

Underfunding of Psychiatric Services for the Civilly and Criminally Committed

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As illustrated by the State of Oregon, a lack of inpatient psychiatric resources for civil commitment and restoration of competency to stand trial has become an increasing problem. In California, the government of Los Angeles County has studied this problem and identified potential solutions. The proposed solutions not surprisingly involve increased resources, including additional inpatient psychiatric beds. Despite recognition of a potential solution, however, sufficient resources have not yet appeared in Los Angeles County. The study of the civil and criminal commitment systems for individuals with mental illness in Oregon and Los Angeles County reveals considerable overlap between these systems and suggests that the two systems be considered as a part of a single mental health system adversely affected by a variety of factors such as homelessness, substance use, and the COVID-19 pandemic.

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Even before reading the article by Hansen and colleagues, “The Dramatic Decline of Civil Commitment in Oregon, 1972 to 2020,”¹ its title immediately conjures up the various legal and social forces that account for this decline, such as: court decisions and statutory revisions that restrict the use of or reduce the effectiveness of civil commitment in favor of the patient’s release (or facilitate treatment refusal if not released); adoption of the use of ever stricter standards for inpatient psychiatric admission (known as Utilization Review or similar names) and for continued inpatient stay (whether by governmental insurers such as Medicare or Medicaid, or private health insurance), and the role of politicians seeking to impose budgetary limitations on spending mental health dollars. Practicing psychiatrists and forensic psychiatrists outside of Oregon have undoubtedly witnessed the decline of available psychiatric inpatient capacity for the civilly committed for the past half century. For this commentary, I have conflated civil commitment with inpatient psychiatric treatment, which would be consistent with the authors’ use of Oregon State Hospital as a marker for civil commitment.

Hansen and colleagues have indeed identified the various legal and social forces that have contributed to this decline, though there has been variation in which forces have come to the forefront over the past half century.¹ Of particular relevance in recent years, Hansen and associates briefly mention the rise in admissions to Oregon State Hospital related to commitments for restoration of competence to stand trial, which supplant the available beds for civil patients.¹ This same author group has already published an exploration into this phenomenon in Oregon covering the two most recent decades (2000 to 2020).² These two articles resonate with my practice in the past several years working simultaneously in a Los Angeles county-run psychiatric emergency department, Los Angeles County Mental Health Court, and the forensic service of a state hospital in adjacent San Bernardino County. Because of my multiple vantage points in the mental health system, I have not infrequently encountered the exact same patient or defendant across these three settings, which made the Oregon articles personally relevant, though most of my direct clinical frustration has involved the civil commitment system in which there is a persistent and ever worsening lack of inpatient psychiatric resources and its associated adverse consequences.

Although a vast literature exists about civil and criminal mental health systems, this commentary utilizes

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recent information about Los Angeles County. The population of Los Angeles County, California hovers around 10 million. Only nine states have a population of more than 10 million. Oregon has a current population of a bit over 4 million. Consequently, using Los Angeles County for illustrative purposes can be comparable with using a state.

On March 8, 2016, the Los Angeles County Board of Supervisors (the five elected persons who govern the County) requested a root cause analysis following a steady increase in incompetent to stand trial (IST) cases from 2010 to 2015 resulting in a 350 percent increase in these referrals to Los Angeles County Mental Health Court. Much of the 2010 to 2015 increase was from misdemeanor cases. The Los Angeles County Health Agency (the umbrella entity created in the recent 2015 administrative reorganization to encompass the Los Angeles County Department of Mental Health, Los Angeles County Department of Health Services, and the Los Angeles County Department of Public Health) responded with a report on September 19, 2016.³ The data suggested the following potential causes for the increased IST cases: lack of acute care and subacute care psychiatric beds; increase in homelessness (up 51% between 2011 and 2015 in the County, from 20,517 to 31,018 persons); change in the defense bar perspective to initiate requests for competence to stand trial instead of attempting to obtain a disposition with expeditious release into the community as defendants frequently returned to their caseload upon re-arrest; increased methamphetamine use by individuals with serious mental illness; and legal changes related to California Assembly Bill 109 (also known as the Public Safety Realignment Act of 2011)⁴ and Proposition 47 passed by referendum on November 4, 2014 (also known as The Safe Neighborhood and Schools Act).⁵ One effect of these two laws was to release more offenders, including those with serious mental illness, into the community, thereby increasing the numbers of those re-arrested and subsequently found IST. The primary recommendations from the report included the need for additional psychiatric beds, structured housing for people with serious mental illness, and increased use of existing mental health interventions such as Assisted Outpatient Treatment⁶ and Lanterman-Petris-Short (LPS) Conservatorships.⁷ In other words, the recommendations for more acute and sub-acute mental health services and a viable solution for homelessness are

what would have been predicted by most as solutions to the increasing IST problem that had become an increasing burden beginning in 2010 and had been highly visible to the general public by way of media attention to this problem.⁸

