June 14, 2022

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

RE: SB 1338 (Umberg) as amended May 19, 2022 - OPPOSE

Dear Assemblymember Stone:

Mental Health America of California (MHAC) is a peer-run organization that has been leading the state in behavioral health public policy and advocacy since 1957. The mission of MHAC is to ensure that people of all ages, sexual orientation, gender identity or expression, language, race, ethnicity, national origin, immigration status, spirituality, religion, age or socioeconomic status who require mental health services and supports are able to live full and productive lives, receive the mental health services and other services that they need, and are not denied any other benefits, services, rights, or opportunities based on their need for mental health services. Along these lines, we support efforts which provide voluntary, community-based services.

While we appreciate and support the Legislature's commitment to improving the lives of people with behavioral health conditions, we do not believe that SB 1338 is the proper vehicle to achieve this goal. We oppose SB 1338 for the following reasons:

1. Voluntary, trauma-informed services are more effective than coercive treatment;
2. The bill does not guarantee stable, affordable housing which is a necessary component to recovery from a behavioral health challenge;
3. Funding involuntary services is inconsistent with the purposes and intent of the Mental Health Services Act (MHSA)
4. Including Transition Age Youth (TAY) in CARE Court is contrary to CalAIM and the work of California's Surgeon General, and will harm young people ages 18-26
5. The bill would expand the Lanterman-Petris-Short (LPS) Act;
6. CARE Court will worsen health disparities and perpetuate institutional racism; and

1. Voluntary Services are demonstrated to be effective

While SB 1338 includes some elements of self-directed care, the overall foundation of CARE (Community Assistance, Recovery & Empowerment) Court puts accountability on both local governments *and* the individual to comply with court-mandated medication and services from the outset of the CARE process. While the bill attempts to allow an individual to access voluntary services prior to a court order, the "voluntary" case management plan is actually ordered by the court[1].

[1] See SB 1338 Section 5977 (b)(3)(C) If the court finds that the petitioner has submitted prima facie evidence that the respondent meets the CARE criteria, the court shall order the county behavioral health agency to work with the

From the perspective of an individual experiencing a behavioral health challenge, any level of coercion decreases an individual's trust in the system and in their care providers. Involuntary services are traumatizing and do not take into consideration a person's autonomy or self-determination[2], and run the risk of violating an individual's civil rights. Furthermore, research has shown that, with appropriate outreach and engagement, people will accept voluntary treatment. Data from the Assisted Outpatient Treatment Program (AOT) shows that 75% of individuals who received AOT services accepted those services voluntarily[3]. A recent study conducted in Santa Clara found that of 400 people offered a permanent home, only one person refused the offer.[4]

SB 1338 creates a new, costly program that will divert funds away from already underfunded community behavioral health services to fund additional court staff and attorneys without a single dollar to increase services.

2. Stable, affordable housing is a necessary component for decreasing homelessness and promoting recovery from behavioral health conditions

While the CARE Court Framework document claims that CARE Court addresses homelessness[5], and that CARE Court will hold counties accountable for providing services, SB 1338 does not mandate that counties provide housing to individuals. The California Health & Human Services Agency (HHS) has stated that $1.5 billion which was previously appropriated for "bridge housing", will be prioritized for CARE Court participants, but not mandated. However, "bridge housing" generally refers to any sort of temporary housing that would bridge the gap between homelessness and permanent housing, and generally refers to shelters or other temporary housing options, not stable, affordable long-term housing.

Although there is no guaranteed right to housing in California, our state has adopted the "Housing First" approach, which recognizes that an unhoused person must first be able to access safe, affordable, permanent housing before stabilizing, improving health, or reducing harmful behaviors[6]. According to state statute, "any California state agency or department that funds, implements, or administers for the purpose of providing housing or housing-based services to people experiencing homelessness or at risk of

---

respondent and the respondent's counsel and supporter to determine if the respondent shall engage in a treatment plan.

[2] Paksarian, D., Mojtabai, R., Kotov, R., Cullen, B., Nugent, K. L., & Bromet, E. J. (2014). Perceived trauma during hospitalization and treatment participation among individuals with psychotic disorders. *Psychiatric services (Washington, D.C.)*, *65*(2), 266–269. https://doi.org/10.1176/appi.ps.201200556 accessed at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4039016/

[3] Laura's Law: Assisted Outpatient Treatment Project Demonstration Project Act of 2002 Report to the Legislature, Department of Health Care Services, May 2021 accessed at: https://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/Lauras-LawLegRpt-July2018-June2019.pdf

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

[5] See California Health and Human Services Agency, CARE Court A New Framework for Community Assistance, Recovery & Empowerment. P. 1 accessed at: https://www.chhs.ca.gov/wp-content/uploads/2022/03/CARE-Court-Framework_web.pdf

[6] Welfare and Institutions Code § 8255

homelessness, must incorporate the core components of housing first"[7].

