September 25, 2024

Hon. Susan Talamantes Eggman
Senator, Fifth District
Room 8530, 1021 O Street
Sacramento, California 95814

Dear Senator Eggman:

This letter is in response to your interest, conveyed by your staff, in our office studying staffing requirements of county patients' rights advocates (PRAs) programs and the potential for statutory staffing ratios. (While the Department of State Hospitals [DSH] and the Department of Health Care Services [DHCS] have a contract with a nonprofit to provide PRA services to state hospital patients, our focus is on county PRA services, as requested.) In this letter, we provide a brief history of PRAs and the growing role and responsibilities of county PRAs over time. We then evaluate current county PRA staffing and provide two case studies of different county PRA programs and the services they provide. We discuss some of the difficulties in establishing a county PRA staffing ratio, but lay out a framework for what a staffing ratio methodology could include. Finally, we provide a number of issues for legislative consideration in establishing a staffing ratio as well as strengthening county PRA oversight and reporting.

Research Methodology. Our office used a wide variety of resources from multiple sources to analyze the issue of staffing for county PRA programs. We relied on previous reports and memos from the Task Force on County PRA Staffing Ratio (in operation from 1986 to 1987), the California Mental Health Planning Council, and the California Association of Mental Health Patients' Rights Advocates (CAMHPRA). These materials included an analysis of county PRA workload in 1987 (prior to the significant expansion of county PRA roles and responsibilities) and a 2017 survey of 31 county PRA programs. We conducted interviews with staff from CAMHPRA, the California Office of Patients' Rights (COPR), and Disability Rights California to attain a statewide perspective of issues. To attain a county perspective of the issues, we conducted interviews with staff of the San Diego County and Placer County PRA programs. We also received data from COPR (including statewide estimates of county PRA staffing), San Diego County, and Placer County on PRA staffing and workload. Finally, we accessed data from DHCS' website on the number of mental health facilities and beds in each county.

Summary of Findings

County PRA Responsibilities and Workload Have Increased Significantly Over Time, While Not Necessarily Directly Related to Total County Population. Prior efforts to establish a staffing ratio were based solely on total county population and were set prior to many county PRAs' current responsibilities. Even at the time those ratios were recommended by state reports,

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those reports acknowledged that they did not account for many of the responsibilities of county PRAs. Additionally, the workload for county PRAs varies by county and is not necessarily directly related to total county population. Factors such as the number of mental health facilities and beds in a county may have a much larger impact on the need for county PRA services. Other, less quantifiable, factors may also impact the need for county PRA services and would likely require a more in-depth evaluation of each county PRA program.

Developing a Staffing Ratio Could Warrant Consideration, but More Information Needed and Fiscal Implications Should Be Considered. In order to first determine whether a staffing ratio could be warranted, it would be necessary to first collect information to understand the level of PRA services being provided in each county. (This is information that has not been collected by the state and was therefore not available in a central location for purposes of our analysis.) The Legislature could then determine whether or not the level of service being provided is sufficient to meet statutory requirements and broad objectives, based on the county-by-county need for PRA services (also information that would need to be newly collected). If the Legislature determined that the level of service being provided is not sufficient, it could direct the development of a staffing ratio to address this problem.

The limited information available to support the development of a staffing ratio reflects that there is currently very limited state oversight of county PRA services. Counties are primarily responsible for ensuring that county PRA programs are meeting their statutorily mandated responsibilities. Ongoing, state monitoring of county PRA workload likely would be needed to ensure that any staffing ratio developed is being met by counties and to evaluate if the staffing ratio meets the level of service needed in each county. Importantly, there are potential state fiscal implications from enacting a staffing ratio that should be considered, including potential county costs and the possibility of creating a reimbursable state mandate. Regardless, however, state oversight of county PRA programs may be beneficial whether or not a staffing ratio is enacted.

