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CONTRA COSTA
MENTAL HEALTH COMMISSION

Mental Health Commission
Justice Systems Committee Meeting
Tuesday, January 25th, 2022, 1:30-3:00 PM
Via: Zoom Teleconference:

https://zoom.us/j/5437776481
Meeting number: 543 777 6481

Join by phone:
1 669 900 6833 US
Access code: 543 777 6481

AGENDA

I. **Call to order/Introductions**

II. **Public comments**

III. **Commissioner comments**

IV. **Chair comments**

V. **APPROVE minutes from the November 23, 2021, Justice Systems Committee meeting**

VI. **RECIEVE a summary of former MHC Commissioner Teresa Pasquini's testimony on Lanterman-Petris-Short Act issues and concerns presented at the December 15, 2021 Joint Informational Hearing of the Health and Judiciary Committees of the California State Senate.**

Link to Teresa Pasquini's testimony: https://www.dropbox.com/s/0ig77a6o1slx2cf/TP.mp4?dl=0

VII. **DISCUSS ways that County agencies and the Mental Health Commission can advocate for the California Governor to appoint a position for oversight of the state's Conservatorship programs.**

VIII. **DISCUSS how AB328 (Reentry Housing and Workforce Development Program) is moving through legislature and being instituted to address housing for formally incarcerated individuals.**

(Continued on Page Two)

IX. DISCUSS data and issues presented in a webinar held January 17, 2022 and sponsored by the Council of State Councils (CSG) Justice Center on the Stepping Up program and the use of contracted mental health services in jails

Link to Step Up Together: https://stepuptogether.org/

X. Adjourn

ATTACHMENTS:

A. "Law-Makers agree: Little change in CA's mental health system", Capitol Weekly, 12/23/21

B. AB328 bill text

C. An adequate supply of affordable housing is necessary in California – CalMatters

D. Time for the Legislature to invest in California by taxing large, profitable corporations – CalMatters

E. LPS Background with Appendices

CALIFORNIA LEGISLATORS:
VOTE NO ON AB 1400
PROTECT California Health Care

CAPITOL WEEKLY
COVERING CALIFORNIA GOVERNMENT AND POLITICS

NEWS

Lawmakers agree: Little change in CA's mental health care system

BY SIGRID BATHEN POSTED 12.23.2021

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In a lengthy, often emotional legislative hearing on California's badly broken mental health system, lawmakers and dozens of witnesses agreed that very little has changed, despite decades of new laws and huge infusions of public funds.

If there was any consensus on solutions during the grueling, all-day Dec. 15 joint hearing of the Assembly Health and Judiciary Committees, it was that the system urgently needs major overhaul — although legislators have long failed to agree on the details of systemic change.

Testimony from the hearing is expected to serve as a template for yet another round of new bills – and some recycled measures – on one of the most vexing issues facing lawmakers in the coming year.

> *"We do so much in this state in silence. It's really frustrating, and inhibits information getting to decision-makers."– Mark Stone*

"We have struggled with this in the Legislature for decades," said Assemblyman Mark Stone, D-Scotts Valley, chair of the Judiciary Committee. The closure of most state mental hospitals in the 1960s and 70s followed myriad investigations and widespread media coverage of abuse and "highly questionable" deaths in the hospitals. But the "community care" touted to replace them never materialized, leaving counties to create patchwork local systems with little or no state oversight.

Stone called the current system "fractured," and cited a "disconnect" between local and state mental health agencies, with counties complaining about state licensing delays and state officials saying there are no backlogs.

"We do so much in this state in silence," he added. "It's really frustrating, and inhibits information getting to decision-makers."

As families of severely mentally ill relatives – mostly parents of adult children — demonstrated outside the Capitol, with banners urging "right to treatment before tragedy," legislators heard wrenching accounts of a system that lacks adequate community treatment facilities, or staff, and is hobbled by laws that block treatment or early intervention, leading to decades of repeat hospitalizations, homelessness, incarceration and early death.

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At-risk students question UC Davis response to

Advocates seeking reform of California's mental health care system gather at the Capitol. *(Photo: Scott Duncan)*

"The way that we treat the seriously mentally ill in our state is shameful and unacceptable!" said Teresa Pasquini, the mother of a severely mentally ill adult son who has been bounced around the system for more than two decades — including more than 40 involuntary detentions, frequent hospitalizations, solitary confinement and homelessness.

Pasquini is a longtime Bay Area mental health activist with the influential National Alliance on Mental Illness (NAMI), which represents families, and her testimony was among the most dramatic of the day-long session, as she angrily recounted her family's tortuous journey to get help for her troubled son.

'Nothing civil or right'

"There has been nothing civil or right about my son's care in California," she said. "We must stop saying that we are progressive protectors of human, civil and disability rights while we are forcing the most vulnerable population into early graves, solitary jail cells or homeless encampments in the name of freedom of choice. There is no choice, no dignity, no freedom under the current system."

> *Local and state public agencies charged with their care and treatment work at cross-purposes, uncoordinated, in a vast, dizzying bureaucracy...*

Despite billions in public funding — and innumerable reports, studies, task forces, government reorganizations and legislation — increasing numbers of seriously ill mentally ill people continue to suffer and die on the streets, in jails, prisons and overwhelmed hospital emergency rooms ill-equipped to help them. Most are repeatedly returned to the streets, with epidemic proportions of mental illness, substance abuse (often a form of "self-medication" in the absence of treatment) and homelessness in cities throughout California.

Local and state public agencies charged with their care and treatment work at cross-purposes, uncoordinated, in a vast, dizzying bureaucracy with long waitlists for treatment, housing or "beds," strictly limited legal options for families, little oversight or accountability — and, predictably, frequent tragedy.

Yet a 1967 law — then widely touted as a "landmark" reform measure — has instead become a barrier to significant change in public mental health policy for more than half a century, largely impervious to policy changes or even limited legislative intervention. Efforts to change the law have often failed, mainly over concerns about individual rights, and the Dec. 15 hearing was carefully titled, "Lanterman-Petris-Short: How Can it be Improved?" Not reformed or replaced, but *improved.*

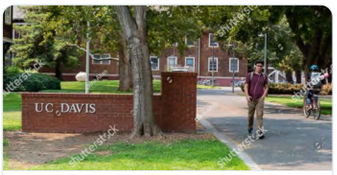
> *One lengthy 1970s state investigation into 1,200 state hospital deaths revealed 140 "highly questionable" deaths in 10 of the 11 state hospitals during one three-year period.*

Named for three well-intentioned legislators (two Democrats, one Republican) deeply committed to righting the wrongs of a brutal and archaic system of forced institutionalization, Lanterman-Petris-Short (LPS) relied on an empty promise: that a robust system of community care would be available for the thousands of "residents" who had spent years, decades even, in state mental hospitals, with limited treatment and little recourse. Many died in the hospitals — which housed both mentally ill and developmentally disabled residents.

One lengthy 1970s state investigation into 1,200 state hospital deaths revealed 140 "highly questionable" deaths in 10 of the 11 state hospitals during one three-year period, according to a series of articles in the *Sacramento Bee*.

Suddenly, as the hospitals were closed, people who had been locked up for years returned to families (if they had any), who were often unable or unwilling to house or care for them (and many more who tried, at tremendous emotional and financial cost). Case follow-up, treatment or financial support were largely nonexistent. Many died, or became homeless, incarcerated, cycling through hospital ER's. Families who tried to help them encountered a largely impenetrable bureaucratic wall of legal restrictions under LPS.

COVID. A petition challenging the administration's decisions has garnered 7,600 signatures. Joshua Aalcides in Capitol Weekly. capitolweekly.net/at-risk-studen… #caleg



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> *State Sen. Susan Eggman has previously said a state ballot measure may be necessary to pass significant reform and has formed a campaign committee for that purpose.*

While a state system of 21 regional centers to provide housing and treatment for developmentally disabled residents, was created in 1977 in legislation by then state Assemblyman Frank Lanterman, R-Pasadena (one of the three authors of LPS 10 years earlier), no such system was designed for the mentally ill. Many mental health policy experts point to the current regional center system as a possible model that should be adopted for effective mental health housing and treatment.

'Lesser than, less 'worthy''

"People with developmental disabilities have a right to treatment in the least restrictive environment" under the 1977 Lanterman law, said Sacramento Mayor Darrell Steinberg, a longtime mental health advocate and former state Senate president who was the author of the Mental Health Services Act (MHSA), the so-called "millionaire's tax" passed by voters as Proposition 63 in 2004.

"The [regional center] system is not perfect," he added, but it does provide housing and services, while no such services exist for the mentally ill, who are often seen as "lesser than, less 'worthy' of our care and treatment."

State Sen. Susan Eggman, D-Stockton, a former social worker and Sacramento State professor who has been the author of major mental health legislation throughout her nine years in the Legislature (eight in the Assembly), was present on the dais as a "guest" of the two Assembly committees holding the Dec. 15 hearing. She has previously said a state ballot measure may be necessary to pass significant reform and has formed a campaign committee for that purpose.

She also suggested at the hearing that a special session of the Legislature be held to finally address systemic legislative change in a deeply entrenched, conflicting system that clearly isn't working. And she said the Legislature should consider re-establishing a state Department of Mental Health, which was eliminated by the Brown administration in 2011, its duties absorbed into other departments.

> *"Nobody in this room is looking to keep more people [detained] against their will." — Susan Eggman*

Major themes in the hearing were the lack of statewide oversight or accountability and notoriously poor or nonexistent data collection on the effectiveness of existing programs. Many cited the lack of a "single point of contact" for state mental health administration, which has long been a complex, often conflicting blizzard of agencies and programs that receive considerable public funding.

Most mental health programs are administered locally by the state's 58 counties, but there is wide variation in consistency and quality, and only limited state oversight, much less accountability. While the counties report some data to state agencies, there is no consistent enforcement mechanism if they fail to provide adequate data, as many do.

"Nobody in this room is looking to keep more people [detained] against their will," Eggman said. "We're not here to expand LPS. Our goal is to help people *not* reach that level. We are at an inflection point in our society, in our politics, everything. It is incumbent on us to get this right, to use the funds we have to help as many as possible.

"We are all distressed by what we see in the streets. It is apparent that we have a huge breakdown in our system. The counties don't have enough money, and we've given them a lot of money. There is a clear disconnect, with mothers of 40- or 50-year-old adult children struggling to get help. As a society, we have failed."

'Funding is a mess'

Funding for LPS comes from a variety of local, state and federal sources, causing further confusion in administering the massive and aging law. "Funding for LPS is a mess," said Assemblyman Jim Wood, D-Santa Rosa, chair of the Assembly Health Committee, "and shouldn't there be a single entity to oversee all of the funding? I'm struggling with who is in charge."

> *Laura's Law is one of the few laws to make significant change in LPS, giving family members a legal avenue to get severely mentally ill relatives into intensive care.*

"Nobody knows what the hell is going on," he added, throwing up his hands in frustration.

Witnesses at the hearing included dozens of local and state officials and representatives of mental-health advocacy groups, clinicians, law enforcement, firefighters, social workers and others on the front lines of mental health programs in California.

State Auditor Elaine Howle, who last year released a scathing report on LPS, remained critical of poor data collection, oversight, and a lack of treatment or follow-up for people leaving care (or recycling through it). "There is a lot of funding," Howle said at the hearing, "yet no overarching, comprehensive, clear view of mental health services. . .How much are we spending for inpatient vs. outpatient [care], incarceration, repeat holds, suicide rates?"

She praised "Laura's Law," passed in 2002 and recently strengthened in Eggman legislation, as a "very effective type of treatment," with documented results. It is one of the few laws to make significant change in LPS, giving family members a legal avenue to get severely mentally ill relatives into intensive care.

Randall Hagar, legislative advocate for the Psychiatric Physicians Alliance of California, who has helped write much of the major mental-health legislation in recent years, called the LPS system "crisis-driven and failure-driven," based on "waiting for danger, which is too late, makes outcomes worse for patients, doesn't help families," and is wildly expensive in both human and public costs such as incarceration and hospitalization.

> *"The financing of the system is crazy." — Randall Hagar*

Concurring with many other experts who testified at the Dec. 15 hearing, he said the system clearly needs "one point of contact" for state oversight, perhaps a new Department of *Community* Mental Health to provide statewide coordination, data collection and accountability at the local level. And he said multiple funding streams for mental health – including the billions raised by the state Mental Health Services Act – need serious examination.

"The financing of the system is crazy," he said, echoing the views of legislators and other mental health experts who spoke at the hearing. He said the 1% "millionaire's tax" is a source of considerable funding but suffers from inconsistent oversight and complex regulations. And it likely will need to be updated, he added, to more accurately reflect the vast sums of wealth acquired in recent years by the "one percent," either as part of broader legislation or a ballot initiative. Both approaches are high on legislative agendas in the coming year.

"Mental health and homelessness are at the top of any public opinion poll in California," Steinberg reminded the committees. "Conventional wisdom says that incremental change is possible in the Legislature, but the fragmentation of the mental health system — and the inability of people to access care – [require] bold and fundamental change.

"The time for that is now."

—

Editors Note: *Sigrid Bathen is a Sacramento journalist and former Sacramento Bee reporter who taught journalism at Sacramento State for 32 years. She has long covered mental-health issues, for several publications, and her writing has won numerous awards. She has covered health care, education and state government for Capitol Weekly since 2005. Her web site is www.sigridbathen.com. She can be reached at sigridbathen@gmail.com*

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AB-328 Reentry Housing and Workforce Development Program. (2021-2022)

Date Published: 01/13/2022 09:00 PM

AMENDED IN ASSEMBLY JANUARY 13, 2022

AMENDED IN ASSEMBLY MARCH 17, 2021

CALIFORNIA LEGISLATURE— 2021–2022 REGULAR SESSION

ASSEMBLY BILL NO. 328

Introduced by Assembly Members ~~Chiu, Kalra, Quirk-Silva~~ *Bryan, Kalra, Quirk-Silva,* and Wicks
(Coauthors: Assembly Members Bonta, Burke, Carrillo, Lee, Luz Rivas, and Stone)
(Coauthor: Senator Wiener)

January 26, 2021

An act to add Chapter 2.9 (commencing with Section 50492) to Part 2 of Division 31 of the Health and Safety Code, relating to housing.

LEGISLATIVE COUNSEL'S DIGEST

AB 328, as amended, ~~Chiu~~ *Bryan.* Reentry Housing and Workforce Development Program.

Existing law establishes the Department of Housing and Community Development in the Business, Consumer Services, and Housing Agency and makes the department responsible for administering various housing programs throughout the state, including, among others, the Multifamily Housing Program, the Housing for a Healthy California Program, and the California Emergency Solutions Grants Program.

This bill would establish the Reentry Housing and Workforce Development Program. The bill would require the department, on or before July 1, 2022, to take specified actions to, upon appropriation by the Legislature, provide grants to applicants, as defined, for innovative or evidence-based housing, housing-based services, and employment interventions to allow people with recent histories of incarceration to exit homelessness and remain stably housed. The bill would require the department to establish a process, in collaboration with the Department of Corrections and Rehabilitation and with counties in which recipients are operating, for referral of participants, in accordance with certain guidelines and procedures.

The bill would require the department to score applicants to the program competitively according to specified criteria. The bill would require recipients of funds from the program to use those funds for, among other things, long-term rental assistance in permanent housing, incentives to landlords, and innovative or evidence-based services to assist participants in accessing permanent supportive housing. The bill would require the department to distribute funds allocated by executing contracts with awarded entities for a term of 5 years, subject to automatic renewal.

The bill would require a recipient of the program to submit an annual report to the department. The bill would require the department to hire an independent evaluator to assess outcomes from the program and would require the department to submit that analysis to specified committees of the Legislature.

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: no

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. The Legislature finds and declares all of the following:

(a) People on parole are seven times more likely to recidivate when homeless than when housed.

(b) Evidence shows that “supportive housing,” or housing that is affordable to people on parole living in extreme poverty that does not limit length of stay and offers tenants services promoting housing stability, or access to job training that provides pathways to livable wage employment, reduces recidivism. In fact, data show evidence-based housing decreases recidivism rates by 60 percent, when compared to control groups, and reduces rearrests by 40 percent.

(c) About half of people experiencing homelessness report a history of incarceration.

(d) Formerly incarcerated people are 27 times more likely to be unstably housed or homeless than the general public. In fact, California data have estimated that one-third to one-half of all people on parole in San Francisco and Los Angeles are experiencing homelessness at any point in time.

(e) African Americans are almost seven times more likely to be homeless than the general population in California, driven by systemic racism that includes disproportionate ~~incarceration,~~ *incarceration* and discharges from prisons and jails into homelessness.

(f) Projected population decline in California’s state prisons in the next few years is expected to reduce future cost growth for Department of Corrections and Rehabilitation (CDCR), both through a reduction in inmates and staff, as well as the closure of two state facilities. In the short term, CDCR will avoid spending several hundreds of millions of dollars due to a decrease in prison population, which decreases per person costs for clothing, food, maintenance, and other costs of operating the prison. The closure of at least two state correctional facilities between 2021 and 2024 would yield savings in utilities, staffing, and equipment, as well as a reduction in the inmate and ward population. The Legislative Analyst’s Office estimates $1.5 billion in total costs could be avoided by 2025 as a result of additional prospective prison closures, freeing valuable resources that should be repurposed for sustainable criminal justice solutions.

(g) It is the intent of the Legislature to repurpose funding from the closure of state prisons to provide innovative or evidence-based solutions to house people experiencing homelessness with histories of incarceration.

(h) The Department of Housing and Community Development, with its expertise in overseeing grant programs for housing and services, counties and continuums of care, and community-based organizations, which often have experience providing housing and services to people exiting incarceration, is an appropriate entity to administer programs offering innovative or evidence-based housing and services interventions to people on parole experiencing homelessness.

SEC. 2. Chapter 2.9 (commencing with Section 50492) is added to Part 2 of Division 31 of the Health and Safety Code, to read:

CHAPTER 2.9. Reentry Housing And Workforce Development Program

50492. For purposes of this article, the following definitions apply:

(a) “Applicant” means a county, a community-based organization, or a continuum of care that has applied to receive funds under the program.