Research has demonstrated that unhoused individuals with behavioral health needs who can access permanent supportive housing have decreased psychiatric emergency visits and increased voluntary mental health care visits than individuals without access to stable housing.[8] Research has also shown that individuals, even those with chronic homelessness, remain housed long-term in permanent supportive housing[9]. In a New York program, individuals with prior jail and shelter stays were offered permanent supportive housing through a state program. At 12 months 91% of these people were housed in permanent housing compared to 28% in the control group who were not offered housing through the program[10]. In a Denver supportive housing program, 86% of participants remained housed after one year, and experienced notable reductions in jail stays[11].

According to the Legislative Analyst's Office, lack of affordable housing is a key driver of homelessness in California[12]. The United States Interagency Council on Homelessness estimates that 161,548 individuals in California experience homelessness on a given day[13]. Yet the CARE Court program is estimated to serve only 7,000-12,000 individuals statewide, only some of which are unhoused. We encourage the Legislature to invest in stable, affordable housing throughout California before initiating new involuntary treatment programs.

3. Funding involuntary programs is inconsistent with the purposes and intent of the Mental Health Services Act (MHSA), and current regulations are sufficient to allow CARE participants to access current MHSA services

The MHSA was passed by voters to increase voluntary, community-based mental health services. The determination about which programs will be funded by the MHSA in each county is guided by a robust, ongoing community planning process that includes "meaningful stakeholder involvement on mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation, and budget allocations."[14]

Current law does not generally allow MHSA funds to be used for involuntary services. Welfare and Institutions Code (WIC) §5813.5(d) requires services funded by the MHSA to be consistent with the philosophy, principles, and practices of the Recovery Vision for

[7] Welfare and Institutions Code § 8255 (e) and § 8256 (a)

[8] Raven MC, Niedzwiecki MJ, Kushel M. A randomized trial of permanent supportive housing for chronically homeless persons with high use of publicly funded services. Health Serv Res. 2020 Oct;55 Suppl 2(Suppl 2):797-806.

[9] Davidson, C., et al. (2014) "Association of Housing First Implementation and Key Outcomes Among Homeless Persons With Problematic Substance Use." Psychiatric Services. 65(11), 65(11): 1318-24

[10] Aidala, A.; McAllister, W; Yomogida, M; and Shubert, V. (2013) Frequent User Service Enhancement 'FUSE' Initiative: New York City FUSE II Evaluation Report. Columbia University Mailman School of Public Health.

[11] Urban Institute (2021) "Breaking the Homelessness-Jail Cycle with Housing First, accessed at https://www.urban.org/sites/default/files/publication/104501/breaking-the-homelessness-jail-cycle-with-housing-first_1.pdf

[12] Legislative Analyst's Office. California's Homelessness Challenges in Context. January 21, 2021. P.1 accessed at: https://lao.ca.gov/handouts/localgov/2021/Homelessness-Challenges-in-Context-012121.pdf

[13] See: https://www.usich.gov/homelessness-statistics/ca/

[14] Welfare & Institutions Code § 5848(a)

mental health consumers, including promoting recovery concepts such as hope, personal empowerment, respect, self-responsibility and self-determination. Involuntary services are entirely inconsistent with principles of recovery, and therefore inconsistent with the MHSA.

Title 9 §3400 of the California Code of Regulations (CCR) states that ***programs*** provided with MHSA funds shall be ***designed for voluntary participation***, but services can be made available to individuals with involuntary status who wish to use these services. This regulation provides sufficient authority to allow CARE Court participants to access Full Service Partnership (FSP) services, and other county MHSA services without any amendments to the MHSA. This regulation also clearly reinforces that the intent of the MHSA is to fund voluntary programs. ***We see a distinct, and very significant difference, between allowing CARE participants to access MHSA services such as FSPs within the existing authority of 9 CCR §3400, and amending the entire Act to allow MHSA funds to be used for any aspect of CARE Courts.***

Over the years, and despite objections by the mental health community, the MHSA has been amended to allow for the use of MHSA funds for Assisted Outpatient Treatment and to allow funds to be used for people participating in diversion, parole or probation. When will this draining of MHSA funds end? We urge the Legislature to protect the intent and purpose of the MHSA and reject the use of MHSA funds for yet another involuntary program.

