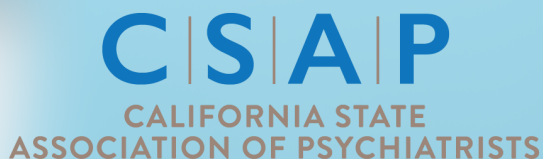


Modernizing Our Behavioral Health Continuum

April 4, 2022



SUSAN TALAMANTES EGGMAN
REPRESENTING SENATE DISTRICT 05

Introduction



Many individuals and families dealing with mental illness are not well served by our current system. Even with record investment in recent years, it will take time to see results in our communities.

This is a package of bills intended to improve the behavioral health system across the continuum, from prevention and early intervention, community supports and services, intersystem collaboration, improving access to assisted outpatient treatment, providing increased accountability through outcome tracking, preventing avoidable conservatorships, and improving the effectiveness of our conservatorship process for those that need them.

Legislation

SB 929

This bill is intended to address a data shortfall that exists on what services are provided to those under various Lanterman-Petris-Short (LPS) Act holds and their outcomes. Due to our fragmented mental health system, many different entities are involved in the identification, investigation, treatment, follow-up, and more when it comes to those experiencing serious mental illness, grave disability, or dangerousness to self or others, and current data requirements are inadequate.

SB 965

Under current law, a petition for conservatorship can be filed when a person is “gravely disabled.” This means that the person is, as a result of a mental health disorder, unable to provide for their basic needs of food, clothing, or shelter. When a petition is made, a temporary conservatorship can be established and a conservatorship investigation commences. This bill would ensure that the court is considering the contents of the report filed at the conclusion of the investigation and that, during conservatorship proceedings, relevant testimony is able to be considered, provided it falls under a hearsay exemption.

SB 970

Applies to MHSA the transformational Continuous Quality Improvement model developed and refined by other state programs. The bill has four main components:

- HHS will establish a suite of measurable outcomes from which each county will identify its goals, in consultation with local stakeholders and a new working group.
- Counties will track and report on their performance, followed by a self-improvement plan and regular progress updates. A statewide online dashboard will make the information easily accessible and allow policymakers and the public to compare counties' progress.
- The state will fund technical assistance to support counties in reaching their goals, including creating collaborative spaces for counties to learn from each other.
- Once the improvement framework is in place, HHS will 1) eliminate the current requirement for counties to spend 80% of their MHSA funds on Community Services and Supports, 20% on Prevention and Early Intervention, and 5% on Innovation, and 2) extend the three-year planning to a five-year cycle, a more realistic timeframe for achieving meaningful progress.

SB 1035

Current law allows court ordered treatment plans to include coordination and access to medication but it does not explicitly permit courts to order medication as part of a treatment plan.

This discrepancy was highlighted in the State Auditors report on the LPS Act. Medication adherence is an essential tool that allows an individual to stay safely in their community. SB 1035 would make explicit that medications can be included in an order for Assisted Outpatient Treatment when they are included in the treatment plan.

SB 1154

Mental illness, like many other health conditions, when treated early and with appropriate supports and services, will be less disabling and result in fewer adverse outcomes. Although 16% of California adults live with a mental illness, more than 60% of those individuals do not receive treatment. While we have seen a small increase in psychiatric beds since 2012, we are still falling well below nationally established standards of 40-60 beds per 100,000 population state and have 30% fewer beds than we had in 1995.

SB 1154 would establish a real-time, internet-based dashboard to collect, aggregate, and display information about beds in inpatient psychiatric facilities, crisis stabilization units, residential community mental health facilities, and licensed residential alcoholism or drug abuse recovery or treatment facilities. Access to an up-to-date database of available beds helps providers quickly find and secure treatment for clients in appropriate settings, reducing delays or extended stays in emergency rooms.

SB 1227

Under current law, counties can establish an option, through their boards of supervisors, to follow a 14-day period of intensive treatment with an additional period of 30 days for those with a mental health disorder that causes them to be a danger to self or others, or gravely disabled. This period is intended to reduce the need for conservatorships if it is expected that the patient will stabilize within 30 days. In situations where the person does not stabilize as expected, this bill would provide for one additional 30 day period as an alternative to conservatorship proceedings.