(b) “Chronically homeless” has the same meaning as in Parts 91 and 578 of Title 24 of the Code of Federal Regulations, as those parts read on January 1, 2021, except that people who were chronically homeless before entering an institution would continue to be defined as chronically homeless upon discharge, regardless of length of institutional stay.

(c) “County” shall include a city that is also a county or cities working with counties to apply for grant funds.

(d) “Community-based organization” means a mission-driven nonprofit organization that qualifies for tax-exempt status under Section 501(c)(3) of the Internal Revenue Code.

(e) “Continuum of care” means a group organized to provide services under this chapter that is composed of representatives of organizations, including nonprofit homeless providers, victim service providers, faith-based organizations, governments, businesses, advocates, public housing agencies, school districts, social service providers, mental health agencies, hospitals, universities, affordable housing developers, law enforcement, organizations that serve homeless and formerly homeless veterans, and homeless and formerly homeless persons to the extent these groups are represented within the geographic area and are available to participate.

(f) “Coordinated entry system” means a centralized or coordinated process developed pursuant to Section 576.400 or 578.7, as applicable, of Title 24 of the Code of Federal Regulations, as that section read on January 1, 2021, designed to coordinate program participant access, assessment, prioritization, and referrals. For purposes of this chapter, a centralized or coordinated assessment system shall cover the geographic area, be easily accessed by individuals and families seeking housing or services, be well advertised, and include a comprehensive and standardized assessment tool. However, the assessment tool may vary to assess the specific needs of an identified population. The centralized or coordinated assessment system shall also specify how it will address the needs of individuals or families who are fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, or stalking.

(g) “Department” means the Department of Housing and Community Development, unless otherwise identified.

(h) “Fair market rent” means the rent, including the cost of utilities, as established by the United States Department of Housing and Urban Development, pursuant to Part 888 and Part 982 of Title 24 of the Code of Federal Regulations, as those parts read on January 1, 2021, for units by number of bedrooms, that must be paid in the market area to rent privately owned, existing, decent, safe, and sanitary rental housing of nonluxury nature with suitable amenities.

(i) “Homeless” has the same meaning as in Section 91.5 of Subpart A of Part 91 of Subtitle A of Title 24 of the Code of Federal Regulations, except that people exiting prison who were homeless when incarcerated and who have no identified residence upon exit, will also be considered “homeless” or “likely to become homeless upon release.”

(j) “Homeless service provider” means an organization that qualifies as an exempt organization under Section 501(c)(3) of the Internal Revenue Code and that contracts as a community-based organization, or with a participating county, or a continuum of care, for the purpose of providing services to people experiencing homelessness.

(k) “Housing First” has the same meaning as in Section 8255 of the Welfare and Institutions Code.

(l) “Permanent housing” means a structure or set of structures with subsidized or unsubsidized rental housing units subject to applicable landlord-tenant law, with no limit on length of stay and no requirement to participate in supportive services as a condition of access to or continued occupancy in the housing.

(m) “Housing navigation” means services that assist program participants with locating permanent housing with private market landlords or property managers who are willing to accept rental assistance or operating subsidies for the program participants to assist those program participants in obtaining local, state, or federal assistance or subsidies; completing housing applications for permanent housing or housing subsidies and, when applicable, move-in assistance; and obtaining documentation needed to access permanent housing and rental assistance or subsidies.

(n) “Innovative reentry housing” means approaches to reentry based on the latest aggregated data to provide housing and workforce development services designed to reduce recidivism and enhance public safety, and provide a pathway for people exiting incarceration to access a livable wage and long-term housing stability. Core components of Housing First, as defined in Section 8255 of the Welfare and Institutions Code, shall apply to innovative models, with a goal of allowing people to access and maintain permanent housing and employment stability.

(o) “Interim interventions” means low-barrier housing that does not qualify as permanent housing, as defined under subdivision (l), including, but not limited to, emergency shelters, motel vouchers, recovery-oriented interim interventions, Project Roomkey or Project Homekey, or reentry program sites used as interim housing, recuperative or respite care, or navigation centers as defined under other federal, state, or local programs. All programs providing interim housing funding pursuant to this chapter shall have partnerships or other linkages to homeless services to connect individuals or families to income, public benefits, health services, and permanent housing. “Low barrier” means the following:

(1) The interim intervention is a Housing First, service-enriched intervention focused on moving people into permanent housing that provides temporary living facilities while case managers connect individuals experiencing homelessness to permanent housing, income, public benefits, and health services. Notwithstanding any other subdivision in this section, for purposes of interim interventions, “Housing First” shall not require a lease.

(2) The interim intervention utilizes best practices to reduce barriers to entry, including, but not limited to, allowing partners and older minors, unless the interim intervention is a population-specific site; allowing pets, with the exception of population specific sites; allowing storage of possessions; allowing residents to engage in treatment for substance use disorders, including obtaining medications for substance use disorder treatment; offering services that connect participants to workforce development services; providing services that help connect persons to permanent housing; providing privacy; and providing linkage to a coordinated entry system.

(3) The interim intervention offers a harm reduction approach, except where tenants request an abstinence-based model, or are enrolled in a population-specific reentry program.

(4) The interim intervention has a system for entering information regarding client stays, demographics, income, and exit destination though a local Homeless Management Information System (HMIS) or similar system.

(p) “Likely to become homeless upon release” means the potential participant has a history of experiencing “homelessness” as that term is used in Section 11302(a) of Title 42 of the United States Code and who meets either of the following:

(1) The person has not identified a fixed, regular, and adequate nighttime residence for release.

(2) The person has an identified residence that includes a supervised publicly or privately operated shelter designed to provide temporary living accommodations, or a public or private place not designed for, or is not ordinarily used as, a regular sleeping accommodation for human beings.

(q) “Operating subsidy” means a subsidy provided to housing projects offering affordable or supportive housing to participants, and that project received local, state, or federal subsidies, and that assist projects in paying for the costs of operating, staffing, and maintaining the project.

(r) “Program” means the Reentry Housing and Workforce Program.

(s) “Reasonable rent” means up to two times the fair market rent that is also consistent with market rent in the community in which the rental unit is located.

(t) “Rental assistance” means a rental subsidy provided to a housing provider, including a developer leasing affordable or supportive housing, to assist a tenant to pay the difference between 30 percent of the tenant’s income and either fair market rent or reasonable rent as determined by the grant recipient and approved by the department.

(u) “Subrecipient” means a unit of local government or a private nonprofit organization that the recipient determines is qualified to undertake the eligible activities for which the recipient seeks funds under the program, and that enters into a contract with the recipient to undertake those eligible activities in accordance with the requirements of the program.

(v) “Supportive housing” means permanent housing with no limit on the length of stay that is linked to onsite or offsite services that assist the supportive housing residents in retaining the housing, improving their health status, and maximizing their ability to live and, when possible, work in the community. “Permanent supportive housing” includes associated facilities if used to provide services to housing residents.

(w) “Tenancy acquisition services” means staff dedicated to engaging property owners to rent housing units to the eligible population through rental assistance.

(x) “Tenancy sustaining services” means using evidence-based service models to provide any of the following:

(1) Early identification and intervention of behaviors that may jeopardize housing security.

(2) Education and training on the rights and responsibilities of the tenant and the landlord.

(3) Coaching on developing and maintaining key relationships with landlords or property managers.

(4) Assistance in resolving disputes with landlords and neighbors to reduce the risk of eviction.

(5) Advocacy and linkage with community resources to prevent eviction when housing may become jeopardized.

(6) Care coordination and advocacy with health care professionals.

(7) Assistance with a housing recertification process.

(8) Coordinating with the tenant to review and update a housing support and crisis plan.

(9) Training in being a good tenant, and lease compliance.

(10) Benefits advocacy.

(11) Evidence-employment services.

(12) Services connecting individuals to education.

(13) Transportation services.

(14) Any other service that supports individuals and families to promote housing stability, foster community integration and inclusion, develops natural support networks, and that are offered through a trauma-informed, culturally competent approach.

(y) “Tenancy transition services” means using evidence-based service models to provide any of the following:

(1) Screening and assessing the tenant’s preferences and barriers to successful tenancy.

(2) Developing an individualized housing support plan that includes motivational interviewing and goal setting.

(3) Assistance with the housing application and search process.

(4) Identifying resources to cover expenses for move-in and furniture costs.

(5) Ensuring that the living environment is safe and ready for move-in.

(6) Assisting and arranging for the details of the move.

(7) Developing a housing support crisis plan that includes prevention and early intervention when housing is jeopardized.

(8) Engagement services.

(9) Any other evidence-based services that an individual tenant may require to move into permanent housing.

(z) “Voluntary services” means services offered in conjunction with housing where the housing is not contingent on participation in services, tenants are not evicted based on failure to participate in services, the service provider encourages the tenant to participate in services using evidence-based engagement models, and services are flexible and tenant-centered.

(aa) “Workforce development” means programs and services that provide people on parolees or those discharged suffering from incarceration within the past five years with job skill development and placement services in livable wage employment.

50492.1. (a) There is hereby created the Reentry Housing and Workforce Development Program. It is the intent of the Legislature that the Department of Corrections and Rehabilitation will calculate the annual costs avoided that result from the closure or warm shutdown of prisons and to redirect 80 percent of those costs avoided to the Reentry Housing and Workforce Development Program within six months.

(b) On or before July 1, 2022, the department shall do all of the following to create the program to, upon appropriation by the Legislature, provide grants for innovative or evidence-based housing, housing-based services, and employment interventions to allow people with recent histories of incarceration to exit homelessness and remain stably housed:

(1) Establish a process, in collaboration with the Department of Corrections and Rehabilitation and with counties in which recipients are operating, for referral of participants who volunteer to participate in the program.

(2) Establish protocols in collaboration with the Department of Corrections and Rehabilitation, at least one community-based organization working to reenter people into communities after discharge, and at least one organization working to provide housing opportunities to people experiencing homelessness, to prevent discharges from prison into homelessness. No person shall be held past their scheduled discharge date from the Department of Corrections and Rehabilitation as a result of homelessness.

(3) Issue guidelines establishing the grant program and a notice of funding availability or request for proposals for five-year renewable grants to applicants based on criteria to score applicants for grant funds competitively. Guidelines shall include the following:

(A) Applicants shall meet all of the following criteria:

(i) The applicant has a contract or memorandum of understanding with or administers the homeless continuum of care, or is offering “innovative reentry housing,” as described in this chapter.

(ii) The applicant has at least two years of experience, or intends to partner with community-based providers with at least this level of experience, or has demonstrated a similar level of organizational ability, to connect people experiencing homelessness to housing and, in the case of providers with two or more years of experience, has achieved a documented housing retention rate in that housing of at least 80 percent.

(iii) The applicant has, or plans to partner with organizations that have, at least two years of experience providing best practice or evidence-based workforce development services.

(iv) The applicant has built a network of agencies that provide services to help people re-enter communities from incarceration, particularly people experiencing homelessness or lack of livable wage employment, in the community in which the applicant intends to provide services or housing.

(v) The applicant has a structure for providing outreach and housing navigation.

(vi) The applicant has relationships with the coordinated entry system serving the geographic area in which the applicant is intending to offer housing.

(vii) The applicant has or plans to have all of the following:

(I) Removed barriers to hiring people with lived experience of incarceration who are living stably in the community.

(II) Employed people with lived experience of incarceration and homelessness who are living stably in the community.

(III) If a community-based organization, at least one individual with lived experience of incarceration and homelessness who are living stably in the community, on the board of directors.

(B) Applicants shall submit all of the following:

(i) A viable plan to provide permanent housing with services based on evidence-based practices, as described in Section 50492.3, or a plan to provide innovative reentry housing, as described in this chapter.

(ii) Performance metrics and goals the applicants shall achieve through this program.

(iii) A description of experience in successfully administering or overseeing, or the ability to successfully administer or oversee, the activities the recipient plans to fund through the program.

(C) Of the total allocated to the Reentry Housing and Workforce Development Program, at least 10 percent, but no more than 20 percent, of the funds shall be allocated to community-based organizations providing innovative reentry housing that comply with the following:

(i) Programs that provide a pathway for participants to access livable wage jobs and permanent housing programs.

(ii) Recipients are community-based organizations that meet all of the following criteria:

(I) Are led by people with lived experience of incarceration in executive level positions.

(II) Employ at least 25 percent of staff with lived experience of incarceration who are now stably housed.

(III) Provide or subcontract to provide housing navigation services in locating and moving into affordable permanent housing.

(iii) Offer a voluntary services model.

(iv) Offer participants, either through direct service provision or a subcontract, the following:

(I) An independent, safe, and decent place to live that participants can afford, where participants shall not be required to share a bedroom.

(II) Evidence-based engagement services to promote participation in services.

(III) Best practice or evidence-based workforce development services to help participants access and obtain livable wage jobs.

(IV) Housing navigation and housing acquisition services to access any housing subsidies participants need and assistance in locating and moving into affordable permanent housing.

(v) Recipients shall not evict a participant for not participating in services or treatment. Recipients shall not end a participant’s housing or evict a participant unless and until a participant has obtained permanent housing of their choice.

(D) Scoring criteria shall include, but not be limited to, the following:

(i) Need, which includes consideration of the number of individuals experiencing homelessness, people on parole, and people with recent histories of incarceration, to the extent data are available, in the community in which applicants will be serving eligible participants.

(ii) Experience providing or demonstrated ability to provide evidence-based tenancy acquisition and housing navigation, tenancy transition, and tenancy sustaining services, evidence-based employment services, and services to people reentering communities from jail or prison.

(iii) The extent of coordination and collaboration between the county, the homeless continuum of care covering the geographic area, and community-based organizations with a history of serving people reentering communities from incarceration.

(iv) Experience using Housing First core components to address the needs of the eligible population.

(v) Partnerships and contractual agreements demonstrating an ability of the applicant or proposed subrecipients to administer or partner to administer funding for rental assistance and evidence-based services interventions.

(vi) The applicant’s documented partnerships with affordable and supportive housing providers and housing navigator providers in the jurisdiction.

(vii) Demonstrated commitment to address the needs of people experiencing homelessness and recent incarceration through existing programs or programs planned to be implemented within 12 months.

(viii) Proposed use of funds and the extent to which the proposed use will lead to overall reductions in homelessness and recidivism.

(ix) For county applicants, the extent to which an applicant demonstrates housing authorities or other county-run housing authorities have eliminated or plan to eliminate restrictions against people with arrests or criminal convictions to access publicly funded housing subsidies, notwithstanding restrictions mandated by the United States Department of Housing and Urban Development.

(c) (1) Individuals and household members in families are eligible for participation in a program funded pursuant to a grant through this chapter if they meet all of the following conditions:

(A) Individuals or families voluntarily choose to participate.

(B) One of the following applies:

(i) Individuals who have been assigned a date of release from prison within 60 to 180 days and they are likely to become homeless upon release.

(ii) Individuals are currently experiencing homelessness as a person on parole or post-release community supervision after discharge from prison.

(iii) Individuals are currently experiencing homelessness and were incarcerated in state prison within the last five years.

(2) A participant shall continue to receive housing and services funded under the program after discharge from parole, so long as the participant needs this assistance.

(3) Recipients shall ensure participants have choice in where to live and the services that they would like to receive, unless enrolled in a population-specific program, and to the extent allowable under conditions of parole or probation.

50492.2. (a) A recipient in the program shall use program funds for the following eligible activities based on the needs of the participants:

(1) Long-term rental assistance in permanent housing in an amount the applicant identifies, but no more than reasonable rent for the community in which the housing is located.

(2) Interim interventions.

(3) Operating subsidies in new and existing affordable or supportive housing units, in an amount the applicant identifies, but no more than reasonable rent for the community in which the project is located. Operating subsidies may include capitalized operating subsidy reserves.

(4) Incentives to landlords, including, but not limited to, security deposits, holding fees, and incentives for landlords to accept rental assistance or operating subsidies.

(5) Innovative or evidence-based services to assist participants in accessing permanent housing, including supportive housing, and to promote stability in housing, including services identified in subdivision (c).

(6) If necessary, and upon demonstrated need, operating support for interim interventions with services to meet the specific needs of the eligible population.

(b) Recipients shall ensure service providers offer evidence-based voluntary services in conjunction with housing to obtain and maintain health and housing stability while participants are on parole and after discharge from parole, for as long as the participant needs the services or until the grant period ends.

(c) Once a participant is released or for participants living in the community, the services shall be offered to participants in their home, or be made as easily accessible to participants as possible. These services shall include the following:

(1) In-reach services to assist eligible participants at least 90 days prior to release from prison, to include any of the other services in this subdivision.

(2) Parole discharge planning.

(3) Housing navigation and tenancy acquisition services.

(4) Tenancy transition services.

(5) Tenancy supportive services.

(6) Food security services.

(7) For housed participants or participants once they are housed, innovative or evidence-based employment services that assist participants to obtain meaningful employment and a liveable wage.

(8) Linkage to other services, including education and childcare services, as needed.

(9) Benefit entitlement application and appeal assistance, as needed.

(10) Transportation assistance to obtain services and health care, as needed.

(11) Assistance obtaining appropriate identification, as needed.

(12) Teaching people to navigate disabilities.

(13) As necessary, assistance in performance activities of daily living and other personal care services.

(14) Wrap-around services, including linkage to Medi-Cal funded mental health treatment, substance use disorder treatment, and medical treatment, as medically necessary.

(d) For participants identified prior to release from prison, upon the provider’s receipt of referral and in collaboration with the parole agent and, if appropriate, staff, the intake coordinator or case manager of the provider shall:

(1) Receive all prerelease assessments and discharge plans.

(2) Partner with providers working in the geographic area where a participant is incarcerated, when participants are incarcerated outside of the recipient’s geographic reach.

(3) Draft a plan for the participant’s transition into interim interventions, and then affordable or supportive housing.

(4) Engage the participant to actively participate in services upon release on a voluntary basis.

(5) Assist in obtaining identification for the participant, if necessary.

