Revised 10/26/17

Title 9 County Patients' Rights Advocates

Highlighting resource, training, and retaliation issues in county patients' rights programs in California.

The California Mental Health Planning Council (CMHPC) is under a federal and state mandate to advocate on behalf of adults with severe mental illness and children with severe emotional disturbance and their families. Our majority consumer and family member council also is statutorily required to advise the Legislature on mental health issues, policies and priorities in California. The CMHPC has long recognized disparities in mental health access, culturally relevant treatment and the need to include physical health. The CMHPC advocates for mental health services that address the issues of access and effective treatment with the attention and intensity they deserve if recovery and overall wellness are to be attained and retained.

Welfare and Institutions Code § 5772

The California Mental Health Planning Council shall have the powers and authority necessary to carry out the duties imposed upon it by this chapter, including, but not limited to, the following:

a) To advocate for effective, quality mental health programs;
b) To review, assess, and make recommendations regarding all components of California's mental health system, and to report as necessary to the Legislature, the State Department of health Care Services, local boards, and local programs.
c) To advise the Legislature, the State Department of Health Care Services, and county boards on mental health issues and the policies and priorities that this state should be pursuing in developing its mental health system.
d) To assess periodically the effect of realignment of mental health services and any other important changes in the state's mental health system, and to report its findings to the Legislature, the State Department of Health Care Services, local programs, and local boards, as appropriate.

Welfare and Institutions Code § 5514

There shall be a five-person Patients' Rights Committee formed through the California Mental Health Planning Council. This committee, supplemented by two ad hoc members appointed by the chairperson of the committee, shall advise the Director of Health Care Services and the Director of State Hospitals regarding department policies and practices that affect patients' rights. The committee shall also review the advocacy and patients' rights components of each county mental health plan or performance contract and advise the Director of Health Care Services and the Director of State Hospitals concerning the adequacy of each plan or performance contract in protecting patients' rights. The ad hoc members of the committee shall be persons with substantial experience in establishing and providing independent advocacy services to recipients of mental health services.

Acknowledgements

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BACKGROUND

History

California was one of the first states to recognize the need to formally protect patients' rights in the mental health treatment process. The establishment of the Lanterman-Petris-Short (LPS) Act in 1969 was the first of the Legislature's attempts to improve the quality of care in psychiatric facilities in the state. The Act required judicial review of mental health commitments and provided for representation of patients in legal proceedings. The legislative intent of the LPS Act was to replace the "warehousing" of individuals with mental health disabilities by ending inappropriate and indefinite mental health commitments and providing community based treatment services in the least restrictive manner.[1]

The existence of laws does not ensure their enforcement. It was soon evident that compliance with patients' rights laws was inconsistent in institutional settings. As a result, the California Legislature established a mechanism for monitoring the treatment of patients and ensuring that their rights were protected. In 1974, the Legislature mandated the establishment of the State Patients' Rights Office.[2]

Still, this resource lacked the capacity to respond to complaints of individual patients in local facilities and state hospitals. In 1976, regulations required county mental health departments and state hospitals to provide advocacy services, although no funds were allocated for this purpose. The regulations also specified responsibilities for the newly created Title 9 county patients' rights advocates (PRAs), including: ensure that patients are notified of statutory rights; receive and investigate patient complaints; advocate on behalf of patients whose rights had been violated; monitor facilities for compliance with patients' rights laws; and provide training and education to mental health providers.[3]

Increasing Advocate Responsibilities

A number of additional responsibilities for county advocates have been added by judicial decisions and legislative mandate throughout the years. In 1979, the Ninth Circuit Court of Appeals confirmed *Doe v. Gallinot*, which found that confinement to a mental institution carries a substantial risk of error and that due process requires review of a person's involuntary commitment to determine whether the facility has sufficient cause to detain beyond 72-hours.[4] In response, California passed Assembly Bill 3454 in 1982, which provided for notice of the certification to the patient; advice and representation by a qualified Patient Advocate or attorney;

[1] California Welfare & Institutions Code § 5001(a); California Welfare & Institutions Code § 5325.1(a)
[2] California Welfare & Institutions Code § 5370.2
[3] California Welfare & Institutions Code § 5520
[4] *Doe v. Gallinot*, 486 F. Supp. 983, 993 (C.D. Cal. 1979)

a probable-cause hearing before a court-appointed, independent Hearing Officer within seven days of the initial detention; and an immediate finding by the decision-maker as to whether or not probable cause for detention exists.[5]

In 1989, the California Supreme Court confirmed *Riese v. Saint Mary's Hospital*, which held that involuntarily committed individuals retain the right to refuse treatment with antipsychotic drugs, absent a judicial finding of incapacity.[6] In 1991, California enacted Senate Bill 665, mandating procedures for informed consent, emergency medication, and capacity hearings to implement *Riese*.[7] In many counties, PRAs are the patient representative in certification review hearings as required under *Gallinot*, and in capacity hearings as required under *Riese*. Additionally, advocates participate in "independent clinical reviews" representing minors admitted into private mental health facilities by their parents, but object to their hospitalization. The law states that the patients' rights advocate's role in this process is to provide information and assistance to the minor concerning the right to obtain a clinical review, and to assist the minor at the review.[8]

"Realignment," and the number of community based treatment options, have increased in the past 40 years, with a corresponding increase in the volume and type of facilities and programs PRAs are responsible for overseeing. Realignment was enacted in 1991 and led counties to reduce high-cost, restrictive placements by removing civilly committed individuals with intensive needs from state hospitals and returning them to their home counties. Individuals with more intensive needs, formerly served in the state hospital by state hospital patients' rights advocates, are now served in the community and in local facilities by county patients' rights advocates.

Another key component of PRA responsibility is to provide advocacy and representation "to secure or upgrade treatment of other services" to which their clients are entitled.[9] Advocacy around access to services became increasingly important since the implementation of county Medi-Cal Mental Health Managed Care Plans in 1995. Many advocates assume the important task to assist and represent clients through all phases of the county Mental Health Plans' grievance and appeals procedure and the state fair hearing process.

PRA Ratio/Resource Issues

In 1979, the California Assembly Subcommittee on Mental Health and Developmental Disabilities held a hearing on "what mental health in California would look like in five years." The Subcommittee determined it could not anticipate the future state of mental health because a

[5] California Welfare & Institutions Code § 5250
[6] *Riese v. St. Mary's Hospital and Medical Center*, 209 Cal.App.3d 1303 (1987)
[7] California Welfare & Institutions Code § 5332
[8] California Welfare & Institutions Code §§ 6002.2 and 6002.30(e)
[9] California Welfare & Institutions Code § 5500(a)

comprehensive, systematic mental health program was not yet in place for California citizens. Subcommittee members unanimously voted to ask a "coalition of mental health providers and consumers," led by the Mental Health Association in California, to develop a proposal for such a system. The result was "A Model for California Community Mental Health Programs," a comprehensive model including standards for mental health advocacy, which is described as having "high priority as a cost effective tool to further the overall goals of preventing chronicity and placing mentally disordered persons in the least restrictive settings." Their proposed standard was: "not less than 1.0 FTE (full time equivalent) per county with a standard of .5/100,000."