4. Including Transition Age Youth (TAY) in CARE Court is contrary to California's Advancing and Innovating Medi-Cal (CalAIM) and the Surgeon General's *Roadmap to Resilience*, and will unduly harm young people ages 18-21

SB 1338 requires that all CARE participants receive a mental health diagnosis prior to receiving court-ordered CARE services. However, Governor Newsom, the Department of Health Care Services (DHCS) and the Office of the California Surgeon General recognize that trauma, toxic stress, and Adverse Childhood Experiences (ACEs) have a profound impact on an individual's health, mental health and behavior. In his letter introducing the Surgeon General's Report, *Roadmap for Resilience*, Governor Newsom writes[15]:

> *"We led with the overwhelming scientific consensus that upstream factors, including toxic stress and the social determinants of health, are the root causes of many of the most harmful and persistent health challenges, from heart disease to homelessness…This report highlights how ACEs and toxic stress, if unaddressed, will cost California over a trillion dollars in the next 10 years due to the costs of direct health care and years of life lost from poor health, disability, or early death.*

ACEs, and their lifelong effects, disproportionately impact Black, Latinx, and Native American communities, people with lower incomes, LGBTQ individuals, and those who are unemployed or unable to work.[16] The Surgeon General's Report stresses the

[15] California Office of the Surgeon General, Roadmap for Resilience: The California Surgeon General's Report on Adverse Childhood Experiences, Toxic Stress and Health, December 9, 2020, pp I,ii

[16] Id p. xxvii

importance of a cross-sector approach to primary, secondary and tertiary prevention strategies for ACEs, with providers who understand the impact of childhood trauma on an individual's behavior and functioning.

In alignment with the Surgeon General's Report, California recently began a sweeping transformation of Medi-Cal with the enactment of CalAIM. CalAIM removes the need for a diagnosis as a prerequisite to accessing specialty mental health services for all Medi-Cal beneficiaries under age 21 and relies instead on an assessment of the youth's past trauma or impaired functioning[17], without any requirement of a diagnosis. Instead of treating a specific diagnosis, the goal of treatment for young adults should involve tertiary prevention interventions, provided in a safe and trusting environment, that recognize the impacts of adverse childhood experiences on a person's current behaviors and mental health. Forcing a young adult into court-ordered care will not serve as a tertiary prevention strategy and will in fact increase that individual's toxic stress.

Youth experiencing a first break or first episode psychosis should be served in voluntary community-based services. It is unconscionable to require young adults to receive involuntary court-ordered care.

5. SB 1338 will further expand the LPS Act

The LPS Act includes protections intended to protect the civil rights of the individual, including referral, evaluation, multiple certification hearings, an investigation, and a court hearing to determine whether the individual is a danger to themself or others, or is gravely disabled. Gravely disabled is defined as an inability to provide for his or her basic personal needs for food, clothing, or shelter. If, after a hearing, a person is found to meet one of these requirements, and if the court finds that they should be detained, they are first placed on 72-hour hold, and then may continue to be placed on successively longer holds, after a certification hearing at each stage, until and if a referral to conservatorship is eventually ordered. A referral to conservatorship requires a comprehensive investigation by an officer, and a determination by the court that a person is gravely disabled, they refuse to accept treatment voluntarily ***and*** that no reasonable alternatives to conservatorship exist.

The creation of a new presumption in the CARE Court program, that noncompliance with ***any*** aspect of the individual's court-mandated plan may result in referral for conservatorship with the new presumption that no alternatives exist[18], effectively bypasses the entire LPS process in a number of ways including, but not limited to:

- A presumption that no alternatives exist could be construed to include the implicit presumption that the person is gravely disabled. Nothing in the CARE Court framework indicates that grave disability is a requirement for referral to conservatorship from the program;
- An individual who complies with the majority of their court-mandated plan could still be referred for fast-track conservatorship for refusing to comply with a single element of their plan, even if they are receiving services voluntarily;

[17] See Department of Health Care Services, Behavioral Health Information Notice No: 21-073, December 10, 2021. p.4

[18] See CARE Court FAQ #8, page 3 https://www.chhs.ca.gov/wp-content/uploads/2022/03/CARECourt_FAQ.pdf

- This process eliminates the 72-hour, 14-day, and 30-day holds which are created in statute to give the individual a chance to stabilize;
- The presumption does not allow for investigation into other alternatives that may exist.

In a recent comprehensive State Audit of LPS protocols and procedures at the county-level was conducted last year, the auditor states: "Expanding the LPS Act's criteria to add more situations in which individuals would be subject to involuntary holds and conservatorships could widen their use and potentially infringe upon people's liberties, and we found no evidence to justify such a change"[19].

6. The bill will worsen health disparities and perpetuate systemic racism

In California, Black individuals are disproportionately impacted by homelessness. While they represent only 5.5% of the population in California, they make up about a quarter of the homeless population[20]. This is due in large part to a long history of racial discrimination in housing, policing, banking, and healthcare. In addition, law enforcement strategies are more likely to be targeted to people of color, and are more likely to be traumatic to people of color, especially Black men, who are likely to be disproportionately involved with the court system.

In California, Black, indigenous, and people of color (BIPOC) are also more likely to be diagnosed with a serious mental illness than white Californians. Adult American Indian and Alaska Native Californians (AIAN) and Black adults have the highest rate of diagnosis, with 6.8 percent of AIAN adults and 5.3% of Black adults diagnosed with a serious mental illness[21].

