SENATE JUDICIARY COMMITTEE
Senator Thomas Umberg, Chair
2021-2022 Regular Session

AB 1331 (Irwin)
Version: June 22, 2021
Hearing Date: July 13, 2021
Fiscal: Yes
Urgency: No
JT

SUBJECT

Mental health: Statewide Director of Crisis Services

DIGEST

This bill requires the Director of the Department of Health Care Services (DHCS) to appoint a full-time Statewide Director of Crisis Services (SDCS) to support and promote a comprehensive behavioral health crisis care system, as specified.

EXECUTIVE SUMMARY

This bill requires DHCS's Director to appoint a full-time SDCS to monitor, support, and coordinate with service providers to have a comprehensive crisis care system, as specified. The bill requires the SDCS to engage and coordinate with the Department of Managed Health Care, the Department of Insurance, and other departments, agencies, and appropriate entities to support and advocate for a comprehensive, integrated network of services for people with mental health or substance use disorders.

The bill is co-sponsored by the California Hospital Association and the National Alliance on Mental Illness and is supported by various mental health advocacy groups. Supporters argue a comprehensive and integrated behavioral health crisis care network will prevent tragedies of public and patient safety, violation of civil rights, extraordinary and unacceptable loss of lives, and waste of resources.

The bill is opposed by the California Department of Health Care Services and the County Behavioral Health Directors Association of California, who argue that the bill is vague, duplicative of existing law, and unnecessary.

The bill passed the Senate Health Committee by a vote of 10-0.

PROPOSED CHANGES TO THE LAW

Existing law:

1) Establishes the Medi-Cal program, administered by the Department of Health Care Services (DHCS), under which qualified low-income individuals receive health care services. (Welf. & Inst. Code § 14001.1.)

2) Establishes a schedule of benefits in the Medi-Cal program, which includes mental health and substance use disorder services included in the essential health benefits package adopted by the state for purposes of implementing the Patient Protection and Affordable Care Act requirement for benefits that must be included in health plans offered in the private individual and small group market and to the Medicaid expansion population. (Welf. & Inst. Code § 14132.03.)

3) Requires the development of county mental health plans for the provision of managed Medi-Cal specialty mental health services at the local level to eligible Medi-Cal beneficiaries, including both adults and children, as specified, which may include crisis stabilization (CS) services and inpatient psychiatric care. (Welf. & Inst. Code §§ 14680, 14684, 14717.5.)

4) Defines "crisis stabilization," pursuant to DHCS's State Plan and in regulations, as a service lasting less than 24 hours to or on behalf of a Medi-Cal beneficiary for a condition that requires more timely response than a regularly scheduled visit, as specified. (9 CCR §1810.210.)

5) Requires crisis stabilization services to be provided on-site at a licensed 24-hour health care facility or hospital-based outpatient program or a provider site certified by DHCS or a county mental health plans to perform crisis stabilization services (known as a crisis stabilization unit). (Welf. & Inst. Code § 1840.338.)

6) Requires the maximum number of hours claimable for crisis services in a 24-hour period to be 20 hours. Prohibits other specialty mental health services from being reimbursable during the same time period CS services are reimbursed, except for targeted case management. (9 CCR § 1840.368.)

7) Requires a psychiatric health facility, as specified, to provide basic services, including, but not limited to, psychiatry, clinical psychology, psychiatric nursing, social work, rehabilitation, drug administration, and appropriate food services for those persons whose physical health needs can be met in an affiliated hospital or in outpatient settings. (Health & Saf. Code §1250.2.)