Alternatives to a Staffing Ratio May Be Viable, but Potential Fiscal Implications Could Still Be an Issue. We find that most of the current statutory responsibilities for county PRA programs are broad and allow for flexibility in how counties choose to meet them. As an alternative to a staffing ratio (in an effort to effectuate a desired minimum level of service), the Legislature could take actions such as adding more specific county PRA program goals to statute or enacting statutory time lines for the completion of PRA activities. However, as with enacting a staffing ratio, the potential fiscal implications of these alternative actions would need to be considered.

BACKGROUND

Establishment of PRAs

Lanterman-Petris-Short (LPS) Act Changed How Individuals With Mental Illness Received Treatment. Prior to the passage of the LPS Act, a large portion of individuals receiving institutional mental health treatment did so in state hospitals. At their peak in 1955, 14 state hospitals housed 37,000 individuals (compared to five state hospitals treating about 8,000 patients in 2023-24). In 1967, the Legislature passed the LPS Act with the intent to end and

provide those individuals with safeguards to individual rights. In 1972, the Legislature further expanded the rights of patients in mental health treatment facilities, including those involuntarily committed. These facilities include local inpatient mental health facilities and state hospitals. While the law set out patients' rights, various reports cited that compliance with the patients' rights law was inconsistent within institutional settings. The LPS Act also created criteria for counties to designate mental health treatment facilities that, among other treatment, can also provide involuntary mental health treatment to individuals who are a danger to themselves or others, or who are gravely disabled. Throughout this letter, we refer to these designated facilities as "LPS facilities."

County PRAs Mandated to Ensure Legal Treatment of Certain Individuals With Mental Illness. County PRAs were created to ensure patients' rights in mental health facilities, even after those rights has been codified. In 1976, the then-existing Department of Mental Health (DMH) enacted regulations that required county behavioral health directors to assign a PRA to handle complaints from patients with mental illness regarding abuse and unreasonable denial or punitive withholding of their guaranteed rights. The basic responsibilities of county PRAs were later codified in 1981 and include: receiving and investigating complaints from patients in licensed health or community care facilities, monitoring mental health facilities to ensure compliance with applicable patients' rights laws, providing training and education about patients' rights to mental health providers, and ensuring that patients are notified of statutory rights.

Significant County Discretion in Exercise of Basic PRA Responsibilities. However, even though codified, the initial set of basic duties for county PRAs are somewhat broad and more conceptual. That is, the duties are stated as high-level objectives, without being specific in terms of particular benchmarks. Consequently, how to meet the objectives of a PRA program and fulfill its basic responsibilities is left to county discretion. For example, counties may determine the scope and frequency of training provided by the PRA to mental health providers or how frequently county PRAs must provide on-site monitoring of mental health facilities.

Roles and Responsibilities of County PRAs Have Evolved Over Time

Increasing Number of Responsibilities for County PRAs. In the 1980s and 1990s, a number of court cases, statutory changes, and state policies significantly increased and specified the roles and responsibilities of county PRAs. One of the biggest changes was the requirement for county PRAs to represent patients in certification hearings to determine if a patient could be involuntarily held after 72 hours. Unlike some other county PRA duties, the process for certification hearings have defined time lines and requirements that have been further specified in recent legislation. These certification hearings are a plurality of many county PRAs' workload. Figure 1 on the next page highlights the major additions to county PRA roles from the 1980s and 1990s.

Figure 1

Evolving Role of County Patients' Rights Advocates (PRAs)

Role of County PRAs	Year	Description
Representation at Certification Hearings	1983	Due process requirements for involuntary commitments at a facility beyond 72 hours.
Representation at Minors' Clinical Review	1989	Independent clinical review for minors aged 14-17 years old who are admitted to medical facilities by their parents but object.
Provision of Service to Increased Number of Patients in Community Mental Health Facilities	1991	Following 1991 realignment, counties began shifting civilly committed individuals from state hospitals to community and local facilities. This increased the number of individuals served by county PRAs.
Representation at Medication Capacity Hearings	1993	Patients may receive a hearing prior to receiving involuntary psychotropic medication.
Assistance to, and Representation of, Patients in Medi-Cal-Related Processes	1995	PRAs provide advocate services in county Medi-Cal Mental Health Plan grievance and appeals procedures.