Less than three years later, on January 22, 2019 the Board of Supervisors requested that the Department of Mental Health (DMH) prepare a report to address the shortage of inpatient psychiatric beds in Los Angeles County, including among other items, a plan to create inpatient psychiatric beds. The DMH filed a 34-page report with the Board of Supervisors on October 29, 2019 entitled Addressing the Shortage of Mental Health Hospital Beds: Board of Supervisors Motion Response.⁹ This DMH report relied in part on the findings of a 142-page report, Countywide Mental Health and Substance Use Disorders Needs Assessment, prepared under the auspices of the Los Angeles County Health Agency, dated August 15, 2019, which was included with the aforementioned 34-page report presented to the Board of Supervisors.⁹ A private contractor, Mercer Health & Benefits LLC completed this needs assessment.⁹ In this needs assessment report, all levels of care ranging from outpatient to inpatient and from child to adult were reviewed, including the interface with state hospital and jail services. Not surprisingly, the need to expand all services was found. This DMH report concluded that additional mental health beds were needed along with the usual plan to identify every efficiency among the various levels of mental health services. Although the DMH report cited the need for 500 additional mental health beds, it was unclear as to how that could be realistically achieved.

From my vantage point in the psychiatric emergency department, a constant dearth of acute psychiatric inpatient beds has remained unchanged since this report. In fact, there would appear to be a planned reduction in adult psychiatric inpatient beds. For example, since the 1994 Northridge, California earthquake, the Department of Psychiatry at the Los Angeles County+University of Southern California (LAC+USC) Medical Center has not had any inpatient psychiatric beds on the campus after the Psychiatric Hospital became one of the earthquake's many casualties. Instead of re-opening inpatient psychiatric beds on campus, other temporary locations have been used to provide inpatient psychiatric services and residency education. Before the 1994 earthquake, the on-campus psychiatric hospital contained

144 adult inpatient psychiatric beds. As I write this commentary, the Department of Psychiatry has 60 adult inpatient psychiatric beds. To bring back the inpatient psychiatric beds and rotating psychiatry residents to the LAC+USC Medical Center campus, the current plan involves renovating unused space on the campus. But the currently proposed number of inpatient adult psychiatric beds for LAC+USC Medical Center falls further to 28.

The 2016 and 2019 reports ordered by the Board of Supervisors about the accelerating IST problem and insufficient inpatient mental health services mirror the exploration of these same subjects and in the same order by Hansen and colleagues¹ and Bloom and associates² though antedating these authors by several years. In other words, the Los Angeles County government has been aware of these problems long before the published Oregon analyses. The County of Los Angeles has not followed the recommendations of their own 2016 and 2019 reports. Even prior to these reports, Los Angeles County had created the Office of Diversion and Reentry (ODR) in November 2015 to divert persons with mental illness or substance use disorders away from the criminal justice system.¹⁰ The ODR has greatly expanded its scope since inception and has had some success with their target population, but the IST problem and lack of inpatient psychiatric beds have persisted. This would not be an unexpected finding since the same amount of funding and resources are available for the care of mental illness in a zero sum game with no significant increase in financial support.

Even though we can exhaustively explore and study the limited use of civil commitment and the related limited inpatient psychiatric resources, as did the DMH and Hansen and associates,¹ and even propose specific solutions as in the Los Angeles County 2016 and 2019 reports, each proposed solution has encountered varying degrees of opposition, inertia, and other systemic problems. A recent presentation (summarized in the next paragraph) highlights this struggle to address some of the gaps in the civil commitment system in California.