Despite the establishment of Title 9 patients' rights advocates, regulations never set forth any staffing ratios to assure that patients' rights advocacy services in the counties were adequate to fulfill the regulatory responsibilities of PRAs. Local site reviews, conducted when the regulations were created, discovered a direct relationship between compliance with patients' rights laws and the staffing level of county patients' rights advocates.[10] To address this problem, a staffing ratio of one advocate per 500,000 county residents was set by the State Director of Mental Health in 1980. This ratio was recommended by the Chief of the State Patients' Rights Office as a minimum standard for adequate staffing of county advocacy programs. This 1:500,000 ratio was established before many additional duties were assigned to PRAs, in particular, representation in certification review and capacity hearings.

There have been multiple efforts to address PRA resource issues in the past 30 years. The *Report of the Task Force on County Patients' Rights Advocate Staffing Ratio* in 1987 conducted a thorough survey and analysis, and made recommendations concerning PRA capacity issues at the time. The Report found: most patients' rights advocacy programs did not have adequate staff time to provide regular advocacy services in mental health facilities other than acute facilities; programs were unable to conduct monitoring reviews of community care facilities; programs were not able to provide adequate patients' rights services to special client populations (ethnic/cultural minorities, geriatrics, minors, homeless mentally ill, and those judicially committed); few programs had adequate time to provide trainings for providers and clients; the duties of PRAs and the number of complaints received had significantly increased in recent years; the complexity of mental health laws had increased; and the resources for training and support of advocates at the state level had reduced significantly since 1981.

The report concluded that the geographic and demographic characteristics of a specific county, including the size, location, nature and number of facilities within the county; the number and acuity and ethnic/cultural affiliations of patients within the county; and the rate of involuntary detentions, certifications and certification review hearings initiated in the county, all affect the

[10] Report of the Task Force on County Patients' Rights Advocate Staffing Ratio (June 1987)

demand for patients' rights advocacy services and should be considered in determining patients' rights advocates staffing.[11]

The report recommended a minimum ratio of 1.0 PRA FTE per 300,000 county residents to conduct basic statutory duties, including limited information and referral services, preparation for and representation at Certification Review Hearings, minimum investigation, and resolution services provided in response to patient complaints as well as limited reporting to the local director of mental health and State Patients' Rights Office. The report acknowledged that this recommended minimum staffing ratio was not adequate to provide advocacy services for specialized client populations or regular monitoring of psychiatric facilities for compliance with patients' rights laws, and allowed for little or no continued training of advocates, including participation in advocacy coalitions and system-reform efforts.[12]

In 1992, the Director of the California Department of Mental Health (DMH) recommended counties reevaluate whether their patients' rights advocacy programs were adequately staffed. He noted the significant increase in advocacy duties and responsibilities since the Department recommended 1.0 PRA FTE advocate position for every 500,000 county residents in 1980. In 2000, the California Association of Mental Health Patients' Rights Advocates (CAMHPRA) sponsored SB 1534 (Perata), which sought to clarify duties and statutory authority of PRAs. Staffing levels, PRA qualifications and oversight also were addressed during SB 1534 discussions, along with recommendations to address PRA resource issues. SB 1534 did not pass. In 2007, Ann Coller, patients' rights specialist at the California Office of Patients' Rights (COPR), wrote a memorandum analyzing PRA resource issues and recommending the PRA to population ratio be revised, noting the significant increase in PRA duties. In 2011, Michele Mudgett, director of COPR, wrote a memorandum to DMH requesting the agency revise the ratio. Ms. Mudgett also noted that the responsibilities of county patients' rights advocates have expanded significantly since 1980.

Many of the efforts to address PRA resource issues have addressed the challenge of recommendations for minimum population-to-PRA ratios in small counties. Mudgett noted in her memorandum to DMH that small counties may require additional staffing beyond the minimum ratio to cover "overhead" and to respond to patients' rights complaints in a timely manner. She also noted that many counties with relatively small populations are geographically large, posing additional challenges for advocates working alone. Further, many counties with smaller populations are home to acute inpatient facilities or long term Institutions for Mental Disease (IMDs) that serve several surrounding counties. PRAs working in these counties have an increased workload because of monitoring and complaint resolution activities for the out-of-county residents at these facilities.

[11] *Id.*
[12] *Id.*

PRA Qualifications & Training

There is debate regarding whether the qualifications, supervision, and oversight of patients' rights advocates is adequate. There are no specified minimum educational or other qualification requirements for PRAs. Each mental health director designates a county mental health patients' rights advocacy office, and is responsible for hiring or contracting with advocates and/or advocacy agencies. The law specifies the duties PRAs must perform in Welfare & Institutions Code § 5520, and thus, arguably establishes minimum qualifications for advocates there. However, concerns persist about the hiring and oversight of PRAs, particularly in small counties. Many small counties only have one advocate who might not participate in the vetting of qualifications, nor the training of their replacement if they leave their position. Additionally, behavioral health departments resistant to changing or upgrading mental health services have little incentive to hire and renew the contracts of qualified PRAs, who are better able to advocate for improvements to the local mental health system.

There are no codified training requirements for PRAs. State law requires the Department of Health Care Services (DHCS), as the successor agency to DMH, to contract with a single, nonprofit entity to "ensure the effective management of the contract and the required activities affecting county patients' rights programs." COPR holds this contract and is responsible for the training and technical assistance for county patients' rights programs. COPR is housed within Disability Rights California (DRC), California's protection & advocacy organization. COPR conducts trainings and assists county advocates through an annual Patients' Rights Advocacy Training (PRAT) conference, provides technical assistance from one patients' rights specialist, maintains a list-serve where advocates can obtain technical assistance from other county offices, and provides sporadic supplemental trainings. PRAT is held once, annually, and generally hosts trainings on a variety of topics applicable to PRAs at all levels of practice. Many county programs, however, are unable to send all, or sometimes any, PRAs because of demanding workloads and/or inability to obtain reimbursement for travel expenses.

New PRAs are typically trained by other PRAs, if available. However, the comprehensiveness and effectiveness of training for PRAs varies widely. PRAs have a diverse range of duties and required skill sets, including representation in administrative hearings, knowledge of patients' rights and mental health laws, ability to work with individuals with mental health disabilities and individuals in crisis, ability to navigate and explain complex mental health treatment systems, ability to interact with administrators and county officials to effectively conduct systemic advocacy, ability to issue spot complaints and draft advocacy letters, and the ability to develop and present trainings to providers and clients. Some large counties have extensive training programs that can last months. Other counties have no established training program and new PRAs filling a single position may need to completely self-train using a patchwork of advocacy materials.