SB 1238

SB 1238 takes a regional approach to evaluation and planning to address the behavioral services and infrastructure shortage. This bill models the existing Regional Housing Needs Assessment to ensure a broader view of the behavioral health needs across the state, including requiring DHCS, in consultation with the COGs, to determine the existing and projected need for behavioral health services for each region.

SB 1416

This bill would modernize the definition of “gravely disabled” within the Lanterman-Petris-Short Act to more accurately provide for the needs faced by individuals experiencing severe mental illness. SB 1416 would include under the definition of “gravely disabled” a condition in which a person, as a result of a mental health disorder, is unable to provide for the basic needs of personal or medical care or self-protection and safety.

While the state continues its work to improve and expand behavioral health infrastructure, bring real accountability and outcomes to behavioral health dollars, increase access to community care and higher levels of treatment like AOT, there are still too many falling through the cracks and onto the streets. Estimates by the Treatment Advocacy Center are that as many as one-third of California’s population experiencing homelessness are also living with a serious mental illness. That could mean, even conservatively, tens of thousands of those living houseless in the community are also experiencing a – likely untreated, or undertreated – mental illness. Recent reporting by CalMatters uses state data indicating up to one-third of incarcerated Californians live with documented mental illness (pre pandemic).

Fact sheets for all of these bills are included on the following pages



March 16, 2022

Honorable Dr. Richard Pan
Chair, Senate Health Committee
1021 O Street, Room 3310
Sacramento, CA 95814

Re: Sponsorship of Senate Bills 929, 965, 970, 1035, 1154, 1227, 1238, and 1416

Chair Pan,

On behalf of the Big City Mayors coalition, representing the 13 largest cities and roughly 11 million residents in California, we are proud to cosponsor the Senate Bills contained in this letter, authored by Senator Eggman.

We have seen firsthand how our communities have struggled to provide appropriate and timely care to those experiencing severe mental illness. Our coalition does not typically sponsor bills, but we feel that the level of crisis we are facing is a top priority that we must all commit to solving.

This package of legislation will take a holistic view of our behavioral health continuum and provide increased opportunities and incentives for early intervention and prevention to reduce the negative outcomes we have come to see on our streets. It will also modernize portions of our treatment system to ensure that those who have fallen through the cracks are able to receive the care that they need to provide for their own needs, safety, and dignity.

Over the last several years, progress on behavioral health service delivery has been slow. This is a problem that predates the COVID-19 pandemic, which has only exacerbated our existing crisis. Inaction across the state has contributed to even greater numbers of untreated or undertreated Californians suffering along freeways and sidewalks. The status quo is unacceptable, and that's why we are advocating for substantial change.

Our constituents are the same as yours, and they are telling us loudly and clearly that we must do more to protect vulnerable Californians from suffering without the treatment and care that they desperately need and deserve.

So please, join us in supporting this package of bills, and let's show California that the wellbeing of our communities will always come first.

SB 929

SB 929 will help us better understand the current state of our LPS system and how it cares for thousands of vulnerable Californians. This bill will provide information that will help evaluate the services and strategies currently utilized, and allow the state to improve outcomes for those who are served.

SB 965

We continue to see the struggles of our community members that cycle in and out of hospitalizations, shelters, and jails without getting the concrete connections to needed medication and treatment. We are encouraging support of SB 965 to ensure that relevant history can be considered by the court in a uniform manner across the state. Tools focused on acute symptoms are not suited for chronic and severe conditions that we see on our streets. This bill will ensure that a complete and accurate picture is presented in court when considering the very serious step of conservatorship.

SB 970

The Mental Health Services Act has been a crucial, dedicated funding mechanism for community behavioral health services for the last 15-plus years, and we are excited to support the continuous improvement of the Act through SB 970. Though the Act has served as an incredible tool to build up community-based services, we feel that a more direct focus on service outcomes, increased transparency and accountability, and frequent progress reports will help improve service delivery that our communities rely on.

SB 1035

Assisted Outpatient Treatment has long been an effective, if underutilized, tool for providing appropriate and intensive outpatient treatment to Californians that have been repeatedly hospitalized or have come into contact with law enforcement due to their serious mental illness. While SB 1035 can be characterized as a clarification, we feel it is important to ensure that there is no ambiguity on the ability to include self-administered medication in a court-ordered treatment plan. Medication may not be a cure-all for the conditions faced by many in our community, but it is a key component of long-term recovery.