8) Establishes the Lanterman-Petris-Short (LPS) Act, which provides for the involuntary detention for treatment and evaluation of people who are gravely

disabled or a danger to self or others. (Welf. & Inst. Code § 5000 et seq.) Defines "grave disability" as a condition in which a person, as a result of a mental disorder, or impairment by chronic alcoholism, is unable to provide for the person's basic personal needs for food, clothing, or shelter. (Welf. & Inst. Code § 5008(h)(1)(A),(2).) Permits counties to designate facilities that are not hospitals or clinics as 72-hour evaluation and treatment facilities and as 14-day intensive treatment facilities the facilities meet requirements the Director of DHCS establishes by regulation. (Welf. & Inst. Code § 5404(a).)

This bill:

1. Finds and declares:
    a. California's system of caring for individuals of all ages experiencing a behavioral health crisis is fragmented and breaking — some would say it is completely broken. An estimated 1.4 million Californians now live with a serious mental illness such as schizophrenia, bipolar disorder, and major depression, while millions of others struggle with day-to-day problems that occasionally rise to the crisis level. There are inadequate crisis services available for individuals, regardless of age, experiencing a behavioral health crisis in virtually every geographic area of the state.
    b. The lack of coordination, a full continuum of crisis services, and continuity among programs in a multifaceted, complex system of state and local agencies frequently results in individuals not receiving the most appropriate level of care in a timely manner, which may also result in more expensive services with poorer outcomes for individuals, including children and youth, and their families. Too often, individuals experiencing a behavioral health crisis are met with delay, detainment, and even denial of service in a manner that creates undue burden on the person, their family, law enforcement, emergency departments, and adult and juvenile justice systems.
    c. The current approach to crisis care is patchwork and delivers minimal treatment for some people while others, often those who have not been engaged in care, fall through the cracks, resulting in multiple hospital readmissions, an inability to work or attend school, life in the criminal justice system, homelessness, early death, and suicide. The absence of sufficient and cost-effective crisis services represents a substantial gap in the continuum of care for children and youth with mental health needs, and this must be addressed.
    d. A comprehensive and integrated behavioral health crisis care network is crucial in preventing tragedies of public and patient safety, violation of civil rights, extraordinary and unacceptable loss of lives, and waste of resources. California requires strong leadership on a statewide basis to develop an effective crisis care system that saves lives and dollars. With continued attention and focused effort, the new Statewide Director of

Crisis Services will be able to provide guidance to address the remaining challenges and barriers, avoid burdensome judicial intervention, and become a leader in ensuring that the mental health crisis needs of all children and their families are met regardless of who they are or where they live.

2. Requires DHCS's Director to appoint a full-time SDCS to monitor, support, and coordinate with service providers to have a comprehensive crisis care system, as specified. Requires the SDCS to engage and coordinate with the Department of Managed Health Care, the Department of Insurance, and other departments, agencies, and appropriate entities to support and advocate for a comprehensive, integrated network of services for people with mental health or substance use disorders.

3. Requires the SDCS to do all of the following:
    a. Convene state and local leaders to develop a cohesive statewide behavioral health crisis care delivery system, including performance criteria and success indicators, utilizing the National Guidelines for Crisis Care published by the United States Substance Abuse and Mental Health Administration in 2020, which the state and local leaders must implement.
    b. Coordinate behavioral health programs and services statewide to ensure continuity of services and access points across county lines, other geographic boundaries, or both, and to promote and enhance cross-agency information exchange and resource sharing.
    c. Identify and make recommendations to address behavioral health services gaps and needs to assist service providers, including, but not limited to, hospitals and community-based organizations, in providing optimal service delivery in order to maximize resources to effectively meet the diverse needs of people and communities.
    d. Make recommendations to appropriate entities on how to maximize the use of existing infrastructures and competencies of behavioral health prevention and early intervention services specific to the needs of the population, including children, adolescents, adults, and older adults.
    e. Make recommendations to appropriate entities on how to financially align behavioral health funding so that it best meets the needs of individuals, regardless of age, across California.
    f. Collect and analyze data on existing behavioral health program results and effectiveness.
    g. Promote the utilization of successful, promising, and evidence-based behavioral health services and service delivery within the child and adult systems of care.
    h. Make recommendations to the DHCS on strategic direction for the establishment of, modification of, or improvements to the existing crisis

care network in order to ensure the existence of a comprehensive, coordinated, consistent system of crisis care delivery.

i. Conduct appropriate planning processes, involving relevant stakeholders, to ensure the crisis care delivery system is on a path of continuous and ongoing quality improvement.
j. Provide technical assistance to improve the consistent application of the laws relating to involuntary commitments under the LPS Act.