CARE Court's focus on individuals with psychotic disorders and on the unhoused will further existing racial bias, and disproportionately subject people of color to court-ordered treatment.

Conclusion

We are grateful to the longstanding commitment of the Legislature for your ongoing dedication to improve the lives of people with behavioral health conditions. However, we believe that CARE Court is NOT the appropriate tool to accomplish this goal. MHAC firmly believes that adequate state investments into accessible, appropriate, voluntary services and stable, affordable housing must be made prior to implementation of coercive programs, especially involuntary programs that do not increase available services.

A program as significant as CARE Court, or any program that threatens civil liberties,

---

[19] Ibid. page 1

[20] California Budget and Policy Center. Who is Experiencing Homelessness in California? February, 2022. Accessed at: https://calbudgetcenter.org/resources/who-is-experiencing-homelessness-in-california/

[21] California Healthcare Foundation. California Health Care Almanac, Health Disparities by Race and Ethnicity in California. October 2021. Accessed at: https://www.chcf.org/wp-content/uploads/2021/10/DisparitiesAlmanacRaceEthnicity2021.pdf

requires extensive consideration, research, and stakeholder input to be effective. CARE Court is being rushed through the legislative process which does not allow for the consideration and debate that a change this significant requires. Our letter to the Administration detailing our initial recommendations for CARE Court is attached (Attachment A).

If you have any questions and or if Mental Health America of California can be of any assistance on this or any other behavioral health bill, please contact me or our Interim Director of Public Policy Karen Vicari at kvicari@mhaofca.org.

In Community,

Heidi L. Strunk
President & CEO

Attachment

March 23, 2022

Governor Gavin Newsom
California State Capitol
1021 O Street, Suite 9000
Sacramento, CA 95814-5704

Secretary Mark Ghaly, MD, MPH
California Health & Human Services Agency
1600 9th St Ste 460
Sacramento, CA 95814-6439

RE: Comments and Recommendations Regarding Community Assistance Recovery and Empowerment CARE Court

Dear Governor Newsom and Secretary Ghaly,

The undersigned organizations represent state and national leaders in behavioral health, criminal justice, substance use disorder services, and homelessness policy and advocacy. Mental Health America of California (MHAC), the lead organization of this letter, is a peer-run organization that has been leading the state in behavioral health public policy and advocacy since 1957.

We support the Administration's goal of providing behavioral health services to some of our state's most vulnerable residents through the recently announced Community Assistance Recovery and Empowerment (CARE) Court Program and we appreciate the opportunity to provide input.

Our comments and recommendations are intended to strengthen the plan by ensuring that every individual participating in the program has the greatest opportunity to succeed. While we agree strongly that California must improve access to services for our residents, both housed and unhoused, who live

www.mhac.org
717 K Street, Suite 232 • Sacramento, CA 95814-3477 • T: (916) 557-1167 • F: (916) 836-3225 PO Box 567, Sacramento, CA 95812-0567

with behavioral health challenges, we believe that the best way to get more people into treatment and services is to ensure that there are adequate voluntary, community-based culturally competent behavioral health services and permanent, safe, affordable supportive housing programs that are provided with dignity and compassion.

Below, we offer our suggestions to strengthen the CARE Court program.

Recommendation #1: Services Should be Voluntary

The mission of MHAC is to ensure that people of all ages, sexual orientation, gender identity or expression, language, race, ethnicity, national origin, immigration status, spirituality, religion, age or socioeconomic status who require mental health services and supports are able to live full and productive lives, receive the mental health services and other services that they need, and are not denied any other benefits, services, rights, or opportunities based on their need for mental health services. In accordance with our mission, we believe that every person deserves access to appropriate, voluntary services within the community that are delivered with compassion and respect for each individual's dignity and autonomy.

While the CARE Court framework includes elements of self-directed care, the overall foundation of the plan puts accountability on both local governments *and* the individual to comply with court-mandated medication and services. The fact that services are court-mandated causes these services to be involuntary, and therefore coercive.

Coercion in behavioral health care can be formal, such as the use of restraints, seclusion, or involuntary hospitalization; or informal, which includes influence or pressure placed on an individual to influence their decisions or choices.[1] Coercion in behavioral health care is often described as a hierarchy of pressures including, at the lower end of the hierarchy: persuasion, interpersonal leverage, inducements; and higher up the hierarchy are threats and compulsory treatment.[2] Coercion can also take the form of perceived coercion[3]--fear by the individual that noncompliance will result in compulsion or forced treatment[4], often referred to as "shadow compulsion" or "the black robe effect".

From the perspective of an individual experiencing a behavioral health challenge, any level of coercion, including perceived coercion reduces the voluntary nature of services by varying degrees, and consequently decreases an individual's trust in the system and in their care providers. Involuntary services are traumatizing and do not take into consideration a person's autonomy or self-determination.