(6) Assist in applying for any benefits for which the participant is eligible.

50492.3. (a) Recipients and providers shall adhere to the core components of Housing First.

(b) Providers shall identify and locate housing opportunities for participants prior to release from state prison or as quickly upon release from state prison as possible.

(c) Housing identified pursuant to subdivision (b) shall satisfy all of the following:

(1) The housing is located in an apartment building, townhouse, or single-family home, including rent-subsidized apartments leased in the open market or set aside within privately owned buildings, or affordable or supportive housing receiving a publicly funded subsidy.

(2) The housing is not subject to community care licensing requirements or is exempt from licensing under Section 1504.5 of the Health and Safety Code.

50492.4. (a) The department shall distribute funds allocated by executing contracts with awarded entities that shall be for a term of five years, subject to automatic renewal. After a contract has expired pursuant to this subdivision, any funds not expended for eligible activities shall revert to the department for use for the program.

(b) A recipient shall submit to the department an annual report on a form issued by the department, pertaining to the recipient’s program or project selection process, contract expenditures, and progress toward meeting state and local goals, as demonstrated by the performance measures set forth in the application. Recipients shall, along with any other data as required by the department, report all of the following on an annual basis:

(1) The number of participants served.

(2) The types of services that were provided to program participants.

(3) Whether the recipient met performance metrics identified in their application.

(4) The outcomes for participants, including the number who remain permanently housed, the number who ceased to participate in the program and the reason why, the number who participated in workforce development programs, including the number of participants placed in livable wage employment, the number who returned to state prison or were incarcerated in county jail, the number of arrests among participants, and the number of days in jail or prison among participants, to the extent data are available.

(c) As part of the annual report required pursuant to subdivision (b), the recipient shall report to the department on the expenditures and activities of any subrecipients for each year of the term of the contract with the department until all funds awarded to a subrecipient have been expended.

(d) The department shall design an evaluation and hire an independent evaluator to assess outcomes from the program, which shall include, but not be limited to, the following:

(1) The total number of parolees served and the type of interventions provided.

(2) The housing status of participants at 12, 24, and 36 months after entering the program, to the extent data are available, including how many participants remain in permanent housing.

(3) Recidivism among participants, including the number of arrests, days incarcerated, and incarceration in jail or prison.

(4) The total number of participants who accessed an innovative reentry housing program. For participants in these programs, the evaluator shall assess both of the following:

(A) The number of placements in livable wage employment.

(B) The number of placements who transitioned into permanent housing, and whether the participants require housing subsidies to afford that housing.

(e) The department may monitor the expenditures and activities of the recipient, as the department deems necessary, to ensure compliance with program requirements.

(f) The department may, as it deems appropriate or necessary, request the repayment of funds from an administrative entity or pursue any other remedies available to it by law for failure to comply with program requirements.

(g) The department shall submit, on or before February 1, 2025, the analysis prepared pursuant to subdivision (d) to the chairs of the Joint Legislative Budget Committee, the Senate Committee on Budget and Fiscal Review, the Assembly Committee on Budget, the Senate and Assembly Committees on Public Safety, the Senate Committee on Housing, and the Assembly Committee on Housing and Community Development.

READER REACTIONS

An adequate supply of affordable housing is necessary in California

BY GUEST COMMENTARY
APRIL 20, 2020

Jeanne Radsick, Bakersfield, President California Association of Realtors

Re: "Legislature should declare a moratorium on new housing bills," April 13, 2020

For NIMBY groups wanting to stop legislation that would address California's housing supply and affordability crisis, COVID-19 is sadly being used as a justification to preserve the status quo.

NIMBYs offer no solutions to California's extreme housing shortage which has not suddenly disappeared. Realtors are proud to back housing bills that will lead to the creation of needed housing and will allow working families to purchase homes that will allow them to live closer to job-rich areas and transit.

We applaud the Legislature's continued commitment to create policies that keep people safe during this difficult time. That is the highest priority. However, in order for California to recover and thrive going forward, expanded housing production and homeownership opportunities are essential.

California will beat COVID-19. Getting California going again will require a full court press of which housing is a necessary part.

CAL MATTERS

MY TURN

This a good time for the Legislature to invest in California by taxing large, profitable corporations

BY GUEST COMMENTARY , FEBRUARY 24, 2021 UPDATED FEBRUARY 25, 2021

Image via iStock

IN SUMMARY

Reversing the housing crisis and addressing homelessness will require large investments, and AB 71 is a bold step.

By Reuven S. Avi-Yonah,

Reuven S. Avi-Yonah is a professor of Law at the University of Michigan, aviyonah@umich.edu.

David Gamage

David Gamage is a professor at Indiana University, Bloomington, dgamage@indiana.edu.

Darien Shanske, Special to CalMatters

Darien Shanske is a professor of law at the University of California, Davis, dshanske@ucdavis.edu.

For the record: An earlier version of this commentary misstated the time frame of when California lawmakers cut the corporate tax rate.

A year into the COVID-19 crisis, the gap between corporate profits and economic security for the average American is wider than ever. Since March 2020, 45 out of 50 of **America's largest companies have made a profit** and in some cases the profit has been **quite substantial**.

Meanwhile, unemployment in California increased dramatically in 2020, from **5.5% in March** to **9% in December.** Many more Californians have been thrown into **housing instability**, worsening an already urgent issue.

Reversing the housing crisis and addressing homelessness in particular will require large and regular investments. **Assembly Bill 71**, introduced by Democratic Assemblymember Luz Rivas, is a bold step to making these investments and takes into consideration that California has a lot of needs, and **its current budget surplus is not expected to last**. Hence, AB 71 funds itself by means of a targeted tax increase that will be paid for only by the largest corporations best able to pay.

This is an appropriate revenue source, as corporations have paid an ever **smaller share** of their profits in taxes over the last several decades. Some of this decline was the result of deliberate decisions: Between 1980 and 1997 California lawmakers cut the corporate tax rate from 9.6% to 8.84% – and it hasn't changed since then.

This decline in taxes paid by large corporations was also because the state failed to act as certain very profitable corporations got cannier about exploiting major loopholes that allow them to avoid paying taxes even further.

Corporate tax avoidance is so rampant that even the 2017 tax bill, which was loaded with **breaks for large corporations and the wealthy**, included several provisions meant to combat these loopholes. In particular, the Trump tax bill established a methodology to both **identify and tax income improperly shifted out** of the U.S. tax base. This income is known by the acronym "GILTI," which stands for Global Intangible Low-Taxed Income.

Restoring California's corporate tax rate to 9.6% on corporations making more than $5 million in profits per year, as well as taxing the shifted income known as GILTI, are two sensible tax reforms that on their own are projected to provide sufficient funds for AB 71's robust approach to reversing the cycle of homelessness.

Don't buy the scare tactics of multinational corporations threatening to move their headquarters from California because of this bill. California's corporate income tax is based on sales made in California and applies regardless of whether a corporation has its headquarters in California or elsewhere. Thus, **bolstering California's corporate income tax** would not create any incentives for California-based corporations to move out of the state.

Even before the pandemic, it made excellent sense to ask our largest and most profitable corporations to pay as much as they did in the 1980s. Given the state's current urgent needs, what was once a good idea is now vital for the future health of our state.

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*The authors are participants in **Project SAFE**. You can read more about their ideas to reform state corporate income taxes **here**.*

STATE CAPITOL
P.O. BOX 942849
SACRAMENTO, CA 94249-0115

Assembly
California Legislature

Joint Informational Hearing

Assembly Health and Judiciary Committees

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

BACKGROUND

INTRODUCTION

The Assembly Committees on Health and Judiciary are convening a hearing to examine the implementation of the Lanterman-Petris-Short (LPS) Act, specifically the involuntary detaining and/or conservatorship of individuals who have been determined to be, as a result of a mental health disorder, either "gravely disabled," or a threat to themselves or others.

Established in 1967, the LPS Act was designed to end the inappropriate, indefinite, and involuntary commitment of persons with mental health disorders, developmental disabilities, and chronic alcoholism, as well as to safeguard a person's rights, provide prompt evaluation and treatment, and provide services in the least restrictive setting appropriate to the needs of each person. While the LPS Act is quite extensive and provides for several different types of conservatorships (housing, probate, etc.), this hearing focuses on the involuntary detention of individuals experiencing mental health disorders and/or chronic alcoholism or drug use.

The hearing will provide committee members and attendees with a fundamental understanding of the LPS Act and how it is implemented in California and help identify areas of possible reform to improve implementation of the Act while protecting the rights of individuals who are subject to its provisions. An overview of the LPS Act and of the 2020 California State Auditor's report on the LPS system will be included. The hearing will also examine the challenges and obstacles experienced by varied stakeholder groups in implementing the LPS Act. Clinical trends in the treatment of the LPS population, legal issues to ensure individual rights are preserved throughout the process and models of excellence will also be discussed. Stakeholder groups will have the opportunity to share any suggested changes or improvements to the current LPS system.

CIVIL COMMITMENT: HISTORICAL ROOTS

The vast majority of mental health services today are provided on a voluntary basis. However, every state provides for the civil commitment of those who meet the requisite legal standard applicable in that state. Involuntary civil commitment in the United States is a legal intervention by which a judge, or someone acting in a judicial capacity, may order that a person with symptoms of a serious mental disorder, and meeting other specified criteria, be confined in a psychiatric hospital or receive supervised outpatient treatment for some period against their wishes. Standards and procedures to impose commitment vary from state to state and nearly all were crafted in the last 50 years.

The first American hospitals established for the care and treatment of individuals with mental illnesses appeared in the late 1700s. Until the mid-1800s their number were so few that it was common for persons with mental illness to land in jail, or be otherwise housed with the indigent, the physically ill or disabled, alcoholics, the senile, and the "slothful." The deplorable conditions these individuals were forced to live in prompted state interest in providing state-run "asylums" for residential care. Following a series of major lawsuits in the late 1800s alleging wrongful commitment, procedures for commitment were tightened. Judicial certification was required in many states, including the right to a jury trial, in order to ensure due process and protect against wrongful confinement. In 1951, the National Institute of Mental Health released a "Draft Act Governing Hospitalization of the Mentally Ill," calling for commitment decision-making to be returned to medical professionals. Many states followed this recommendation and established procedures for medical certification with the right to a hearing after admission.

As early as 1845, the concept of "dangerousness" began to evolve. In that year, a Massachusetts court ruled, in *Matter of Josiah Oaks* (Mass. 1845) 8 Law Rep. 123, "The question must then arise in each particular case, whether a patient's own safety or that of others, requires that he should be restrained for a certain time, and whether restraint is necessary for his restoration…[.]"[1] In 1964, Congress enacted the Ervin Act (Act) that controlled commitment in the District of Columbia. The Act established dangerousness as a standard for commitment and recognized less restrictive alternatives to hospitalization as an appropriate option. In 1966, the DC Court of Appeals interpreted the Act to require consideration of less restrictive alternatives, stating, "Deprivations of liberty solely because of dangers to the ill persons themselves should not go beyond what is necessary for their protection."[2] The 1999 U.S. Supreme Court ruled, in *Olmstead v. L.C.* – without addressing 14th Amendment claims – that mental illness was a disability and covered under the Americans with Disabilities Act, requiring all governmental agencies, including state hospitals, to make "reasonable accommodations" to move people with mental illness into community-based treatment to end unnecessary institutionalization that was isolating and unduly restrictive.[3] This laid the groundwork for recognizing that a commitment

[1] *In re Oaks* (1845) Mass. LEXIS 193, 6.
[2] *Lake v. Cameron* (D.C. Cir. 1967) 364 F.2d 657, 660.
[3] *Olmstead v. L.C.* (1999) 527 U.S. 581, 597.

order might extend to services outside a hospital and opened the door to outpatient civil commitment.

Prior to the 1960s, mental health services in the United States were primarily provided in large state hospitals. Because of the court rulings described above, as well as the development of new and promising anti-psychotic medications, by the late 1960s and early 1970s, the trend was away from the use of large, state institutional care and to instead ensure community resources were provided at the local level. In theory, this shift would allow individuals to obtain treatment within their own communities in less restrictive settings, unless a court determined that institutional care was necessary for the care and safety of the individual or others.

The magnitude of deinstitutionalization of the severely mentally ill qualifies it as "one of the largest social experiments in American history."[4] While in 1955, there were 558,239 severely mentally ill patients in the nation's public psychiatric hospitals, in 1994, the number of individuals confined in such hospitals was 71,619, a reduction that is particularly noteworthy given the increase in the nation's population during those 40 years.[5]

HISTORY OF CONSERVATORSHIPS AND GUARDIANSHIPS IN CALIFORNIA

California adopted its first conservatorship statute in 1957. Prior to that time, a court could appoint a "guardian" for any person, child or adult, who was deemed "incompetent" to manage his or her daily affairs. After 1957, the law distinguished between a "guardianship," created for a minor, and a "conservatorship," created for an adult. There are specific types of conservatorships for persons who are considered "gravely disabled" by reason of mental illness or chronic alcoholism and subject to confinement in a locked psychiatric facility under the LPS Act in the Welfare & Institutions Code (WIC), for "developmentally disabled adults" under the Probate Code and for adults who are unable to manage their financial or personal needs, often as the result of a dementia, also under the Probate Code. California law provides for a Public Guardian for any person "who requires a guardian or conservator and there is no one else who is qualified and willing to act," and requires the Public Guardian to seek a conservatorship under the Probate Code for a person if there is an imminent threat to that person's health or safety or estate. Recently, California created an involuntary outpatient treatment program, known as Laura's Law (discussed later).

While not the subject of this hearing, but discussed in more detail below, a "housing conservatorship" was passed in 2018 and further amended in 2019, creating a pilot program for a "housing conservatorship" in San Francisco, San Diego, and Los Angeles Counties set to expire January 1, 2024. This pilot conservatorship markedly differs from LPS and Probate

[4] PBS Frontline, "Deinstitutionalization: A Psychiatric 'Titanic'," May 10, 2005, available at https://www.pbs.org/wgbh/pages/frontline/shows/asylums/special/excerpt.html.
[5] *Ibid.*

conservatorships in that it qualifies a person for conservatorship, in part, based on their substance use disorder and history of repeated 72-hour detentions for evaluation and treatment pursuant to the LPS Act.

CONSTITUTIONAL AND FEDERAL LIMITATIONS ON DEPRIVING INDIVIDUALS OF LIBERTY THOUGH INVOLUNTARY CONFINEMENT OR FORCED TREATMENT

Federal and state constitutional law prohibits individuals from being deprived of their liberty without due process of law. The 14th Amendment to the U.S. Constitution states that no state shall "deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws." The California Constitution provides: "A person may not be deprived of life, liberty, or property without due process of law or denied equal protection of the laws."[6] In the 1975 U.S. Supreme Court case *O'Connor v. Donaldson*, the Court declared that a person had to be a danger to themselves or to others for confinement to be constitutional.[7] In *O'Connor,* the plaintiff was confined to a mental hospital in Florida for 15 years, received a minimal amount of psychiatric care, and challenged his confinement numerous times before successfully suing his attending physician for violating his 14th Amendment right to liberty. The Court upheld the verdict in favor of the plaintiff:

> The fact that state law may have authorized confinement of the harmless mentally ill does not itself establish a constitutionally adequate purpose for the confinement. . . . Nor is it enough that Donaldson's original confinement was founded upon a constitutionally adequate basis, if, in fact, it was, because even if his involuntary confinement was initially permissible, it could not constitutionally continue after that basis no longer existed.[8]

In the specific facts presented in *O'Connor*, the Court held that a person could not be placed on a conservatorship if others were willing to care for that person, holding that a state "cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends."[9] In short, while the Court recognized that government might subject a mentally ill person to involuntary holds and treatments when necessary to prevent harm to that person or others, the government's power to do so is not unlimited and must respect the due process and liberty interests protected by the 14th Amendment. Understandably, the Court has not drawn any bright lines or offered up any neat "factor" test for identifying the precise conditions that would justify treating mentally ill persons against their will. Most states, including California, have statutes setting forth the requisite conditions in purposefully general language, and those statutes,

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[6] Cal. Constitution, Art. I, Sec 7.
[7] *O'Connor v. Donaldson* (1975) 422 U.S. 563, 574-75.
[8] *Ibid.*
[9] *Id.* at 576.

and the manner in which they are implemented, are subject to judicial review. Generally speaking, the courts demand that statutes are written and implemented in a way that requires government to achieve its legitimate interest in the least restrictive manner possible. But at some point, a statute that goes beyond the boundaries of *O'Connor* – if it allowed the detention of persons who do not *currently* suffer from a grave disability, do not *currently* constitute a threat to themselves or others, or disregarded the availability of others to provide basic necessities of life, for example – could be found by a court to be unconstitutional.

In addition to baseline constitutional requirements, according to the Supreme Court, the federal Americans with Disabilities Act (ADA) prohibits the segregation of individuals with disabilities. In *Olmstead*, the Court held that placing individuals with mental illness in institutions "severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment,"[10]and unjustified institutionalization constitutes discrimination under the ADA.[11] Integrated services provided in the community should be provided instead.

However, under a significant exception to the *Olmstead* requirement to provide integrated services, a state or local jurisdiction can seek to show that providing integrated community services would be too costly or beyond their capacity in light of "the responsibility the State has undertaken for the care and treatment of a large and diverse population of persons with mental disabilities."[12] State and local jurisdictions must provide community-based services to individuals with disabilities (which include mental disabilities) provided the services are appropriate, the individuals do not oppose the services, and community-based services can be reasonably accommodated.[13] California's LPS Act creates a similar duty to find alternatives, when available. For example, an LPS conservator must find an alternative placement for a conservatee within seven days of being notified by a facility's director that the conservatee no longer needs the care or treatment offered by that facility. However, this requirement can only be fulfilled if such an alternative, community-based facility exists.[14] As discussed below, the LPS Act operates within a broader mental health ecosystem that, unfortunately, too often offers too few actual alternatives to LPS holds and conservatorships. In light of the real-world scarcity of high-quality outpatient programs, along with a weak legal mandate (i.e. allowing an exception based upon cost and capacity concerns), the mandate of the ADA for integrated services to be provided in the community is somewhat illusory in practice.

