File No. 220281 **Committee Item No.** 2
Board Item No.

COMMITTEE/BOARD OF SUPERVISORS

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Prepared by: Alisa Somera **Date:** May 20, 2022
Prepared by: **Date:**

FILE NO. 220397 RESOLUTION NO.

[Supporting California State Senate Bill Nos. 929, 965, 970, 1035, 1154, 1227, 1238, and 1416 (Eggman) - Legislation Modernizing California's Behavioral Health Continuum]

Resolution urging the California State Legislature to pass California State Senate Bill Nos. 929, 965, 970, 1035, 1154, 1227, 1238, and 1416, introduced by California Senator Susan Eggman, on legislation modernizing California's Behavioral Health Continuum.

WHEREAS, California State Senate Bill Nos. (SB) 929, SB 965, SB 970, SB 1034, SB 1154, SB 1227, SB 1238, and SB 1416 constitute a package of bills introduced by Senator Susan Eggman to improve California's behavioral health system across the continuum, through prevention and early intervention, community supports and services, intersystem collaboration, improving access to assisted outpatient treatment, providing increased accountability through outcome tracking, preventing avoidable conservatorships, and improving the effectiveness of our conservatorship process for those that need them; and

WHEREAS, Passage of these bills would represent a significant overhaul of California's response to the behavioral health needs of individuals suffering from severe mental illness; and

WHEREAS, The changes incorporated into Senator Eggman's legislation are necessary and overdue; and

WHEREAS, The effects of California's failure to provide adequate mental health care is reflected in the fact that 81% of the unhoused, unsheltered people living on San Francisco's streets suffer from some sort of psychiatric condition, addiction, or both, and our local psychiatric emergency services have been on condition-red since May 2020; and

WHEREAS, SB 929 would require the State to collect data on the number of people placed on temporary psychiatric holds, clinic outcomes for individuals placed in each type of hold, and services provided in each category; and

WHEREAS, SB 965 would ensure that the court considers the contents of reports filed at the conclusion of conservatorship investigations and that, during conservatorship proceedings, relevant testimony may be considered, provided it falls under a hearsay exemption; and

WHEREAS, SB 970 would amend the Mental Health Services Act to establish a clear guide of measurable outcomes that counties can use to identify goals and create mechanisms for counties to track and report on their performance, followed by promulgation of self-improvement plans and regular progress updates; and

WHEREAS, SB 1035 would explicitly allow courts to order medication as part of a treatment plan, an essential tool that allows individuals to safely remain in their communities and manage their mental illness; and

WHEREAS, SB 1154 would establish a real-time online dashboard to collect, aggregate, and display information about beds in inpatient psychiatric facilities, crisis stabilization units, residential community mental health facilities, and licensed residential community mental health facilities; and

WHEREAS, SB 1227 would provide additional flexibility for counties in treating individuals placed on 14-day psychiatric holds by allowing a second 30-day extension for patients who do not stabilize after an additional 14-day hold and 30-day extension; and

WHEREAS, SB 1238 would require the Department of Health Care Services to determine existing and projected needs for behavioral health services on a regional basis, and would require councils of local governments to provide data on total bed capacity, total utilization, and unmet need in a variety of categories; and

WHEREAS, SB 1416 would modernize the Lanterman-Petris-Short Act by defining those who, as a result of a mental health disorder, are unable to provide for their basic needs of personal or medical care or self protection and safety, as “gravely disabled;” and

WHEREAS, This package of legislation is endorsed by the Big City Mayors coalition, representing the 13 largest cities and roughly 11 million residents in California; now, therefore, be it

RESOLVED, That the Board of Supervisors supports California Senate Bill Nos. 929, 965, 970, 1035, 1154, 1227, 1238, and 1416; and, be it

FURTHER RESOLVED, That the Board of Supervisors hereby directs the Clerk of the Board to transmit a copy of this Resolution to San Francisco's state legislative delegation, and the Office of the Chief Clerk of the Assembly and Office of the Secretary of the Senate.

AMENDED IN SENATE MARCH 28, 2022

SENATE BILL No. 929

Introduced by Senator Eggman
(Coauthors: Senators Grove, Hurtado, and Rubio)

February 7, 2022

An act to amend Section 5402 of the Welfare and Institutions Code, relating to mental health.

LEGISLATIVE COUNSEL'S DIGEST

SB 929, as amended, Eggman. Community mental health services: data collection.