---

[1] Hotzy, F., & Jaeger, M. (2016). Clinical Relevance of Informal Coercion in Psychiatric Treatment-A Systematic Review. Frontiers in psychiatry, 7, 197. https://doi.org/10.3389/fpsyt.2016.00197

[2] Szmukler G, Appelbaum PS. Treatment pressures, leverage, coercion, and compulsion in mental health care. J Ment Health (2008) 17(3):233–44.10.1080/09638230802156731

[3] Lee, M.H.; Seo, M.K. Perceived Coercion of Persons with Mental Illness Living in a Community. Int. J. Environ. Res. Public Health 2021, 18, 2290. https://doi.org/10.3390/ijerph18052290

[4] Szmukler G (2015) Compulsion and "coercion" in mental health care. World Psychiatry 14, 259.

Two main elements of the CARE Court plan include formal or informal coercive measures. First, the CARE Court process begins with an evaluation followed by immediate involvement of the court system and court-mandated treatment. Attending court is stressful for most people, but for the unhoused or individuals with mental health conditions, being ordered to court, especially for no reason other than the existence of a mental health condition not only causes trauma and stigma, it also impacts the therapeutic relationship[5].

Second, the CARE Court Proposal creates a new presumption under the Lanterman-Petris-Short (LPS) Act that "failure to participate in any component of the Care Plan may result in additional actions…including possible referral for conservatorship with a new presumption that no suitable alternatives exist"[6]: The threat of conservatorship in and of itself causes treatment to no longer be perceived as voluntary.

We firmly believe that, with appropriate outreach and engagement, and active involvement of certified peers, individuals will accept voluntary housing and treatment. A recent study conducted in Santa Clara found that of 400 people offered a permanent home, only one person refused the offer.[7] Data from the Assisted Outpatient Treatment Program (AOT) shows that 75% of individuals who received AOT services accepted those services voluntarily[8]. We believe this number could be further increased with focused and extensive outreach and engagement efforts prior to an individual's mandatory participation in CARE Court.

Unhoused, and particularly unsheltered individuals have been subject to extreme levels of trauma that most of us cannot conceive. Not only does early trauma play a role in many individuals becoming unhoused[9], but the process of becoming unhoused, and the situations leading up to homelessness are traumatic. Furthermore, unhoused individuals are exposed to a multitude of traumatic events, including being victims of personal violence[10], witnessing serious violence[11], and frequent encounters with police which are often unrelated to criminal activity [12]. In addition, court and law enforcement strategies are

[5] See Lee, M.H; Seo, M.K. (2021)
[6] Care Court Frequently Asked Questions, p.3 https://www.chhs.ca.gov/wp-content/uploads/2022/03/CARECourt_FAQ.pdf
[7] Maria C. Raven MD, MPH, MSc,Matthew J. Niedzwiecki PhD,Margot Kushel MD, Human Health Research, A randomized trial of permanent supportive housing for chronically homeless persons with high use of publicly funded services, September 25, 2020. Available at https://doi.org/10.1111/1475-6773.13553
[8] Laura's Law: Assisted Outpatient Treatment Project Demonstration Project Act of 2002 Report to the Legislature, Department of Health Care Services, May 2021 accessed at: https://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/Lauras-LawLegRpt-July2018-June2019.pdf
[9] Alison B. Hamilton, Ines Poza, Donna L. Washington,"Homelessness and Trauma Go Hand-in-Hand": Pathways to Homelessness among Women Veterans, Women's Health Issues, Volume 21, Issue 4, Supplement, 2011,Pages S203-S209, ISSN 1049-3867, https://doi.org/10.1016/j.whi.2011.04.005.
[10] Kagawa, R.M.C., Riley, E.D. Gun violence against unhoused and unstably housed women: A cross-sectional study that highlights links to childhood violence. Inj. Epidemiol. 8, 52 (2021). https://doi.org/10.1186/s40621-021-00348-4
[11] Buhrich, N., Hodder, T., & Teesson, M. (2000). Lifetime Prevalence of Trauma among Homeless People in Sydney. Australian & New Zealand Journal of Psychiatry, 34(6), 963–966. https://doi.org/10.1080/000486700270
[12]Rountree, J., Hess, N., Lyke A. Health Conditions Among Unsheltered Adults in the U.S.. California Policy Lab. Policy Brief. (10/2019) p.7 Accessed at: https://www.capolicylab.org/wp-content/uploads/2019/10/Health-Conditions-Among-Unsheltered-Adults-in-the-U.S.pdf

more likely to be targeted to people of color, and are more likely to be traumatic to people of color--especially Black men, who are likely to be disproportionately involved with the court system. For this reason, it is essential that a trusting relationship be developed between an unhoused individual and the peer outreach worker, to enable the individual to seek voluntary treatment.