Recent Changes in Behavioral Health System May Also Increase the Number of Individuals Eligible for County PRA Services. A number of recently enacted bills and state programs will likely increase the number of individuals eligible for PRA services. These include:

- ***Chapter 960 of 2022 (AB 2275, Wood).*** The bill, among other changes, clarifies that a 72-hour involuntary hold begins at the time when an individual is first detained rather than when they are admitted to an LPS facility. This has the effect of increasing the number of certification hearings (discussed in the figure above) as well as the number of hearings that occur at certain other mental health facilities.
- ***Chapter 43 of 2023 (SB 43, Eggman).*** The bill makes substantial changes to the LPS Act. In particular, it expands the definition of gravely disabled to include non-cooccurring substance use disorder. More individuals will qualify for involuntary holds under this expanded definition, increasing the number of certification hearings. Due to a potential lack of involuntary treatment beds for substance use disorder, there may be issues in placing individuals held in emergency rooms which further increases the number of hearings that will be held outside of LPS facilities. Currently, most counties have elected to delay implementation of the bill until 2026.
- ***Behavioral Health Continuum Infrastructure Program (BHCIP).*** The 2021-22 spending plan included $2.2 billion total funds over a multiyear period for grants to develop new behavioral health treatment facilities. (Following reductions in the 2024-25 spending plan, the total funding for the program is now $1.8 billion.) In March 2024, voters passed Proposition 1, which included $4.4 billion in bond funding to BHCIP to build additional behavioral health facilities. Inpatient behavioral health facilities built by BHCIP will increase the number of patients who will be eligible for county PRA services.
- ***California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment Demonstration.*** In 2023, the administration submitted a waiver to the Centers for Medicare & Medicaid Services which upon federal approval would, among other changes, allow federal reimbursement for short-term stay facilities

designated as institutes for mental disease (IMDs). To the extent additional federal funding incentivizes the expansion or creation of IMDs, county PRAs would experience an increased workload.

- ***Community Assistance, Recovery and Empowerment (CARE) Program.*** Chapter 319 of 2022 (SB 1338, Umberg and Eggman) created the CARE Program—a new civil court proceeding that will allow specific people to seek assistance for certain adults with severe mental illness. While individuals in the program are not compelled into treatment, individuals could decide to receive treatment in inpatient facilities that are served by county PRAs.

In summary, county PRA programs today have a mix of statutory duties that have specific time lines and requirements, such as certification hearings, and broader, less-prescriptive responsibilities to ensure patients' rights are being upheld at mental health facilities.

Structure of PRA Governance and Oversight

Counties Have Primary Responsibility for Ensuring PRAs Meet Statutory Duties. County behavioral health departments are required to provide county PRA services to all eligible individuals. There is currently no requirement for counties to report PRA activities to the state, meaning it is largely left to counties to determine the level of service provided by their PRA programs. Consequently, each county may determine that different PRA services are important based on the unique needs of the county or county priorities. As will be discussed below, the lack of reporting on PRA services by counties limits a comprehensive analysis on PRA staffing needs across the state.

Statewide Entities Have Limited Oversight of County PRAs. DSH and DHCS jointly contract with a nonprofit to operate COPR. COPR primarily provides PRA services to state hospitals, but also provides training and training materials for county PRAs. In addition, COPR performs annual program reviews that consist of evaluating county PRAs' ability to meet their statutorily mandated duties and include an assessment of staffing. However, COPR's current contract with the state only includes one employee dedicated to providing training and oversight of county PRAs. Accordingly, COPR currently has capacity to perform just two reviews of county PRA programs a year. Aside from its role in contracting with DSH, DHCS has no oversight or monitoring responsibilities with respect to, or receives any direct reporting from, county PRAs. In summary, the only state-level evaluation or monitoring of county PRAs is done by COPR on a very limited basis. As a result, the extent to which county PRA programs are meeting statutory time lines and the broader statutory goals for county PRA programs is unknown.

