June 8, 2022

The Honorable Jim Wood, Chair
Assembly Health Committee
1020 N Street, Room 390
Sacramento, CA 95814

RE: SB 1416 (Eggman) as amended May 19, 2022 – OPPOSE

Dear Chair Wood,

The organizations submitting this letter advance and protect the rights of Californians living with mental health disabilities. We advocate for voluntary, community-based treatment and services options and the expansion of choices, rights, and liberties for people living with mental health disabilities. Because it contracts the rights and liberties of people living with mental health disabilities by enlarging the population eligible for involuntary treatment under the Lanterman-Petris-Short (LPS) Act's definition of "gravely disabled," **we oppose SB 1416**.

As discussed in detail below, our reasons for opposing SB 1416 are: (I) expanding the category of people eligible for involuntary treatment under

the definition of "gravely disabled" defeats the purpose of the LPS Act and is not justified; (II) the Legislature should prioritize investing in evidence-based practices that address the Author's reasons for seeking to expand the definition of "gravely disabled"; (III) the Legislature lacks data to support an expansion of involuntary treatment; and (IV) California lacks the infrastructure and workforce to support an expansion of involuntary treatment.

I. By expanding the category of people eligible for involuntary treatment under the definition of "gravely disabled," SB 1416 defeats the purpose of the LPS Act and is not justified.

SB 1416 seeks to expand the universe of people who can be detained for involuntary mental health treatment under the LPS Act by adding one's inability to provide for "*basic personal needs for medical care or self protection and safety"* to the definition of "gravely disabled."[1] Such an expansion is contrary to one of the primary purposes of LPS Act, which is to "end the inappropriate, indefinite, and involuntary commitment of persons with mental disorders."[2] As indicated by the State Auditor, "expanding or revising the LPS Act's criteria for involuntary holds to include standards that are overly broad—such as the ability to live safely in one's community—could be used to widen the use of involuntary holds and pose significant concerns about infringement of individual rights."[3]

According to a recent UCLA study, people who are unhoused at the time they are placed on LPS Act hold are especially vulnerable to increased infringements on liberty if the definition of "gravely disabled" is expanded.[4] Over a three-year period lasting from January 2016 through December

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[1] The current definition of "gravely disabled" that SB 1416 seeks to change is "[a] condition in which a person, as a result of a mental health disorder, is unable to provide for his or her basic personal needs for food, clothing, or shelter." Welf. & Inst. Code § 5008(h)(1)(A).

[2] Welf. & Inst. Code § 5001(a).

[3] California State Auditor, *Lanterman-Petris-Short Act: California Has Not Ensured That Individuals With Serious Mental Illnesses Receive Adequate Ongoing Care* (July 2020) at 21 (http://auditor.ca.gov/pdfs/reports/2019-119.pdf) (hereinafter "LPS Audit").

[4] Kristen R. Choi, Ph.D, R.N., *et al*., *Mental Health Conservatorship Among Homeless People with Serious Mental Illness*, Psychiatric Services, 2021; 00:1-7 (advance copy provided by author) (hereinafter "UCLA Study").

2018, UCLA researchers analyzed the cases of 795 adult patients (ages 18-56) admitted on involuntary LPS Act holds to a 28-bed inpatient psychiatric unit at a safety net hospital near downtown Los Angeles.[5] 362 of these patients were unhoused at the time of admission.[6]

Based on their review of data, UCLA researchers concluded that patients who were unhoused at the time of admission experienced longer hospitalizations and were more likely to remain unhoused when discharged.[7] They further concluded that reliance on conservatorships as a means to secure longer-term shelter and mental health treatment is a signal of systemic gaps in California's system of care.[8] This finding aligns with the State Auditor's conclusion that, "just because the LPS Act's criteria for involuntary holds and conservatorships are sufficient to meet [the Act's] intent, it does not mean that California is adequately providing services to people living with severe mental illness."[9] We agree with this conclusion.

II. <u>The Legislature should prioritize investing in evidence-based practices that exist to address the Author's reasons for seeking to expand the LPS Act's definition of "gravely disabled."</u>

[5] *Id*. at 2.

[6] *Id*. at 3.

[7] *Id*. at 4. The following data from the UCLA study is of note:

The average length of stay for patients who were unhoused at admission was 2.5 times greater than patients who were housed at the time of admission.

14% of patients who were unhoused at admission were placed on an LPS Act conservatorship, compared with only 3% of people who were housed at the time of admission.

Overall, 56% of patients who were unhoused at the time of their admission were unhoused at the time of their discharge from the acute psychiatric unit.