We believe that every person can achieve improvements in their mental wellness but, for our most vulnerable citizens who have been unhoused for longer periods of time, extensive outreach and engagement by a trained peer is necessary to build a trusting relationship. Because peers have "been there," there is less fear of stigma and judgment from those who they are helping. Peer support builds relationships that are based upon mutuality, shared power, and respect[13]. When a trusting relationship which is built on shared power and respect is created between a peer and a person with a behavioral health challenge, that individual will receive services voluntarily, which leads to self-empowerment for the individual. Self-empowerment, in turn, has been shown to improve quality of life, self-esteem, and reduce mental health symptoms[14], and is therefore a key variable of success.

Recommendation #2: Mandate that Certified Peer Support Specialists are Meaningfully Involved at Every Stage of the Process in Every County

In addition to the peer outreach worker, we ask that certified peer specialists be incorporated throughout the entire CARE Court process. The CARE Court framework describes a "Case Worker" and "Supporter" who assists the individual in various aspects of the CARE Court process, however the required qualifications of this supporter are not made clear in the current CARE Court framework. We believe that this Case Worker and Supporter must be a mandated certified peer support specialist in every county and in all circumstances.

Peer support is an evidence-based practice that has been shown to reduce re-hospitalization[15], reduce the number of homeless days[16], and improve quality of life, among many proven benefits. Trained and certified peers with lived experience of homelessness and/or behavioral health conditions are uniquely positioned to provide support and build a trusting relationship with people who are currently unhoused and/or people living with behavioral health conditions.

For the CARE Court program to meet its goal of improving the lives of people with behavioral health conditions, peer support specialists must be actively and meaningfully involved at every stage of the program, beginning with robust initial outreach and engagement efforts designed to encourage voluntary participation, and continuing until the individual completes the program.

---

[13] Mead S. Intentional Peer Support; 2001. [2020-02-28]. Peer Support as a Socio-Political Response to Trauma and Abuse https://docs.google.com/document/d/1trJ35i4dXX5AIWRnbg78OaT7-RfPE9_DbPm5kSST9_Q/edit

[14] Patrick W Corrigan, Dale Faber, Fadwa Rashid, Matthew Leary, The construct validity of empowerment among consumers of mental health services, Schizophrenia Research,Volume 38, Issue 1,1999

[15] Bergeson, S. (2011). Cost Effectiveness of Using Peers as Providers. Accessed at:https://www.nyaprs.org/e-news-bulletins/2013/bergeson-cost-effectiveness-of-using-peers-as-providers

[16] van Vugt, M. D., Kroon, H., Delespaul, P. A., & Mulder, C. L. (2012). Consumer-providers in assertive community treatment programs: associations with client outcomes. Psychiatric Services, 63(5), 477–481. doi:10.1176/appi.ps.201000549.

Recommendation #3: Provide Permanent Supportive Housing Before Services are Mandated

California has adopted the "Housing First" approach, which recognizes that an unhoused person must first be able to access safe, affordable, permanent housing ***before*** stabilizing, improving health, or reducing harmful behaviors[17].According to state statute, "any California state agency or department that funds, implements, or administers for the purpose of providing housing or housing-based services to people experiencing homelessness or at risk of homelessness, must incorporate the core components of housing first"[18].

Permanent supportive housing, which follows the Housing First approach, is targeted to individuals with mental health, substance use, or other disabilities who have experienced long-term homelessness. It provides long-term rental assistance in combination with supportive services. Research has shown that individuals, even those with chronic homelessness, remain housed long-term in permanent supportive housing[19]. In a New York program, individuals with prior jail and shelter stays were offered permanent supportive housing through a state program. At 12 months 91% of these people were housed in permanent housing compared to 28% in the control group who were not offered housing through the program[20]. In a Denver supportive housing program, 86% of participants remained housed after one year, and experienced notable reductions in jail stays[21].

To give every individual the best chance of succeeding, it is imperative that individuals who have been found to qualify for the CARE Court program be offered permanent supportive housing and a chance to stabilize and accept voluntary services before any services are court mandated.

Recommendation #4: Analyze and Publicly Report Plans for Addressing the Permanent Housing Needs of CARE Court Participants

Permanent, stable housing is essential to the successful participation in treatment, services and supports of people with behavioral health care needs; the State should analyze and publicly document the projected permanent housing needs for people who may participate in the CARE Court program. That analysis and public documentation should include clear information regarding:

- The projected permanent housing needs of potential CARE Court participants;
- The permanent housing options that are expected to be made available to meet those needs;
- The number of those housing options currently available;
- How additional housing options will be funded, and when they will be available to CARE Court participants; and
- The expectations regarding choice among permanent housing options to be provided to CARE Court participants.