SB 1154

A sometimes-incapacitating challenge in our fragmented behavioral health continuum is a lack of care coordination between various provider types and a lack of information about which resources are accessible and available in the community. SB 1154 will address both issues by establishing a

database of behavioral health and substance use placements with the ability to collect important data to help assess the capacity of our system.

SB 1227

Current law allows for a gravely disabled person receiving 14 days of intensive treatment to be certified for an additional 30 days. Continuing the goal of most of the bills in this package to reduce the need for additional conservatorships, SB 1227 would allow for a single 30-day extension of the existing option for 30-day intensive treatment. Our hope is that an additional 30 days to recover and reconstitute can reduce the need for conservatorship.

SB 1238

As we have seen with our struggles with housing and homelessness, people frequently cross city and county lines seeking shelter, community, and treatment. Despite the state's view of these issues as regional in nature, behavioral health needs are not viewed in the same way. SB 1238 would establish a regional planning process to evaluate whether behavioral health services and infrastructure are meeting the needs we have today and identify the needs that we should be planning for in the future.

SB 1416

Despite all efforts to reduce the need for conservatorship, the reality is that they can sometimes be the last resort to provide critical treatment to those who are gravely disabled. These individuals are the hardest to reach and often suffer from anosognosia, a condition which prevents them from being cognitively aware of the severity of their illness. The current definition and interpretation of "gravely disabled" does not accurately reflect the realities we are seeing in our communities and on the streets. SB 1416 would include in this definition a person's ability to provide for their own personal or medical care, or self-protection and safety, to ensure that those who are truly vulnerable receive the help they need.

As was noted above, we do not typically sponsor legislation as a coalition. We feel that we have truly reached a crisis point of seriously mentally ill Californians languishing in our communities. This package of bills will make improvements across the continuum of care and better position us to support our county partners with service delivery and provide the care that our constituents are desperately seeking.

Thank you for your consideration.

Sincerely,

A handwritten signature in black ink, appearing to read "Libby Schaaf", with a stylized, flowing script.

Mayor Libby Schaaf
Oakland CA
Chair of Big City Mayors



SUSAN TALAMANTES EGGMAN

REPRESENTING SENATE DISTRICT 05

SB 929 – Lanterman-Petris-Short Act: Improved Data

SUMMARY

This bill is intended to address a data shortfall that exists on what services are provided to those under various Lanterman-Petris-Short (LPS) Act holds and their outcomes. Due to our fragmented mental health system, many different entities are involved in the identification, investigation, treatment, follow-up, and more when it comes to those experiencing serious mental illness, grave disability, or dangerousness to self or others, and current data requirements are inadequate.

BACKGROUND

The Lanterman-Petris-Short Act of 1967 was the state's attempt to deinstitutionalize those experiencing serious mental health disorders and shift to community-based services. Unfortunately, following the closure of many of these facilities, those services did not follow.

Changes at both the state and federal level followed, further slashing federal funding for community mental health and shifting mental health program responsibility to the counties. Voters then passed the Mental Health Services Act in 2004 to provide dedicated funding for community supports and services and prevention and early intervention. Shifting responsibility to the counties can provide for more nuanced decision-making around local needs, but it has also hindered our ability to fully understand how programs have worked across the state. Throughout all of these changes, we have lacked crucial data about how the LPS Act has worked and some additional ways that services provided under involuntary treatment orders can be improved to ensure the best outcomes.

Further, the state has also experienced a dramatic decline in inpatient psychiatric bed availability, which contributes to the struggles to locate appropriate services and provide for timely access to care. The Department of Health Care Services is currently required to collect and publish data on the numbers of holds under the LPS Act, but there are numerous challenges when it comes to forming

a complete picture of what is provided and how it impacts outcomes.

The most recent report, published in July of 2021, demonstrates the need for more specificity in this requirement. The tables include totals reported by each county for each of the LPS classifications, including a table of the rates of detention per 10,000 people. This data is collected from three primary sources: reports on services provided in county jails, reports on conservatorships from the Superior Court of the county, and the quarterly report on involuntary detentions.