Of the patients placed on LPS Act conservatorship who were unhoused at the time of admission, 64% were discharged to a locked facility, 18% were discharged to an unlocked facility, and 10% were unhoused at the time of discharge. The authors noted that being discharged to a locked or unlocked facility "is not equivalent to being stably and voluntarily housed at the end of inpatient treatment."

The average length of stay in the acute psychiatric unit for all people placed on LPS Act conservatorship was 154.8 days. This does not include days spent in a locked psychiatric facility after discharge.

[8] *Id*. at 5.

[9] LPS Audit at 2.

According to the Author's fact sheet for SB 1416, "[t]he focus of the LPS Act on the ability to provide for one's food, clothing, and shelter is inadequate to address the real needs in our communities" and there are "still too many falling through the cracks and onto the streets," despite State efforts to expand community-based care.

Expanding the definition of "gravely disabled" to include one's inability to "provide for personal or medical care, or self protection and safety" does nothing to address the real needs of Californians living with mental health disabilities, especially those who are unhoused. Indeed, the UCLA researchers cited above concluded that, in California's current housing landscape, there is no guarantee that a person who was unhoused at the beginning of an LPS Act commitment will remain stably housed after a conservatorship ends.[10] Moreover, the State Auditor concluded that "involuntary holds are but one component of a more comprehensive mental health care system, and people who receive crisis intervention are not always being effectively served by the broader system. Despite the current adequacy of LPS Act criteria, significant change is needed to ensure that California is providing adequate mental health treatment to people who need it."[11]

The real needs of unhoused people living with mental health disabilities include housing and voluntary, community-based treatment and services. Permanent Supportive Housing and Assertive Community Treatment are two evidence-based practices that California should expand to meet these needs, instead of expanding involuntary treatment.

Permanent Supportive Housing (PSH) combines subsidized affordable housing with voluntary support services to address the needs of chronically homeless people with disabilities.[12] PSH is offered on a Housing First basis, which is an evidence-based, client-centered approach that recognizes housing as necessary to make other voluntary life changes,

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[10] UCLA Study at 4-5.

[11] LPS Audit at 21.

[12] California Statewide Housing Plan, Definitions (https://statewide-housing-plan-cahcd.hub.arcgis.com/pages/definitions).

such as seeking treatment or medical care.[13] The goal of Housing First is to provide housing to people quickly, with as few obstacles as possible, along with voluntary support services according to their needs.[14] A recent UCSF randomized controlled study of unhoused high utilizers of public systems in Santa Clara County found that PSH with intensive case management significantly reduced psychiatric emergency room visits and increased the rate of scheduled outpatient mental health visits compared to the control group.[15] The results of this study show that PSH can stop people from falling through the cracks, while allowing them to live in the community.

Instead of expanding involuntary treatment, which is not proven to yield long-term positive outcomes, the Legislature should focus on shoring up California's ability to provide PSH on the scale that it is needed. Through initiatives like Project Homekey and No Place Like Home, California is making investments in the supply of PSH. However, the State must match these housing production investments with investments in programming and workforce, in order to ensure the availability, integration, and continuity of supportive services for people who need them.[16] In addition, the State could exercise greater oversight over local jurisdictions to ensure that unhoused people are actually offered and placed in available PSH.[17]

Assertive Community Treatment (ACT) is an evidence-based practice that utilizes a multidisciplinary team approach to provide a wide range of community-based intensive services to people living with severe mental

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[13] *Id*. *See also* Welf. & Inst. Code § 8255.

[14] *Id*.

[15] Maria C. Raven, M.D., M.P.H., M.Sc., *et al*., *A Randomized Trial of Permanent Supportive Housing for Chronically Homeless Persons with High Use of Publicly Funded Services*, Health Services Research 2020;55 (Suppl. 2): 797 at 803.

[16] Recent reporting by Cal Matters underscored the challenges that must be addressed to ensure that PSH is used to its full potential in California. See Jackie Botts, *Five Challenges in Expanding California's Permanent Supportive Housing—and Potential Solutions*, Cal Matters, January 17, 2022 (https://calmatters.org/california-divide/2022/01/california-homeless-permanent-supportive-housing-5-challenges/).