Retaliation

Over the years, multiple incidents of alleged retaliation against PRAs by their hiring county have taken place for conducting advocacy work as mandated by statute. State law requires each local mental health director appoint staff or contract for the services of one or more county patients' rights advocates.[13] The duties of PRAs include oversight of county mental health facilities and receiving and investigating complaints at those facilities. Occasionally, PRAs may need to contact licensing or other state regulatory officials over egregious and intractable patients' rights violations at county facilities. The ability of the county to fire PRAs, or terminate a contract, can create an inherent conflict of interest and imbalance of power in the county's favor. PRAs employed by the county may have some whistleblower protections against retaliation, but contracted agencies and individuals have limited recourse if counties simply do not renew the contract for what they might perceive as overly aggressive advocacy.

[13] California Welfare & Institutions Code § 5520

SURVEY DESCRIPTION & PARTICIPATION

The Patients' Rights Committee of the CMHPC decided to conduct a survey of PRAs to better advise the California Department of Health Care Services (DHCS) regarding current practices and policies. The PRA survey was a collaborative effort between the CMHPC and the California Association of Mental Health Patients' Rights Advocates (CAMHPRA). CAMPHRA assisted in the development of the survey through multiple rounds of feedback and editing.

The goal of the survey was to inform both groups about capacity, training, and common roles and responsibilities. Questions focused on three areas:

a) Are PRA offices sufficiently staffed?
b) Are PRAs adequately trained?
c) Are PRAs able to work without fear of retaliation from their county employer?

The online survey was finalized in early 2017, and consisted of 31 items, which included a mix of multiple-choice and open-ended questions. In early February, a link to the survey was sent out to PRAs along with a joint-letter from CAMHPRA and the CMHPC.[14] Responses were collected through the end of April 2017.

A total of 74 PRAs completed the online survey. When asked to identify which county they worked for, 31 of the 58 counties in California were named, as shown on the accompanying map. Four counties were identified that employed PRAs serving multiple counties. Most counties only had one or two respondents, but several larger counties had more, including ten respondents from Los Angeles, nine from Alameda, six from Orange County, and five from San Diego County. Most larger population counties were represented, but smaller population counties were underrepresented.

There were a number of limitations to this survey and subsequent analysis. First, there was a significant skew in the data because a number of small-population counties did not participate. Advocacy programs in these counties are most in need of support as they have fewer resources and their institutional knowledge and memory is at risk due to having less than 1.0 FTE PRA. Second, the data is self-reported. Self-reported data may not reflect the objective level of services provided county to county. More research and analysis is needed to better clarify how resources, training, and retaliation affect the efficacy of county patients' rights programs.

[14] Most county offices who initially did not respond to the survey were directly followed up with by CAMHPRA. Prizes were offered in the form of a raffle drawing at PRAT as an incentive to complete the survey.


2017 Survey of California County
Patients' Rights Advocates
Responses
No Responses
Overlap with multi-county offices
Del Norte
Siskiyou
Modoc
Humboldt
Trinity
Shasta
Lassen
Tehama
Plumas
Mendocino
Glenn
Butte
Sierra
Colusa
Yuba
Nevada
Placer
Lake
Sutter
Yolo
El Dorado
Sonoma
Napa
Sacramento
Amador
Alpine
Solano
Marin
Contra Costa
San Joaquin
Calaveras
Tuolumne
Mono
San Francisco
Alameda
Stanislaus
Mariposa
San Mateo
Santa Clara
Merced
Madera
Santa Cruz
San Benito
Fresno
Inyo
Monterey
Kings
Tulare
San Luis Obispo
Kern
San Bernardino
Santa Barbara
Ventura
Los Angeles
Orange
Riverside
San Diego
Imperial

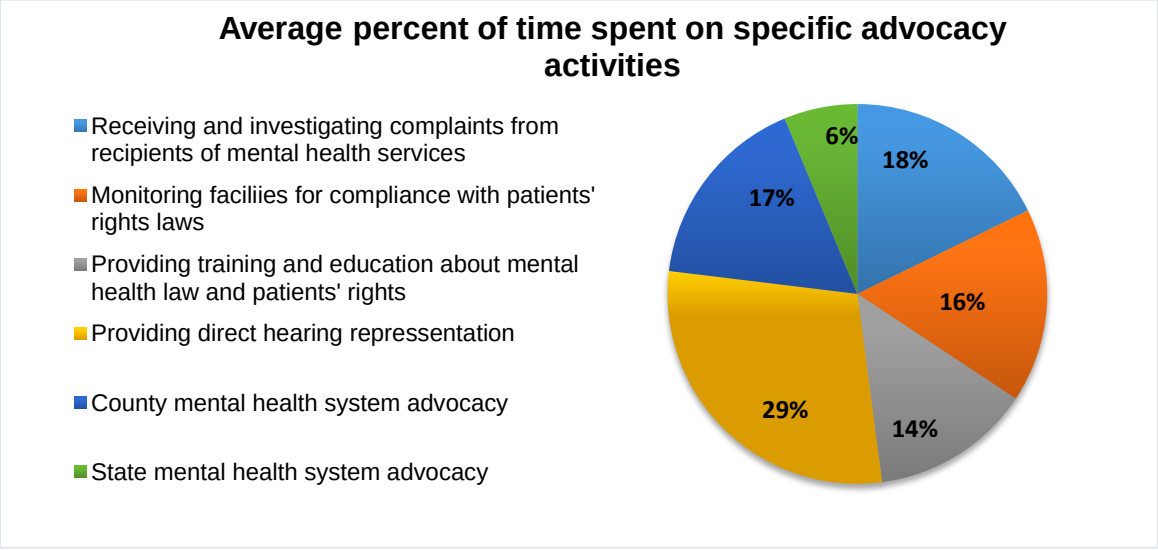
SURVEY RESULTS & DISCUSSION

A. PRA Resource Issues

Survey participants were asked whether they believed that there are enough PRAs in their county to provide all statutorily mandated advocacy services. There were four answer choices: (a) too many advocates, (b) adequate number of advocates, (c) shortage of advocates, or (d) severe shortage of advocates. Forty-nine percent of respondents reported a shortage of advocates in their county patients' rights program, and eight percent reported a *severe* shortage of advocates. Only forty-two percent reported an adequate number of PRAs in their county. No respondents responded that there were too many PRAs in their county. Overall, 57% of participants reported that their county does not have enough PRAs to adequately serve the patients in their communities. Based on this data, PRA responses were divided into two categories: (1) shortage group and (2) non-shortage group. The two categories were used to analyze responses and examine differences between the two groups.

