December 10, 2021

The Honorable Mark Stone, Chair
Assembly Committee on Judiciary
1020 N Street, Room 104
Sacramento, CA 95814

The Honorable Jim Wood, Chair
Assembly Committee on Health
State Capitol, Room 6005
Sacramento, CA 95814

RE: December 15, 2021, Joint Hearing on Lanterman-Petris-Short Act

Dear Chairs Stone and Wood:

The California Association of Social Rehabilitation Agencies (CASRA) would like to thank you for the opportunity to submit the following written testimony in advance of the December 15, 2021, joint hearing on the Lanterman-Petris-Short Act (LPS). CASRA, which was founded more than 40 years ago, represents 28 behavioral health agencies across the state that provide services to more than 75,000 individuals annually. Our community-based organizations contract with County Behavioral Health systems throughout California to provide services to those individuals most seriously impacted by serious mental illness. As such we have extensive experience in providing services to those who are homeless, dually diagnosed with substance abuse disorders as well as those who are often characterized as difficult to engage into services.

Although a detailed agenda has yet to be made public, CASRA believes the hearing will center on the possibility of redefining and expanding a key criterion involved in W&I §5150/5250 involuntary detentions as well as making other changes that would expand the conditions under which an LPS conservatorship would be permitted, and expanding the powers granted under those conservatorships. The comments below focus on involuntary detentions as they are the pathways to more restrictive LPS conservatorships.

It is CASRA's position that LPS's current definition of "grave disability" should remain unchanged. This is precisely the same conclusion reached by the State Auditor in its July 2020 report, which was ordered by the Joint Legislative Audit Committee. The State Auditor made three key findings:

- LPS's criteria and framework, including the definition of grave disability, appropriately enable County Behavioral Health Departments and the courts to place individuals in need of involuntary treatment on holds or conservatorships.

- The continuum of services, from intensive treatment to step down community-based options, are not readily available for people in need. Both the State and local facilities lack adequate capacity to treat all individuals who require care under LPS.

- There is an explicit need for transparency and accountability on the part of the State, and the County Behavioral Health System, both with the expenditure of funds as well as outcome performance measures.

You will no doubt hear and receive important testimony from others that will lay out the legal ramifications of the Legislature pursuing a course that would further erode civil liberties and an individual's right to receive voluntary services of their choosing in the community. CASRA is in full agreement with these points and will be willing to join in any future legal action that may become necessary to protect these rights. At the same time, CASRA would also like to advance a practical, efficacy-based argument – people, including individuals who have been diagnosed with a mental illness, will not do anything they do not want to do for very long.

Put another way, the current call for an expansion of LPS criteria is a continuation of our tendency, where mental illness is concerned, to continue to blame the customer for our inability to make the sale. If you ask anyone who has worked in sales, what we really need are better product lines, better sales pitches and sometimes, different salespersons.

The good news is that thanks to recent/intended policy changes and historic funding allocations made by the Legislature and the Administration, the first two of these three key elements, infrastructure, and assessments/eligibility/documentation, should be addressed over the next few years, and the third, workforce, though somewhat more daunting, is at least recognized by almost everyone as a key component of achieving success.

Changing/expanding LPS will do absolutely nothing to move the needle in a positive direction for any of these three elements. Moreover, the time and energy associated with contending with proposed changes to LPS will only serve to undermine the efforts to make improvements in all three.

With respect to infrastructure, the more than $3 billion contained in the Behavioral Health Continuum Infrastructure Program and the Community Care Expansion Program represent once in a generation investments in creating the program space necessary to provide a wide range of voluntary, community-based treatment and intervention options for Californians. It is these options that constitute the more appealing "product line" mentioned above. It is much easier to connect people with options to which they are attracted.

These investments are as overdue as they are welcome. They are also certain to take several years to result in new program and other space - such is the nature of rehabilitation and construction projects – they never move as fast as you (or the public) would like. However, it should be plainly obvious that changing LPS criteria will do nothing to speed along these admittedly slow processes.

When it comes to assessments/eligibility/documentation, or the "sales pitch" part of the equation, the public mental health system, and private plans have continuously applied a "one size fits all" approach. Effective salespeople recognize that each sales pitch must be tailored to each customer, especially when the customer is not already fully convinced of the merits of the product. Instead of receiving tailored, tangible assistance up front, clients, consumers, and patients in our current systems are asked a serious of questions to determine eligibility, given return appointments that can be weeks down the road, all the while not receiving anything that actually improves their situation. When they do not return, they are labeled as "difficult to treat" and "resistant" and therefore require other interventions, including involuntary treatment, to address/overcome their lack of "insight".

Here too there is hope. The California Advancing and Innovating Medi-Cal (CalAIM) initiative promises to dramatically alter and improve the ways in which people are treated on the front end of their care experience. Instead of focusing on eligibility via diagnosis, the public mental health system and its providers will be able to focus on helping from the beginning so that the trusting relationships that are so vital for effective care can be established. This change in customer experience should do much to help people engage in and stick with care. In the private health plan world, improved enforcement of parity regulations around timeliness, access to care and the expansion in types of care should have a similar effect.

But like all initiatives, CalAIM has a schedule, which has been pushed back for reasons that are completely understandable such as the pandemic and bandwidth in agencies and departments that have been given many new initiatives to implement. Likewise, parity enforcement, as anyone involved in that space can tell you is an arduous process, but substantial gains have been made over the years. More will follow, but these things take time.

Once again, when it comes to effectively engaging people in treatment, changing LPS law does nothing to expediate the process or increase the benefits. There is plenty of research that shows that the quality of the relationship is the single most important and controllable facet of an intervention's success. Easing the ability to force people into treatment only serves to undermine the trusting relationships necessary for services to be effective.

Finally, sometimes you must realize that you (we) might be the problem. California has experienced a behavioral health workforce shortage for many years. This shortage has reached crisis levels during the pandemic. Added to this has been a long-standing incongruence in diversity between those providing services and those receiving them. Your salesforce will have better sales if your customers see themselves in your salesforce. Why would this be any different when it comes to "selling" behavioral health services?

Fortunately, efforts around Peer Certification and the use of community health workers are moving forward in California, as are efforts to further diversify the workforce. These are efforts that will take years to fully reach their goals. A high school student who decides today that they want to pursue a

career in behavioral health is still at minimum a few years away from being able to enter that workforce.

As before, changing LPS law will not add to the diversity of the workforce, nor will it develop the pipelines necessary to bring in the thousands of new workers that will be needed to bring the more than a dozen behavioral health initiatives that are slated to launch in the next couple of years to fruition.

Staying the course on LPS will be difficult in the face of growing and what CASRA believes to be ill-informed calls to do otherwise. The much stated and unsupported causal link between untreated mental illness and homelessness cloaks the complexity of the issue and turns attention away from far more important factors such as poverty and lack of affordable housing. All indicators point to the likelihood that the homelessness crisis is likely to get worse. This will not be due to an increase in the numbers of people experiencing mental illness, but rather a somewhat delayed impact of the economic consequences of the pandemic. Changing LPS will do nothing in terms of properly addressing the worsening crisis.

Staying the course on LPS will be difficult, but it is precisely what the State Auditor has recommended, and it is precisely what is needed to allow for the several critical and positive efforts mentioned above to have a chance to transform what we offer into something that far more people – our customers - will want.

Thank you again for this opportunity to provide testimony.

Sincerely,

Chad Costello, CPRP
Executive Director