[10] *Olmstead v. L.C., supra,* 527 U.S. at 601.
[11] *Id.* at 597-98.
[12] *Id.* at 604.
[13] *Id.* at 607.
[14] Welfare and Institutions Code Section 5359.

THE LPS ACT

The LPS Act was signed into law in 1967[15] and provides for involuntary commitment for varying lengths of time for the purpose of treatment and evaluation, provided that certain requirements or preconditions are met. Additionally, the LPS Act provides for LPS conservatorships, resulting in involuntary commitment for the purposes of treatment, if an individual is found to meet the "grave disability" standard in which a person, because of a mental disorder, or impairment by chronic alcoholism, is unable to provide for their basic personal needs for food, clothing, or shelter.

The LPS Act provides for a conservator of the person, of the estate, or of both the person and the estate for a person who is gravely disabled because of a mental health disorder or impairment by chronic alcoholism or use of controlled substances. The person for whom such a conservatorship is sought has the right to demand a court or jury trial on the issue of whether they meet the gravely disabled requirement. The purpose of an LPS conservatorship is to provide individualized treatment, supervision, and placement for the gravely disabled person.

The LPS Act, along with the court ordered outpatient services available through Laura's Law provides a system for mandating intensive inpatient and outpatient care, along with general oversight, for those who may not be able to care for themselves because of a mental health disorder.

There are several levels of "holds" within the LPS Act, progressing from an initial 5150 (5150 pertains to the WIC section number) hold through to a 5350 conservatorship. They are described below and shown graphically in Appendix A.

Detention of Mentally Disordered Persons for Evaluation and Treatment - WIC Section 5150: Typically, the first interaction with the LPS Act is through what is commonly referred to as a 5150 hold. This allows an approved facility to involuntarily commit a person for up to 72 hours for evaluation and treatment if they are determined to be, because of a mental health disorder, a threat either to themselves or to others, or are gravely disabled. The peace officer, or other authorized person, who initially detains the individual must know of facts that would lead a person of ordinary care and prudence to believe that the individual meets this standard. When making the determination, the peace officer or other authorized person may consider the individual's historical course, which includes evidence presented by an individual who has provided or is providing mental health or related support services to the person on the 5150 hold; evidence presented by one or more members of the family of the person on the 5150 hold; and, evidence presented by the person on the 5150 hold, or anyone designated by that person, if the historical course of the person's mental disorder has a reasonable bearing on making a determination that the person requires a 5150 hold. There is no oversight or due process protections under 5150.

[15]SB 677 (Short) Chap. 1667, Stats. 1967.

Certification for Intensive Treatment - WIC Section 5250: Following a 72-hour hold, the Section 5250 permits an individual to be held for an additional 14 days of intensive treatment, without court review, if they are found to still be, because of a mental health disorder, a threat to themselves or others, or gravely disabled. When determining whether the individual is eligible for an additional 14-day confinement, the professional staff of the agency or facility providing evaluation services must find that the individual has additionally been advised of the need for, but has not been willing or able to accept, treatment on a voluntary basis. Additionally, the individual cannot be found at this point to be gravely disabled if they can survive safely without involuntary detention with the help of responsible family, friends, or third parties who are both willing and able to help. A notice of certification is required for all persons certified for intensive treatment under a 5250, and a copy of the notice for certification is required to be personally delivered to the person certified, the person's attorney, or the attorney or advocate, as specified. A certificate review hearing, which usually occurs in the facility holding the individual, must be held within either seven days of the initial detention of the individual or four days of the 5150 hold, unless judicial review is requested through a writ of habeas corpus.[16] The certificate review hearing may be conducted by a broad range of hearing officers, including a physician, licensed psychologist or marriage and family therapist, or even a certified law student.[17] The individual is represented by a patient advocate. By contrast, at a judicial writ hearing, the hearing officer is almost always a judge (or a commissioner), the hearing occurs at court, and the individual is represented by an attorney.

Additional Intensive Treatment of Suicidal Persons - WIC Section 5260: If, during the 14-day period of intensive treatment or the original 72-hour evaluation period, a person threatened or attempted to take their own life or was detained for evaluation and treatment because they threatened or attempted to take their own life and the person continues to present an imminent threat of taking their own life, that individual may be detained, after the expiration of the 14-day period under a 5250 hold, for an additional period not to exceed 14 days. A notice of certification is also required for this additional 14-day period.

Additional Intensive Treatment - WIC Section 5270: If a person is still found to remain gravely disabled and unwilling or unable to accept voluntary treatment following either their 5250 or 5260 holds, they may be certified for an additional period of not more than 30 days of intensive treatment.[18] The individual may request judicial review of this involuntary detention, and if judicial review is not requested, the individual must be provided a certification review hearing. Additionally, the professional staff of the agency or facility providing the treatment, must analyze the person's condition at intervals not to exceed 10 days, and determine whether the person continues to meet the criteria for continued confinement. If the person is found to no longer meet the requirements of the 30-day hold, then their certification must be terminated.

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[16] Welfare & Institutions Code Section 5254 specifies that the review hearing must be conducted within four days of the 5120 certification (unless judicial review is requested); *but see Doe v. Gallinot* (9th Cir. 1982) 657 F.2d 1017, which requires that mandatory review hearings of involuntary confinement under the LPS Act must occur within seven days of confinement, which, assuming there is one 72-hour (three day) 5150 hold, would be the fourth day of the 5250 confinement.

[17] Welfare & Institutions Code Section 5256.1.

[18] Welfare & Institutions Code Section 5270.15.

Post-Certification Procedures for Imminently Dangerous Persons - WIC Section 5300: At the expiration of the 14-day period of intensive treatment under WIC Section 5250, an individual may be further confined for treatment for an additional period, not to exceed 180 days if they are deemed to be imminently dangerous based on one of the following conditions:

a) The individual has attempted, inflicted, or made a serious threat of substantial physical harm on another person after having been taken into custody, and while in custody, for evaluation and treatment and who, because of a mental health disorder, presents a demonstrated danger of inflicting substantial physical harm upon others;
b) The individual has attempted, or inflicted physical harm upon a person, that act having resulted in the individual being taken into custody and who presents as a result of a mental health disorder, a demonstrated danger of inflicting substantial physical harm upon others; or,
c) The individual has made a serious threat of substantial physical harm upon another person within seven days of being taken into custody, that threat having at least in part resulted in the individual being taken into custody and the individual presents, as a result of a mental health disorder, a demonstrated danger of inflicting substantial physical harm upon others.

Conservatorship for Gravely Disabled Persons – WIC Section 5350: Finally, the LPS Act provides for the appointment of a conservator of the person, of the estate, or of both the person and the estate for a person who is gravely disabled because of a mental health disorder or impairment by chronic alcoholism. The purpose of an LPS conservatorship is to provide individualized treatment, supervision, and placement for the gravely disabled individual. The individual for whom such a conservatorship is sought has the right to demand a court or jury trial on the issue of whether they meet the gravely disabled requirement, and has the right to be represented by counsel. An LPS conservatorship lasts for one year, but can be renewed.

The common criteria to commit a person under the LPS Act is that the person must almost always have a mental disorder that results in either a "grave disability" or a physical danger or harm to the person or others. A "grave disability" finding requires that the person presently be unable to provide for food, clothing, and shelter due to a mental disorder, or severe alcoholism, to the extent that this inability results in physical danger or harm to the person. In making this determination, the trier of fact must consider whether the person would be able to provide for these needs with the assistance of a family member, friend, or other third party's assistance if credible evidence of such assistance is produced at the LPS conservatorship hearing. The courts have found that this definition of "gravely disabled" is not unconstitutionally vague or overbroad, but rather is sufficiently precise in that it excludes "unusual or nonconformist lifestyles" and turns on an inability or refusal on the part of the individual to care for their basic personal needs.

According to data provided by the Judicial Council, California courts heard over 60,000 LPS cases in each of the last three state fiscal years, hearing 68,872 in fiscal year 2018-19, 64,125 in 2019-2020, and 62,664 in 2020-2021. These cases include certificate review hearings, which

may not occur in court or involve a judicial officer. The LPS cases account for about 75 percent of all mental health cases in California in which courts are involved.[19]

Laura's Law

As an alternative to an LPS conservatorship, current law provides for court-ordered *outpatient* treatment through Laura's Law, or the Assisted Outpatient Mental Health Treatment Program (AOT) Demonstration Project enacted in 2002.[20] In participating counties, the court may order a person into an AOT program if the court finds that the person either meets existing involuntary commitment requirements under the LPS Act or the person meets non-involuntary commitment requirements, including that the person has refused treatment, their mental health condition is substantially deteriorating, and AOT would be the least restrictive level of care necessary to ensure the person's recovery and stability in the community. Originally, Laura's Law was only operative in those counties in which the county board of supervisors, by resolution, authorized its application and made a finding that no voluntary mental health program serving adults and no children's mental health program would be reduced in order to implement the law. The initial sunset provision provided for within Laura's Law was extended several times until 2020 when legislation was passed requiring that, rather than counties opting into Laura's Law, they would have to, by board of supervisors resolution, opt out of the program. Additionally, the sunset provision was removed from the law, making the program permanent.

Laura's Law is designed to provide counties with tools for early intervention in mental health crises. It allows for family members, relatives, cohabitants, treatment providers, or peace officers to initiate the AOT process with a petition to the county behavioral health director or the director's designee. The health director or designee must then determine how to proceed. If the individual is found to meet the AOT eligibility requirements, a preliminary care plan is developed to meet that person's needs. If this process results in the person voluntarily engaging with treatment, then the patient is deemed to no longer meet the criteria and the petition is no longer available. However, if the client declines their preliminary plan, then a public defender is assigned and the petition process proceeds. A judge either grants or rejects the AOT petition; and if an AOT petition is approved, treatment is ordered and continues for up to 180 days.

Oversight

The Department of Health Care Services (DHCS) administers the LPS Act and adopts the rules, regulations, and standards necessary for implementation. DHCS must consult with the County Behavioral Health Directors Association of California (CBHDA), the California Behavioral Health Planning Council, and the Office of the Attorney General in developing these rules, regulations, and standards. Any adoption of said rules, regulations, or standards requires approval of the CBHDA. Additionally, DHCS is charged with collecting and annually

[19] The others include matters in the criminal courts, such as cases where a defendant's competency to stand trial is at issue.
[20] AB 1421 (Thompson) Chap. 1017, Stats. 2002.

publishing quantitative information concerning the operation of the LPS Act. The data to be reported includes the number of persons admitted for 72-hour evaluation and treatment, 14-day and 30-day periods of intensive treatment, and 180-day post certification intensive treatment, the number of persons transferred to mental health facilities from penal institutions, as well as the number of persons for whom temporary conservatorships are established, and the number of persons for whom conservatorships are established in each county. Each local mental health director, and each facility providing services to individuals under the LPS Act, are to provide DHCS with any information, records, and reports which DHCS determines are necessary to monitor the LPS Act.

A review of the data contained on the DHCS website reflects the following for the fiscal years 2005-06; 2010-2011; and 2019-2020.

Year	72-Hour Evaluations (Adult)	14-Day Intensive Treatment	Additional 14-Day Intensive Treatment (Suicide)	30-Day Intensive Treatment	180-Post Certification Intensive Treatment	Temporary Conservatorships	Permanent Conservatorships
2005-2006	138,295	57,386	269	3,569	21	5,371	10,226
2010-2011	133,913	68469	231	4,367	333	4,592	8,692
2018-2019	98,475	49,416	304	4,722	3,282	1,372	4,380

It should be noted, in regard to these reports, that more than 50 percent of the counties do not provide accurate information about their LPS detentions. Those counties are not mandated reporters (do not have a "designated facility" within their county), do not report the requested data at all, or provide incomplete data making it nearly impossible to determine at any point in time what the actual statewide LPS caseload is or has been for any given year. Such lack of data also makes it nearly impossible for policy makers at the state and local level to plan and forecast services and resources needed to provide appropriately for the LPS population. Additionally, under existing law, there are no consequences to counties who fail to either report data or provide incomplete data.

In addition to the oversight responsibility of DHCS, the LPS Act provides that each county may designate facilities, other than hospitals or clinics, as 72-hour evaluation and treatment facilities and as 14-day intensive treatment facilities if these facilities meet DHCS requirements. The terms "designated facility" or "facility designated by the county for evaluation and treatment" mean facilities that are licensed or certified as a mental health treatment facility or a hospital.

They may include, but are not limited to, a licensed psychiatric hospital, a licensed psychiatric health facility, and a certified crisis stabilization unit.

Individual counties are thus responsible for determining whether general acute care hospitals, psychiatric health facilities, acute psychiatric hospitals and other licensed facilities qualify to be designated facilities. Designated facilities are health facilities that have been designated by a local emergency medical services agency (LEMSA) to perform specified emergency medical services systems functions pursuant to guidelines established by the LEMSA. DHCS is responsible for the approval of designated facilities as determined by the counties. While peace officers and other authorized individuals are required to take an individual first to a designated facility, if one does not exist, they may transport individuals to a non-designated facility, which is also any facility participating in Medicare that is therefore required by federal Emergency Medical Treatment and Active Labor Act (EMTALA) laws to provide medical services to any individual who shows up requiring medical attention (i.e. acute care hospitals).

Finally, a shortage of designated individuals to conduct initial assessments for determination of placement for further evaluation and treatment can and often does result in individuals being held for longer periods of time in a system referred to as "stacked" or "serial" 5150s (as 72-hours approaches, new holds are placed on individuals until such time as the assessment for evaluation and treatment or placement can occur, potentially both violating federal constitutional and statutory requirements).

LPS Funding

Despite the complexities of the LPS system, there is no defined funding source for the LPS Act. The system impacts county mental health departments, county court systems, county guardian and conservator services, as well as the DHCS, the Department of State Hospitals, and the California Department of Corrections and Rehabilitation. While responsibility for most of the funding for the various services provided by the counties, with the exception of direct mental health services and the courts, fall directly on county budgets. Counties do not report their LPS implementation costs to the state.

Counties receive billions of dollars annually from state and federal revenue sources to fund their mental health systems. The primary sources of these funds are Medi-Cal, 1991 Realignment, 2011 Realignment, and the Mental Health Services Act (MHSA), passed in 2004 that levies an annual tax on taxable income that exceed $1 million. In the fiscal year 2018-19, approximately $7.7 billion dollars were allocated to counties to fund their mental health programs. Medi-Cal is the largest single provider of funds and covers a range of mental health services that includes some crisis stabilization services, inpatient care, and residential treatment. Counties typically fund their LPS-related activities from these pots of monies; however, there are certain restrictions that prevent counties from using certain funds for specific LPS services. For example, state regulations establish that MHSA funds cannot pay for long-term hospital or

institutional care.[21] While there are various sources of funds used for LPS services and activities at both the state and county level, there is no accounting for the actual costs of the LPS Act, making it difficult to assess the effectiveness of LPS services against dollars expended for those services.

RELATED PROGRAMS AND SUPPORTS

The LPS system of involuntary holds and conservatorships is limited to those with serious mental illness and does not apply to those who may not be able to make decisions for themselves, but are not, based on serious mental illness, a danger to themselves or others or gravely disabled. Included outside the LPS system are individuals with organic brain disorders, brain trauma, dementia, or developmental disabilities. For these individuals, there are other legal avenues for assistance and restrictions on choices that may apply.

Housing Conservatorship within the LPS Act.

The first alternative is a pilot project for an alternative conservatorship created by the Legislature in 2018 within the LPS Act itself, known as the "housing conservatorship." It applies to those who have both serious mental illness and substance use disorder (SUD).[22] The counties of Los Angeles, San Diego, and San Francisco may, through January 1, 2024, elect to establish this new conservatorship, but only after, among other requirements, the board of supervisors determines that money will not be taken from other mental health and conservatorship programs and the board of supervisors ensures that necessary services are available in sufficient quantity, resources, and funding levels to serve the identified population, including access to supportive community housing with wraparound services, public conservators, mental health services, SUD services, and service planning and delivery services.

This new six-month conservatorship, which may be established following a 28-day temporary conservatorship, is designed for those who are incapable of caring for their own health and well-being due to a serious mental illness andSUD, as evidenced not by a contemporary grave disability, but by at least eight 72-hour involuntary holds under Section 5150 in the preceding 12 months. San Francisco had asked for this new conservatorship to address a target population who, following a period of sobriety obtained during a 72-hour hold have their psychiatric symptoms abate to the point that they are no longer considered gravely disabled and thus do not qualify for a longer involuntary hold under the LPS Act, yet repeatedly are brought in for 72-hour holds. To ensure that this new conservatorship is truly filling a gap and not replacing any existing conservatorship or program, the investigator must consider all alternatives to the proposed conservatorship and only recommend the new conservatorship if no less restrictive

[21] California State Auditor, *Lanterman-Petris-Short Act: California has Not Ensured that Individuals with Serious Mental Illnesses Receive Adequate Ongoing Care,* Report 2019-119, July 2020, at 15.
[22] SB 1045 (Wiener & Stern) Chap. 845, Stats. 2018; revised by SB 40 (Wiener & Stern) Chap, 467, Stats. 2019.

alternatives exist and it appears the individual will not qualify for a conservatorship under the Probate Code or the LPS Act. So far, only San Francisco has elected to participate in the pilot and as of earlier this year, only one person has actually been conserved under the program, though more individuals could soon be eligible because they were approaching the requisite number of 5150 holds.[23] The pilot requires a thorough evaluation, which should assist the Legislature in determining the need for, and success of, the program.

Conservatorships and Other Arrangements in the Probate Code.

There are alternative arrangements in the Probate Code for protecting those who may have various impairments that prevent them from caring for themselves or protecting their finances from undue influence, but are not seriously mentally ill.