Type of Advocacy Conducted

Advocates were asked to list the amount of time they devote to specific advocacy activities. Advocacy activities were divided into six categories: (1) receiving and investigating complaints, (2) monitoring facilities, (3) providing training and education about mental health law and patients' rights, (4) direct hearing representation, (5) county mental health systems advocacy, and (6) state mental health systems advocacy. Respondents were asked to indicate the percentage of time spent on advocacy activities in increments of 10% (e.g. 0-10%, 10-20%, etc.).[15]



[15] It should be noted that this is not the most precise way of measuring these percentages, as the lowest percent that could be captured if every respondent checked 0-10% is 5%, even if all respondents really conduct that activity 0% of the time.

Based on the survey data, PRAs spend the most time "providing direct hearing representation," with advocates spending a mean percentage of 29% of their time on this work. These hearings can include certification review hearings for 14-day involuntary mental health holds, certification review hearings for 30-day holds, *Riese*/Capacity hearings, and Independent Clinic Reviews. However, a number of survey respondents do not provide hearing representation in their county as they have no acute facilities, which lowers the percentage for advocates in counties in which direct hearing representation is provided. Generally, advocates with acute facilities in their county spend approximately 40% of their time providing direct hearing representation. However, this can vary significantly from county to county, with an advocate in Monterey County spending 20-30% of time on hearing representation, while the average time spent in Los Angeles County is 42%, and the average time in Sacramento County is around 67%.

Generally, survey respondents reported an equal amount of time spent on receiving and investigating complaints, monitoring facilities for compliance with mental health laws, training, and local systemic advocacy.

Very few advocates conduct state mental health system advocacy. A large majority of respondents indicated 0-10% for this activity, with the exception of some advocates who supervise their county patients' rights program, and advocates heavily involved in CAMHPRA. No significant difference in activity was found comparing participants reporting a PRA shortage in their county and those who felt there were an adequate number of advocates, suggesting the division of work is fairly consistent, regardless of staffing.

Asked what services would benefit from having additional PRAs in their county, participants answered as follows (participants were allowed to check multiple boxes):

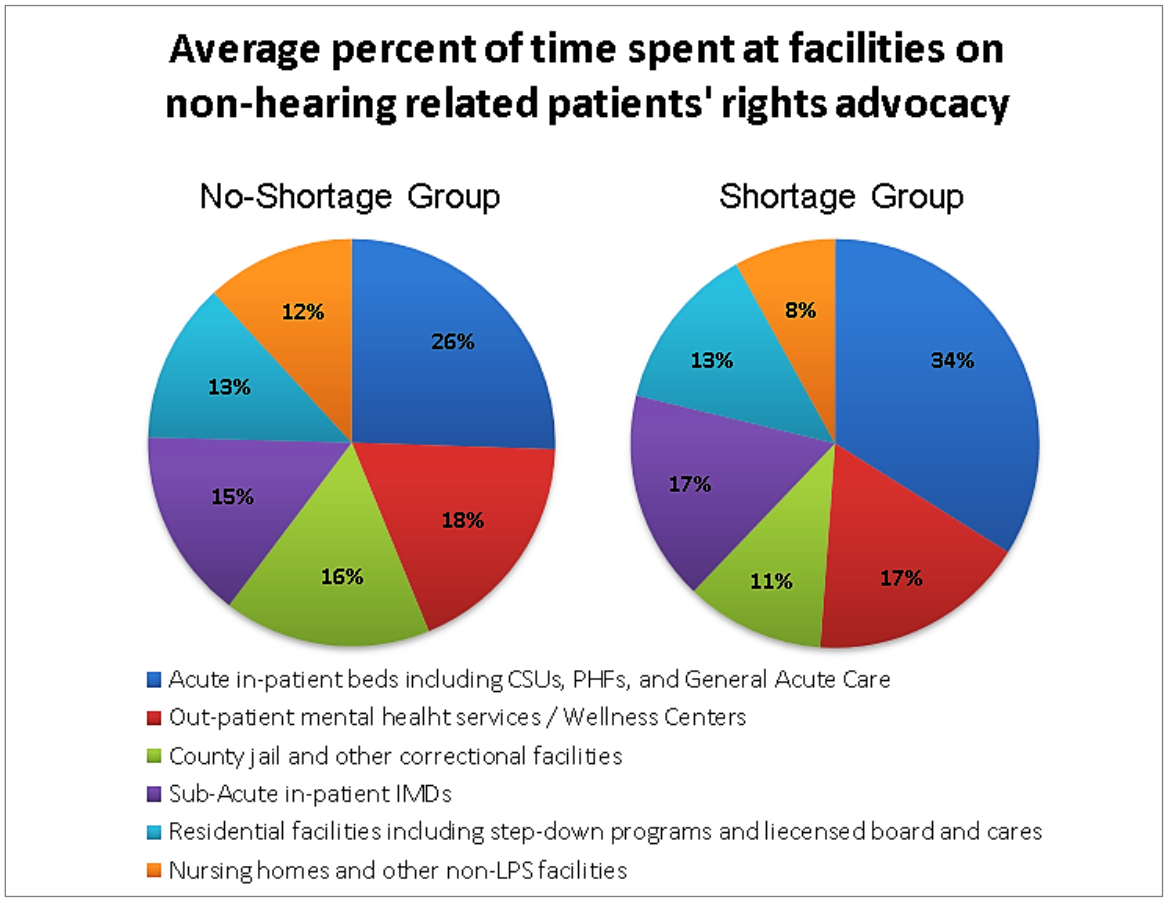
If you believe that more advocates are needed in your county, what services would benefit from additional staff? Please check all that apply. (PRA Shortage group only)		
Services	**Count**	**Percentage**
Receiving and investigating patients' rights complaints of mental health services	26	62%
Monitoring facilities for compliance with patients' rights laws	36	86%
Providing training and education about mental health laws and patients' rights	31	74%
Adequate advocacy in certification/capacity hearings	12	29%
County mental health system advocacy	23	55%
Total respondents: 42		

More than 50% of respondents indicated that monitoring, complaint investigation, training, and systemic advocacy work would benefit from additional PRAs in their counties. Respondents

singled out facility monitoring as most likely to improve with increased staffing. Only 29% responded that direct hearing representation would improve with more staffing.