[17] See, e.g., Nuala Bishari, *In San Francisco, Hundreds of Homes for the Homeless Sit Vacant*, San Francisco Public Press and Pro Publica, February 24, 2022 (https://www.sfpublicpress.org/in-san-francisco-hundreds-of-homes-for-the-homeless-sit-vacant/).

illness.[18] ACT teams operate 24 hours a day, seven days a week, and services are available for as long as needed and wherever they are needed.[19] ACT is a highly-integrated, team-based service delivery model, not a case management program, and is proven to be effective for people who have not been adequately served by traditional service delivery approaches.[20] ACT is designed to be delivered with fidelity to an evidence-based model.[21]

The recent behavioral health needs assessment published by DHCS found that ACT is not yet available with fidelity on the scale necessary to support optimal care for people who could benefit from the level of engagement that it offers.[22] The multi-disciplinary teams that provide ACT are not a covered benefit under Medi-Cal, despite their established effectiveness in helping people living with serious mental illness remain in the community.[23] Expanding the availability of high-fidelity ACT in California would address community needs more effectively than expanding involuntary treatment.

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[18] State of California, Department of Health Care Services, *Assessing the Continuum of Care for Behavioral Health Services in California: Data, Stakeholder Perspectives, and Implications* (January 10, 2022) at 60 (https://www.dhcs.ca.gov/Documents/Assessing-the-Continuum-of-Care-for-BH-Services-in-California.pdf) (hereinafter "DHCS Assessment").

[19] *Id*.

[20] Substance Abuse and Mental Health Services Administration (SAMHSA), *Assertive Community Treatment Evidence-Based Practice Kit: Building Your Program* at 5 (https://store.samhsa.gov/sites/default/files/d7/priv/buildingyourprogram-act_1.pdf).

[21] *Id*. at 16. The primary difference between California's Full Service Partnerships (FSP) and ACT is that there is no evidence-based model that FSPs must follow. There is significant variation in FSP delivery across counties. Some counties have ACT programs as part of their FSP offerings. When offered as part of an FSP, ACT generally provides a more engaged level of service than the standard FSP. ACT is different than Assisted Outpatient Treatment (AOT) because it is meant to be provided in accordance with recovery principles, including consumer choice, not involuntarily under a court order.

[22] DHCS Assessment at 14.

[23] *Id*. at 15. Stakeholders interviewed as part of the DHCS Assessment suggested leveraging the State's proposed SMI/SED 1115 Demonstration Program (otherwise known as the Medi-Cal IMD Exclusion Waiver) to allow Medi-Cal coverage of high-fidelity ACT teams to support programs that would divert people from inpatient hospitalization or incarceration. *Id*. at 131. We oppose any attempt to waive the Medi-Cal IMD Exclusion. However, if the State chooses to move forward with this plan, it should follow the lead of other states that have successfully added ACT to the menu of Medicaid reimbursable services as part of CMS's requirement to expand community-based care in conjunction with approval for Medicaid reimbursement for IMD services.

III. The Legislature should not expand involuntary treatment under the LPS Act because it lacks the data to support such an expansion.

Any changes to California's mental health system should be driven by clear data that supports the changes. As discussed at length during the day-long hearing held in the Assembly last December, data about all aspects of care provided under the LPS Act are severely lacking. Significantly, there is no statewide data tracking the outcomes for people placed on short-term holds or conservatorships under the LPS Act. Put simply, there is no evidence to suggest that expanding the ability to place people on LPS Act holds under the criteria of "gravely disabled" will lead to good long-term outcomes for people. Greater public availability of civil commitment statistics, including frequency of use, who is affected, durations of commitments, treatment outcomes, and trend over time, is needed to develop evidence-based civil commitment practices.[24]

In addition, baseline data is missing from the analysis of SB 1416: how many additional people are expected to be placed on LPS Act holds under the proposed expanded definition of "gravely disabled"? This critical data point is necessary to analyze the financial, infrastructure, and workforce effects of this bill.

Currently, there is legislation pending in both the Assembly and the Senate that is aimed at addressing the dearth of data related to LPS Act outcomes. If enacted, such legislation will create a framework for collecting outcomes data that can be analyzed and provide the basis for changes to the laws that govern the delivery of mental health treatment in California. Until outcomes data is available, the Legislature should not act to infringe on civil liberties of Californians living with mental health disabilities by expanding the availability to subject people to involuntary treatment.

IV. California lacks the infrastructure, workforce, and allocated program funding to support the expansion of involuntary mental

[24] Nathaniel P. Morris, M.D., *Detention Without Data: Public Tracking of Civil Commitment*, Psychiatric Services 2020; 71:741 at 742.

health treatment that would result from expanding the LPS Act's definition of "gravely disabled."