FINDINGS ON CURRENT COUNTY PRA STAFFING

Data Limitations Impact Ability to Evaluate PRA Staffing and Workload on a Statewide Basis. While the state does not collect data on PRA staffing and workload, we were able to use data collected and published by COPR. Specifically, COPR aggregates total PRA staffing by county based on episodic county reporting. These data do not include information on workload, however. Moreover, data on PRAs per county over time is very limited. Absent these data, we

cannot assess how PRA staffing over time has changed in response to their increasing roles and responsibilities. Given the lack of statewide data, we developed case studies of San Diego and Placer Counties to assess trends and differences in counties based on size and population. While these insights can be informative for legislative deliberations, absent more comprehensive data, we cannot develop statewide findings on PRA staffing and workload.

PRA Workload and Focus of Services Vary Significantly Across Counties

Services Provided by County PRAs Depends on Unique County Factors. There are approximately 178 county PRAs across the state, however, county-level staffing varies considerably. Specifically, excluding management and administrative staff, counties range from one part-time PRA to 27 full-time PRA staff per county. Counties are required to provide a minimum level of PRA services to eligible individuals, but in addition to the broad discretion given to counites on how PRA programs meet certain responsibilities, differences in eligible populations served and facilities within each county lead to differences in implementation and workload. This is illustrated by our case studies of the PRA workload in San Diego and Placer Counties that follow.

San Diego County PRA Workload. San Diego County PRA services are contracted to two organizations, with one providing inpatient and residential PRA services and the other providing outpatient PRA services. We interviewed the Jewish Family Service Patient Advocacy Program (which provides inpatient and residential PRA services), which consists of 14 full-time PRAs, and reviewed the program's workload. San Diego County has 17 LPS adult inpatient facilities (around 770 beds) and three child and adolescent inpatient facilities (around 70 beds) that are all eligible for PRA services. In 2023-24, staff time was spent roughly equally across hearings, responding to complaints, providing training, and facility monitoring and other duties. Since 2020-21, the program has experienced a roughly 25 percent decline in the number of hearings, decreasing from almost 4,500 to 3,400 in 2023-24. There was a 30 percent decrease in the number of complaints the program received during the COVID-19 pandemic, but the number of complaints returned to pre-pandemic levels.

Placer County PRA Workload. Placer County PRA services are provided by a county employee who also provides PRA services to Sierra County. Placer County contains one LPS facility with 16 beds that is eligible for PRA monitoring and services. Approximately half of staff time in 2023-24 was spent scheduling and attending hearings (30 percent) and investigating complaints (20 percent). The remaining staff time was spent in training and supporting facility staff, performing monitoring duties of health facilities, and other PRA duties. The Placer County PRA held 76 fewer hearings in 2023-24 than 2021-22 (a 22 percent decrease) while complaints fluctuated by around 50 percent (up and down) each year over the same period.

County PRA Program Differences in Workload Appear to Depend on More Than Population. Based on our review of San Diego and Placer County PRA program workload, total workload seems to be related to the number of LPS facilities and beds (per capita). However, even accounting for differences in the number of LPS facilities and beds, our review found that the *composition* of county PRA services varied across counties. For example, San Diego County has a higher number of LPS facilities and beds per capita than Placer County, and thus has a