Existing law requires the State Department of Health Care Services to collect and publish annually quantitative information concerning the operation of various provisions relating to community mental health services, including the number of persons admitted for evaluation and treatment for certain periods, transferred to mental health facilities, or for whom certain conservatorships are established, as specified. Existing law requires each local mental health director, and each facility providing services to persons under those provisions, to provide the department, upon its request, with any information, records, and reports that the department deems necessary for purposes of the data collection and publication.

This bill would additionally require the department to collect and publish annually quantitative information relating to, among other things, *the number of persons detained for 72-hour evaluation and treatment,* clinical outcomes for individuals placed in each type of hold, services provided in each category, waiting periods, and needs for treatment beds, as specified. ~~To~~ *The bill would additionally require each other entity involved in implementing the provisions relating to*

detention, assessment, evaluation, or treatment for up to 72 hours to provide data to the department upon its request, as specified.

To the extent that the bill would increase the duties of local mental health ~~directors or~~ *directors,* facilities of local ~~entities~~ *entities, or any other local entities* with regard to providing the department, upon its request, with new types of data, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 5402 of the Welfare and Institutions Code is amended to read:

5402. (a) The State Department of Health Care Services shall collect and publish annually quantitative information concerning the operation of this division, including the number of persons admitted *or detained* for 72-hour evaluation and treatment, *admitted for* 14-day and 30-day periods of intensive treatment, and *admitted for* 180-day postcertification intensive treatment, the number of persons transferred to mental health facilities pursuant to Section 4011.6 of the Penal Code, the number of persons for whom temporary conservatorships are established, the number of persons for whom conservatorships are established in each county, the clinical outcomes for individuals placed in each type of hold, the services provided to individuals in each category, the waiting periods for individuals prior to receiving care, current and future needs for treatment beds and services, an assessment of all contracted beds, historical information on county bed waiting lists and referrals to certain types of facilities, and plans for the creation of new beds.

(b) Each local mental health director, ~~and~~ each facility providing services to persons pursuant to this division, *and each other entity*

involved in implementing Section 5150 shall provide the department, upon its request, with any information, records, and reports that the department deems necessary for the purposes of this section. The department shall not have access to any patient name identifiers.

(c) Information published pursuant to this section shall not contain patient name identifiers and shall contain statistical data only.

(d) The department shall make the reports available to medical, legal, and other professional groups involved in the implementation of this division.

SEC. 2. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

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AMENDED IN SENATE APRIL 6, 2022

AMENDED IN SENATE MARCH 15, 2022

SENATE BILL No. 965

Introduced by Senator Eggman

February 9, 2022

An act to amend Section 5354 ~~of~~ *of, and to add Section 5122 to,* the Welfare and Institutions Code, relating to conservatorships.

LEGISLATIVE COUNSEL'S DIGEST

SB 965, as amended, Eggman. Conservatorships: gravely disabled persons.

Existing law, the Lanterman-Petris-Short Act, authorizes a conservator of the person, of the estate, or of the person and the estate to be appointed for a person who is gravely disabled as a result of a mental health disorder or impairment by chronic alcoholism. Existing law requires the officer providing the conservatorship investigation, which may include a public guardian or a county mental health program, to investigate all available alternatives to conservatorship and to recommend conservatorship to the court only if no suitable alternatives are available. Existing law requires the officer to render a written report of investigation to the court prior to the hearing that contains specified information, including all relevant aspects of the person's medical, psychological, financial, family, vocational, and social condition. Existing law authorizes the court to receive the report in evidence and to read and consider the contents of the report in rendering its judgment.

This bill would require, rather than authorize, the court to receive the report in evidence and to read and consider the contents of the report in rendering its judgment. The bill would also require the officer, if the officer determines that information about the historical course of the

person's mental disorder and adherence to prior treatment plans has a reasonable bearing on the determination as to whether the person is gravely disabled as a result of the mental disorder, to include that information in the report and would require the court to consider the ~~information.~~

~~By~~ *information. By* expanding the duties of the county officer providing conservatorship investigation, this bill would impose a state-mandated local program.

Existing law establishes the hearsay rule, which provides that evidence of a statement that was made other than by a witness while testifying at a hearing and that is offered to prove the truth of the matter stated, is inadmissible. Existing law provides exceptions to the hearsay rule to permit the admission of specified kinds of evidence, including a social study, as defined, prepared by the petitioning agency to establish jurisdiction in a matter involving the custody, status, or welfare of a minor in a dependency proceeding, as specified.