The bottlenecks that exist at all levels of California's behavioral health treatment system are well-documented. In a recent study published by the California Health Care Foundation, counties throughout the state pointed to problems with patient "throughput"—flow across the system of care—being obstructed by a lack of capacity at one or more different levels, causing ripple effects throughout the system.[25] These bottlenecks are especially severe at the point when a person is placed on an involuntary LPS Act hold. As discussed during the Assembly's hearing on the LPS Act last December, many people placed on 5150 holds languish for days in hospital emergency departments while they await referrals to community-based services or placement in acute psychiatric units, if necessary. This places increased stress on emergency departments and does not serve the treatment needs of patients. DHCS's behavioral health system assessment identified a lack of "upstream" services that could be helpful in diverting people from EDs and potential admission into inpatient facilities or incarceration and bottlenecks in "downstream" services that are necessary to transition people out of facilities in a timely manner.[26] Expanding the LPS Act's criteria for involuntary mental health treatment will only exacerbate the bottlenecks that currently exist.

The infrastructure that will come online via the State's Behavioral Health Continuum Infrastructure Program (BHCIP) will not be available soon enough to absorb additional involuntary holds that will result if the changes to the definition of "gravely disabled" under SB 1416 are enacted. 65% of the $2.2 billion in infrastructure funding under BHCIP will not even be put

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[25] California Health Care Foundation, *Medi-Cal Behavioral Health Services: Demand Exceeds Supply Despite Expansions*, September 2021 at 7-8 (https://www.chcf.org/publication/medi-cal-behavioral-health-services-demand-exceeds-supply-despite-expansions/). For example, if beds, rooms, or services are unavailable in residential and community settings, bottlenecks form that can maroon patients in acute inpatient settings and emergency departments even after they are ready for discharge. These bottlenecks can exacerbate the pressure on inpatient beds by forcing those facilities to keep patients longer than necessary at the expense of would-be new arrivals who instead receive care in a community setting that may not be appropriate for their needs. Inadequate residential placements and outpatient services can, in turn, precipitate a crisis, with people ending up at hospital emergency departments because appropriate non-hospital based services are unavailable. *Id*.

[26] DHCS Assessment at 130.

out for RFA until the second half of 2022.[27] Given the time it takes to build out infrastructure, most projects funded by BHCIP are not likely to be available in the near future. Moreover, BHCIP only funds brick-and-mortar infrastructure, not service delivery.[28] Without additional funding to provide services, counties and community-based organizations will struggle to offer expanded services necessary to meet community need.

On top of issues related to infrastructure and funding availability for services, California is in the midst of a historic behavioral health workforce shortage. The Legislature and the Administration are making efforts to address this crisis. However, as with the state's infrastructure investments, it may take time to fully realize efforts to expand the behavioral health workforce.

Lastly, over-burdened systems outside of behavioral health will also be affected by an increase in the number of people placed on short-term LPS Act holds and conservatorships. Patients' rights advocates and public defenders will have higher caseloads because more people placed on involuntary holds means more people entitled to legal representation in due process hearings. Similarly, county counsel offices and court systems will experience increased costs resulting from higher LPS caseloads. Lastly, public guardian offices—which are already stretched far beyond capacity—will have to shoulder the burden of managing an increased number of LPS Act conservatees.

V. Conclusion

The changes proposed by SB 1416 are short-sighted, costly, and do not address the underlying causes of the problems that the Author seeks to fix. If enacted, the changes to the LPS Act's existing definition of "gravely disabled" would unnecessarily infringe upon the civil liberties of Californians living with mental health disabilities. As the Los Angeles Times Editorial

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[27] Department of Health Care Services, *Behavioral Health Infrastructure Program and Community Care Expansion Listening Session*, October 2021, at slide 16 (available at: https://ahpnet.adobeconnect.com/p5w2e0xlbaxx/).

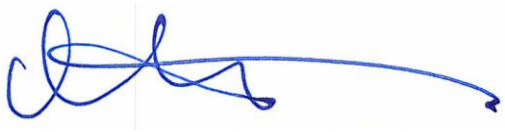
[28] DHCS Assessment at 23.

Board opined in 2018 when Assembly Bill 1971 (Santiago), another bill to expand the definition of "grave disability," was before the legislature,

> California's failure is on the service supply end. Current law already gives officials the ability to take into custody people who can't see their most basic care. But, it doesn't actually supply any of the care. Neither would the proposed change… without [housing or clinical care], changing the law to get more people off of the street just makes the revolving door of street-to-hospital-to-street spin faster.[29]

Respectfully, we oppose SB 1416.

Sincerely,



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[29] *Los Angeles Times* Editorial Board, *Well-Meaning Proposals to Change California's Mental Health Law Fall Short* (June 23, 2018) (https://www.latimes.com/opinion/editorials/la-ed-grave-disability-20180623-story.html).

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