Division of Time at Facilities

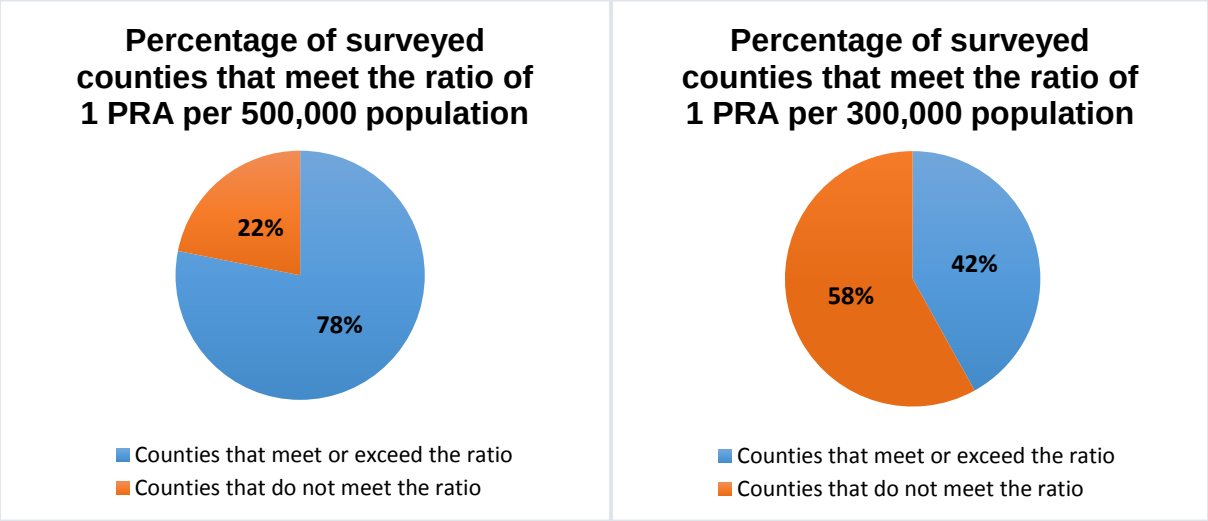
Survey participants listed the types of facilities in which they conduct non-hearing related advocacy. Similar to the advocacy activities question, respondents were asked to indicate the percentage of time spent at facilities based on increments of 10%. The answers below are divided between the "shortage" and the "no shortage" groups.



The results show significant differences between the two groups in the types of facilities in which advocates conduct non-hearing related advocacy. PRAs who reported a shortage of advocates spent less time at non-acute facilities. Advocates who reported an adequate number of advocates spent more time at all non-acute facilities, with the exception of residential facilities, which was the same percentage between the two groups. This is likely because PRAs are often at acute facilities already conducting hearings. PRAs with less time have less ability to advocate at non-acute facilities.

PRA Ratios

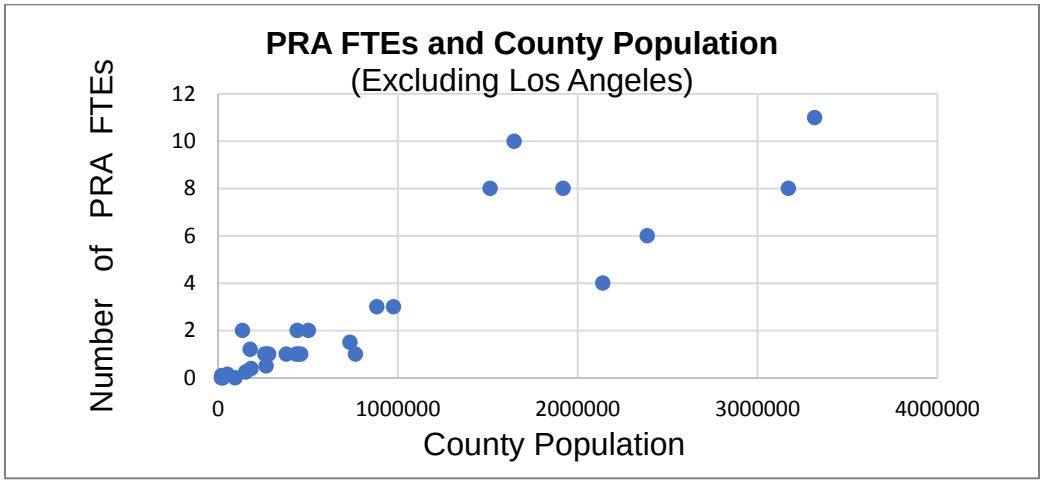
Participants were asked how many FTE PRAs work in their county. [16] PRA-to-county population ratios were compared to the standard of 1.0 FTE PRA per 500,000 county population, as recommended by the Department of Mental Health in 1980, and to a ratio of 1:300,000, as recommended in 1987 by the Task Force on County Patients' Rights Advocate Staffing Ratio.



Of the 31 counties for which there is survey data, 78% met the ratio of 1:500,000 and 22% did not. Using the ratio of 1:300,000, 42% met the ratio and 58% did not. There were several instances in which counties had less than 1.0 FTE PRA, yet met the ratio due to small county population. The range of PRA-to-population ratio varied widely, even in counties with large populations. For example, San Bernardino County reported four FTE advocates despite a county population of 2.128 million: a ratio of 1.0 PRA to every 532,000 residents.[17] Santa Clara County reported 8.0 FTEs with a population of 1.918 million: thus ratio of 1.0 FTE PRA per 240,000 residents.[18] Los Angeles County has a ratio of 1:424,000 and Orange County has a ratio of 1:278,261.

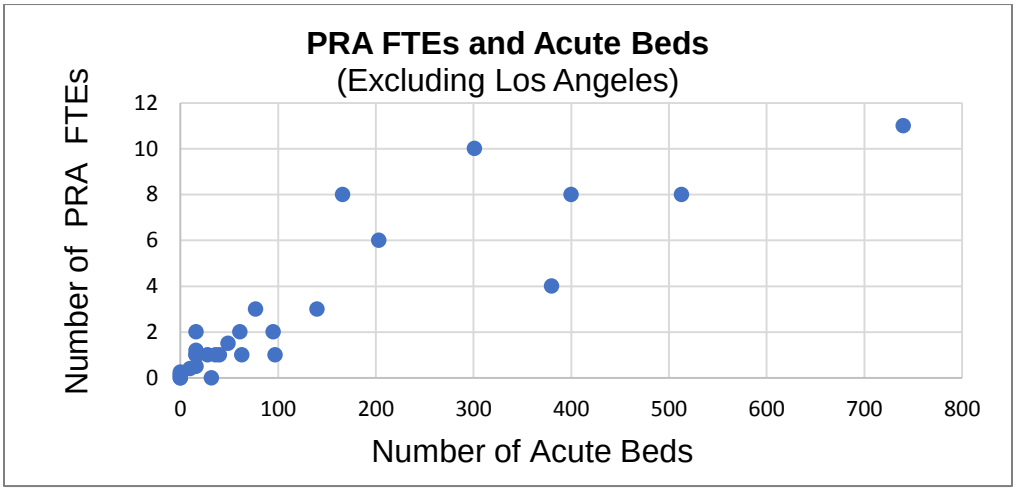
[16] The highest number of FTEs was used for counties with multiple respondents who had conflicting answers.
[17] US Census Bureau 2015
[18] Santa Clara County's PRA contract recently increased 75% due to several new facilities opening, including a large Acute Psychiatric Hospital which serves multiple surrounding counties.