THIS BILL

This bill would require the state Department of Health Care Services to collect additional data on the implementation of the LPS Act annually, including: outcomes for individuals placed in each type of hold, the services provided to individuals in each category, the waiting periods for individuals prior to receiving care, current and future needs for treatment beds and services, and more.

SUPPORT

Big City Mayors Coalition (Cosponsor)
Psychiatric Physicians Alliance of CA (Cosponsor)
CA State Association of Psychiatrists (Cosponsor)

FOR MORE INFORMATION

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SUSAN TALAMANTES EGGMAN

REPRESENTING SENATE DISTRICT 05

SB 965 – Conservatorships: Relevant History

SUMMARY

Under current law, a petition for conservatorship can be filed when a person is “gravely disabled.” This means that the person is, as a result of a mental health disorder, unable to provide for their basic needs of food, clothing, or shelter. When a petition is made, a temporary conservatorship can be established and a conservatorship investigation commences. This bill would ensure that the court is considering the contents of the report filed at the conclusion of the investigation and that, during conservatorship proceedings, relevant testimony is able to be considered, provided it falls under a hearsay exemption.

BACKGROUND

Under existing law, the Lanterman-Petris-Short Act of 1967 (LPS) establishes the rights, protections, and process for the provision of involuntary behavioral health treatment for someone who is “gravely disabled” or a danger to themselves or others. LPS consists of various evaluation and treatment periods, ranging from 72-hours up to renewable periods of one year under a conservatorship.

When a conservatorship petition is made to provide treatment to an individual believed to be “gravely disabled,” the person may be placed under a temporary conservatorship to allow for additional investigation. A conservatorship investigation is conducted by a public guardian employed by the county, and a report is filed with the court, which includes information on the subject of the petition’s medical, psychological, financial, family, vocational, and social condition. WIC 5008.2 also makes clear that relevant historical information about the course of one’s mental disorder shall be considered when it has a direct bearing on the determination of whether the person is gravely disabled.

In 2016, the California Supreme Court held in *People v. Sanchez*, that when any expert witness relates to the jury case-specific out-of-court statements (such as the conservatorship

investigation report), and treats those statements as true and accurate to support the expert witness’ opinion, those statements may constitute hearsay unless they fall under an existing hearsay exemption. .

There are concerns, instances of which have already come to fruition, that important medical record information may be considered hearsay within conservatorship proceedings due to *Sanchez*. In response to the LPS Audit in 2020, LA County wrote that the Legislature should: “Add state law that would allow medical experts to share details with a court about a proposed conservatee that are observed by other medical personnel and staff as recorded in a medical record and not just those directly observed as limited by *People v. Sanchez*, 63 Cal 4th 665.”

That is what this bill intends to accomplish.

THIS BILL

SB 965 would require the court to consider relevant history and the comprehensive report submitted by the public guardian after investigation. It would also create a hearsay exemption for information contained in a medical record in order to ensure all relevant information can be presented to, and considered by, the court.

SUPPORT

Big City Mayors Coalition (Cosponsor)
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SUSAN TALAMANTES EGGMAN

REPRESENTING SENATE DISTRICT 05

SB 970 – MHSA Outcomes and Accountability Act

SUMMARY

Requires counties to set ambitious goals for their Mental Health Services Act (MHSA) programs and the state to monitor and publicly report their progress. It also shifts the focus of spending priorities to focus on achievable outcomes rather than specific buckets.

BACKGROUND

Since its passage by voters in 2004, the MHSA has provided more than \$18 billion to strengthen the state's behavioral health infrastructure and support services focused on wellness and recovery. Its successes include broad expansion of the proven Full Service Partnership model, creation of wellness and recovery centers throughout the state, and a shift in public attitudes toward people with behavioral health problems.

But California still faces major challenges closely linked to behavioral health disorders:

- Deaths from opioid and methamphetamine use have skyrocketed.
- More than 50,000 people experiencing homelessness live with a serious mental health condition.
- Rates of major depression among adolescents increased by more than 50% over 12 years. This contributed to a doubling in the number of ER visits by suicidal children and teenagers.