[17] Welfare and Institutions Code § 8255
[18] Welfare and Institutions Code § 8255 (e) and § 8256 (a)
[19] Davidson, C., et al. (2014) "Association of Housing First Implementation and Key Outcomes Among Homeless Persons With Problematic Substance Use." Psychiatric Services. 65(11), 65(11): 1318-24
[20] Aidala, A.; McAllister, W; Yomogida, M; and Shubert, V. (2013) Frequent User Service Enhancement 'FUSE' Initiative: New York City FUSE II Evaluation Report. Columbia University Mailman School of Public Health.
[21] Urban Institute (2021) "Breaking the Homelessness-Jail Cycle with Housing First, accessed at https://www.urban.org/sites/default/files/publication/104501/breaking-the-homelessness-jail-cycle-with-housing-first_1.pdf

This information is essential for assessing the viability and potential success of the CARE Court proposal, and the lack of such information currently makes a full assessment of the proposal impossible.

Recommendation #5: Ensure Integrated Care of Behavioral Health – Mental Health and Substance Use Disorder Services

Due to the unique behavioral health care funding streams in California, individuals receiving specialty mental health services who also have a substance use challenge must navigate two separate systems (county mental health plans for mental health and county drug Medi-Cal for substance use disorder) to access services. This system fragmentation often results in lack of care coordination and disruptions in care[22], which ultimately results in inadequate services.

To ensure that every individual who is eligible for CARE Court has the greatest opportunity to succeed, it is imperative that every person participating in the program, and those who are pre-enrollment, but receiving outreach and engagement services, be provided with integrated mental health and substance use care.

Recommendation #6: Address System Gaps and Require an Independent Ombudsperson

We believe strongly in the right of all individuals to have access to voluntary, high-quality health and behavioral health services. Services and supports must be available and accessible, and be representative of the diverse needs of Californians. Before California creates another new program, we must first ensure that appropriate services are available for all who need them.

It is well recognized that California has not fully developed system capacity for the full continuum of behavioral health services [23]. California's lack of system capacity includes workforce shortages[24], lack of diversity in mental health professionals[25], and network inadequacy of County Mental Health Plans[26]. Furthermore, the recent report by the State Auditor found that the continuum of services, from intensive treatment to step-down community-based options, are not readily available for people in need[27]. The same report also found that in San Francisco, only about 5% of individuals with five or more holds over 3 years were connected to intensive aftercare services. In Los Angeles, this number was around 10%.

In addition to lack of available services, individuals who receive Specialty Mental Health Services through a County Plan do not always have a source of independent, unbiased assistance or support to help them access needed services. While individuals with HMO insurance can access assistance from the Department of Managed Health Care (DMHC), and individuals with Medi-Cal Managed Care can

[22] California Health Care Foundation, Behavioral Health Integration in Medi-Cal: A Blueprint for California, dated February, 2019. Accessed at: https://www.chcf.org/wp-content/uploads/2019/02/BehavioralHealthIntegrationBlueprint.pdf
[23] California Health Care Foundation, Mental Health in California: For Too Many Care Not There, dated March 15, 2018.
[24] UCSF, Healthforce Center, California's Current and Future Behavioral Health Workforce, February 12, 2018.
[25] Ibid.
[26] Department of Health Care Services, Report to CMS: Annual Network Certification on Specialty Mental Health Services. 2020
[27] See Bureau of State Audits, Lanterman-Petris-Short Act: California has Not Ensured That Individuals with Serious Mental Illnesses Receive Adequate Ongoing Care, July 2020. Available at www.bsa.ca.gov/pdfs/reports/2019-119.pdf.

receive assistance from the DMHC or the Medi-Cal Ombudsman, individuals receiving Specialty Mental Health Services are limited to the county Patients' Rights Advocate (PRA) or the county appeal and grievance process.

Although PRAs are authorized by statute to assist individuals to "secure or upgrade treatment or other services to which they are entitled"[28], there are no minimum PRA staffing ratios defined in the guidelines which results in inadequate staffing of county Patients' Rights Offices so PRAs spend much of their time representing people at certification review hearings and capacity hearings.[29] Another challenge with PRAs is the inherent conflict of interest which arises from the fact that they are either employees or contractors of the county, so their efforts to assert the rights of an individual requires the PRA to essentially dispute their employer which has resulted in multiple instances of retaliation.[30] Lastly, the California Office of Patients' Rights (COPR) is a contract dually executed by the Department of State Hospitals (DSH) and the Department of Health Care Services, however funding for the COPR contract is provided solely by DSH, which results in a majority of COPR's efforts being geared towards supporting PRAs in state hospitals. Support for the county PRAs is very limited, which results in their limited capacity to assist individuals with access to appropriate specialty mental health services and supports.

Without a PRA or an ombudsperson, the county appeal and grievance process can be intimidating, confusing, and lengthy. Individuals rarely know this assistance is available, much less know how to access the process. In addition, lower income individuals often do not have access to computers or internet access, which makes the grievance and appeal process nearly impossible.