4. Permits the SDCS to undertake other activities to accomplish their duties.

5. Requires DHCS to ensure that the SDCS has resources necessary, both in funding and staff, to achieve the duties of the position.

COMMENTS

1. Author's statement

The author writes:

> The data has shown that California is facing a mental health crisis and that our current system is not enough. Too often, as a result of not receiving timely and appropriate crisis treatment, Californians face arrest, involuntary detention, homelessness, and worse. This fractured system places an undue burden on law enforcement, emergency departments, and our communities. AB 1331 seeks to address this fragmented system by to establishing a statewide position that would ensure that Californians receive the care they deserve in an expedited and efficient manner regardless of their county.

2. Background

According to the Health Committee's analysis of this bill, DHCS currently has a Behavioral Health Deputy Director (BHDD) position, the responsibilities of whom include:

- Providing leadership in the formulation and administration of policy to achieve DHCS's mission, and serving as liaison to federal and state partner agencies in the area of behavioral health treatment services;
- Developing and overseeing a strategic plan for assessment, delivery, coordination and integration of behavioral health services;
- Directing and coordinating the behavioral health treatment programs with one another and with primary care to ensure uniform program direction and maximum efficiency of program delivery in accordance with state and federal requirements and agreements;

- Directing and evaluating the policy, planning, fiscal, and ongoing performance management activities necessary to ensure compliance with federal and state requirements and to improve operations within various DHCS internal divisions; and
- Representing DHCS in collaborative work with public and private organizations, community stakeholders, and local, state, and federal government officials in Medi-Cal-related behavioral health program matters, including pertinent relationships with corrections, probation, and local law enforcement.

The analysis states:

> In September 2020, Governor Newsom also announced the appointment of a Deputy Secretary of Behavioral Health at the California Health and Human Services Agency (CHHSA). In early 2020, CHHSA announced the launch of the CHHSA Behavioral Health Task Force, which works to address the urgent behavioral health needs across California. The Task Force advises the Administration's efforts to advance statewide behavioral health services, prevention, and early intervention to stabilize conditions before they become severe, and includes members from a broad range of stakeholders, including people living with behavioral health conditions, family members, advocates, providers, health plans, counties, and state agency leaders.
>
> DHCS also convenes a Behavioral Health Stakeholder Advisory Committee (BH-SAC), which is a broad-based body to disseminate information and receive coordinated input regarding DHCS's behavioral health activities. It was created as part of the ongoing DHCS effort to integrate behavioral health with the rest of the health care system, and incorporates existing groups that have advised DHCS on behavioral health topics. The BH-SAC advises the DHCS Director on the behavioral health components of the Medi-Cal program, as well as behavioral health policy issues more broadly, and includes a diverse and visible stakeholder advisory group of leaders and representatives from key behavioral health concerns, including counties, providers, and policy organizations to provide feedback and guidance to DHCS on behavioral health issues.
>
> There is also in state government the California Behavioral Health Planning Council (CBHPC), which is within DHCS, that is mandated by federal and state statute to advocate for children with serious emotional disturbances and adults and older adults with serious mental illness; review and report on the public behavioral health system; participate in statewide planning; and advise the Legislature on priority issues while reviewing, evaluating, and advocating for an accessible and effective

> behavioral health system. The Mental Health Services Oversight and Accountability Commission (MHSOAC) was established pursuant to the Mental Health Services Act (MHSA) to oversee the implementation of the MHSA, develop strategies to overcome mental health stigma, and advise the Governor and the Legislature regarding actions the state may take to improve care and services for people with mental illness. The MHSOAC also is permitted to work in collaboration with DHCS and the CBHPC, and in consultation with the County Behavioral Health Directors Association of California, in designing a comprehensive joint plan for a coordinated evaluation of client outcomes in the community-based mental health system, as specified. CHHSA is responsible for leading a comprehensive joint plan effort.