The scatter plot below displays the PRA-to-population ratios across California.



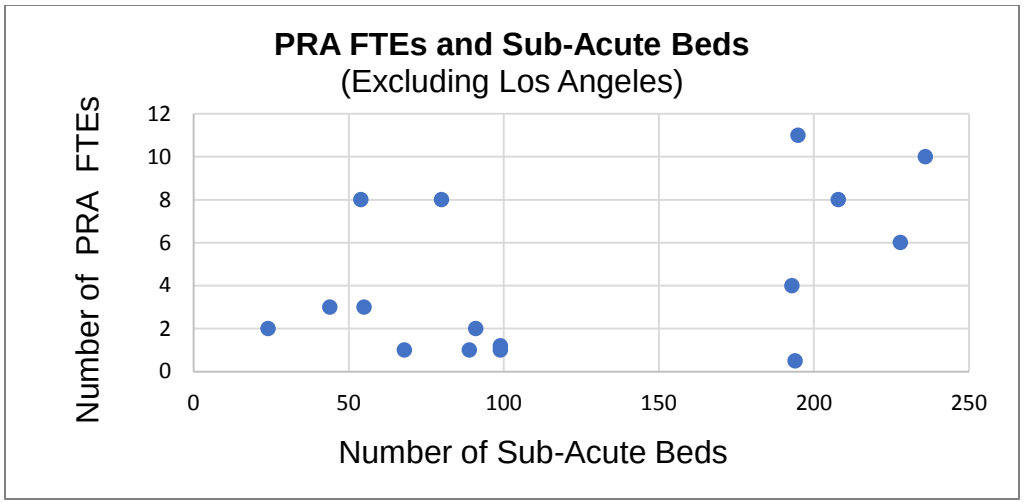
There is clear positive correlation between PRA FTEs and county population. However, as displayed above, ratios vary widely. While the number of PRA FTEs seems to be related to county population, there does not appear to be any relation to county size in square miles. This may pose a problem if PRAs in counties with low populations but large geographic areas have difficulty serving the entire county.

PRA FTEs also were compared to the number of acute psychiatric beds available in each represented county.[19]



In participating counties with beds, there is a positive relationship between the number of acute beds and the number of PRA FTEs in a county. The average number of PRA FTEs to acute beds was 1:40.[20]

[19] The acute beds tallied include beds in Crisis Stabilization Units (CSUs), Psychiatric Health Facilities (PHFs), mental health units in General Acute Care Hospitals, among others; acute bed data gathered from *California's Acute Psychiatric Bed Loss*, California Hospital Association (2015).
[20] This data is bi-modal due to the low number of inpatient beds in smaller population counties.



There does not appear to be a clear positive correlation of PRA FTE to sub-acute beds.[21] It is particularly important for PRAs to have a sufficient presence at these facilities because patients have increased vulnerability due to a higher percentage being out-of-county residents and thus more isolated from family and friends.

PRA Hearings Volume

The volume of hearings can vary widely from county to county. While there is a positive correlation between the number of acute beds and population size, other factors contribute, such as practices concerning voluntary treatment in local mental health facilities, and the availability of outpatient resources that reduce in-patient hospitalizations. Santa Clara County reported an average of 251 certification review hearings per month, and 30 capacity hearings per month. Los Angeles County reported approximately 2,000 hearings per month of all types. San Diego County reported an average of 501 certification review hearings per month.[22]

The Orange County patients' rights office is unique in that it divides the workload into two groups: one only conducts certification review hearings and the other performs other PRA duties such as receiving and investigation complaints, training, and facility monitoring. Orange County has 3.5 PRA FTE staff dedicated to conducting certification review hearings and 8.0 PRA FTE staff whom conduct other PRA duties.[23] PRAs in Orange County reported approximately 353 hearings per month.[24] This is about 16 hearings per business day and about 4.5 per day per dedicated FTE staff.[25] Orange County has 513 inpatient psychiatric beds.[26] This is a ratio of 1.0

[21] Sub-acute beds are facilities federally categorized as Institutes of Mental Disease (IMDs). The facilities included here are licensed in California as Mental Health Rehabilitation Centers (MHRCs) and Skilled Nursing Homes/Special Treatment Programs (SNF/STPs); data gathered from the California Department of Health Care Services (2014).
[22] Around 75% of the hearings in Los Angeles and San Diego County are calendared.
[23] *Revision* - a previous version of this paper had incorrectly reported the FTE PRAs in Orange County.
[24] The Orange County Patients' Rights Office only conducts certification review hearings. Capacity hearings are conducted by the Public Defender's Office.
[25] Using an average of 22 business days per month.
[26] *California's Acute Psychiatric Bed Loss*, California Hospital Association (2015).

FTE PRA per 45 inpatient beds and 1.0 PRA FTE per 147 beds, specifically for certification review hearings representation. Orange County is frequently acknowledged in the PRA community for their best practices in the scope of advocacy work they are able to conduct. Their office's unique division of PRA duties make their staffing ratios insightful for other counties.

PRA Opinions on Improvements

When asked, what was needed "for more effective advocacy in your county," responses were diverse. About 45% of the comments indicated a need for more advocates or more hours for existing advocates working part-time. More than a quarter of responses pointed to a need for more training and support for PRAs in their county, and several mentioned a need for higher wages. One participant elaborated on the consequences of being under-staffed: "O*ne full-time advocate cannot cover all duties consistently, particularly in a county this size, so activities are completed as they come in, but pursuing trainings, regular site visits (monitoring) are reactionary responses*."

