**Written Testimony of Kim Lewis, Managing Attorney, National Health Law Program**

**Joint Assembly Health and Judiciary Committee**
**Informational Hearing on The Lanterman-Petris-Short Act: How Can it be Improved?**
**Wednesday, December 15, 2021 – 9:00 a.m. to 5:00 p.m.**
**State Capitol, Room 4202**

Good afternoon Chairs Wood and Stone, and members of the Committees, my name is Kim Lewis, and I am the managing attorney of the California office of the National Health Law Program. It is my privilege to be here today to talk to you about The Laternman-Petris-Short (LPS) Act, and how to improve the delivery of mental health services in California. By way of background, I am very familiar with California's mental health system and the LPS Act, as I have worked on these issues for over 30 years. Specifically, I worked for 10 years as the Legal Director of a patients' rights program in San Diego County where I was directly responsible for addressing the rights of children and adults who were patients at LPS facilities in the county. I represented hundreds clients who were involuntarily committed to psychiatric hospitals and at the county jails or placed on LPS conservatorships.

Today I want to make 3 points the Committees and Legislature should strongly consider in determining whether any further changes to the LPS Act need to be made, and which points do not support further broadening of involuntary behavioral health treatment in California. While I do not plan to focus my comments specifically on the civil and constitutional rights that are at risk of being further eroded, these fundamental rights are of paramount importance and must be considered. The LPS Act has been repeatedly expanded since its enactment in 1967, as my testimony this morning outlined a few of these changes in greater detail.

First, *the LPS Act has been expanded numerous times, most recently in 2021, and those laws have not been demonstrated with outcomes to be successful or effective, and some of those requirements have not even been implemented*. For example, the conservatorship "pilots" allowed in San Francisco, Los Angeles and San Diego created by SB 1045 in 2018 and further broadened by AB 40 in 2019 allow for appointment of a conservator for a person who is incapable of caring for his or her own health and well-being due to a serious mental illness and substance use disorder, as evidenced by frequent detention for evaluation and treatment under 72-hour involuntary holds. Those conservatorships give these counties expanded authority by eroding the existing more narrow grave disability criteria allowed under the LPS Act. Yet, where is the evidence that these are either effective or must be further broadened? In fact, a final report on these very questions is not due to the Legislature until January 1, 2023. Similarly, the Assisted Outpatient Treatment program ("AOT" or "Laura's Law") has been expanded multiple times, first in 2013 (through SB 364), and recently in 2020 (through AB 1976), and again in 2021 (through SB 507). The most recent of those bills has not even taken effect yet, and still more bills are continuing to be introduced to further broaden these civil commitment laws and remove people's civil liberties. Where is the justification to broaden AOT when there are not yet any demonstrated benefits or evaluation of outcomes from the changes the Legislature and Governor have recently made?

Further, every randomized controlled study of AOT has demonstrated that there is no evidence that mandating outpatient treatment through a court order is effective.[1] As these studies have shown, there are effective voluntary community-based services that are evidence-based, and those should be the focus of state policy solutions, such as Assertive Community Treatment (ACT), which is a highly individualized, team-based service designed to support adults with the most intensive mental health needs.[2] There is extensive international research on the effectiveness of ACT and it is endorsed and supported by the federal Substance Abuse and Mental Health Services Administration (SAMHSA).

Second, *more supportive housing and "Housing First" models are needed.* There can be no question that one of the fundamental needs of people with mental health conditions and substance use disorders who are unhoused is the both affordable and supported housing - that is, individual housing transition and tenancy support services provided to individuals who need support to transition to and maintain housing. Such services may include an assessment to identify preferences and barriers to housing, developing a housing support plan with short and long-term goals, developing a housing crisis plan to prevent disruption of housing, early identification and intervention for behaviors that may jeopardize housing, education and training about how to maintain housing and the roles of landlords and tenants, assistance in resolving disputes, and linkage to other community resources to prevent eviction. In fact Proposition 63, the Mental Health Services Act (MHSA) championed by then Assemblymember Steinberg, was specifically intended to expand voluntary services of AB 34/2034 enacted in 1999/2000 (Statutes of 1996, chapter 153 (SB 659)) to establish the "integrated services" model of supported housing for adults in California who have serious mental illnesses and are, or are at-risk of becoming, homeless. AB 34/2034 services include outreach, medical care, short- and long-term housing, prescription drugs, vocational training, and self-help and social rehabilitation. A 2003 report to the Legislature found that AB 34/2034 services had been highly successful at reducing participants' hospitalizations, incarcerations, and homelessness, while increasing their employment. In fact, this program was seen as a national model for addressing the issue of homelessness and mental illness. Yet to date, these supported housing programs have not received adequate investment or been brought to scale statewide despite evidence from at least one large study by USCF that found people will accept supportive housing if it is offered to them.[3]