Each of these heartbreaking facts compels us to ask whether MHSA funds are focused on meeting our communities' greatest needs. The Act allows counties great spending flexibility, leading some to embrace innovation. What's missing is accountability for setting goals, tracking outcomes, and continually improving approaches to address state and local challenges.

THIS BILL

Applies to MHSA the transformational Continuous Quality Improvement model developed and refined

by other state programs. The bill has four main components:

1. **Establishing measurable outcomes that address top public priorities.** Health and Human Services Agency (HHS) will convene a stakeholder working group that includes data and metric experts. Based on their recommendations and the outcomes specified in the bill, HHS will establish a suite of measurable outcomes from which each county will identify its goals, in consultation with local stakeholders.
2. **Publicly tracking progress and continuously improving.** Counties will track and report on their performance, followed by a self-improvement plan and regular progress updates. A statewide online dashboard will make the information easily accessible and allow policymakers and the public to compare counties' progress.
3. **Supporting counties and sharing best practices.** The state will fund technical assistance to support counties in reaching their goals, including creating collaborative spaces for counties to learn from each other.
4. **Allowing county goals to drive spending.** Once the improvement framework is in place, HHS will 1) eliminate the current requirement for counties to spend 80% of their MHSA funds on Community Services and Supports, 20% on Prevention and Early Intervention, and 5% on Innovation, and 2) extend the three-year planning to a five-year cycle, a more realistic timeframe for achieving meaningful progress.

This powerful next step in the MSHA's evolution will bring the act closer to fulfilling its promise to tackle major statewide challenges. A relentless insistence on accountability and improvement will focus energy where it belongs: facilitating the recovery and thriving of Californians who live with severe mental illness and substance use disorders.



SUSAN TALAMANTES EGGMAN

REPRESENTING SENATE DISTRICT 05

SB 970 – MHSA Outcomes and Accountability Act

SUPPORT

Steinberg Institute (sponsor)

Big City Mayor Coalition (Cosponsor)

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SUSAN TALAMANTES EGGMAN

REPRESENTING SENATE DISTRICT 05

SB 1035– AOT: Medication Requirements

SUMMARY

This bill will give courts the express authority to include self-administered medication requirements in assisted outpatient treatment plans.

BACKGROUND

In 2020, AB 1976 required the implementation of Assisted Outpatient Treatment (AOT) statewide unless a county chose to opt out. At this time, over 30 counties have adopted a program, ensuring that this effective and community-based approach to mental health treatment will continue to serve individuals in need. Last year, SB 507 updated the eligibility requirements by allowing individuals exiting 5150 holds or those who have recently left conservatorships to benefit from the continuum of treatment and services that AOT offers. It also added a small step towards medication adherence by addressing an individual's capacity to give informed consent regarding psychotropic medication. As we continue to build a strong infrastructure improving access and availability of both voluntary and court-ordered treatment, medication compliance is vital to ensuring long term stabilization and the ability to thrive in the community.

Current law allows court ordered treatment plans to include coordination and access to medication but it does not explicitly permit courts to order medication as part of a treatment plan. This discrepancy was highlighted in the State Auditors report on the LPS Act. Medication adherence is an essential tool that allows an individual to stay safely in their community. Adopting this recommendation would give counties a mechanism to ensure that individuals that are at a high risk of medication noncompliance remain on their medication and maintain their stability. This allows recovery to take place in the least restrictive environment possible which is the intent of our State's mental health system.

According to the State Auditor's findings, the prevailing factor that determines why individuals

cycle back into restrictive settings is medication non-compliance. The report further determined that 12 other states include court ordered medication in their outpatient treatment plans, specifying medication plan details and administering practices. Explicitly allowing court-ordered medications to be incorporated into assisted outpatient treatment plans with the clear intent that an individual will self-administer the medication is key to preserving their stability and decreasing their high risk of repeated hospitalization, or arrest and incarceration.

THIS BILL

SB 1035 would make explicit that medications can be included in an order for Assisted Outpatient Treatment when they are included in the treatment plan.