Under this bill, a written report, and the hearsay evidence contained in it, furnished to the court and to all parties or their counsel by the officer conducting the conservatorship investigation or by another specified individual, in a matter involving the status or welfare of a conservatee or proposed conservatee, would be admissible and constitute competent evidence upon which the appointment of conservator may be ordered by the court, as specified. The bill would apply to a conservatorship proceeding described above and to specified conservatorship proceedings in the County of Los Angeles, the County of San Diego, or the City and County of San Francisco for the appointment of a conservator for a person who is incapable of caring for the person's own health and well-being due to a serious mental illness and substance use disorder. The bill would require the preparer of the report to be made available for cross-examination upon a timely request by a party. Under the bill, if a party raises a timely objection to the admission of specific hearsay evidence, the evidence would not be sufficient by itself to support an appointment of a conservator unless the petitioner establishes an exception, including, among other things, that the evidence would be admissible in any civil or criminal proceeding under any exception to the prohibition against hearsay or that the hearsay declarant is available for cross-examination.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 5122 is added to the Welfare and Institutions Code, to read:

5122. (a) For purposes of this section, "report" means any written report furnished to the court and to all parties or their counsel by the officer conducting conservatorship investigation, the county public guardian or conservator, or any other appointed conservator, in any matter involving the status or welfare of a conservatee or a proposed conservatee in a conservatorship proceeding, including a court or jury trial regarding the initial appointment of a conservator and subsequent proceedings to reestablish conservatorship pursuant to Chapter 3 (commencing with Section 5350) or Chapter 5 (commencing with Section 5450).

(b) The report, and any hearsay evidence contained in it, is admissible and constitutes competent evidence upon which the appointment of a conservator pursuant to Section 5350 or 5451 may be ordered by the court, to the extent allowed by subdivisions (e) and (f).

(c) The preparer of the report shall be made available for cross-examination upon a timely request by a party. The court may deem the preparer available for cross-examination if it determines that the preparer is on telephone standby and can be present in court within a reasonable time of the request.

(d) The court may grant a reasonable continuance upon request by any party if the report is not provided to the parties or their counsel within a reasonable time before the hearing.

(e) (1) If a party raises a timely objection to the admission of specific hearsay evidence contained in the report, the specific hearsay evidence shall not be sufficient by itself to support an appointment of a conservator unless the petitioner establishes one or more of the following exceptions:

(A) The hearsay evidence would be admissible in any civil or criminal proceeding under any statutory or decisional exception to the prohibition against hearsay.

(B) The hearsay declarant is a health practitioner described in paragraphs (21) to (28), inclusive, of subdivision (a) of Section 11165.7 of the Penal Code, or a social worker licensed pursuant to Chapter 14 (commencing with Section 4991) of Division 2 of the Business and Professions Code. For purposes of this subparagraph, evidence in a declaration is admissible only to the extent that it would otherwise be admissible under this section or if the declarant were present and testifying in court.

(C) The hearsay declarant is available for cross-examination. For purposes of this section, the court may deem a witness available for cross-examination if it determines that the witness is on telephone standby and can be present in court within a reasonable time of a request to examine the witness.

(2) For purposes of this subdivision, an objection is timely if it identifies with reasonable specificity the disputed hearsay evidence and it gives the petitioner a reasonable period of time to meet the objection prior to a contested hearing.

(f) This section shall not be construed to limit the right of a party to subpoena a witness whose statement is contained in the report or to introduce admissible evidence relevant to the weight of the hearsay evidence or the credibility of the hearsay declarant.

~~SECTION 1.~~

SEC. 2. Section 5354 of the Welfare and Institutions Code is amended to read:

5354. (a) The officer providing conservatorship investigation shall investigate all available alternatives to conservatorship and shall recommend conservatorship to the court only if no suitable alternatives are available. The officer shall render to the court a written report of investigation prior to the hearing. The report to the court shall be comprehensive and shall contain all relevant aspects of the person's medical, psychological, financial, family, vocational, and social condition, and information obtained from the person's family members, close friends, social worker, or principal therapist. If the officer determines that information about the historical course of the person's mental disorder and adherence to prior treatment plans has a reasonable bearing on the determination as to whether the person is gravely disabled as a

result of the mental disorder, the officer shall include that information in the report and the court shall consider the information. The report shall also contain all available information concerning the person's real and personal property. The facilities providing intensive treatment or comprehensive evaluation shall disclose any records or information which may facilitate the investigation. If the officer providing conservatorship investigation recommends against conservatorship, the officer shall set forth all alternatives available. A copy of the report shall be transmitted to the individual who originally recommended conservatorship, to the person or agency, if any, recommended to serve as conservator, and to the person recommended for conservatorship. The court shall receive the report in evidence and shall read and consider the contents of the report in rendering its judgment.