higher number of hearings and complaints per capita as well. However, we found that the composition of each county's workload varied, with more of San Diego County PRA staff's time spent on complaints and more of Placer County PRA staff's time spent on hearings. There were approximately 37 complaints per 100,000 county residents in San Diego County compared to 11 in Placer County. Placer County had about 14 hearings per bed, while San Diego County had about four hearings per bed. (We compare complaints per 100,000 county residents as complaints are not necessarily connected to facilities or beds, while hearings are much more dependent on the number of beds in LPS facilities.) Accordingly, while measures such as the number of LPS facilities and beds per capita may be helpful in establishing a staffing ratio, a needs-based evaluation of county-by-county workload would likely be needed. This is because the composition of each county PRA's workload can vary (due to unique county factors) and may be impacted differently by changes to PRA responsibilities.

Small and Medium-Sized County Workload May Fluctuate Significantly Based on a Single Incident. Placer County PRA staff discussed that many of the year-over-year workload fluctuations were based on single incidents that had an outsized impact on the reported numbers. For example, in 2023, the county opened a 24-hour mental health crisis center and around ten patients filed complaints, which represented over half of the year-over-year increase in complaints from 2022-23 to 2023-24. These complaints mostly stemmed from patients not understanding the role and services provided by the crisis center. As staff at the center have worked to better educate patients, the number of complaints from the new facility have subsided. In another instance, the PRA worked on training staff at the county's psychiatric health facility to lift holds on patients no longer meeting the involuntary hold criteria prior to a patient's scheduled hearing. Staff at the facility were also trained in offering voluntary status for clients who do meet involuntary hold criteria but who wish to stay voluntarily. This extra training effort resulted in a decline in the total number of hearings in 2023-24 even while the number of AB 2275 hearings increased. Additional staffing for small and medium-sized counties, beyond what would be estimated from their population, could mitigate unexpected increases in workload due to single incidents like the first one discussed above. On the other hand, county PRA programs should remain flexible when unexpected incidents lessen the need for certain PRA services, thereby allowing PRA staff to focus on other areas of need in the county.

ESTABLISHING A PRA STAFFING RATIO

Prior Efforts and Challenges to Create a PRA Staffing Ratio

Prior Efforts to Create Staffing Ratio Based on County Population. The first recommended staffing ratio for county PRAs was one advocate per 500,000 county residents and was set by the State Director of Mental Health in 1980. This was set prior to the requirements of certification review hearings. In 1987, DMH convened a task force to reevaluate the DMH recommendation of one advocate per 500,000 county residents. The task force recommended a ratio of one advocate per 300,000 county residents to provide minimally adequate levels of services. However, the task force concluded that this ratio would not be sufficient to meet a number of then-current PRA responsibilities. The ratio did not, for example, include sufficient capacity for regular facility monitoring, providing ongoing training and education to mental health facility

staff, or specialized advocacy for vulnerable populations (for example, minors or older adults). There have been a handful of papers and surveys released since the 1987 study detailing the need for more staffing, but none have developed a ratio.

Recent Reports Have Emphasized Increasing County PRA Responsibilities and Unique Needs of Each County in Developing a Staffing Ratio. The California Mental Health Planning Council (CMHPC), in coordination with CAMHPRA, have released a number of reports in recent years reevaluating the increasing and changing roles of PRAs. In a 2017 white paper, they conducted a survey of county PRAs and found that, on average, county PRAs spend the most staff time (29 percent) on certification hearings but that this increased to 40 percent in counties with acute mental health facilities. The white paper concluded with a recommendation for legislation that set a staffing ratio for PRAs based primarily on the number of acute mental health beds in a county and county population, but to also consider subacute beds, acute and residential facilities, county jail populations, and the geographic size of a county.