Independent Ombuds serve as a liaison between an individual and their health care payor without fear of retaliation. Research has shown that Ombuds increase accountability[31], increase access to health care[32], monitor the functioning of policies, and much more. We believe that access to an independent and unbiased Ombudsperson or entity, either at the state or county level, would have the dual effect of assisting individuals with accessing appropriate services, and identify local gaps in necessary services prior to crisis.

Recommendation #7: Do Not Expand the Lanterman-Petris-Short (LPS) Act

The LPS Act includes protections intended to protect the civil rights of the individual, including referral, evaluation, multiple certification hearings, an investigation, and a court hearing to determine whether the individual, because of a mental health condition or alcohol use, is a danger to themself or others, or is gravely disabled. Gravely disabled is defined as an inability to provide for his or her basic personal needs for food, clothing, or shelter. If, ***after a hearing***, a person is found to meet one of these

[28] Welfare and Institutions Code § 5500(a)
[29] California Behavioral Health Planning Council, Title 9 County Patients' Rights Advocates, highlighting resource, training, and retaliation issues in county patients' rights programs in California. 10/2017 p. 5
[30] Id. Page 8
[31] Durojaye, E., & Agaba, D. K. (2018). Contribution of the Health Ombud to Accountability: The Life Esidimeni Tragedy in South Africa. Health and human rights, 20(2), 161–168.
[32] Silva, R., Pedroso, M. C., & Zucchi, P. (2014). Ouvidorias públicas de saúde: estudo de caso em ouvidoria municipal de saúde [Ombudsmen in health care: case study of a municipal health ombudsman]. Revista de saude publica, 48(1), 134–141.

requirements, and if the court finds that they should be detained, they are first placed on 72-hour hold, and then may continue to be placed on successively longer holds, after a certification hearing at each stage, until and if a referral to conservatorship is eventually ordered. A referral to conservatorship requires a comprehensive investigation by an officer, and a determination by the court that a person is gravely disabled, they refuse to accept treatment voluntarily ***and*** that no reasonable alternatives to conservatorship exist.

The creation of a new presumption in the CARE Court program, that noncompliance with ***any*** aspect of the individual's court-mandated plan may result in referral for conservatorship with the new presumption that no alternatives exist[33], effectively bypasses the entire LPS process in a number of ways including, but not limited to:

- ***A presumption that no alternatives exist could be construed to include the implicit presumption that the person is gravely disabled.*** Nothing in the CARE Court framework indicates that grave disability is a requirement for referral to conservatorship from the program;
- An individual who complies with the majority of their court-mandated plan could still be referred for fast-track conservatorship for refusing to comply with a single element of their plan, even if they are receiving services voluntarily;
- This process eliminates the 72-hour, 14-day, and 30-day holds which are created in statute to give the individual a chance to stabilize;
- The presumption does not allow for investigation into other alternatives that may exist.

The new presumption represents a dangerous expansion of LPS law. A recent comprehensive State Audit of LPS protocols and procedures at the county-level was conducted last year[34]. The auditor states: "Expanding the LPS Act's criteria to add more situations in which individuals would be subject to involuntary holds and conservatorships could widen their use and potentially infringe upon people's liberties, and we found no evidence to justify such a change"[35].

In closing, we strongly support the goal of reducing homelessness and providing mental health services to everyone who needs those services. We believe strongly that individuals can and will succeed when they have access to appropriate services that meet their individual needs.

Thank you for the opportunity to provide comments and recommendations on the CARE Court Framework. We look forward to continuing to collaborate with the Administration as this proposal continues to be developed.

[33] See CARE Court FAQ #8, page 3 https://www.chhs.ca.gov/wp-content/uploads/2022/03/CARECourt_FAQ.pdf
[34] See Bureau of State Audits, Lanterman-Petris-Short Act: California has Not Ensured That Individuals with Serious Mental Illnesses Receive Adequate Ongoing Care, July 2020. Available at www.bsa.ca.gov/pdfs/reports/2019-119.pdf.
[35] Ibid. page 1

In community,

Heidi. L. Strunk
President & CEO
Mental Health America of California
California Youth Empowerment Network

Nan Roman
Chief Executive Officer
National Alliance to End Homelessness

Sam Lewis

Sam Lewis
Executive Director
Anti-Recidivism Coalition

Guyton Colantuono

Guyton Colantuono, NCPS
Executive Director
Project Return Peer Support Network

Sharon Rapport
Director
California State Policy
Corporation for Supportive Housing

Mark Salazar, MHA
President & CEO
Mental Health Association of San Francisco

Courtney Hanson
Development & Communications Coordinator
California Coalition for Women Prisoners

Angela Chan

Angela Chan
Chief of Policy
San Francisco Public Defender's Office

Christopher Martin

Christopher Martin
Policy Director
Housing California

Guyton Colantuono

Statewide Directors
California Association of Peer Supporters
Academy