General Probate Conservatorship. In California, if an adult is, based on clear and convincing evidence, unable to provide properly for their personal needs for physical health, food, clothing, or shelter, a conservator *of the person* may be appointed by the court. If an adult who is, based on clear and convincing evidence, substantially unable to manage their own financial resources or resist fraud or undue influence, a conservator *of the estate* may be appointed by a court to manage the adult's financial matters. The appointment process requires an investigation by a court investigator and approval by the court. The conservator can be a family member, friend, a professional fiduciary, or, more rarely, a county public conservator. A conservatorship involves a court-appointed third party – the conservator – making far-reaching, life-changing decisions on behalf of the conservatee. Historically, a conservatorship lasts until the death of the conservatee or a court order terminating it, based on someone seeking a petition for termination.[24] However, AB 1194 ((Low), Chap. 417, Stats. 2021), requires that these conservatorships be reviewed annually by the probate court and terminated unless the court can legally reestablish them. Unfortunately, AB 1194 cannot be implemented until the Legislature specifically allocates funding for it, thus allowing conservatorships to continue indefinitely, despite the recent change in state law.

Enhanced Dementia Powers. Unlike an LPS conservatorship, a probate conservatee is generally not placed in a locked facility nor forcibly medicated. However, if a conservator can establish that the conservatee has a major cognitive disorder – i.e., dementia – the conservator can seek court approval for special powers to place the conservatee in a locked facility and also authorize administration of psychotropic medication.[25] The statute sets out the specific findings that a court must make before granting such powers.

Limited Conservatorship. Adults with developmental disabilities may become subject to a limited conservatorship of the person, the estate, or both. Unlike the general probate conservatorship, a limited conservatorship is meant to be as minimal as necessary in order to

[23] Mallory Moench, *S.F. has compelled only one person into treatment for mental illness and drug addiction in the past year,* S.F. Chronicle, March 12, 2021.
[24] Probate Code Section 1860.
[25] Probate Code Section 2356.5.

allow the individual the most possible rights, and the court must decide what specific rights to grant to the conservator. As stated in statute:

> A limited conservatorship may be utilized only as necessary to promote and protect the well-being of the individual, *shall be designed to encourage the development of maximum self-reliance and independence of the individual,* and shall be ordered only to the extent necessitated by the individual's proven mental and adaptive limitations. The conservatee of the limited conservator shall not be presumed to be incompetent and shall retain all legal and civil rights except those which by court order have been designated as legal disabilities and have been specifically granted to the limited conservator. The intent of the Legislature… that developmentally disabled citizens of this state receive services resulting in more independent, productive, and normal lives is the underlying mandate of this division in its application to adults alleged to be developmentally disabled.[26]

As a result, a limited conservator only has the powers specified by the court. These can include the power to (1) determine where the limited conservatee lives; (2) consent or withhold consent to marriage; (3) give or withhold medical consent; (4) choose the limited conservatee's social and sexual contacts and relationships; and (5) make educational decisions.[27] Unfortunately, it has been reported that most limited conservators seek and are granted all of the specified powers, making a limited conservatorship nearly identical to a general conservatorship.

Historically, a limited conservatorship lasts until the death of the conservatee, the death of the conservator, or a court order terminating it, based on a petition for termination.[28] Similar to the general conservatorship, AB 1194 requires that these conservatorships be reviewed annually by the probate court and terminated unless the court can legally reestablish them. Unfortunately, as discussed above, these provisions from AB 1194 are not effective until specifically funded, thus allowing limited conservatorships today to continue indefinitely.

Durable Power of Attorney and Advance Health Care Directive. A durable power of attorney[29] and an advance health care directive[30] allow an individual to give another person the ability to make financial and medical decisions for them if they are not able to do so themselves. These documents can be signed when a person has capacity and then become operative when they no longer have capacity. It gives the individual control over who their decision-maker will be and what decisions that person should be making when they no longer can do so for themselves. These tools can be used to avoid court, avoid a conservatorship, and avoid an involuntary loss of decision-making.

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[26] Probate Code Section 1801(d) (emphasis added).
[27] Probate Code Section 2351.5.
[28] Probate Code Section 1860.5.
[29] Probate Code Section 4000 *et seq.*
[30] Probate Code Section 4600 *et seq.* for general provisions; *see* Probate Code Section 4700 *et seq.* for statutory form.

Alternative Arrangements.

Supported Decision-Making. Outside of statutory law, supported decision-making allows an individual to choose trusted family or friends to help them make important choices in their life. Unlike a power of attorney or advanced health care directive, where the individual is transferring their right to make decisions to another person, a supported decision-making agreement allows the individual to choose those who will support them in making their decisions, but does not transfer to them the right to make those decisions. While supportive decision-making does not need to be formalized, formalization into a written agreement can help ensure that third parties, such as doctors and banks, honor the decisions that the individual makes through this process. This process allows the supported individual to retain their autonomy and their choices, while still getting the help they need to make reasonable decisions and maintain their independence.

Voluntary, Community-Based Supports and Services. In addition to other community-based voluntary mental health services and supports, in 2004 California voters adopted Proposition 63, which created the MHSA. The MHSA imposed a one-percent surtax on the wealthiest Californians in order to fund mental health programs and services across the state. Under the MHSA, the DHCS allocates Proposition 63 funds to mental health programs and services through contracts with individual counties. The Mental Health Services Oversight and Accountability Commission (MHSOAC), created by Proposition 63, reviews county plans and approves various programs and expenditures.

MHSA programs have three key components: community services and support (CSS); prevention and early intervention (PEI); and innovation. CSS programs, which account for about 80 percent of allocated funds, provide direct services to individuals with severe mental illness. The guiding concept of CSS program is to do "whatever it takes" to meet the mental health needs of those who are unserved or underserved. PEI programs, which may account for up to 20 percent of a county's funding, seek to identify early mental illness (especially in children and young adults) before it becomes severe and disabling. Finally, counties may use up to five percent of their funding for "innovation," or developing, testing, and implementing new approaches that may not yet have demonstrated effectiveness.[31]

While the LPS Act and MHSA have different histories and functions, they share the common goal of helping people obtain treatment for mental illness in the least restrictive and most effective manner possible. The MHSA has the potential to provide alternatives to the sometimes stark choices presented by the LPS system.

[31] Little Hoover Com., *Promises Still to Keep: A Decade of the Mental Health Services Act* (Jan. 2015) at 8.

CONCERNS WITH THE LPS ACT AND ITS IMPLEMENTATION

2020 Audit Report

In July of 2020, the California State Auditor released a report entitled, "Lanterman-Petris-Short Act: California Has Not Ensured That Individuals with Serious Mental Illnesses Receive Adequate Ongoing Care."[32] The Joint Legislative Audit Committee called for the audit and the State Auditor examined the implementation of the LPS Act in Los Angeles County, San Francisco County, and Shasta County. Essentially the audit found that California has not ensured adequate care of individuals with serious mental illnesses in its broader mental health system. The audit found that "perhaps most troublingly, many individuals were subjected to repeated instances of involuntary treatment without being connected to ongoing care that could help them live safely in their communities."[33]

Specific audit highlights include:

- The LPS Act's criteria for involuntary mental health treatment allows counties sufficient authority to provide involuntary treatment to people who need it and no evidence was found to justify expanding the "grave disability" criteria, which could "potentially infringe upon people's liberties."[34]
- Although the LPS Act's criteria are sufficient for involuntary holds and conservatorships, significant issues were found with how Californians with serious mental illnesses are cared for.
    - Individuals on conservatorships have limited treatment options – many could not receive specialized care in state hospital facilities for an average of one year because of a shortage of available treatment beds;
    - Individual existing involuntary holds have not been enrolled consistently in subsequent care to help them live safely in their communities – in two counties, no more than nine percent of these individuals were connected to ongoing services and supports; and,
    - Less than one-third of the State's counties – only 19 at the time of the audit – had adopted AOT even though it is an effective community-based approach to mental health treatment to help prevent future involuntary holds and conservatorships.

The audit concluded with several specific recommendations that will be discussed later in this background paper but also, that because of the disjointed and incomplete tools and data related to public reporting of mental health services, policy makers and other stakeholders do not have the

[32] California State Auditor, *Lanterman-Petris-Short Act: California has Not Ensured that Individuals with Serious Mental Illnesses Receive Adequate Ongoing Care, supra*.
[33] Elaine Howell to Governor of California, President pro Tempore of the Senate, and Speaker of the Assembly, July 28, 2020, in California State Auditor, *Lanterman-Petris-Short Act: California has Not Ensured that Individuals with Serious Mental Illnesses Receive Adequate Ongoing Care,* Report 2019-119, July 2020.
[34] California State Auditor, *Lanterman-Petris-Short Act: California has Not Ensured that Individuals with Serious Mental Illnesses Receive Adequate Ongoing Care, supra*, at 1.

information needed to assess the effectiveness of the billions of dollars California invests in its mental health system each year. The report recommended an overhaul of mental health reporting requirements in order to bring greater accountability to the system.

LPS System Only Part of California's Muddled Mental Health System

While the audit rightly noted the shortcomings of LPS holds and conservatorships, those shortcomings are not solely attributable to problems within the LPS Act or its implementation. LPS cannot "connect" persons to "ongoing care" if such care does not exist. The LPS Act, after all, was enacted to "end the inappropriate, indefinite, and involuntary commitment of persons with mental health disorders."[35] Its primary purpose is not to provide mental health services per se, but to establish commitment criteria that protect the due process rights of persons who are experiencing a dangerous or debilitating mental health crisis. In the absence of voluntary and less restrictive treatment options, the various professionals who make determinations under the LPS Act too often face the choice of releasing a seriously mentally ill person back into the community, or committing them against their will to a locked psychiatric facility. This Hobson's choice does not reflect flaws in the LPS system as much as it exposes a lack of alternatives to it.

It was precisely this lack of alternatives in the wider mental health system that prompted California voters in 2004 to adopt the MHSA, discussed above. A 2016 report by the Little Hoover Commission[36] cited several successful and promising local programs developed through the MHSA, but the Commission's overall conclusion was that a "muddled" governance structure makes it difficult to determine if counties use MHSA funds in the most efficient and effective manner and who should be held accountable when they do not. For example, current law assigns various responsibilities for implementation of the MHSA to three different agencies: DHCS, which absorbed the administrative responsibilities of the now-disbanded Department of Mental Health Services in 2012; MHSOAC, which although created by Proposition 63 has oversight responsibilities for the mental health care system as a whole; and the Mental Health Planning Council, which reviews program performance of the overall mental health system, including MHSA programs. Unfortunately, members of these three agencies informed the Little Hoover Commission that the broad and sometimes overlapping responsibilities mean, in practice, that there is no clear designation of who is responsible for what.[37]

On one key issue, the Little Hoover Commission's report on MHSA found the same problem that the State Auditor found in the LPS system: insufficient data collection. "Despite compelling claims that the MHSA has transformed mental health services in communities across California," the Commission stated, "the state cannot yet demonstrate meaningful, statewide outcomes across the range of programs and services supported by Proposition 63 dollars." Without robust data, policymakers cannot know which programs work with which specific populations. The

[35] Welfare & Institutions Code Section 5001.
[36] Little Hoover Com., *Promises Still to Keep: A Second Look at the Mental Health Services Act,* Paper #233, September 2016.
[37] *Id.* at 10.

Commission found that some counties – Los Angeles in particular – have done better than others in tracking outcomes of specific programs. The Commission recommended that the Legislature establish a MHSA data working group within DHCS to build upon the best of the county programs and develop a statewide MHSA database. As guidance, the Commission suggested that the Legislature look to the experience of a working group established in 2014 to collect data on the effectiveness of juvenile justice programs.[38]

If effectively utilized, the MHSA programs may well obviate the need for an LPS hold or conservatorship in the first place, or they might provide less expensive and more effective alternatives to the choice of either releasing or committing persons experiencing mental illness. However, LPS decision-makers must first have knowledge of these programs and their effectiveness with various populations, which would require much more data and analysis as well as cooperation and collaboration.

Psychiatric Bed/Facility Shortages

Not every patient who experiences a Section 5150 hold requires inpatient hospitalization. According to a 2014 fact sheet from the California Hospital Association (CHA), more than 75 percent of individuals detained or transported on an involuntary hold could be discharged within 23 hours; resulting in less than 25 percent requiring a 72-hour (or longer) hold in an in-patient setting. However, there is an acute shortage of in-patient psychiatric beds in California resulting in long delays for placement of individuals suffering an acute mental health crisis. These delays in placement can result in extended wait times for patients either in hospital emergency rooms or in other crisis type facilities that are intended to only care for individuals for up to 24 hours and then those patients should be either transported to an in-patient facility or released. In addition, the shortage of in-patient beds and facilities oftentimes results in individuals being transported well outside their "community" to a different locale that has an open psychiatric bed for care and treatment. It is not uncommon for individuals to be transported to counties other than their home county, which further complicates treatment, funding, and ultimately the treatment planning for continuity of care upon the release of patients.

CHA reports that of California's approximately 440 hospitals, only 130 provide in-patient psychiatric care. It states that within California's 58 counties, 45 percent have zero in-patient psychiatric beds; 81 percent have zero child or adolescent psychiatric beds; 97 percent have zero geriatric psychiatric beds; and 86 percent have zero chemical dependency beds.

Further, since 1995 the state has lost 44 facilities, either through the elimination of psychiatric in-patient care, or complete hospital closure, representing a nearly 25 percent drop. CHA reports that while there has been an overall increase in psychiatric beds since 2012, according to 2015

[38] *Id.* at 16-18. The working group to improve collection of juvenile justice data justice data was established by AB 1468 (Committee on Budget) Chap. 26, Stats. 2014, and issued its final report in 2016. *See* California Juvenile Justice Data Working Group, "Rebuilding California's Juvenile Justice Data System: Recommendations to Improve Data Collection, Performance Measures, and Outcomes for California Youth: Report to the Legislature," January 2016. *See also* Penal Code Section 6032.

data, California has lost nearly 30 percent of the psychiatric beds it had in 1995, a drop of almost 2,800 beds, making the state's psychiatric bed rate one bed for every 5,922 people, compared to a national average of one bed for every 5,006 people. CHA states that the recommended number of psychiatric beds is 50 per 100,000 individuals, which is contingent upon the availability of appropriate outpatient services in the community. As of 2015, California has 16.91 inpatient beds per 100,000 people.

Specific challenges that contribute to the lack of crisis and in-patient care capacity include:

- The federal Medicaid Institution for Mental Disease exclusion, which prohibits states from receiving federal matching funds for mental health in-patient services they provide to adult Medicaid enrollees aged 18-65 years in a hospital, nursing home, or other in-patient care setting with more than 16 beds. It should be noted that DHCS, as part of the state's Medicaid reform is planning to seek a Centers for Medicare & Medicaid Services exclusion waiver to this prohibition; and,
- Stigma and discrimination, due to negative attitudes and myths about the dangerousness of people with mental illness. Counties and providers often face substantial community opposition when attempting to construct or repurpose a facility intended to be used for individuals in psychiatric crisis or in need of in-patient care.

Severe Shortage of Housing and Supportive Housing in California

A shortage of housing generally and supportive housing in particular, adds difficulty and complexity to the challenge of addressing the mental health needs of Californians, especially those experiencing mental health challenges. California's oft-discussed housing shortage has many components. At bottom, there is simply a shortage of available homes, with estimates of the shortfall ranging as high as 3.5 million units.[39] Competition for scarce housing, in turn, has driven up housing costs. For example, in the City of Los Angeles, average rent increased by 65 percent between 2010 and 2019, as compared to 36 percent nationwide over the same period.[40]

California also has the highest poverty rate in the nation, with 17.2 percent of residents living below the poverty line in 2019 when accounting for the cost of living and housing.[41] California's housing shortage is particularly acute for these lower-income households. Data

[39] *See, e.g.,* McKinsey Global Institute, *A Tool Kit to Close California's Housing Gap: 3.5 Million Homes by 2025* (Oct. 2016) at 3, available at: https://www.mckinsey.com/~/media/McKinsey/Industries/Public%20and%20Social%20Sector/Our%20Insights/Closing%20Californias%20housing%20gap/Closing-Californias-housing-gap-Full-report.pdf ["California would need to build 3.5 million housing units by 2025 to close its housing gap."].

[40] Jack Flemming, *L.A. rent rose 65% over the last decade*, Los Angeles Times (Dec. 27, 2019), available at: https://www.latimes.com/business/real-estate/story/2019-12-27/l-a-rent-rose-65-percent-over-the-last-decade-study-shows.

[41] U.S. Census Bureau, "The Supplemental Poverty Measure: 2019," Report Number P60-272 (2020) at Table 5, available at: https://www.census.gov/library/publications/2020/demo/p60-272.html.

from 2019 show a shortage of more than 1.3 million affordable rental units for households earning 50 percent of the area median income or less.[42]

Supportive housing. It is in the area of supportive housing that California's shortage is most pronounced. The term "supportive housing" describes housing that is both affordable (i.e., costs no more than 30 percent of a household's income) and is coupled with supportive services for residents, such as mental and physical health services, substance use counseling and treatment, and/or education and job training. Such services are crucial to ameliorating the conditions that may lead to an LPS involuntary detainment. The term "permanent supportive housing" generally refers to long-term housing for individuals who may require services for some or all of their tenancies.