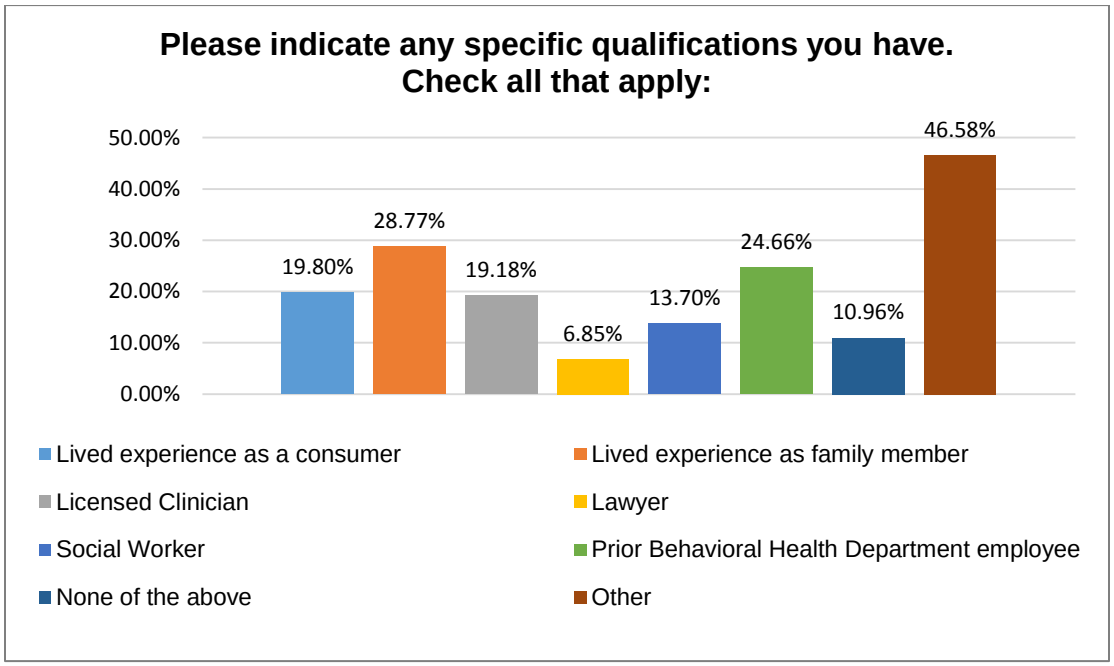
B. PRA Training

PRA Experience

Asked how many years of experience they had, 32% of respondents reported having 10+ years, 31% had 3-10 years, and 36% had worked as a PRA for less than 3 years. This suggests the experience level of advocates is evenly distributed with a fair number staying in the field for significant lengths of time, and a substantial number of new advocates as well. However, the experience level varies across counties. Many small counties have difficulty keeping advocates in part-time PRA positions, either because of limited hours and the perceived undesirability of part-time work, or the county preferring to hire a different advocate instead of renewing an existing contract.

PRA Qualifications

Participants were asked about their qualifications and background. The question allowed respondents to check all categories that were applicable to them.

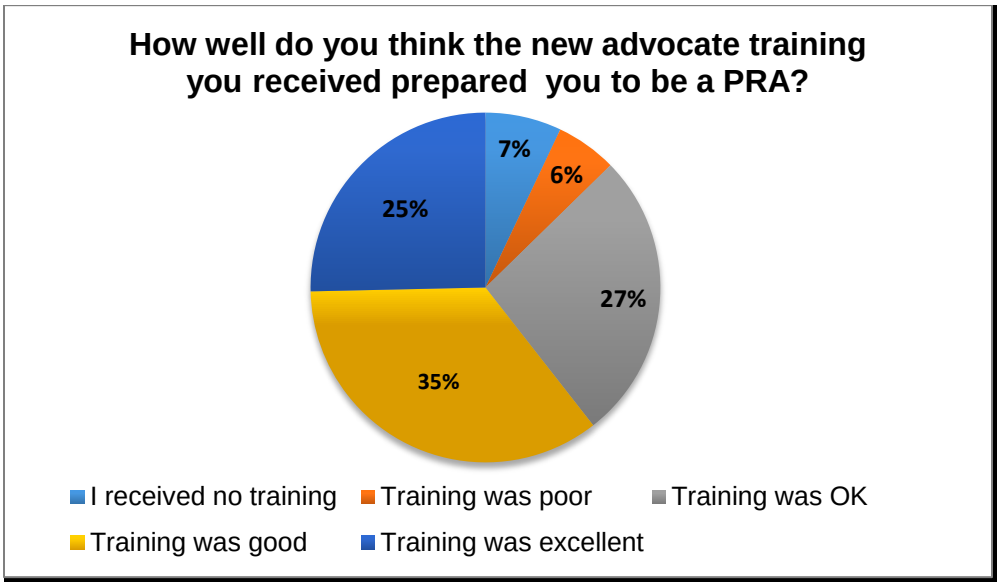


Almost 30% of respondents reported lived experience as a family member a person with a mental health condition, close to 25% were prior behavioral health department staff, and almost 20% had lived experience as a consumer. A large portion (47%) checked the "other" category. Written responses for the "other" category were very diverse, including qualifications such as academic degrees in psychology and social work, staff work in legal services, experience as case managers, residential staff and caregivers, etc.

PRA Training Program

Regarding training and work activity, slightly more than 77% of participants reported having received training prior to assuming their duties. Around 12% said that they had not received training, but that their employer currently provides training, and 11% said that they had not received training and that their employer does not provide training. The most common forms of training reported were "formal discussions with other advocates" (76%), "written materials, including online training materials" (73%), and "in-person conference" (55%). Additionally, 28% percent responded that they had educated themselves. Although this usually was included with other answers, 13% selected "I educated myself" as the only answer regarding training.

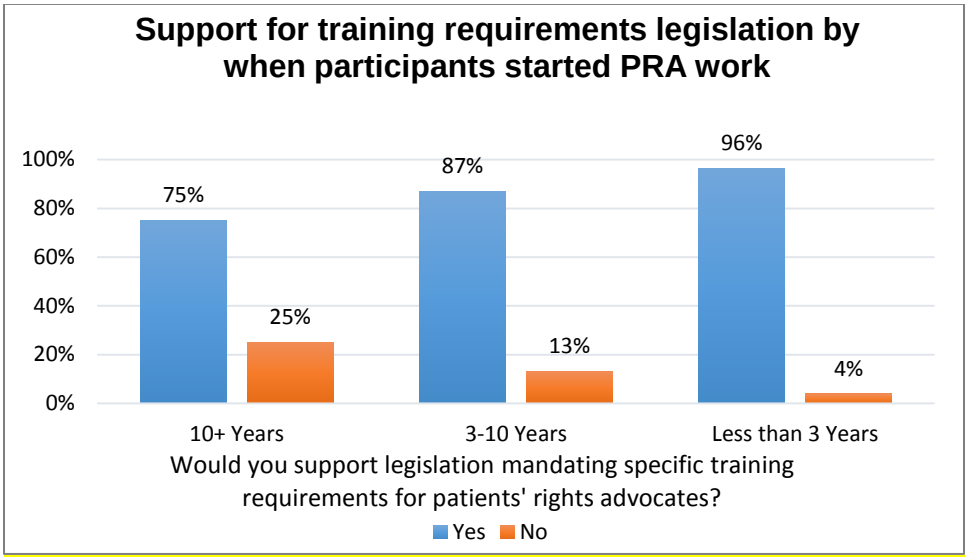
Respondents were asked how well they believed their training prepared them to be a PRA.



The majority of respondents characterized their training as "excellent" or "good." However, 40% reported their training was "ok," "poor," or that they had "received no training."

PRA Support for Legislation Mandating Training Requirements

Asked whether they supported legislation mandating training requirements, responses were divided along advocate experience levels.