SUPPORT

Big City Mayors Coalition (Cosponsor)
Psychiatric Physicians Alliance of California (Cosponsor)
CA State Association of Psychiatrists (Cosponsor)
Steinberg Institute
California State Sheriff's Association

FOR MORE INFORMATION

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SUSAN TALAMANTES EGGMAN

REPRESENTING SENATE DISTRICT 05

SB 1154 – Behavioral Health Bed Database

SUMMARY

SB 1154 would establish a real-time, internet-based dashboard to collect, aggregate, and display information about beds in inpatient psychiatric facilities, crisis stabilization units, residential community mental health facilities, and licensed residential alcoholism or drug abuse recovery or treatment facilities. Access to an up-to-date database of available beds helps providers quickly find and secure treatment for clients in appropriate settings, reducing delays or extended stays in emergency rooms.

BACKGROUND

In 2019, the federal Substance Abuse and Mental Health Services Administration (SAMHSA), along with the National Association of State Mental Health Program Directors (NASMHPD), began work with 23 states “to improve their coordination of crisis services by making web-based bed registries accessible to front line crisis counselors in local behavioral health agencies, mobile crisis teams, crisis call centers, and hospital emergency departments.” Hospital emergency departments continue to be frontline responders to those in behavioral health crisis, and finding the most appropriate treatment, as timely as possible, is critical to improve outcomes.

Mental illness, like many other health conditions, when treated early and with appropriate supports and services, will be less disabling and result in fewer adverse outcomes. Although 16% of California adults live with a mental illness, more than 60% of those individuals do not receive treatment. While we have seen a small increase in psychiatric beds since 2012, we are still falling well below nationally established standards of 40-60 beds per 100,000 population state and have 30% fewer beds than we had in 1995.

Many individuals receive initial assessment and stabilization for a psychiatric crisis in the emergency department, which is a crucial piece of the safety net for individuals with difficulty accessing mental health services including those

who lack awareness of their own mental health condition. However, due to a combination of a difficult to navigate crisis response system which lacks adequate capacity - an environment not conducive to the stabilization of psychiatric crisis - and a lack of mental health programs, facilities and professionals, individuals in crisis often languish untreated in emergency departments for long periods of time as ED staff struggle to find open beds.

In addition to streamlining access to care, these databases can be useful data tools. Nine of the state projects use bed registry data to measure bed capacity and utilization to monitor resources, promote their appropriate use, and inform budget and policy decisions. Five states use bed registry data to measure the effectiveness of diversion policies and strategies to treat crises in the least-restrictive environment

THIS BILL

This bill requires the California Department of Public Health, in consultation with the State Department of Health Care Services and the State Department of Social Services to establish a database for psychiatric, substance use disorder, and community mental health bed openings, to be updated and maintained as changes in availability occur in order to streamline communication and reduce patient waiting time for placement in appropriate beds.

It would require the database to include a minimum of specific information, including the contact information for a facility’s designated employee, and have the capacity to, among other things, enable searches to identify beds that are appropriate for the treatment of individuals in a mental health or substance use disorder crisis.

SUPPORT

Big City Mayors Coalition (Cosponsor)
Psychiatric Physicians Alliance of California (Cosponsor)
CA State Association of Psychiatrists (Cosponsor)



SUSAN TALAMANTES EGGMAN

REPRESENTING SENATE DISTRICT 05

SB 1154 – Behavioral Health Bed Database

Steinberg Institute
California State Sheriffs' Association
Alcohol Justice

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SUSAN TALAMANTES EGGMAN

REPRESENTING SENATE DISTRICT 05

SB 1227 – Additional 30 Days of Intensive Treatment

SUMMARY

Under current law, counties can establish an option, through their boards of supervisors, to follow a 14-day period of intensive treatment with an additional period of 30 days for those with a mental health disorder that causes them to be a danger to self or others, or gravely disabled. This period is intended to reduce the need for conservatorships if it is expected that the patient will stabilize within 30 days. In situations where the person does not stabilize as expected, this bill would provide for one additional 30 day period as an alternative to conservatorship proceedings.

BACKGROUND

Under existing law, the Lanterman-Petris-Short Act of 1967 (LPS) establishes the rights, protections, and process for the provision of involuntary behavioral health treatment for someone who is “gravely disabled” or a danger to themselves or others. LPS consists of various evaluation and treatment periods, ranging from 72-hours up to renewable periods of one year under a conservatorship.