(b) Notwithstanding Section 5328, if a court with jurisdiction over a person in a criminal case orders an evaluation of the person's mental condition pursuant to Section 5200, and that evaluation leads to a conservatorship investigation, the officer providing the conservatorship investigation shall serve a copy of the report required under subdivision (a) upon the defendant or the defendant's counsel. Upon the prior written request of the defendant or the defendant's counsel, the officer providing the conservatorship investigation shall also submit a copy of the report to the court hearing the criminal case, the district attorney, and the county probation department. The conservatorship investigation report and the information contained in that report, shall be kept confidential and shall not be further disclosed to anyone without the prior written consent of the defendant. After disposition of the criminal case, the court shall place all copies of the report in a sealed file, except as follows:

(1) The defendant and the defendant's counsel may retain their copy.

(2) If the defendant is placed on probation status, the county probation department may retain a copy of the report for the purpose of supervision of the defendant until the probation is terminated, at which time the probation department shall return its copy of the report to the court for placement into the sealed file.

~~SEC. 2.~~

SEC. 3. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to

local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

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AMENDED IN SENATE MARCH 10, 2022

SENATE BILL No. 970

Introduced by Senator Eggman
(Principal coauthor: Senator Stern)
(Principal coauthors: Assembly Members Carrillo, Friedman, and Quirk-Silva)
(Coauthor: Senator Glazer)

February 10, 2022

An act to amend Sections 5651, 5847, 5848, 5891, 5891.5, and 5892 of, and to add Section 5846.5 to, the Welfare and Institutions Code, relating to mental ~~health.~~ *health, and making an appropriation therefor.*

LEGISLATIVE COUNSEL'S DIGEST

SB 970, as amended, Eggman. Mental Health Services ~~Act: accountability and planning.~~ *Act.*

Existing law, the Mental Health Services Act (MHSA), an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, establishes the Mental Health Services Fund (MHSF), a continuously appropriated fund, to fund various county mental health programs, including children's mental health care, adult and older adult mental health care, ~~and~~ prevention and early intervention *programs, and innovative* programs. ~~The~~ *Existing law authorizes the MHSA to be amended by a ⅔ vote of each house of the Legislature if the amendments are consistent with, and further the intent of, the MHSA.*

The MHSA requires a certain percentage of funds in the MHSF to be used by the counties for specified purposes, including requiring 20% of all unexpended and unreserved funds on deposit in the MHSF each month to be distributed to the counties and used for prevention and early intervention programs and requiring 5% of the total funding for

each county mental health program for children's mental health care, adult and older adult mental health care, and prevention and early intervention to be utilized for innovative programs, as specified.

This bill would amend the MHSA by eliminating those percentage funding requirements commencing with the 2024–25 fiscal year. By changing the purposes for which the funds in the MHSF may be used, the bill would make an appropriation.

The MHSA ~~established~~ *establishes* the Mental Health Services Oversight and Accountability Commission and requires the counties to prepare and submit a 3-year program and expenditure plan, and annual updates, as specified, to the commission and the department.

~~Existing law authorizes the MHSA to be amended by a ⅔ vote of each house of the Legislature if the amendments are consistent with, and further the intent of, the MHSA.~~

This bill would amend the MHSA by, instead, requiring the counties to prepare and submit 5-year program and expenditure plans, and annual updates, as specified.

This bill would require the California Health and Human Services Agency, by July 1, 2024, to establish the California MHSA Outcomes and Accountability Review (MHSA-OAR), consisting of performance indicators, county self-assessments, and county MHSA improvement plans, to facilitate a local accountability system that fosters continuous quality improvement in county programs funded by the MHSA and in the collection and dissemination by the department of best practices in service delivery. The bill would require the agency to convene a workgroup, as specified, to establish a workplan by which the MHSA-OAR shall be conducted, including a process for qualitative peer reviews of counties' MHSA services and uniform elements for the county MHSA system improvement plans. The bill would require the agency to establish specific process measures and uniform elements for the county MHSA improvement plans and updates. The bill would require the counties to execute and fulfil components of its MHSA system improvement plan that can be accomplished with existing resources. The bill would require the agency to report to the Legislature, on an annual basis, a report that summarizes county performance on the established process and outcome measures during the reporting period, analyzes county performance trends over time, and makes findings and recommendations for common MHSA services improvements identified in the county MHSA self-assessments and county MHSA system improvement plans. By imposing new

requirements on counties, this bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

Vote: ⅔. Appropriation: ~~no~~ *yes*. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 5651 of the Welfare and Institutions Code is amended to read:

5651. (a) Counties shall comply with the terms of the county mental health services performance contract.

