to mental illness – unable to provide for food, clothing, shelter
- How do patients get to an ED?
  - One-third by law enforcement (squad car)
  - One-third by EMS/transport (ambulance)
  - One-third by family/friend/self

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## CHA Historical Evolution

- 2006-2009 – increasing number of concerns expressed by non-LPS designated hospital EDs of patients on 5150 detainments being dropped off
- 2006 – CHA publishes data on available psychiatric inpatient beds by county – 25 counties have none
- 2009 – CHA sponsors SB 743 to amend H&S 1799.111, relating to mental health, extends ability for non-designated EDs to hold patients from 8 hours to 23 hours

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## CHA Historical Evolution

- 2010 – CHA conducts ED survey
  - Appropriate use of EDs: on average 42% of patients with mental health needs could have been cared for at a non-emergent level of care
  - Average wait time for admission :
    - From ED to psych bed – 16 hours
    - From an ED to a med/surg bed – 7 hours
- 2012 – Evaluation of ED utilization by individuals with a psychiatric diagnosis shows a 76% increase between 2006 and 2011.

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## Historical Evolution

- 2007-Present – downturn in economy
- Reduction in County resources
  - Law enforcement
  - County Mental Health
  - County Physical Health
- 2011 – County realignment expanded
- 2012 – DMH dissolved, duties absorbed by other government entities

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## Historical Evolution

- 2012 – CHA allocates resources for:
  - Legal review of entire law
  - Data analytics of ED utilization
  - County-by-county analysis of the current application of the law

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## CHA's Modernization Focus

Pre-Admission

- Focus on adult population only
- W&I 5150 – detain and transport
- W&I 5151 – assessment
- W&I 5152 – treatment
- Revise statutorily mandated 5150 form
- State oversight – move from DSS to DHCS in Governor's budget
- Clarification – new and existing LPS Act definitions
- Encourage development of community-based crisis services
- Clarify “LPS Designation” status – move to deemed status for hospitals

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## CHA's Modernization Focus

- Establish uniform statewide standards for who can detain and transport an individual for an assessment under a 5150 hold.
- Clarify who can conduct a 5151 assessment to validate the 5150 detainment.
- Clarify who can release an individual from a 5150 detainment.
- Establish a uniform statewide standard on when the 5152 72-hour involuntary treatment clock starts and stops.
- Ensure statewide consistent application of the Act to achieve equity and equal protection for all citizens in California.

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## Where to get more information

- [www.calhospital.org](http://www.calhospital.org) includes:
  - Psychiatric bed data
  - LPS Act problem summary
  - Detainment criteria
  - LPS Designations by county

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