At the 2022 Annual Meeting of the American Academy of Forensic Sciences (AAFS), Cheng¹¹ presented on the limited experience from a very recently enacted California statute¹² that established a six-month housing conservatorship aimed at individuals with serious mental disorders and substance use disorders who have at least eight involuntary psychiatric

detentions¹³ in a 12-month period. Under the civil commitment laws in effect since 1969 with the LPS Act,¹³ a conservatorship would be difficult to obtain because once involuntarily committed persons improve with treatment, they would no longer meet the criteria for grave disability¹⁴ required for an LPS conservatorship. Individuals must also not be eligible to participate in an Assisted Outpatient Treatment program and have declined to voluntarily participate in treatment for mental or substance use disorders. The housing conservatorship statute would allow the conservator to make both treatment and housing decisions. In the pilot implementation of this law, of the three major counties involved (Los Angeles, San Diego, and San Francisco), only San Francisco County participated and only two individuals had been conserved under this new statute. As of the time of the AAFS presentation, neither of these two conservatees had successfully completed the substance use disorders treatment program. Part of the rationale for this housing conservatorship statute was based on the 2019 figure that of the 151,000 homeless Californians, 23 percent were known to have severe mental illness and 17 percent to have a substance use disorder.¹⁵ Despite the usual opposition to this statute from those voicing civil liberty concerns, the reality is that this program has been unfunded and both local governments and mental health departments appear to lack interest in using this mechanism to increase the likelihood of psychiatric stabilization, treatment compliance, and reduction of substance use by taking the homelessness factor out of the equation.¹¹

A half century ago, at the 1972 starting point for Hansen and associates' study period, Abramson¹⁶ published an article in *Hospital and Community Psychiatry* that posited a relationship between changes in the then new civil commitment statute (LPS Act, effective July 1, 1969, also known by some as the "Magna Carta" for individuals with mental illness) and an increase of arrest and incompetent to stand trial commitments in a California county in the year following implementation of the statute. Abramson wrote, "From my vantage point as a psychiatric consultant to a county jail system, county courts, and the adult division of a county probation department, I believe that as a result of LPS, mentally disordered persons are being increasingly subjected to arrest and criminal prosecution" (Ref. 16, p 103). A half century later, I have Abramson's multisite perspective along with the data and observations from the State of Oregon^{1,2} and

information locally from Los Angeles County, and can conclude there is indeed a relationship between what has traditionally been considered the civil and the criminal mental health systems. Long gone is the simple model in which patients recirculate in and out of the psychiatric hospital, or even Abramson's 1972 observation that restriction in civil commitments lead to increased utilization of the criminal justice system by those living with mental illness.¹⁶ Instead, the more appropriate model would be that there are no distinct civil and criminal mental health systems but rather one single mental health system that is adversely affected by clinical factors (e.g., substance use), social factors (e.g., homelessness), legal factors imposed by statutes and then modified by case law, and political and economic forces.

Borrowing from physics, the second law of thermodynamics would appear to apply to a singular mental health system, in which the entropy of the system is ever increasing. Hansen and colleagues' study¹ ends in 2020 at the start of the current COVID-19 pandemic. The chaotic influence of the pandemic on the mental health system can be readily demonstrated by the growing IST problem^{17,18} resulting from the California state hospitals' limiting admissions. What had been a prepandemic admission waiting list of about 750 pretrial defendants with a mean time on the list of 86 days in 2017 (for the four state hospitals that admit patients for competency restoration) (Ref. 19, p 700) has at the time of writing this commentary more than doubled.²⁰ Reducing the entropy in the mental health system will require considerable energy, or in the nonphysics terminology, many more mental health resources (funding) beyond what had ever been previously envisioned.

I close this commentary with an example from real life beyond the array of numbers in Oregon and Los Angeles County.^{1-3,9} A front page feature article in the Sunday edition of the Los Angeles Times on November 28, 2021²¹ chronicled the life of a 45-year-old man living with schizophrenia who has encountered all the major elements described in the Hansen *et al.*¹ and Bloom *et al.*² articles and the two aforementioned Board of Supervisors ordered reports.^{3,9} These include the civil commitment system (with conservatorship), substance use, homelessness, criminal arrest, diversion, and commitment to the state hospital as IST, as well as his siblings' continuing struggle to assist him.²¹ While this man's story exemplifies the very findings of the articles and Los Angeles County studies, it also describes the far-reaching and challenging nature of these problems, as one of this man's siblings is my psychiatrist colleague at the state hospital.²¹

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