The most-commonly referenced statutory definition of "supportive housing" is: "[H]ousing with no limit on length of stay, that is occupied by the target population, and that is linked to onsite or offsite services that assist the supportive housing resident in retaining the housing, improving their health status, and maximizing their ability to live and, when possible, work in the community."[43] The term "target population," in turn, has a complex definition that essentially encompasses individuals, families, and youth who are currently, or were previously, homeless.[44]

Examples of programs that fund supportive housing development in California include:

- *Project Homekey, administered by the Department of Housing and Community Development* (HCD). Homekey provides billions of dollars in direct grant funding for both temporary and permanent supportive housing. Much of this funding is being used to acquire and convert hotel properties that were facing large-scale vacancies due to COVID-19.[45]
- *Federal and State Low-Income Housing Tax Credits, administered by the California Tax Credit Allocation Committee*. These credits are provided to housing developers that develop supportive housing.[46]
- *The Supportive Housing Multifamily Housing Program, administered by HCD*, provides low-interest loans to developers of permanent affordable rental housing that contain supportive housing units.[47]
- *Rental assistance subsidy programs for supportive housing, generally administered through local housing authorities.* One example is the Veterans Affairs Supportive Housing program,

[42] National Low Income Housing Coalition, *Gap Report: California*, available at: https://reports.nlihc.org/gap/2019/ca.
[43] Health and Safety Code Section 50675.14 (b)(2).
[44] Health and Safety Code Section 50675.14 (b)(3).
[45] Cal. Dept. of Housing and Community Development, *Homekey: Bringing California Home*, available at: https://homekey.hcd.ca.gov/.
[46] Cal. State Treasurer, *California Tax Credit Allocation Committee*, available at: https://www.treasurer.ca.gov/ctcac/.
[47] Cal. Dept. of Housing and Community Development, *Supporting Housing Multifamily Housing Program*, available at: https://www.hcd.ca.gov/grants-funding/active-funding/shmhp.shtml.

which pairs Section 8 housing vouchers with supportive services offered at local Veterans Affairs medical centers.[48]

Benefits of supportive housing. California has a critical shortage of supportive housing, despite state and federal funding sources to develop such housing. Supportive housing is recognized as an evidence-based best practice that allows people with mental health disabilities to live successfully in their communities. Many state and federal public health agencies, as well as advocates for the disabled and mentally ill, recognize and promote supportive housing as a successful, cost-effective model for providing housing and services to people who would otherwise be institutionalized or at risk of institutionalization. A large body of research shows that the vast majority of people who live in supportive housing are able to stay stably housed in the community.[49] The research supports four main conclusions:

- Supportive housing helps people with disabilities live stably in the community.
- People with disabilities in supportive housing reduce their use of costly systems, especially emergency health care and corrections.
- Supportive housing can help people with disabilities receive more appropriate health care and may improve their health.
- People in other groups, including seniors trying to stay in the community as they age and families trying to keep their children out of foster care, likely also benefit from supportive housing.[50]

According to Disability Rights California, in its important and thorough examination of the topic of supportive housing:

> An important benefit of supportive housing is that it allows people with disabilities to live in the community, along with people who do not have disabilities. In the 1999 case of *Olmstead v. L.C.*, the U.S. Supreme Court held that the use of public funds to unnecessarily institutionalize people with disabilities violates the Americans with Disabilities Act (ADA) by segregating these individuals from the rest of the population. The 2014 revisions to HCBS Medicaid regulations recognize the integration mandate by providing that Medicaid services provided in home and community-based settings must be chosen by the individual, be integrated into the community and supportive of community activities including employment, facilitate the individual's choice in supportive services, and otherwise promote individual rights such as privacy, dignity, respect and freedom from coercion and restraint.[51]

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[48] Cal. Dept. of Veterans Affairs, *Housing & Supportive Services*, available at: https://www.calvet.ca.gov/VetServices/Pages/Housing-Supportive-Services.aspx.
[49] Dohler, Bailey, Rice, and Katch, *Supportive Housing Helps Vulnerable People Live and Thrive in the Community*, (May 2016) Center on Budget and Policy Priorities, available at: https://www.cbpp.org/research/housing/supportive-housing-helps-vulnerable-people-live-and-thrive-in-the-community.
[50] *Ibid.*
[51] Disability Rights California, *Everyone's Neighborhood: Addressing "Not in My Backyard" Opposition to Supportive Housing for People with Mental Health Disabilities*, (Sept. 2014), pp. 13-14 (internal citations omitted).

Challenges in developing affordable housing. There are three primary challenges to providing supportive housing. The first is cost, both for initial development and for the ongoing provision of services. However studies have also repeatedly shown that, in the long run, providing supportive housing is more cost-effective than not providing it, because its absence often leads to individuals relying on high-cost public services like emergency rooms, mental health institutionalization, or incarceration in jail or prison.[52] As should be obvious, neither emergency services nor jail are effective at addressing chronic or long-term issues that may ultimately lead to an LPS conservatorship. They are also the most costly way to provide mental health services.

The second challenge is finding appropriate locations for supportive housing. California's real estate market makes it challenging to find appropriate parcels of land for supportive housing units to be constructed. The second challenge is compounded by a third, related challenge – a more general failure of local governments to appropriately address the need for supportive housing. State law provides that local governments, typically city councils and county board of supervisors, are responsible for nearly all aspects of local planning, zoning, development permitting.[53] Thus, it is the responsibility of local governments to both plan for and site supportive housing developments and to ensure adequate funding of projects utilizing state resources. However, homelessness and the mental health care system, especially outside of the state's largest municipalities, are rarely issues that can be handled by a single jurisdiction in a vacuum. The regional nature of homelessness and mental health care pose significant coordination problems at the local level. Illustrative of the state as a whole, in 2018, an Orange County Civil Grand Jury reported that "many cities address issues such as homelessness in a 'silo'" and that doing so "ignores the regional nature of homelessness."[54] The Grand Jury noted that because cities tend to operate with their own governing bodies and municipal staff, they miss critical opportunities to collaborate regionally.

Furthermore, when the hyper-local approach to developing and approving supportive housing is mixed with local opposition to such projects, the political will to develop critical regional solutions to homelessness quickly fades.[55] Interestingly, the Orange County Grand Jury report also noted that a localized approach to tackling homelessness breeds distrust between local jurisdictions. The Grand Jury found that, "it was instructive to note the number of cities…who believe they are doing more than any other city in the county with respect to providing homeless services and housing."[56] Because of the lack of state oversight and the dysfunction and distrust at the local level, too many communities are attacking the homelessness problem in "crisis mode rather than from any strategic plan developed to address the housing shortage."[57] To address these shortcomings, the Grand Jury suggested that comprehensive regional plans to address homelessness are critical. These plans must focus on utilizing multi-year funding sources

[52] *See, e.g.* Sarah B. Hunter, *et al., Evaluation of Housing for Health Permanent Supportive Housing Program* (2017) RAND Corp., available at: https://www.RAND.org/pubs/research_reports/RR1694.html.
[53] *See, e.g.,* Gov. Code Section 65000 *et seq.*
[54] Orange County Grand Jury, *Where There's a Will, There's a Way: Housing Orange County's Chronically Homeless* (2017-2018), p. 18.
[55] *Id.* at 26.
[56] *Id.* at 19.
[57] *Id* at 22.

available at the county-level to ensure all housing needs are addressed and municipalities work in cooperation on siting housing and supportive services.[58] However, until the state expands its oversight role over mental health and housing funds, there appears to be little likelihood that individual municipalities will be able to effectively provide an adequate supply of supportive housing and coordinate services for the homeless.[59]

In recent years, California has attempted to remove numerous barriers to supportive housing, including allowing developers to build projects in any area zoned residential "by right," meaning the projects should not need special local approvals. However, as California's housing market has grown increasingly expensive and competitive, supportive housing developers note that properties that would qualify as "by right" locations for supportive housing are frequently purchased by private investors before a non-profit can generate the funding needed to purchase the property.[60] Furthermore, the specialized needs of supportive housing developments, including resident capacity, parking availability, or height requirements, often require these projects to obtain a conditional use permit, special use permit or planned unit development permits, thus forcing supportive housing projects to seek the specialized approvals from local government entities that the state law was attempting to eliminate.[61] Because all of these specialized approvals are subject to public hearings and votes "Not in My Backyard" or "NIMBY" opposition to supportive housing can often stop many a worthwhile project. The hyper-localized nature of many local decisions on housing also provides incentives to local elected officials to acquiesce to NIMBY opposition to supportive housing to simply make homelessness the issue of a neighboring jurisdiction.[62] More state oversight, direction, and coordination, as well as local support, could help increase the development of supportive housing across the state.

Behavioral Health Workforce

Compounding and deepening the serious threat to the provision of adequate behavioral health care for not only individuals involved in the involuntary detention and conservatorship aspect of the LPS Act, but for all Californians is the imminent shortage of mental health professionals in California. It was estimated in 2014, that while one in six adults in California have been diagnosed with a mental illness, one in twenty-five had serious mental illness. While California had over 80,000 licensed behavioral health professionals in 2016, these professionals are not distributed evenly across the state. Additionally the workforce simply does not reflect either the racial, ethnic, or gender diversity of the state's population.

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[58] *Id.* at 21.
[59] Little Hoover Com., *Promises Still to Keep: A Decade of the Mental Health Services Act*, *supra,* at. 28.
[60] Tim Iglesias, *Managing Local Opposition to Affordable Housing: A New Approach to NIMBY,* 12 J. Affordable Housing, 79, 103.
[61] *Id.* at 83.
[62] Orange County Grand Jury, Where There's a Will, There's a Way: Housing Orange County's Chronically Homeless, *supra,* at 21.

In a *California Healthline* article reviewing a research report conducted by the University of California – San Francisco's Healthforce Center and funded by the California Health Care Foundation, entitled "California's Current and Future Behavioral Health Workforce," it was stated that "if nothing is done to fill the void, by 2028, many people diagnosed with mental health conditions will struggle to get the medication and counseling they need."[63] The report projects that because of a serious and growing lack of community-based behavioral health services, more people could end up in the emergency rooms and primary care clinics, where providers may not have the same training in treating mental health (and SUD) as psychiatrists, psychologists; therapists and licensed clinical social workers. For the LPS population, emergency rooms are already the first line of examination and treatment.

In the best-case scenario examined, the report, in projecting what the state would need if current trends in how services are used continue, without figuring in "unmet needs," stated that by 2028 California will have 41 percent fewer psychiatrists and 11 percent fewer psychologists, therapists and social workers than would be needed.[64]

The Governor's 2021-22 budget made unprecedented strides to address these pending shortages. The budget includes an $834 million, one-time expansion of behavioral health programs with funding for workforce training, $300 million to reduce health disparities and support a public health workforce, and $16 million to include community health workers as Medi-Cal providers, along with $150 million for a range of new and existing programs aimed at growing the health workforce providing care for underserved populations. Funding and programmatic efforts to enhance the pipeline of behavioral health workers may have long-term benefits for Californians with mental illness, but for those in immediate need of comprehensive in-patient and/or out-patient community based behavioral health services, obtaining those services in order to improve health outcomes, is very much a day-to-day challenge.

Limitations of "Gravely Disabled"

As previously described, Section 5150 of the LPS Act allows a police officer or a designated mental health professional to place a person on a 72-hour involuntary hold if the person is a danger to themselves or others, or if the person is deemed to be "gravely disabled," meaning that, *due to a mental illness or chronic alcoholism,* the person is no longer able to provide the basic needs of clothing, food, or shelter. After 72 hours, the treating psychiatric facility may "certify" a 14-day hold for "intensive treatment," if it determines that the conditions that gave rise to the 72-hour hold still exist.[65] These initial 72-hour and 14-day holds most often reflect a determination that the person is a danger to self or others.

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[63] Brian Rinker, *Forecast Shows Deepening Shortage of Mental Health Professionals in California* (Feb. 2018) California Healthline, available at: https://californiahealthline.org/news/forecast-shows-deepening-shortage-of-mental-health-professionals-in-california/.

[64] Janet Coffman, *et al., California's Current and Future Behavioral Health Workforce* (Feb. 2018) Healthforce Center at the University of California – San Francisco, p. 55

[65] Welfare & Institutions Code Sections 5250 and 5251.

How "gravely disabled" is interpreted is crucial to balancing the conservatee's treatment needs against their civil liberties. For purposes of the LPS conservatorship, the definition is deceptively simple: a person is gravely disabled if that person "as result of mental health disorder [or chronic alcoholism], is unable to provide for [their] basic personal needs of food, clothing, or shelter."[66] To begin with, it is important to note that the person must be unable to provide these basic needs as *a result of mental illness or chronic alcoholism*. Therefore, experiencing homelessness or food insecurity alone does not meet the criteria. A grave disability would not include, as one court put it, "unusual or nonconformist lifestyles" that are rationally, if unconventionally, chosen.[67] Moreover, a court may not assign a conservator for a person who could survive with the help of a friend, family member, or other third party who is willing to care for the person.[68]

In addition, courts have long and repeatedly held that the grave disability must be a *present* condition. That is, a conservatorship should not be imposed merely because it seems probable, or even likely, that the person will *become* gravely disabled at some point in the future. As discussed above, the State Auditor has found that counties are applying the gravely standard appropriately, consistently, and not overly narrowly.[69] Further, she found that: "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 widen the use of involuntary holds and pose significant concerns about infringement on individual rights. We found no evidence to justify such a change."[70] The Auditor's findings have not been without controversy from some, such as the Los Angeles County Department of Mental Health and the Steinberg Institute, seeking to expand use of LPS conservatorships for, among others, those with mental and physical health comorbidities,[71] although the Auditor forcefully disputes those critics.[72]

Despite the Auditor's findings, there are those that argue that the term grave disability is presently interpreted so narrowly that it fails to protect Californians. While data is very limited, anecdotes and some with first-hand experiences, argue that the definition is failing those in need. They argue that in some instances, individuals who can feed themselves from trash bins and seek shelter under overpasses have been deemed able to provide for themselves even as their mental health continues to deteriorate, and that tens of thousands of people are living on the streets

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[66] Welfare and Institutions Code Sections 5008(h)(1)(A). This section also defines "gravely disabled" to mean a condition in which a person has been found mentally incompetent to stand trial under Penal Code Section 1370. However, that definition is not relevant to this discussion.
[67] *Conservatorship of Chambers* (1977) 71 Cal. App. 3d 277, 284.
[68] *Conservatorship of Jesse G.* (2016) 248 Cal. App. 4th 453, 460. The United States Supreme Court has also held, as a matter of federal law under the due process clause of the 14th Amendment and pursuant to a lawsuit brought under Section 1983 of the Civil Rights Act of 1871 – a person shall not be placed on a conservator if there are others willing to care for that person. *See O'Connor v Roberson* (1975) 422 U.S. 563, 576 (holding that a state "cannot constitutionally confine without more a non-dangerous individual who is capable of surviving safely in freedom by himself *or with the help of willing and responsible family members or friends."*) [Emphasis added.]
[69] California State Auditor, *Lanterman-Petris-Short Act: California has Not Ensured that Individuals with Serious Mental Illnesses Receive Adequate Ongoing Care, supra*, at 20-21.
[70] *Id.* at 21.
[71] *See, e.g.,* State Auditor, *LPS Audit,* Response of Los Angeles County Department of Mental Health, at 83-98.
[72] *Id.* at 99-103.

because of untreated mental illness and that each year, hundreds die in pain and isolation because of their mental illness. According to these groups, grave disability should be defined by being unable to live safely in the community, guided by an individual's need for supervision and assistance, their risks of bodily injury, their housing situation, their physical health challenges, their patterns of behavior, and their degree of psychiatric deterioration. Opponents of an expansion of the definition of grave disability including many service providers and civil liberties advocates, counter that significant and ongoing investment into community-based services, as well as providing a seamless offering of supports and services across jurisdictions in order to engage individuals "where they are" is what is required. The State Auditor in her report about the LPS System also made this point.

Even if there was agreement that an expansion of the definition of "gravely disabled" was necessary, any such expansion would have to pass constitutional scrutiny. In recent years, the Legislature has enacted measures that modify the principle that the conditions justifying an LPS hold or conservatorship must be *present* and not merely foreseen. As discussed above, Laura's Law permits a court (in participating counties) to order a person into an AOT program. While AOT is certainly less restrictive that an LPS conservatorship that places the person in a locked psychiatric facility, it allows a court to order a person into outpatient treatment based on clear and convincing evidence that the person's condition is *likely* to deteriorate to the point of grave disability. In addition to Laura's Law, the so-called "housing conservatorship" pilot projects authorized by SB 1045 and SB 40 allow persons to be placed on a conservatorship if they have been subject to a Section 5150 hold eight times in the previous 12 months. Presumably, this requirement is based on the assumption that a person placed on an LPS hold so many times in a single year is likely to once again become a danger to themselves or others, or gravely disabled. It should be noted that this threshold marks a significant departure from prior statutory and case law requirements that the danger to self or other, or the grave disability, be a *present* condition and not based on speculation as to what might occur in the future.

In remains to be seen whether the pilot projects, when eventually implemented to their full extent, will pass constitutional muster. Existing case law[73] suggests that, as a matter of statutory interpretation, the conditions justifying an LPS hold or conservatorship must be present conditions, and the pilot projects fall short of that requirement by allowing the imposition of a conservatorship based on history. However, the existing case law has only interpreted the language of existing statutes. A court may determine, therefore, that Legislature may abandon its own "present" condition requirement for the limited purpose of a pilot project aimed at a particularly difficult-to-treat population. Yet, as *O'Connor* made clear, state law must still meet the requirements of the due process clause of the 14th Amendment: "The fact that state law may have authorized confinement of the harmless mentally ill does not itself establish a constitutionally adequate purpose for the confinement."[74] It can be argued that California's LPS Act passes muster under this rule because it does not authorize involuntary confinement for the "harmless" mentally ill; it only applies where the subject is a danger to self or others or is unable to provide basic needs. However, *O'Connor* also makes clear that even if the statute's

[73] *See, e.g., Conservatorship of Chambers* (1977) 71 Cal. App. 3d 277.
[74] *O'Connor* at 574.

conditions for involuntary confinement and treatment are constitutionally permissible, it is not constitutionally permissible to continue the confinement and treatment after those conditions no longer exist.[75] To the extent that the housing conservatorship established by SB 1045 and SB 40 authorizes involuntary treatment based on a history of prior holds, as opposed to an existing condition, a court may find both bills to be constitutionally suspect.

The Question of Discrimination in the LPS System, and the Need for Better Data

One question that deserves further exploration is whether LPS detentions and conservatorships are being imposed in a discriminatory fashion; that is, whether individuals are more likely to be conserved due to their race, gender, or other protected characteristics, rather than because they objectively met the criteria for an involuntary hold or conservatorship.