Potential Staffing Ratio Based Only on Total County Population Likely Not Sufficiently Refined. While factors such as the total number of LPS facilities and beds may be somewhat related to county population, in counties with a disproportionately high number of beds, workload could be higher than the population numbers might suggest. The survey conducted by CMHPC and CAMHPRA found that according to the 74 respondents (representing 31 counties), six counties did not meet the one advocate per 500,000 resident ratio and 13 counties would not meet the one advocate per 300,000 resident ratio. Based on the 2024 data provided by COPR, two counties would not meet the one advocate per 500,000 resident ratio and ten counties would not meet the one advocate per 300,000 resident ratio. However, in the survey of county PRAs, 57 percent of respondents reported that their county did not have enough staffing to "adequately serve" all patients in their communities. This discrepancy may indicate that previous staffing ratios based solely on county population, even when met, are not sufficiently accounting for the workload of county PRAs. (The survey conducted by CMHPC and CAMHPRA was released online and sent to individuals PRAs, so multiple PRAs in a single county may have responded.)

Challenges Creating a Staffing Ratio. Creating an evidence-based staffing ratio would require data that are currently not collected by the state and is beyond the scope of this letter. At a high level, developing a staffing ratio generally would require evaluating the current need for PRA services and the level of staffing that would be necessary to meet that need. A combination of administrative and survey data likely would be able to provide an estimate of the current workload of county PRAs, but there is no researched estimate for the optimal number of PRAs needed based on the level of demand for each PRA service. However, we have worked to develop a framework for a staffing ratio based on some of the key factors that drive PRA workload.

Framework for Establishing a Staffing Ratio

Basic Structure of Framework. A combination of currently available administrative data (the number of LPS facilities and other mental health facilities such as IMDs in each county) and new survey information (the number of PRAs currently employed and the amount of staff time spent on different activities) could be used to develop a staffing ratio. Specifically, this

information would be used to determine the marginal impact of different factors on PRA workload, and then develop a staffing ratio that is responsive to those factors and thus sensitive to the unique needs of different counties. We discuss some of the main factors to consider when developing a PRA staffing ratio below.

Factors That Impact PRA Workload. There are a number of factors that may impact PRA workload and will vary among counties. Some of the major drivers that impact PRA workload include:

- ***Number and Size of LPS Facilities.*** The majority of hearings take place in LPS facilities and PRAs have responsibilities to provide education and training to staff at LPS facilities as well. Patients may also be more likely to file complaints in these locations since they provide involuntary care. Comparing the ratio of LPS facilities and beds to county population can help to identify counties with a disproportionately high workload.
- ***Number and Size of Other Inpatient Mental Health Facilities.*** IMDs, Psychiatric Health Facilities, and other facilities that provide inpatient or residential mental health services (including services to those individuals in conservatorships) are also likely to drive PRA workload. PRAs must ensure patients are fully aware of their rights and must regularly monitor these facilities to assess whether any patient rights are being violated. Additionally, these facilities are likely to generate complaints and require other advocacy services.
- ***County Population***. While we highlighted the limits of basing a staffing ratio solely on county population, the higher the population the more individuals will need mental health treatment or come in contact with the mental health system. This, in turn, increases the number of individuals in need of PRA services.
- ***Other Considerations.*** Counties with small populations or populations that are spread out may need a minimum number of PRAs above what would be calculated with a staffing ratio. With the implementation of AB 2275 ramping up, emergency departments and urgent care facilities may become a driver of hearings in certain counties and could be considered in establishing a staffing ratio. Many of the factors we discuss require PRAs to respond to patients' needs (hearings and investigating complaints). Additional staffing considerations will need to be made for county PRA services that are initiated by the PRA, such as facility monitoring, education for mental health providers, and receiving additional training.

ISSUES FOR LEGISLATIVE CONSIDERATION

Further Data Collection and Analysis Needed to Evaluate Sufficiency of Current County PRA Staffing Levels. There has been no statewide analysis of the current level of county PRA services being provided, whether current service levels are meeting legislative goals for county PRA services, and what level of staffing is needed to meet those goals. The Legislature may first consider a detailed survey of county PRA programs, in order to attain data not currently available on the number of hearings, complaints, trainings, and facility reviews performed by each county

PRA. Relatedly, the survey could help assess the more-difficult-to-measure reasons for county-by-county differences in workload that go beyond population and the number of mental health facilities/beds. For example, the program reviews currently performed by COPR—if expanded statewide—would provide much of the information we think should be considered when evaluating the current level of county PRA services.

