December 3, 2021

The Honorable Jim Wood, Chair, Committee on Health
The Honorable Mark Stone, Chair, Committee on Judiciary

RE: Mental Health America of California's Testimony
Joint Hearing: The Lanterman-Petris-Short Act: How Can It Be Improved?

Mental Health America of California (MHAC) is a peer-run organization that has been leading the state in public policy and advocacy since 1957. We appreciate the opportunity to provide written testimony to the Joint Information Hearing *The Lanterman-Petris-Short Act: How Can It Be Improved?*

MHAC understands the focal point of the hearing is to explore redefining and updating the term "grave disability" and potentially making other changes to the Lanterman-Petris-Short Act (LPS Act) to expand conservatorship authority.

We believe that a revision to LPS law is not a solution to the issue of individuals obtaining requisite services from their community. The issue is access to services and supports that meet the needs of individuals currently, as well as in the forthcoming second public health emergency—that of an added mental health demand resulting from the COVID-19 pandemic.

MHAC recognizes the expansive need for prevention and early intervention assistance, and the provision of comprehensive services and supports, treatment, and housing for persons with behavioral health care needs offered through a person-centered, culturally-competent approach. We strongly believe resource development to expand access to services across the continuum, coupled with better care coordination, offers the greatest opportunity to address the needs of Californians. True compassion requires building trust with each individual by understanding and addressing their unique needs and circumstances.

The MHAC perspective is outlined below.

First, an expansive State Audit of LPS protocols and procedures at the county-level was conducted last year.[1] Among many aspects, the approach included a three-year look back regarding involuntary holds, the referral sources for those holds, and the number of individuals placed under repeated initial holds. Conservatorships were also reviewed as part of this process.

Three key findings were identified by the State Auditor as follows:

- The LPS Act'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 the LPS Act.
- 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.

The State Auditor clearly notes: "Expanding the LPS Act's criteria to add more situations in which individuals would be subject to involuntary holds and conservatorships could widen their use and potentially infringe upon people's liberties, and we found no evidence to justify such a change." [2]

Current law already allows for involuntary treatment of individuals. LPS defines grave disability as an individual's inability, as a result of a mental health disorder, to provide for his or her basic personal needs for food, clothing or shelter. An individual who is gravely disabled can be held for a period of time, and if needed, put on a conservatorship where the conservator ensures provision of food, clothing and shelter. Most individuals on conservatorships live in locked, psychiatric institutions.

Further, Assisted Outpatient Treatment (AOT) enables counties to provide services for individuals with serious mental illnesses when a court determines that a person is unlikely to survive safely in the community without supervision and the person has a history of non-compliance with treatment. Individuals refusing available care for life threatening medical conditions are regularly conserved by courts when found necessary.

There has been no identification of barriers in practice or in existing law that prevent counties from utilizing the existing LPS and AOT processes and to provide services, including those offered through Section 17000 of Welfare and Institutions Code.

Second, there are several federal, State and County mandates that obligate the provision of health and human services to individuals, including behavioral health. These various mandates offer legal entitlement to services that are to be equitable and provided in a non-discriminatory manner. This includes the following:

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[1] See Bureau of State Audits, Lanterman-Petris-Short Act: California has Not Ensured That Individuals with Serious Mental Illnesses Receive Adequate Ongoing Care, July 2020. Available at www.bsa.ca.gov/pdfs/reports/2019-119.pdf.

[2] See page 1 of the audit, last paragraph.

- The federal Patient Protection and Affordable Care Act (ACA) of 2010, among other things, included mental health and substance use disorder services under its definition of essential health benefits which must be covered, including within the Medicaid Program (Medi-Cal), Covered California, and employer-sponsored insurance. Medicaid is governed by a labyrinth of federal and State laws and policies requiring that services must be available on a statewide basis, provided with reasonable promptness, including emergency services, and be sufficient in amount, scope, and duration to reasonably achieve their purpose. This includes Specialty Mental Health services as well as mental health services provided through Medi-Cal Managed Care Plans.

  Further, the ACA offered States the opportunity to expand coverage within their Medicaid programs which California did effective January 1, 2014. This coverage expansion has enabled over 4.2 million low-income adults to become Medi-Cal eligible, and entitled to medically necessary mental health services.[3] Medi-Cal is projected to serve about 15.6 million people in 2021-22.[4]

- The Adult and Older Adult Systems of Care Act[5] underscores the State's intent that mental health care is a basic human right and requires community support services to prevent inappropriate removal from home and community to more restrictive and costly placements. Service requirements include: (1) client directed services that employ psychosocial and recovery principles; (2) housing that is immediate, transitional, and/or permanent; and (3) individual personal services to plan to ensure living in the most independent, least restrictive housing feasible in the local community.

- The Mental Health Service Act, among other things, is intended to expand services consistent with the principles and practices of Recovery Vision[6] for mental health consumers and to assure the provision of services pursuant to the children's system of care[7] and to the adults and older adults system of care.[8]

- Section 17000 of Welfare and Institutions Code obligates counties to serve as the provider of "last resort" for indigent Californians who have no other means of support. It states as follows:

  > *Every county and every city and county shall relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease or accident, lawfully resident therein, when such persons are not supported and relieved by their relatives or friends, by their own means, or by state hospitals or other state or private institutions.*

- Federal and State enacted behavioral health parity laws, including SB 855, Statutes of 2020, have expanded coverage requirements for the provision of behavioral health services, including requiring all Knox-Keene licensed Managed Care Plans to adopt a standardized definition of medical necessity for these treatments. Both the Department of Health Care Services and the Department of Managed Care regulate these provisions across the broad health care sectors of California.