The analysis additionally states:

> While arguments for this bill cite a lack of statewide focus on crisis services, it appears that the state has made efforts to increase its focus on behavioral health issues, including various bodies that convene to provide input in addition to established state entities, particularly the BHDD currently within DHCS whose responsibilities appear to mirror the duties of the SDCS in this bill. It is unclear what all the current entities working in this space have omitted that the SDCS will achieve.

3. <u>The LPS Act</u>

Before the 1950s, people with serious mental illnesses were typically confined in expansive state-run institutions, often for their entire lives, based on a mere finding by a physician that the person had a mental illness and was in need of treatment. Following a series of exposes[1] and the advocacy efforts of civil rights attorneys and mental health professionals, this model gave way to an approach that instead privileged individual liberty. States like California began "deinstitutionalizing" psychiatric patients, allowing them to seek treatment in their own community, premised on the largely unrealized expectation that the resources to provide the treatment would be available.

[1] One journalist described "the frightful squalor these unfortunates live in--beds jammed against one another, holes in the floor, gaping cracks in the wall, long rows of hard, unpainted benches, dirty toilets, dining halls where the food is slopped out by unkempt patient attendants and, above all, the terrifying atmosphere of hopelessness in institutions where thousands of patients are penned in day after day and night after night endlessly staring at blank walls." Another author described mental hospitals as "buildings swarming with naked humans herded like cattle and treated with less concern, pervaded by a fetid odor so heavy, so nauseating, that the stench seemed to have almost a physical existence of its own." (Gordon, Sara, *The Danger Zone: How the Dangerousness Standard in Civil Commitment Proceedings Harms People with Serious Mental Illness* (2016) 66 Case W. Res. 657, 660, fn. 30.)

Signed into law in 1967 by Governor Ronald Reagan, the LPS Act includes among its goals "ending the inappropriate and indefinite commitment of the mentally ill, providing prompt evaluation and treatment of persons with serious mental disorders, guaranteeing and protecting public safety, safeguarding the rights of the involuntarily committed through judicial review, and providing individualized treatment, supervision and placement services for the gravely disabled by means of a conservatorship program." (§ 5001.) The LPS Act "governs the involuntary detention, evaluation, and treatment of persons who, as a result of mental disorder, are dangerous or gravely disabled," (*Conservatorship of John L.* (2010) 48 Cal.4th 131, 142), meaning that they are unable to meet their basic personal needs for food, clothing, or shelter. (§ 5008(h)(1)(A).) "Before a person may be found to be gravely disabled and subject to a year-long confinement, the LPS Act provides for a carefully calibrated series of temporary detentions for evaluation and treatment." (*Conservatorship of Ben C.* (2007) 40 Cal.4th 529, 541.)

"[I]in accordance with the legislative purpose of preventing inappropriate, indefinite commitments of mentally disordered persons, such detentions are implemented incrementally." (*Ford v. Norton* (2001) 89 Cal.App.4th 974, 979 [citation omitted].) Typically, one first interacts with the LPS Act through a section 5150 evaluation and detention in response to an acute emergency. In a 5150 evaluation, county behavioral health services, mobile crisis teams, law enforcement, or medical professionals determine if there is probable cause that a person is gravely disabled or a danger to themselves or others, in which case the person may be detained in an approved facility for up to 72 hours for further evaluation and treatment. (§ 5150.)