Staffing Ratio Based on Multiple Factors Could Warrant Consideration, Based on Findings From Data Collection and Analysis. If the Legislature determined that the level of service provided by county PRA programs is not sufficient to meet statutory requirements and broad objectives (based on the data collection and analysis discussed above), it could consider directing the development of a staffing ratio to address the identified shortfall. Prior recommendations for staffing ratios have been based on county population. However, such an approach does not appear to adequately capture the different needs of each county. For example, one county may have a disproportionately high number of mental health facilities given its population, while another county may focus on providing education and training to local mental health providers. Additionally, county PRA workloads could differ based on the types of facilities in a county, with some facilities leading to a higher or lower number of hearings and complaints. We laid out the above multiple factors for the Legislature to consider as a framework for establishing a staffing ratio. The Legislature could consider a pilot program to assess the impact of such a staffing ratio on certain county PRA programs prior to statewide implementation.

Conducting Ongoing Oversight of County PRA Programs. As a component of our framework for establishing a staffing ratio, the Legislature could include a regular review of county PRA programs and their workload once a staffing ratio is established. Such reviews could be used to assess whether county PRA programs are meeting the staffing ratio requirement and whether those requirements are sufficient to meet legislative goals for service levels. Even if staffing ratios were not enacted, we think that there would be benefits from enhancing the level of oversight of county PRA programs. These include improving data collection and analysis as a means to ensure that statutory requirements and broad objectives as they relate to county PRA programs are being met on an ongoing basis. The Legislature could consider expanding COPR's contract, or shifting the responsibilities over county PRAs to a state entity like DHCS, to enable more direct state oversight and to provide more ongoing oversight of all county PRA programs.

Consider Potential Fiscal Implications of a Staffing Ratio. Establishing a staffing ratio for county PRA programs could have state fiscal implications, namely the possibility of creating a reimbursable state mandate. In some cases, when the state imposes a new requirement or higher level of service on local governments, the state must pay for the associated costs. In responding to your request, we were unable to arrive at a full understanding of the potential application of state mandate law to a statutorily required county PRA staffing ratio. Further analysis would need to be done if the Legislature proceeds with enacting a staffing ratio in the future.

Statutory Alternatives to a Staffing Ratio Could Serve Similar Purposes. The Legislature could consider alternatives to establishing a staffing ratio to help ensure that counties are meeting a desired minimum level of service in their PRA programs. As discussed, most of the current statutory responsibilities for county PRAs are broad and allow for flexibility in how counties

choose to have their PRA programs meet them. The Legislature could consider creating more prescriptive requirements (such as time lines) or more specific goals for county PRA programs in statute to ensure that the level of service provided by county PRA programs is consistent across the state. For example, statute could provide a specific list of the type of mental health facilities county PRAs are required to monitor, list the specific monitoring activities to be performed, and establish how many times a year county PRAs must perform site visits to those facilities. It would then fall to counties to ensure that their PRA programs meet these minimum levels of service. However, the Legislature could still consider establishing ongoing state oversight to ensure county PRA programs are meeting their statutorily mandated duties. There could be costs associated with such an approach as well, however, further analysis would be required to assess that cost based on the specific set of requirements and applicable mandate implications.

If you are interested, we would welcome the opportunity to discuss any of this letter's background information, findings, and analysis with you and/or your staff. Please contact Will Owens of my staff if you have any questions or would like to request a briefing. Will can be reached by e-mail at William.Owens@lao.ca.gov or by phone at (916) 319-8341.

Sincerely,

Gabriel Petek
Legislative Analyst