It has been our position that use of Prop 63 funds to pay for the costs of existing services other than an AB 34/2034 program violates the maintenance of efforts requirements of that law. Instead, MHSA funds are being used to fund involuntary mental health AOT [per SB 585 (Steinberg), Statutes of 2013], and as a fiscal match for Medi-Cal covered behavioral health services for all Medi-Cal covered populations. The state

[1] M. Susan Ridgely et al., RAND Health and RAND Institute for Civil Justice, The Effectiveness of Involuntary Outpatient Treatment: Empirical Evidence and the Experience of Eight States (2001); Tom Burns, Community Treatment Orders for Patients with Psychosis, The Lancet, vol. 381, pp. 1627-33 (May 11, 2013); Steve R. Kisely, et al.. Compulsory community and involuntary outpatient treatment for people with severe mental disorders, Cochrane Database of Systematic Reviews (2017).

[2] Substance Abuse and Mental Health Services Administration. Assertive Community Treatment: The Evidence. DHHS Pub. No. SMA-08-4344, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2008. https://store.samhsa.gov/sites/default/files/d7/priv/theevidence_1.pdf

[3] Maria C. Raven et al., University of California San Francisco, A randomized trial of permanent supportive housing for chronically homeless persons with high use of publicly funded services, Health Serv Res., vol. 55 (Issue S2), pp. 797–806 (September 25, 2020) (researchers found all but one of 424 most chronically homeless people in Santa Clara who most frequently ended up in the emergency room or jail accepted permanent housing when offered; nearly 90% of the 169 participants placed in supportive housing, which included voluntary treatment, stayed in housing for several years), https://doi.org/10.1111/1475-6773.13553.

must require increased investment, including MHSA funds, to grow evidence-based supportive housing models, and behavioral health crisis response services, instead of increasing reliance on AOT or broader LPS conservatorships.

Third, *more resources are needed to improve accountability and build capacity in California's behavioral health system.* Medi-Cal is the largest payer of behavioral health services with over 13.5 million low-income Californians relying on it for coverage. The state is also in the midst of undertaking a major overhaul of Medi-Cal through the California Advancing and Innovating Medi-Cal ("CalAIM") Initiative, including an expansion of eligibility for specialty mental health services and substance use services and coverage of new types of services (for example, peer support specialists and community health worker services). Yet access remains a major concern and the public behavioral health system cannot meet the current demand for services. The most recently released Department of Health Care Services 2020 report to the federal Centers for Medicare and Medicaid Services (CMS) on Annual Network Certification for Medi-Cal Specialty Mental Health Services stated that less than a quarter of the 56 County Mental Health Plans in California received a passing network adequacy rating.[4]

A September 2021 California Health Care Foundation report that examined behavioral health needs challenges in California related to access to behavioral health services for Medi-Cal enrollees found that demand exceeds supply.[5] It found the factors contributing to these access issues include chronic workforce shortages, the complexity of the Medi-Cal behavioral health services system and lack of integrated behavioral and physical health care, and capacity and services gaps that exist within different levels of care (for example, the availability of mobile crisis services). Rather than expanding involuntary commitment laws and adding psychiatric hospital and Institute for Mental Disease (IMD) beds at a higher cost, which will only funnel more scarce resources into institutional care, California needs to address the current access crisis that has been further exacerbated by the ongoing public health emergency, as multiple surveys have found significantly increased levels of adverse mental health conditions, substance use, and suicidal ideation because of the COVID-19 pandemic.

The goal is to have a behavioral health system that is responsive to needs when and where they arise, with sufficient outreach engagement to populations who are unhoused, so they don't end up being hospitalized or incarcerated in the first place. To that end, we urge you to focus any legislative proposals concerning mental health and substance use disorder on ensuring and expanding the availability of community-based behavioral health services and supportive housing.

Thank you for the opportunity to testify on this important topic and I am happy to answer any questions.

[4] Department of Health Care Services, Annual Network Certification on Specialty Mental Health Services, September 14, 2020, https://www.dhcs.ca.gov/Documents/2020-Annual-Network-Certification-Report.pdf (only 13 of the 56 County Mental Health Plans in California received a passing network adequacy rating; the remaining 43 plans obtained a "conditional pass" and must submit Corrective Action Plans (CAPs) to the DHCS to address not meeting the various timely access and provider network standards as required in both State and federal law).

[5] Blue Sky Consulting Group, Medi-Cal Behavioral Health Services: Demand Exceeds Supply Despite Expansions, California Health Care Foundation, 2020 Regional Markets Study series, September 10, 2021, https://www.chcf.org/publication/medi-cal-behavioral-health-services-demand-exceeds-supply-despite-expansions/#related-links-and-downloads.