Following a 72-hour hold, the individual may be held for an additional 14 days, without court review. (§ 5250.) After the 14-day period, a person found by a superior court to be imminently dangerous may be involuntarily committed for an additional 180 days. (§§ 5300, 5301.) If the person is not imminently dangerous but is still found to be gravely disabled and unwilling or unable to accept voluntary treatment, they may be certified for an additional 30 days of intensive treatment. (§ 5270.15.) After the initial 72-hour detention, the 14-day and 30-day commitments each require a certification hearing before an appointed hearing officer to determine probable cause for confinement unless the detainee has filed a petition for the writ of habeas corpus. (§§ 5256, 5256.1, 5262, 5270.15, 5275, 5276.) "This series of temporary detentions may culminate in a proceeding to determine whether the person is so disabled that he or she should be involuntarily confined for up to one year." (*Conservatorship of Ben C.*, *supra*, 40 Cal.4th at 541; § 5361.)

The only provision in this bill that appears to be squarely in this Committee's jurisdiction is the requirement that the Statewide Director of Crisis Services provide technical assistance to improve the consistent application of the laws relating to involuntary commitments under the LPS Act. Supporters of the bill argue that promoting a more uniform approach to behavioral health will better protect civil

liberties and ensure better care is provided to individuals suffering from behavioral health challenges.

4. Support

In a letter echoed by several supporters, co-sponsors NAMI and CHA write:

> The state has never had a comprehensive, integrated network of services on which people in a mental health or substance use disorder crisis can rely. Instead, we have a complex patchwork of state and local agencies involved at different touch points, with services that vary by county and based on whether a person is covered by Medi-Cal or private insurance. As a result, people in a behavioral health crisis too often face arrest, involuntary detention, multiple hospitalizations, homelessness, and even early death.
>
> In many communities, behavioral health crisis services are delivered too late — either by law enforcement or in hospital emergency departments. Although emergency department doors are always open to anyone in need, hospitals are not typically equipped with the array of community-based resources needed to serve this population and ensure they receive necessary long-term support. Once discharged, too few people get the intensive follow-up care needed to prevent a crisis from recurring.
>
> AB 1331 would create a new leadership position within DHCS who would build a system that:
>
> - Promotes successful and evidence-based behavioral health service delivery
> - Convenes state and local leaders to develop a cohesive approach to statewide crisis care
> - Ensures continuity of services and access points through statewide coordination of programs
> - Collects and analyzes data on existing behavioral health program effectiveness
> - Maximizes competencies and infrastructure to advance prevention and early intervention
>
> A comprehensive and integrated crisis network of voluntary care — that is available statewide — is a first line of defense in protecting civil rights and civil liberties, and in preventing tragedies of public and patient safety. Effective crisis care saves lives and dollars, but we must invest in a systemic approach and establish leadership at the state level.

5. Opposition

DHCS writes:

> DHCS is supportive of increased coordination of behavioral health crisis care statewide. However, legislation is not needed to establish the position required by AB 1331. In addition, given the fiscal implications of adding an executive position, and the additional staffing needed to support the required activities of the position, this proposal would be more appropriately addressed through the budgetary process.
>
> Furthermore, the work proposed for the Statewide Director of Crisis Services would be duplicative of existing efforts by the California Health and Human Services Agency (CHHS). CHHS currently has a Deputy Secretary of Behavioral Health who acts as a senior advisor to the Undersecretary and Secretary on behavioral health policy. The deputy secretary supports coordination and collaboration on behavioral health policy across departments within the agency, as well as with other state agencies and departments. The deputy secretary may act as a liaison for the agency engaging with a wide variety of behavioral health partners and stakeholders on relevant policy issues. CHHS has also convened the Behavioral Health Task Force, which advises the Administration's work to advance statewide behavioral health services, prevention, and early intervention.