If a person is detained for 72 hours and has been evaluated, they may be certified for up to 14 days of further intensive mental health treatment (or treatment related to impairment by chronic alcoholism) if the professional staff of the agency or facility providing care has found the person is gravely disabled or a danger to self or others; a state designated facility agrees to provide the intensive treatment; the person will not accept necessary treatment voluntarily; they don’t have others that can help them meet their needs of food, clothing, and shelter. The certification must then be delivered to the person certified and their attorney or advocate. The person has a right to a certification review hearing, to be held within 4 days of their certification, and the review hearing shall be conducted by either a court-appointed commissioner or a referee, or a certification review hearing officer. If the hearing determines there is not probable cause to believe the person is a

danger or gravely disabled then the person may no longer be detained.

If there is probable cause, the person will continue to receive involuntary treatment for up to 14 days. They will then be released at the end of 14 days, unless: they agree to voluntary treatment, they are certified for an additional 14 days of treatment (additional treatment for suicidal persons), they are certified for 30 days of additional intensive treatment, or they are the subject of a conservatorship petition.

The 30-day intensive treatment (WIC 5270.10-5270.65) is only an option in counties that have adopted a resolution authorizing it. If the professional staff believe a person completing a 14-day hold would benefit from an additional 30 days of treatment, they repeat the certification process above. A 30-day intensive hold is not required prior to a conservatorship. WIC 5270.55 (a) states specifically that if conservatorship appears likely, a referral should be made during the initial 14-day intensive treatment period. According to WIC 5270.55 (b): If it appears that with up to 30 days additional treatment a person is likely to reconstitute sufficiently to obviate the need for appointment of a conservator, then the person may be certified for the additional 30 days.

THIS BILL

SB 1227 would allow this certification process to be repeated for one additional period of 30 days of intensive treatment, if it appears likely they will recover in that time and a conservatorship can be avoided.

SUPPORT

Big City Mayors Coalition (Cosponsor)
Psychiatric Physicians Alliance of CA (Cosponsor)
CA State Association of Psychiatrists (Cosponsor)

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SUSAN TALAMANTES EGGMAN

REPRESENTING SENATE DISTRICT 05

SB 1238 – Behavioral health services: existing and projected needs.

SUMMARY

This bill requires the Department of Health Care Services (DHCS) to work with each council of governments (COG) to identify each regions' projected need for behavioral health services. This bill follows the model established by the Regional Housing Needs Assessment to take a broad and holistic view of regional behavioral health needs to ensure the collaboration needed to provide the most appropriate and timely care.

BACKGROUND

Currently across the state there is a shortage of adequate placements for people suffering from behavioral health issues. There is a growing need for behavioral health services across the continuum, from inpatient psychiatric beds and Assisted Outpatient Treatment to community-based prevention and early psychosis interventions.

DHCS recently completed an assessment of our behavioral health service continuum in California and included a number of findings indicating that there is a lack of appropriate services. Specifically, the assessment reported:

- "...the rate of serious mental illness in California as reported in survey data has increased by more than 50 percent from 2008 – 2019"
- "One in 13 children in California has a [serious emotional disturbance], with rates higher for low-income children and those who are Black or Latino, relative to other racial and ethnic groups"
- "...marginalized groups in California often are at higher risk for behavioral health issues, but also are less likely to be able to access services."
- "...close to one in three adults in prison (30 percent) received mental health services in 2017, more than doubling the rate since 2000. Jails typically have even higher rates of individuals living with mental health and substance use disorders, largely because

people may have been arrested and incarcerated for nuisance crimes associated with their conditions"

- "Among Californians seeking mental health services, more than four in ten (43 percent) reported that it was somewhat or very difficult to secure an appointment with a provider who accepts their insurance."