There is limited demographic data available to assess this question. Under California law, the DHCS must collect certain data regarding the number and types of involuntary detentions, but many counties fail to report complete data to DHCS; moreover, the required data does not include demographic information.[76] Some localities do collect demographic information, however. The City and County of San Francisco publishes an annual report[77] regarding implementation of the housing conservatorship pilot.[78] This report includes demographic data regarding detention under Section 5150. The data shows that Black individuals were significantly overrepresented in the population of detained individuals. Blacks comprise approximately 5.6 percent of San Francisco's population.[79] Nonetheless, they represented 31 percent of 5150 evaluations at San Francisco General Hospital's Psychiatric Emergency Services Department.[80] Sampling and analysis of officer-involved detentions showed that 23 percent of individuals subject to such detention were Black.[81] Gender analysis of these detentions shows that 57 percent were male, 42 percent were female, and one percent were non-binary. Additionally, as discussed in the next section, a recent report on involuntary detentions in eight states shows California has the *highest* longer-term detention rate of those states based on percent of the population.

It is crucial, when considering any proposed expansion of LPS involuntary detainments or conservatorships, to understand whether the current LPS system is subject to invidious discrimination. Given the disturbing lack of available demographic data, it is important for the state to consider whether to require counties to report demographic information, and given

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[75] *Id.* at 574-576.
[76] *See* Welfare & Institutions Code Section 5402. Reports may be found at Cal. Dept. of Health Care Services, *Involuntary Detention*, available at: https://www.dhcs.ca.gov/services/MH/Pages/InvoluntaryDetention-MH.aspx.
[77] *See* Harder & Co., *San Francisco Housing Conservatorship: Annual Evaluation Report* (Jan. 2021), available at: https://www.sfdph.org/dph/files/housingconserv/SF_Housing_Conservatorship_Annual_Report_Updated_01.11.21.pdf.
[78] *See* SB 1045 (Wiener & Stern) and SB 40 (Wiener & Stern), *supra.*
[79] Harder & Co., *supra*, at 11.
[80] *Id.* at 8.
[81] *Id.* at 11.

incomplete reporting even under the current statute, what methods should be used to ensure that accurate data is obtained.

Voluntary versus Involuntary Services – Availability and Effectiveness

Involuntary psychiatric treatment occurs when a person is held against their will and forced to undergo mental health evaluation and possibly state-ordered confinement. Involuntary mental health treatment occurs in a variety of contexts. The traditional type of involuntary mental health treatment is court-ordered commitment to an in-patient mental health facility. However, involuntary treatment also includes involuntary medication or other treatments, whether court-ordered or imposed by mental health professionals; treatment imposed upon persons with mental health conditions in prisons and jails or as a condition of probation, supervision or parole; outpatient commitment; and treatment imposed as the result of a guardianship or conservatorship.

Recent trends – increased frequency of involuntary treatment. The rate of involuntary treatment — lasting anywhere from a few days to years — has risen sharply over the past decade, according to a study by researchers at the University of California, Los Angeles (UCLA) Luskin School of Public Affairs.[82] The analysis shows that in the nearly half of U.S. states for which data was available, involuntary psychiatric detentions outpaced population growth by a rate of three to one on average in recent years.[83]

Among the eight states that provided data on longer-term detentions, California had the *highest* rates, of involuntary psychiatric detention, with 159 per 100,000 residents.[84] This is contrasted with lows of 25 (Oklahoma) and 27 (Missouri) per 100,000 residents.[85] These longer-term detentions were, on average, 42.2 percent of the eight states' rate of all emergency detentions.[86] Five of the states studied — Florida, California, Massachusetts, Texas and Colorado — accounted for 59 percent of the population of those 24 states but were responsible for 80 percent of the total detentions in the most recent year with data reported.[87]

Philosophical and therapeutic objections. Some advocates for patients say involuntary treatment is the wrong strategy because of its significant disadvantages for both the patient's experience, and therapeutic outcome. For example, Mental Health America "believes that effective protection of human rights and the best hope for recovery from mental illness comes from access to voluntary mental health treatment" and that "involuntary treatment should only occur as a last resort and should be limited to instances where persons pose a serious risk of physical harm to themselves or others in the near future and to circumstances when no less restrictive alternative will respond adequately to the risk," which is consistent with constitutional

[82] Lee and Cohen, *Incidences of Involuntary Psychiatric Detentions in 25 U.S. States* (Nov. 2020) Psychiatry Online available at: https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201900477.
[83] *Ibid.*
[84] *Ibid.*
[85] *Ibid.*
[86] *Ibid.*
[87] *Ibid.*

requirements.[88] Critics of involuntary treatment argue that forced treatment "interrupts the therapeutic relationship, changing the quality of the communication according to whether it comes from the patient's doctor, an alternate doctor, or a judicial authority."[89] A similar argument has been made against coerced substance abuse counseling.[90]

Effectiveness – lack of data, especially about inpatient treatment. Apart from any philosophical or patient preference objections to involuntary treatment, it is unclear whether involuntary treatment is effective because there is very little empirical evidence about the topic. Nineteen counties have adopted Laura's Law since it was enacted as AB 1421 (Thompson) in 2002.[91] DHCS reports that "[d]ata indicate AOT and program support are contributing factors in helping clients avoid or reduce hospitalization, homelessness, and incarceration."[92] In Nevada County, for instance, Laura's Law reduced hospitalization 46.7 percent; incarceration, 65.1 percent; homelessness, 61.9 percent; and emergency contacts 33.1 percent.[93] As a result, Laura's Law has saved Nevada County an estimated $213,300 in incarceration costs and $75,000 in hospital costs.[94]

Therefore, *outpatient* commitment appears to significantly improve adherence to medication regimens and is associated with decreases in substance use, rehospitalization, homelessness, and violent victimization among certain groups of severely mentally ill patients. No similar data seems to exist regarding the efficacy of *inpatient* involuntary treatment.

Lack of transitional and supportive services and resulting issues. Long before the 2016 report by the Little Hoover Commission, the RAND Corporation studied the effectiveness and availability of outpatient mental health services in eight states, including California. The

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[88] Mental Health America Board of Directors, Position Statement 22: Involuntary Mental Health Treatment (Adopted March 7, 2015), available at https://www.mhanational.org/issues/position-statement-22-involuntary-mental-health-treatment

[89] Anna Saya*, et al*., *Criteria, Procedures, and Future Prospects of Involuntary Treatment in Psychiatry around the World: A Narrative Review.* (Apr. 29, 2019) Frontiers in Psychiatry, available at: https://www.frontiersin.org/articles/10.3389/fpsyt.2019.00271/full.

[90] While dealing with the topic of substance abuse disorder treatment, rather than mental health treatment, the recent veto message of AB 1542 (McCarty, 2021) reflects similar reasoning. The bill would have created a pilot program for an inpatient drug treatment facility in Yolo County for persons convicted of qualifying drug-motivated crimes. The Governor's veto message included a statement that:

> "I am especially concerned about the effects of such treatment, given that evidence has shown coerced treatment hinders participants' long-term recovery from their substance use disorder."

[91] AB 1421 (Thompson), *supra*.

[92] *Laura's Law: Assisted Outpatient Treatment Demonstration Project Act of 2002*, (March 2020) Department of Health Care Services, available at: https://www.dhcs.ca.gov/Documents/CSD_KS/Laura's Law/Laura's-Law-Legislative-Report-2018-19.pdf

[93] *Myths About Laura's Law (AB 1421)* Mental Illness Policy Org, available at https://mentalillnesspolicy.org/states/california/lauraslawmyths.html.

[94] *Ibid.*

resulting report[95] highlighted the lack of supportive mental health services that were available in California, and despite the passage of 20 years and significant funding of mental health services since then (see discussion of the MHSA above), this lack of supportive services remains a problem today.

Services following release from a hold are critical to patient success. Services can range from appointments for wellness visits and therapy services to more intensive levels of care, such as full-service partnerships or AOT programs. In particular, full-service partnerships and AOT involve a personal case manager for each client who coordinates care across a variety of services, including psychiatric services and housing assistance. These programs are the most comprehensive and intensive methods available to all counties for providing community-based care to individuals with serious mental illnesses and help avoid the more expensive and restrictive involuntary detention and imprisonment.

As the State Auditor pointed out in her 2020 report on the LPS system, "people leaving LPS Act holds often need continuing mental health services; in particular, individuals who have experienced several short-term holds represent a high-need population that should be connected to counties' most intensive community-based care."[96] When that care is not available or not provided, these individuals might end up incarcerated, on the streets, back in on a 5150 hold, or all three.

The audit found that, of nearly 7,400 people who experienced five or more short-term involuntary holds between 2015 and 2018 in Los Angeles County, only nine percent were enrolled in AOT or full-service partnerships in 2018-19. These are two strategies designed to keep people in their communities by providing them with housing, therapy, transportation, or whatever else they might need to avoid further holds.

While there is a lack of data regarding the effectiveness of both inpatient and outpatient programs, outpatient programs are clearly less expensive than inpatient ones. Voluntary programs are also less problematic from a civil liberties and legal perspective than involuntary ones. If a voluntary outpatient treatment program were available, it would be the least restrictive alternative for treatment, and therefore would be preferable to an inpatient or involuntary program as a matter of law, as well as being preferable in terms of economics and civil liberties. The dilemma arises when there are insufficient services and supports in the community, or insufficient funding for those services and supports; and even when services and supports are available and adequately funded, they may fail to meet individuals with mental health issues "where they are," leading to the unwillingness to voluntarily participate in the much-needed programs.

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[95] Susan Ridgely, *et al.*, *The Effectiveness of Involuntary Outpatient Treatment: Empirical Evidence and the Experience of Eight States* (2001). Mental Health Law & Policy Faculty Publications, available at https://digitalcommons.usf.edu/mhlp_facpub/268.

[96] California State Auditor, *Lanterman-Petris-Short Act: California has Not Ensured that Individuals with Serious Mental Illnesses Receive Adequate Ongoing Care, supra,* at 2.

While there are no easy fixes to these complex policy and treatment issues, effective voluntary treatment programs do exist and California has experience implementing them. An innovative approach, begun under Assembly Bill 34 in 1999,[97] combined prevention services with a full range of *integrated services to treat the whole person*, with the goal of self-sufficiency for those who may have otherwise faced homelessness or dependence on the state for years to come. The overarching goal of the Whole Person Care (WPC) Pilots is the coordination of health, behavioral health, and social services, as applicable, in a patient-centered manner with the goals of improved beneficiary health and wellbeing through more efficient and effective use of resources.

The program was recognized in 2003 as a model program by the President's Commission on Mental Health. That same year, the California Department of Mental Health (which later became part of DHCS) studied the effectiveness of voluntary programs that offered "integrated services" (medical, mental health, housing, etc.) in one location to unhoused adults. California's Medi-Cal Section 1115 waiver authorized the state up to $1.5 billion in federal funds to create a 5-year pilot program to test county-based initiatives that coordinate health, behavioral health, and social services for vulnerable Medi-Cal beneficiaries who are high users of multiple systems and have poor outcomes. The WPC ran from January 1, 2016 until December 31, 2020.

WPC pilots were authorized to target individuals experiencing or at risk of homelessness who had a demonstrated medical need for housing and/or supportive services. Housing interventions included: tenancy-based care management supports to assist the target population in locating and maintaining medically necessary housing; and contributions to a countywide housing pool that would directly provide support for medically necessary housing services, with the goal of improving access to housing and reducing churn in the Medicaid population. While housing subsidies were not eligible for federal financial reimbursement, funds saved as a result of reduced utilization of health care services could be spent on subsidies and other direct support for housing services.

In October 2019, an analysis by the UCLA Center for Health Policy Research (UCLA Center) found, three years into the WPC Pilots, "many WPC Pilots made significant progress in building needed infrastructure and delivering cross-sector care coordination services."[98] At the same time, the UCLA Center found that programs could do more to (1) promote person-centered practices that more effectively engage vulnerable patients in care, and (2) leverage WPC resources and partnerships to help address structural problems outside of WPC Pilots' control.[99]

In addition to funding the 25 WPC Pilot programs, the 2019-20 Governor's Budget encouraged additional counties to initiate WPC-like pilot capacity with a one-time funding allocation of $20 million and multi-year spending authority through June 30, 2025 from the Mental Health Services Fund. However, concerns have been raised about the difficulty of building sustainable

[97] AB 34 (Steinberg) Chap. 617, Stats. 1999.
[98] E. Chaung, *et al., Whole Person Care Improves Care Coordination for Many Californians* (Oct. 2019) UCLA Center for Health Policy Research, at 8.
[99] E. Chaung, *et al.,* Whole Person Care Improves Care Coordination for Many Californians, *supra,* at 98.

programs, even ones that prove successful, with one-time funding. Even if the one-time funding may be renewed in subsequent years, it is difficult to plan, develop, and implement the large-scale programs California needs without ongoing funding.

Inconsistent Application of LPS Laws and Lack of Required Due Process Protections

In preparation for this hearing, committee staff have talked to a number of stakeholders from differing organizations who have confirmed that there are significant inconsistencies in the application of LPS laws. For example, there appears to be some confusion over when a 72-hour hold actually begins. Some argue that it does not begin until an individual is brought to an appropriate facility for assessment, even if they are actually detained before that time. However, constitutionally required due process protections, according to the courts, require that the time clock begins when the individual is first detained. Some individuals placed on a 72-hour hold are not appropriately assessed in a timely manner to ensure either appropriate placement into a psychiatric facility or released during that initial 72-hour hold period. Instead, they may remain strapped to a gurney in a hospital hallway for an indefinite period of time awaiting assessment by a county "designated individual" and/or appropriate placement that has not yet come through. As a result, those who can legally initiate the hold – "a peace officer, professional person in charge of a facility designated by the county for evaluation and treatment, member of the attending staff of a facility designated by the county for evaluation and treatment, designated members of a mobile crisis team, or professional person designated by the county"[100] – will sometimes simply reissue the 5150 hold allowing the 72-hour clock to begin again. This can happen multiple times before the person is actually assessed for placement or release. Once the LPS assessment occurs, it may take additional time beyond the 72 hours to find a facility that can begin to provide the necessary evaluation and treatment. As discussed above, because the due process protections in the law may not begin until the fourth day of the subsequent 5250 hold, a person under this scenario may be held for more than seven days before receiving the required due process certification review hearing or before being able to request a writ of habeas corpus from a court. This practice does not comply with *Doe v. Gallinot* (9th Cir. 1982) 657 F.2d 1017, which requires that a hearing be held within *seven* days of *confinement*. This lack of compliance could be remedied by either (1) disallowing "serial" 5150 holds (including lobby "releases" immediately followed by a new 5150 hold) within a reasonable period of time, unless some new action has arisen justifying the new hold, or (2) requiring that the 5250 certification review hearing, or alternatively, the writ to request a writ in court, occur within seven days of initial detainment, rather than four days of a 5250 hold. The latter option would ensure that the required due process protections apply whenever a person is detained against their will, regardless of what section of the LPS Act that they have been detained under.

[100] Welfare & Institutions Code Section 5150(a).

POSSIBLE CHANGES/ALTERNATIVES TO THE LPS SYSTEM

In order to provide much-needed mental health services and supports to individuals in need of those services and supports, while still protecting their civil liberties, the LPS system and California's mental health system in general could be improved in many ways. Possible improvements include the following:

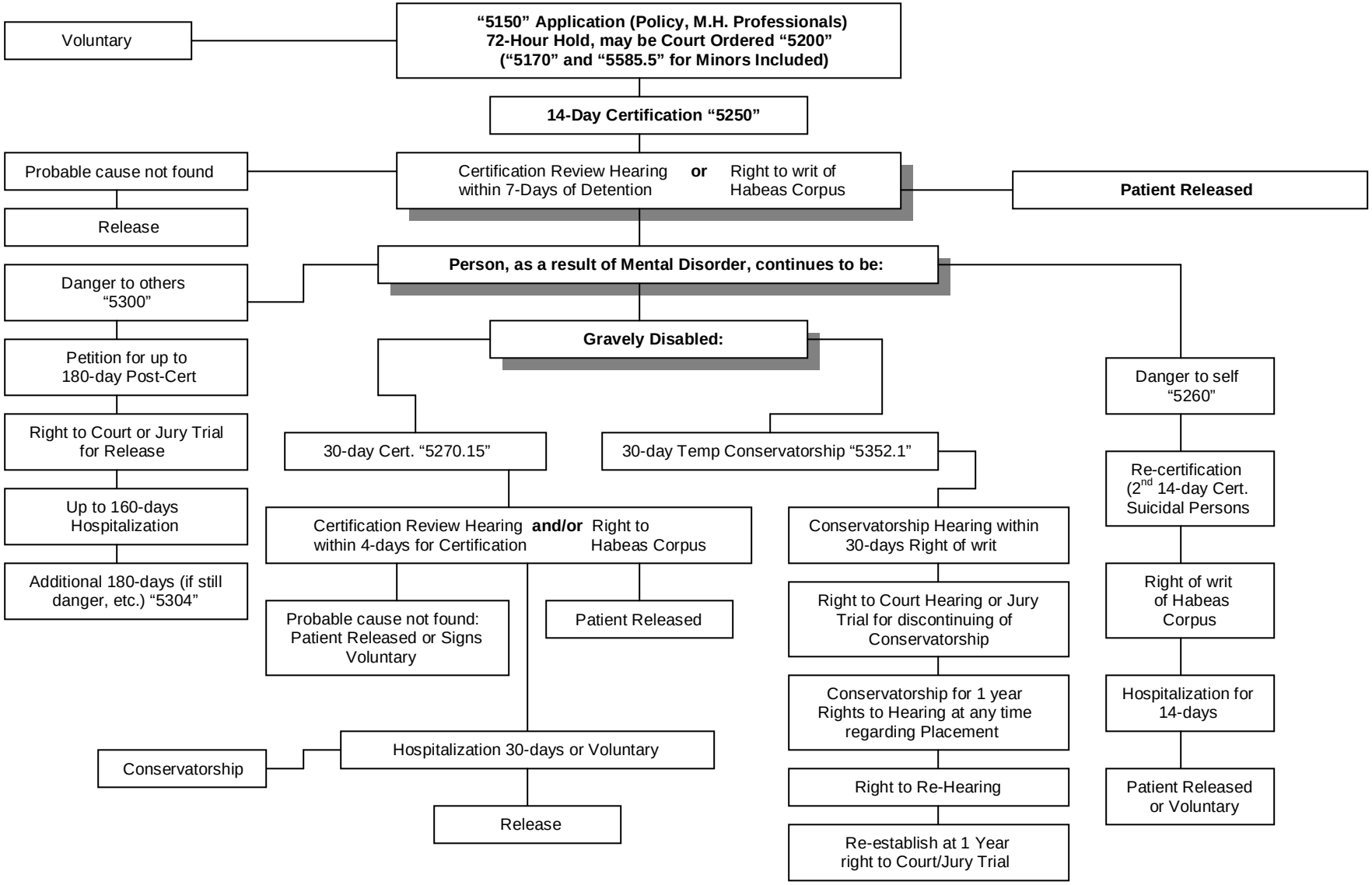
- Improve data collection on all aspects of California's mental health systems, including the LPS system, and across all jurisdictions;
- Identify gaps in California's mental health services and supports and work to eliminate them, including gaps in supports and services and gaps between jurisdictions;
- Increase state oversight of California's mental health system;
- Ensure adequate safeguards of civil liberties, including due process protections;
- Provide sufficient state and local funding for the Public Guardians;
- Increase the quantity and quality of wrap-around services;
- Increase the quantity and expand the location of supportive housing;
- Increase use of alternative supportive arrangements, such as supportive decision-making;
- Establishment of a comprehensive "988: Behavioral Health Emergency Response system, similar to 911; and,
- Consider alternatives to the current involuntary detention process that builds and enhances outreach and relationship building in order to provide community-based care and treatment with a focus on "meeting people where they are."