CBHDA writes:

> As written, AB 1331 is overbroad, vague, and duplicative in setting out the responsibility of the Statewide Director of Crisis Services. According to the sponsors, the bill intends to cover not just the public behavioral health system, but also incorporate private insurance regulated by the Department of Managed Health Care and Department of Insurance. The bill language does not state this purpose, nor coordinate with these entities.
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> While AB 1331 fails to incorporate behavioral health crisis services within the private insurance market, the outlined responsibilities of the Statewide Director of Crisis Services cover programs and services well beyond the crisis arena. The provision in AB 1331 maximizing the use of existing infrastructures and competencies of behavioral health prevention and early intervention (PEI) services exceeds the scope of overseeing behavioral health crisis services. Furthermore, the Mental Health Services Oversight and Accountability Commission (MHSOAC) is already responsible for setting out priorities for specific PEI funds pursuant to SB

1004 (Pan) Chapter 843, Statutes of 2018. Additionally, the AB 1331 provision requiring that the financial alignment of behavioral health funding best meets the needs of individuals across California has no language limiting this alignment to crisis services. This provision goes beyond simply addressing crisis services and looks to address the overall behavioral healthcare system. As outlined in this bill, the newly created Statewide Director of Crisis Services would be responsible for identifying and addressing behavioral health services gaps and needs to ensure optimal service delivery. Again, this provision goes beyond addressing crisis services. Additionally, the Department of Health Care Services already plans to hire a consultant to evaluate gaps in the behavioral healthcare continuum for county behavioral health, thereby creating a duplicative function in this newly created crisis services position. The current language in AB 1331 fails to include all crisis services while at the same time being both overbroad and duplicative.

SUPPORT

California Hospital Association (co-sponsor)
National Alliance on Mental Illness – California (co-sponsor)
Association of California Healthcare Districts
Association of Regional Center Agencies
California Alliance of Child and Family Services
California Children's Hospital
California Emergency Nurses Association
Casa Pacifica Centers for Children and Families
Didi Hirsch Mental Health Services
Dignity Health
Hathaway-Sycamores
Scripps Health
Steinberg Institute
Tenet Healthcare

OPPOSITION

County Behavioral Health Directors Association of California
Department of Health Care Services

RELATED LEGISLATION

Pending Legislation: AB 383 (Salas, 2021) creates an Older Adult Behavioral Health (BH) Services Administrator (Administrator) within DHCS who is required to oversee BH services for older adults. Sets forth various responsibilities for the Administrator,

including working in close coordination and collaboration with various state and local entities, as specified. The bill is pending in the Senate Appropriations Committee.

Prior Legislation:

AB 480 (Salas, 2019) was identical to AB 383. AB 480 was held on the Senate Appropriations Committee suspense file.

AB 682 (Eggman of 2019), AB 1136 (Eggman of 2018), and AB 2743 (Eggman of 2016) would have required the Department of Public Health (DPH) to apply for a specified federal grant to develop a real-time, web-based database to collect, aggregate and display information about available beds in inpatient psychiatric facilities, crisis stabilization units, residential community mental health facilities, and licensed residential alcoholism or drug abuse recovery or treatment facilities. AB 682 was held on the Assembly Appropriations Committee suspense file. AB 1136 was held on the Senate Appropriations Committee suspense file. AB 2743 was held on the Assembly Appropriations Committee suspense file.

AB 1550 (Bonta, 2019) and AB 1372 (Levine, 2017) would have permitted a certified CS unit designated by a CMHP to provide medically necessary CS services to individuals beyond 24 hours if the individual needs inpatient psychiatric care or outpatient care and those services are not reasonably available, when certain requirements are met. AB 1550 was amended on the Senate Floor to address a different issue. AB 1372 was placed on the inactive file on the Senate Floor.

PRIOR VOTES:

Senate Health Committee (Ayes 10, Noes 0)
Assembly Floor (Ayes 78, Noes 0)
Assembly Appropriations Committee (Ayes 16, Noes 0)
Assembly Health Committee (Ayes 15, Noes 0)

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