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[3] See Department of Health Care Services, November 2020 Medi-Cal Estimate, caseload page A, for 2020-21.
[4] See Department of Health Care Services, November 2020 Medi-Cal Estimate, caseload page A, for 2021-22.
[5] See Sections 5800 through 5815 of Welfare and Institutions Code.
[6] See Section 5813.5(d) of Welfare and Institutions Code.
[7] See Section 5878.1 of Welfare and Institutions Code.
[8] See Section 5813.5 (c) of Welfare and Institutions Code.

MHAC fervently believes in the right of all individuals to have access to health and behavioral health services of high quality, offered through a person-centered approach and without bias. But services and supports need to be available and accessible, and be representative of the diverse needs of Californians.

Third, it is well recognized that California needs to assertively develop system capacity for the full continuum of behavioral health services.[9] Mental health disorders are among the most common health conditions faced by Californians. Nearly 1 in 6 adults' experience a mental illness of some kind, and 1 in 25 have a serious mental illness that makes it difficult to carry out major life activities. Yet only about two-thirds of adults with a mental illness and two-thirds of adolescents with major depressive episodes did *not* get treatment.

Medi-Cal pays for a significant portion of mental health treatment in California. The number of adults receiving specialty mental health services through Medi-Cal and County Behavioral Health Departments increased by nearly 50 percent from 2012 to 2015, coinciding with expansion of Medi-Cal eligibility.[10] Yet service capacity did *not* commensurately increase to address this need.

Various examples of a lack of system capacity can be cited, along with significant barriers to accessing care, including gaps in coverage, concern with workforce adequacy (lack of diversity and shortages), and systemic discriminatory practices which often become reflected in health disparities. Examples include the following:

- Acute psychiatric beds per 100,000 population decreased 42 percent from 1995 through 2014. During this time 44 facilities either eliminated inpatient psychiatric care or closed it completely.[11] However, emergency department visits resulting in an inpatient psychiatric admission increased by 30 percent between 2010 and 2015.
- California will have 41 percent fewer psychiatrists than needed and 11 percent fewer psychologists, licensed marriage and family therapists, licensed professional clinical counselors and licensed clinical socials works than need by 2028. [12]
- African Americans and Latinos are underrepresented among psychiatrists and psychologists relative to California's population. Latinos are also underrepresented among counselors and clinical social workers.[13]
- Latino, African American, Native American, and multi-racial adults have rates of serious mental illness well above the state average.[14]
- People with serious mental illness die 25 years earlier, and people with a substance use disorder die 22.5 years earlier. Many of these deaths are from preventable physical illnesses.[15]

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[9] Statistical references in this paragraph are from the California Health Care Foundation's publication: Mental Health in California: For Too Many, Care Not There, dated March 15, 2018.
[10] California Health Care Foundation, Mental Health in California: For Too Many Care Not There, page 2, dated March 15, 2018.
[11] Ibid, page 37 and page 2.
[12] UCSF, Healthforce Center, California's Current and Future Behavioral Health Workforce, February 12, 2018.
[13] Ibid.
[14] California Health Care Foundation, Mental Health in California, presentation dated February 26, 2019.
[15] Ibid.

Further, the most recently released DHCS 2020 report on Annual Network Certification on Specialty Mental Health Services to the federal CMS, informed that *only 13 of the 56 County Mental Health Plans in California received a passing network adequacy rating.* The remaining 43 County Mental Health 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 presently required in both State and federal law.

Through his Budget release, Governor Newsom recognizes the substantial need to build service capacity. It will be critically important to work with diverse advocacy organizations, providers, Counties and policymakers on shaping the framework and implementation of these much needed resources to expanded services.

Fourth, we also believe the phase-in of CalAIM, beginning January 1, 2022 will enhance care coordination of behavioral health and health care services, clarify medical necessity to facilitate more immediate access to care, and it will add new benefits—Enhanced Care Management and In-Lieu of Services. This substantial undertaking is designed to also improve transparency and accountability.

Fifth, we would like to ensure the LPS is not expanded with the intent of use against individuals as a proposed solution to warehousing or otherwise forcing California's unhoused/unsheltered populations off the streets. When given the choice of permanent, supportive housing, people choose a permanent home over living on the streets, without conservatorship. In one recent study, only one of 400 chronically homeless people in Santa Clara County rejected the offer of a permanent home.[16]

Capacity building and care coordination are integral in addressing the continuum of care for services, improving client choice, and achieving improved outcomes, including addressing systemic discriminatory practices. This is where we believe we need to focus.

Thank you again for this opportunity to provide testimony.

Sincerely,

Heidi Strunk
President and CEO

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[16] Maria C. Raven MD, MPH, MSc,Matthew J. Niedzwiecki PhD,Margot Kushel MD, Human Health Research, *A randomized trial of permanent supportive housing for chronically homeless persons with high use of publicly funded services*, September 25, 2020. Available at https://doi.org/10.1111/1475-6773.13553