Lack of appropriate treatment options funnels patients to emergency rooms, county jails, and homelessness instead of a proper treatment option. The Rand Corporation recently partnered with CalMHSA to study projected psychiatric bed need regionally in California. This report recommended that the state:

"Prioritize psychiatric bed infrastructure in the areas with the greatest need. In terms of an absolute shortfall of beds, the shortfall was greatest in terms of subacute beds, driven partly by four regions (Los Angeles County, San Francisco Bay Area, Inland Empire, Superior region) that represented a shortfall of more than 2,000 beds—more than a quarter of all additional beds needed throughout the state. If policymakers examine the psychiatric bed shortfall as a proportion of regional adult population, this might lend greater weight to regions with smaller or more rural populations: For example, the shortfall of subacute beds is 5.2 beds per 100,000 adults in Los Angeles County compared with 17.2 per 100,000 adults in the Southern San Joaquin Valley. (p.4)"

THIS BILL

SB 1238 takes a regional approach to evaluation and planning to address the behavioral services and infrastructure shortage. This bill models the existing Regional Housing Needs Assessment to ensure a broader view of the behavioral health needs across the state, including requiring DHCS, in consultation with the COGs, to determine the existing and projected need for behavioral health services for each region.



SUSAN TALAMANTES EGGMAN

REPRESENTING SENATE DISTRICT 05

SB 1238 – Behavioral health services: existing and projected needs.

SUPPORT

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Psychiatric Physicians Alliance of California (Co-Sponsor)
California State Association of Psychiatrists (Co-Sponsor)

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SUSAN TALAMANTES EGGMAN

REPRESENTING SENATE DISTRICT 05

SB 1416 – Modernizing “Gravely Disabled” in the LPS Act

SUMMARY

This bill would modernize the definition of “gravely disabled” within the Lanterman-Petris-Short Act to more accurately provide for the needs faced by individuals experiencing severe mental illness. SB 1416 would include under the definition of “gravely disabled” a condition in which a person, as a result of a mental health disorder, is unable to provide for the basic needs of personal or medical care or self-protection and safety.

BACKGROUND

The Lanterman-Petris-Short Act of 1967 was the state’s attempt to deinstitutionalize those experiencing serious mental health disorders and shift to community-based services. Unfortunately, following the closure of many state institutions, those services did not follow.

Changes at both the state and federal level followed, further slashing federal funding for community mental health and shifting mental health program responsibility to the counties. Voters then passed the Mental Health Services Act in 2004 to provide dedicated funding for community supports and services and prevention and early intervention. While this funding has shown so much promise and helped provide access to critical care to many Californians, including through full service partnerships, there are still many barriers to providing the appropriate and timely care to many struggling at the margins, disconnected from treatment.

While the state continues its work to improve and expand behavioral health infrastructure, bring real accountability and outcomes to behavioral health dollars, increase access to community care and higher levels of treatment like AOT, there are still too many falling through the cracks and onto the streets. Estimates by the Treatment Advocacy Center are that as many as one-third of California’s population experiencing homelessness are also living with a serious mental illness. That could mean, even conservatively, tens of thousands of those living houseless in the community are also

experiencing a – likely untreated, or undertreated – mental illness. Recent reporting by CalMatters uses state data indicating up to one-third of incarcerated Californians live with documented mental illness (pre pandemic).

The 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. While some may point to the State Auditor’s recommendation that the criteria are adequate and consistently applied, this is not a finding corroborated by many in the behavioral health community. The Legislature has taken, and will continue to prioritize, steps to develop access to community-based treatment, early intervention, supported decision-making, assisted outpatient treatment, and every other step along the continuum to prevent the need for LPS Act holds and conservatorships.

In its written response to the Audit, San Francisco County noted: “While a very small proportion of individuals with serious mental illness have episodes of violence, individuals with mental illness are disproportionately victims of violence in our communities. We encourage every effort to protect these individuals and support patient rights protections to ensure that involuntary care is a last resort to support the recovery and wellness of an individual; however, as experts in behavioral health it is our professional opinion that these resources are needed in serious cases.”

There are serious risks faced by those living with serious mental illness that extend beyond their ability to provide for food clothing and shelter. This bill takes those additional risks into account when it comes to providing behavioral health care.

THIS BILL

SB 1416 would amend the definition of “gravely disabled” to add additional core criteria that a person experiencing serious mental illness should have the capacity to provide for their own personal or medical care, and their own self-protection and



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safety when considering whether a conservatorship or other involuntary intervention is appropriate.

SUPPORT

Big City Mayors Coalition (Cosponsor)
Psychiatric Physicians Alliance of California
(Cosponsor)
CA State Association of Psychiatrists (Cosponsor)

FOR MORE INFORMATION

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