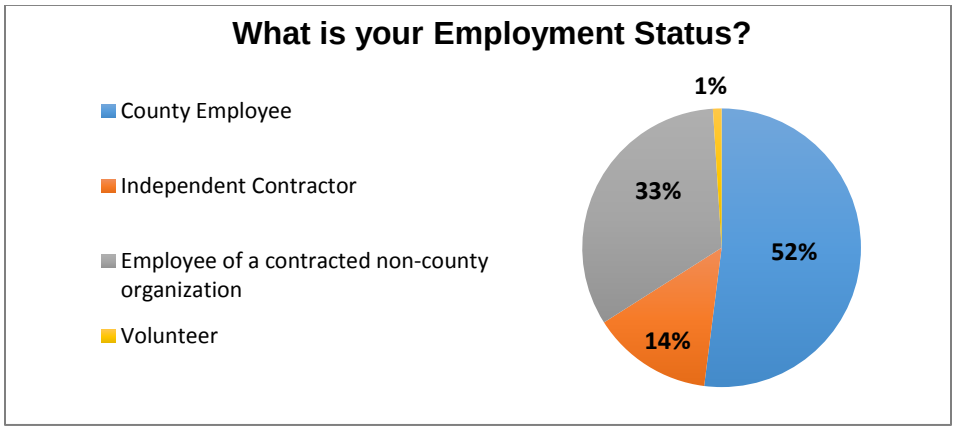


From the responses, eighty-six percent indicated support for legislation mandating specific training requirements for PRAs. Most of those not in favor of such legislation were from small-population counties and/or counties with only one PRA. Participants from these counties also reported receiving less training in the form of written materials, formal discussions, and in-person conferences, and had a higher rate of self-education. Across counties, PRAs who reported having more experience were less supportive of mandated training requirements.

C. Retaliation Against PRAs for Conducting Advocacy

Employment Status

Participants were asked about their employment status.



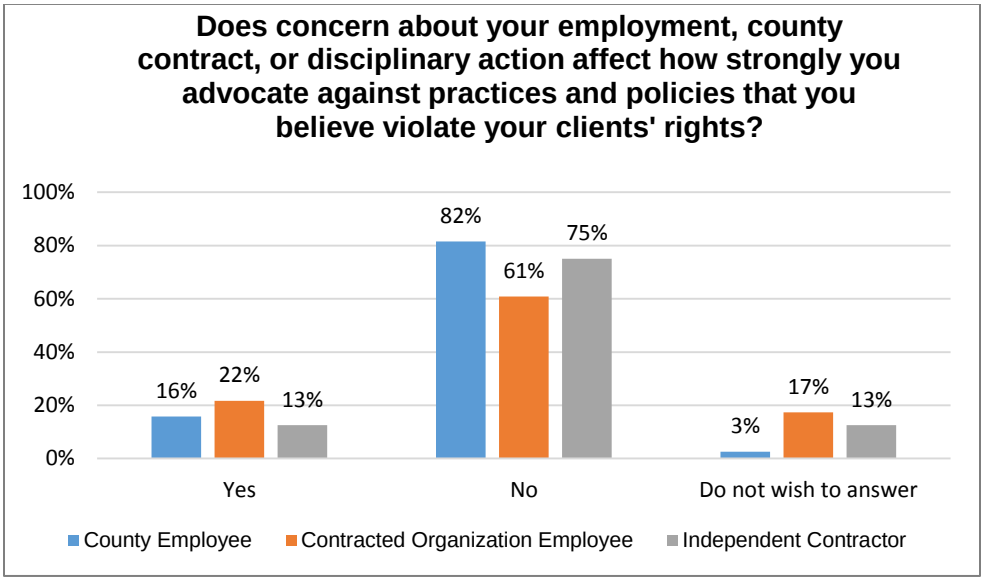
A little more than half of the respondents reported being county employees, 33% work for contracted organizations, and 14% of respondents are independent contractors. One participant reported being a volunteer.

PRA Perceived Support from County Behavioral Health and Facilities

Asked whether they felt supported by county behavioral health and community mental health facilities, about 85% of respondents "somewhat agreed" or "strongly agreed" their advocacy was supported. Answers do not appear to be related to employment status. A combined 89% of survey participants indicated that they "strongly agree" or "somewhat agree" that staff at licensed health and community care facilities support their work. Only two chose "somewhat disagree," and none chose "strongly disagree." PRAs who reported having a shortage of advocates in their county also reported less support from both county behavioral health and behavioral health facilities.

PRA Fear of Retaliation and Effect on Advocacy Work

PRAs were asked whether concern about their employment effects how strongly they advocate against practices and policies they believe violate their clients' rights.



Responses varied significantly based on employment status. Sixty-one percent of employees of county-contracted advocacy organizations selected "no." Thirty-nine percent either selected "yes" or declined to answer. A significantly lower percentage of county employees declined to answer.

Survey Respondent Quotes on Retaliation Concerns

One respondent commented: "*It is clear that our position as County Advocates is not a completely autonomous position from the flow of business in our county. Our BH Department needs the few facilities we have; therefore, it is very important that we stay cognizant of our role to advocate, but tread lightly. When push comes to shove, we know it is easier to replace an advocate than to lose a business partner.*"

Another participant described their observations regarding contention between the County Behavioral Health Director and PRAs: "*Allowing the County MH Director to set the course for advocacy services allows for conflict of interest, as business relationships will trump patients' rights in the real world. There is no autonomy or protection from administrators that may see you as an adversary or thorn in their side… The BH Director can choose to divert or silence the efforts of an advocate at any time. Whether we are contract providers or county employees, all of us are subject to unchecked repercussions if we ruffle the wrong feathers.*"

RECOMMENDATIONS

The following recommendations are based on the survey results, subsequent analysis, related past studies, and discussions between CAMHPRA and CMHPC Patients' Rights Committee members.

PRA Staffing

- Establish a minimum level of staffing for patients' rights advocacy services in all counties, requiring sufficient resources and supports allowing PRAs to perform both administrative and statutory duties.
- Seek legislation requiring specific ratios for PRAs based on the number of acute mental health beds and county population. Legislation should also require counties to consider factors such as sub-acute beds, number of acute facilities, number of residential facilities, county jail population, and geographic size and difficulty of cross-county travel, in determining PRA staffing.

PRA Training

- Mandated and standardized training requirements for PRAs. This could include a certificate like program to be completed within a specific time period of hire and required shadowing/mentorship for PRAs providing representation in hearings.
- County reimbursement for all training costs, including travel expense reimbursement for PRA-specific training conferences, such as PRAT.
- Expansion of the California Office of Patients' Rights' (COPR) contract to allow development and monitoring of PRA training programs and increased support and technical assistance for county patients' rights programs.

PRA Retaliation

- Seek legislation providing whistleblower protections for county contractors in watchdog roles.