CONCLUSION

There is general agreement that the LPS system and California's broader mental health system are failing far too many people. Although there may not be agreement on all of the various proposed solutions, the various options mentioned in this paper may provide a roadmap for how California can reform its mental health system. All Californians – particularly those who are mentally ill and those who love and care for them – deserve so much better.

Appendix A

LANTERMAN-PETRIS-SHORT ACT CIVIL COMMITMENT FLOW CHART
Welfare & Institution Code, Section 5000 et seq.



Provided by Judicial Council

LPS HOLDS CHART

LPS HOLDS	CRITERIA			COURT PROCEEDINGS
	GRAVELY DISABLED	DANGER TO SELF	DANGER TO OTHERS	
72-HOUR WIC 5150 EVALUATION & TREATMENT	ONE OR ALL MAY APPLY			1. No probable cause hearing 2. May request Riese hearing (Decision regarding Riese carries through 14-day hold)
14 DAY WIC 5250 3-DAY EXTENSION WHEN CONSERVATORSHIP APPLIED FOR	ONE OR ALL MAY APPLY			1. Probable cause hearing must be held during first 4 days of hold unless patient request by-pass writ of habeas corpus, 24 hr. postponement, and signs voluntary or is discharged. 2. Patient may request one writ of habeas corpus hearing at any time during 14-day hold. 3. Riese hearing maybe requested anytime during 14-day hold. Each subsequent hold requires a new Riese hearing.
ADDITIONAL 14-DAY WIC 5260		ONLY CRITERIA WHICH APPLIES		1. No probable cause or court hearing required. 2. Original additional 14 certification form and 2 affidavits must be sent to mental health court. 3. Patient may request writ of habeas corpus any time during 14-day period. 4. New Riese hearing may be requested anytime during 14-day period.
30-DAY WIC 5270	ONLY CRITERIA WHICH APPLIES			1. Probable cause hearing must be held during first 4 days of hold unless patient requests by-pass writ of habeas corpus, 24 hr. postponement, and signs voluntary or is discharged. 2. Patient may request writ of habeas corpus any time during 30-day period. 3. New Riese hearing may be requested anytime during 30-day period.
180-DAY WIC 5300 RENEWABLE			ONLY CRITERIA WHICH APPLIES	1. Requires contact with D.A. several days prior to expiration of 14-day hold. 2. Requires the District Attorney to file a petition with the court and an arraignment hearing in court. 3. New Riese hearing may be requested anytime during 180-day period.
TEMPORARY CONSERVATORSHIP 30 DAYS TO 6 MONTHS	ONLY CRITERIA WHICH APPLIES			1. Requires application by the treating physician to the Public Guardian's Office 2. Judge reviews application and determines whether to grant or deny temporary conservatorship (T-Con). 3. Patient may request writ of habeas corpus any time during T-Con period. 4. New Riese Petition may be filed with County Counsel. Hearing held in Dept. 95A.
"PERMANENT" CONSERVATORSHIP 1 YEAR RENEWABLE	ONLY CRITERIA WHICH APPLIES			1. Requires court hearing in Dept 95A. Physician may be required to testify in court. 2. Patient may request re-hearing on conservatorship, rights denied, disabilities imposed once every six months.
RE-APPOINTMENT OF "PERMANENT" CONSERVATOR	ONLY CRITERIA WHICH APPLIES			1. Requires conservator petitioning for reappointment and a court hearing.

NOTE: Each hold requires a new Riese hearing except when going from the 72 hour to the 14-day.

Superior Court of California, Los Angeles County, Office of the Counselor in Mental Health

Appendix B

LPS Act Bills Introduced in the California Legislature 2017-2021

Introduced in the Legislature in 2021

- **AB 574 (Chen) Guardians ad litem: mental illness.** This bill establishes a new procedure for the appointment of a guardian ad litem for a person who lacks the capacity to make rational informed decisions regarding medical care, mental health care, safety, hygiene, shelter, food, or clothing with a rational thought process due to a mental illness, defect, or deficiency. The bill authorizes certain persons to petition the court for the appointment of a guardian ad litem under these provisions, and establishes the procedures that would govern the filing of a petition, the content of its notice provisions, and court procedures. Under certain circumstances, the bill requires the court to appoint the public defender or private counsel to represent a person who is the subject of such a petition. Status: Asm Health.

- **AB 681 (Ramos) Mental health: information sharing.** The bill would, among other things, require a designated facility to submit a quarterly report to the State Department of Health Care Services that identifies people admitted to the facility because of grave disability pursuant to the LPS Act. Status: Asm Health.

- **AB 1340 (Santiago) Mental health services.** This bill expands the definition of "gravely disabled" under the LPS Act, allowing for involuntary commitment and treatment of persons with specified mental health disorders to apply to a broader group of people. The bill also seeks to implement recommendations by the State Auditor for improving the provision of mental health services in California. Status: Asm Health.

- **AB 1443 (McCarty) Mental health: involuntary treatment.** This bill permits any county to develop training and procedures related to taking, or causing to be taken, a person into custody for an involuntary detention, as specified; and requires the County of Sacramento to develop a written policy for training and procedures for designating persons who are employed by the City of Sacramento and who meet specified criteria to involuntarily detain individuals. Status: Chap. 399, Stats. 2021.

- **SB 340 (Stern) Lanterman-Petris-Short Act: hearings.** This bill authorizes a family member, friend, or acquaintance with personal knowledge of the person receiving treatment under the LPS Act to make a request to testify in the judicial review proceedings, in writing, to the counsel of a party to the judicial review. The bill requires the receiving counsel, or their designee, to determine whether the

requester's testimony will assist the proceeding and, within a reasonable time, respond to the requester, in writing, with an approval or denial. Status: Asm Health.

- **SB 507 (Eggman) Mental health services: assisted outpatient treatment.** This bill broadens criteria to permit assisted outpatient treatment (AOT) for a person who is in need of AOT services, as specified, without also requiring the person's condition to be substantially deteriorating. The bill also permits specified individuals to testify at a court hearing via videoconferencing, as specified. This bill permits a court to order AOT for eligible conservatees, as specified, when certain criteria are met. Status: Chap. 426, Stats. 2021.

- **SB 516 (Eggman and Stern) Certification for intensive treatment: review hearing.** This bill permits evidence considered in a certification review hearing under the LPS Act to include information regarding a person's medical condition, as defined, and how that condition bears on certifying the person as a danger to self or others, or as gravely disabled. Status: Asm Health.

- **SB 578 (Jones) Lanterman-Petris-Short Act: hearings.** This bill clarifies and strengthens an existing statute that makes proceedings under the LPS Act presumptively nonpublic by clarifying that all hearings under the LPS Act, including certification review hearings and jury trials, are presumptively closed to the public if the hearings involve the disclosure of confidential information. The bill permits an individual who is the subject of an LPS proceeding to request the presence of a family member or friend without waiving the right to keep the proceeding closed to the rest of the public. Status: Chap. 389, Stats. 2021.

- **SB 782 (Glazer) Assisted outpatient treatment programs.** This bill permits a court to order a person to obtain AOT services if the court finds that the petition establishes the person either is a conservatee or former conservatee and would benefit from AOT services to reduce the risk of deteriorating mental health, as specified. Status: Asm Rules.

Introduced in the 2019-20 Legislative Session

- **AB 333 (Eggman) Whistleblower protection: county patient's right advocates.** This bill extends existing whistleblower protections to county mental health patients' rights advocates. Status: Chap. 423, Stats. 2019.

- **AB 1572 (Chen) Mental health services: gravely disabled.** This bill would have changed the definition of "gravely disabled" under the LPS Act to be a condition in which a person, as a result of a mental health disorder, is incapable of making informed decisions about, or providing for, the person's own basic personal needs for food, clothing, shelter, or medical care without significant supervision and assistance from another person and, as a result of being incapable of making these

informed decisions, the person is at risk of substantial bodily harm, dangerous worsening of a serious physical illness, psychiatric condition, or access to essential needs that could result in bodily harm. Status: Dead, Asm Health.

- **AB 1946 (Santiago and Friedman) Mental health services: involuntary commitment.** This bill would have expanded the definition of "gravely disabled" under the LPS Act and clarified that funds from the Mental Health Services Fund could be used for certain services authorized under the LPS Act. Status: Dead, Asm Health.

- **AB 1976 (Eggman) Mental health services: assisted outpatient treatment.** This bill, commencing July 1, 2021, requires a county or group of counties to offer AOT mental health programs under "Laura's Law," unless a county or group of counties opts out by a resolution passed by their governing body stating the reasons for opting out and any facts or circumstances relied upon in making that decision. The bill also authorizes a county to instead offer those mental health programs in combination with one or more counties, subject to specified implementation provisions. Finally, the bill repeals the expiration of Laura's Law, thereby extending it indefinitely. Status: Chap. 140, Stats. 2020.

- **AB 2015 (Eggman) Certification for intensive treatment: review hearing.** This bill would have provided that the evidence presented at the 14-day LPS Act certification review hearing include information regarding the person's medical condition and how that condition bears on certification of the person as either a danger to themselves or others or gravely disabled. This bill would have required that that information be considered by the hearing officer in the determination of whether probable cause exists to believe that the person certified is, as a result of a mental disorder or impairment by chronic alcoholism, a danger to others, or to themselves, or gravely disabled. Status: Dead, Asm Judiciary.

- **AB 2679 (Gallagher) Conservatorship for serious mental illness and substance use disorders: County of Butte.** This bill would have expanded to Butte County the recently created "housing" conservatorship pilot project for individuals who suffer from both serious mental illness and substance use disorder, as evidenced by eight or more detentions for evaluation and treatment in the preceding 12 months, which now is permitted to operate only in Los Angeles, San Diego, and San Francisco Counties, and is set to expire on January 1, 2024, with reports on the pilot due to the Legislature on January 1, 2021 and January 2, 2023. Status: Dead, Asm Health.

- **AB 2899 (Jones-Sawyer) Mental health: involuntary commitment.** This bill would have removed the 14-day limit on the period of time for which a person could be certified for intensive treatment after being involuntarily detained for 72 hours because they are a danger to themselves or others, or are gravely disabled, as the result of a mental health disorder. The bill would have authorized the person to be certified for intensive treatment for a period longer than 14 days, as

determined by the professional staff providing the evaluation. Status: Dead, Asm Health.

- **AB 3242 (Irwin) Mental health: involuntary confinement.** This bill authorizes the use of telehealth to examine, assess, or evaluate individuals for the purposes of involuntarily detention under, among other things, the LPS Act. Status: Chap. 149, Stats. 2020.

- **SB 40 (Wiener and Stern) Conservatorship: serious mental illness and substance use disorders.** This bill amends and expands the process for establishing a "housing conservatorship," a mechanism for involuntary commitment for treatment of an individual suffering from a serious mental illness and a substance use disorder, pursuant to a pilot program previously authorized for Los Angeles, San Diego, and San Francisco Counties. Specifically, this bill removes the requirement that assisted outpatient treatment be unsuccessfully attempted or denied before a housing conservatorship can be established, expands the scope of the evaluation of the pilot program, requires that a housing conservatorship be preceded by a temporary conservatorship of up to 28 days during which a clinical evaluation is performed, clarifies conditions for qualification for a conservatorship, details opportunities to challenge the conservatorship, and specifies burdens of proof for demonstrating that criteria for conservatorship have been met. Status: Chap. 467, Stats. 2019.

- **SB 590 (Stone) Mental health evaluations: gravely disabled due to chronic alcoholism.** This bill would have added a person who is impaired by chronic alcoholism to the existing petition screening process in the LPS Act, which permits any individual to request a county-designated entity to provide a comprehensive screening to determine if the person impaired by chronic alcoholism is a danger to self or others, or gravely disabled. Status: Dead, Asm Appropriations.

- **SB 640 (Moorlach) Mental health services: gravely disabled persons.** This bill would have expanded the definition of "gravely disabled" under the LPS Act. Status: Dead, Sen Health.

- **SB 1251 (Moorlach) Conservatorships: serious mental illness and substance use disorders: counties.** This bill would have allowed any county to implement the housing conservatorship pilot created by SB 1045 (Wiener and Stern), Chap. 845, Stats. 2018 and amended by SB 40 (Wiener and Stern), Chap. 467, Stats. 2019. Status: Dead, Sen Judiciary.

- **AB 1254 (Moorlach) Guardians ad litem: mental illness.** This bill would have established a new procedure for the appointment of a guardian ad litem for a person who lacks the capacity to make rational informed decisions regarding medical care, mental health care, safety, hygiene, shelter, food, or clothing with a rational thought process due to a mental illness, defect, or deficiency. The bill would have authorized certain persons to petition the court for the appointment of

a guardian ad litem under these provisions, and established the procedures that would govern the filing of a petition, the content of its notice provisions, and court procedures. Under certain circumstances, the bill would have required the court to appoint the public defender or private counsel to represent a person who is the subject of such a petition. Status: Dead, Sen Judiciary.

Introduced in the 2017-18 Legislative Session

- **AB 191 (Wood) Mental health: involuntary treatment.** This bill adds licensed marriage and family therapists and licensed professional clinical counselors to those health providers who are authorized to sign a notice of certification, as specified, when a patient is certified as needing intensive treatment under the LPS Act. Status: Chap. 184, Stats. 2017.

- **AB 1119 (Limón) Developmental and mental health services: information and records: confidentiality.** This bill authorizes, during the provision of emergency services and care, the communication of patient information and records between specified health care professionals and others to effectively treat patients with developmental disabilities and mental health disorders. Status: Chap. 323, Stats. 2017.

- **AB 1539 (Chen) Mental health.** This bill would have expanded the definition of "gravely disabled" under the LPS Act to also include a condition in which a person, as a result of a mental health disorder or chronic alcoholism, as applicable, is unable to provide for their medical care. Status: Dead, Asm Health.

- **AB 2099 (Gloria) Mental health: detention and evaluation.** This bill requires a copy of the application that permits an individual to be involuntarily detained, as specified, to be treated as the original for purposes of evaluation and treatment. Status: Chap. 258, Stats. 2018.

- **AB 2156 (Chen) Mental health services: gravely disabled.** This bill would have expanded the definition of "gravely disabled' under the LPS Act. Status: Dead, Asm Health.

- **AB 2316 (Eggman) Mental health: county patients' rights advocates: training materials.** This bill requires the memorandum of understanding between the Department of State Hospitals and the Department of Health Care Services to make specified training materials for county patients' rights advocates (PRAs) available online; and requires a county to verify that PRAs review training materials and to keep a record of the verification, as specified. Status: Chap. 237, Stats. 2018.

- **AB 2317 (Eggman) Whistleblower protection: county patients' rights advocates.** This bill would have extended whistleblower protections to

individuals and entities that have contracts with state or local government to oversee compliance with patients' rights in county mental health treatment facilities. Status: Vetoed.

- **AB 2442 (Santiago) Mental health.** This bill would have required that if a determination is made that a person may be treated without being detained under the LPS Act, and if the person is experiencing homelessness, they must be provided written information about local housing options, employment opportunities, and available public social services. Status: Dead, Asm Health.

- **SB 565 (Portantino) Mental health: involuntary commitment.** This bill requires a mental health facility, prior to a certification review hearing under the LPS Act to extend intensive mental health treatment services to 30-days, to make reasonable attempts to notify family members or any other person designated by the patient at least 36 hours prior to the certification review hearing. Status: Chap. 218, Stats. 2017.

- **SB 931 (Herzberg) Conservatorships: custody status.** This bill addresses cases in which an individual is held in custody, and as a result, may not be scheduled for an investigation to determine whether an LPS conservatorship would be appropriate. To promote the timely evaluation of individuals and avoid unnecessary delays, this bill clarifies that the custody status of a person — whether or not they are in jail – cannot be the sole reason for not scheduling an investigation for conservatorship. This bill seeks to ensure that when an individual is released, there are services and support immediately available. Additionally, the bill allows the professional person providing mental health treatment at a county jail, or that person's designee, to recommend an LPS conservatorship. Status: Chap. 458, Stats. 2018.

- **SB 1045 (Wiener and Stern) Conservatorship: serious mental illness and substance use disorder.** This bill creates, until January 1, 2024, a new conservatorship for individuals who are incapable of caring for their 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, in Los Angeles, San Diego, and San Francisco Counties. Status: Chap. 845, Stats. 2018.