(b) The county mental health services performance contract shall include all of the following provisions:

(1) That the county shall comply with the expenditure requirements of Section 17608.05.

(2) That the county shall provide services to persons receiving involuntary treatment as required by Part 1 (commencing with Section 5000) and Part 1.5 (commencing with Section 5585).

(3) That the county shall comply with all requirements necessary for Medi-Cal reimbursement for mental health treatment services and case management programs provided to Medi-Cal eligible individuals, including, but not limited to, the provisions set forth in Chapter 3 (commencing with Section 5700), and that the county shall submit cost reports and other data to the department in the form and manner determined by the State Department of Health Care Services.

(4) That the local mental health advisory board has reviewed and approved procedures ensuring citizen and professional involvement at all stages of the planning process pursuant to Section 5604.2.

(5) That the county shall comply with all provisions and requirements in law pertaining to patient rights.

(6) That the county shall comply with all requirements in federal law and regulation, and all agreements, certifications, assurances, and policy letters, pertaining to federally funded mental health programs, including, but not limited to, the Projects for Assistance in Transition from Homelessness grant and Community Mental Health Services Block Grant programs.

(7) That the county shall provide all data and information set forth in Sections 5610 and 5664.

(8) That the county, if it elects to provide the services described in Chapter 2.5 (commencing with Section 5670), shall comply with guidelines established for program initiatives outlined in that chapter.

(9) That the county shall comply with all applicable laws and regulations for all services delivered, including all laws, regulations, and guidelines of the Mental Health Services Act.

(10) The State Department of Health Care Services' ability to monitor the county's five-year program and expenditure plan and annual update pursuant to Section 5847.

(11) Other information determined to be necessary by the director, to the extent this requirement does not substantially increase county costs.

(c) The State Department of Health Care Services may include contract provisions for other federal grants or county mental health programs in this performance contract.

SEC. 2. Section 5846.5 is added to the Welfare and Institutions Code, to read:

5846.5. (a) This section shall be known, and may be cited as, the Mental Health Services Act (MHSA) Outcomes and Accountability Review Act of 2022.

(b) The California Health and Human Services Agency shall establish, by July 1, 2024, the California MHSA Outcomes and Accountability Review (MHSA-OAR) to facilitate a local accountability system that fosters continuous quality improvement in county programs funded by the MHSA and in the collection and dissemination by the department of best practices in service delivery. The MHSA-OAR shall cover MHSA-funded services provided to current and former recipients and shall include the programmatic elements that each county offers as part of its MHSA service array, as well as any local program components, and shall

consist of performance indicators, a county MHSA self-assessment process, and a county MHSA system improvement plan.

(c) (1) (A) On or before October 1, 2023, the agency shall convene a workgroup comprised of representatives from the State Department of Health Care Services, the Mental Health Services Oversight and Accountability Commission, county behavioral health agencies, legislative staff, interested behavioral health advocacy and research organizations, current and former MHSA service recipients, organizations that represent county behavioral health agencies and county boards of supervisors, researchers, people with lived experience, county behavioral health agency partners, and any other entities or individuals that the department deems necessary. The workgroup shall establish a workplan by which the MHSA-OAR shall be conducted, including a process for qualitative peer reviews of counties' MHSA services.

(B) The department shall report annually to the Subcommittee on Health and Human Services of the Senate Committee on Budget and Fiscal Review and the Subcommittee on Health and Human Services of the Assembly Committee on Budget during the budget process with an update on the schedule for development of, and future changes to, the MHSA-OAR.

(2) At a minimum, in establishing the work plan, the workgroup shall consider existing MHSA performance indicators being measured, additional, alternative, or additional and alternative process and outcome indicators to be measured, development of uniform elements of the county MHSA self-assessment and the county MHSA system improvement plans, timelines for implementation, recommendations for reducing the existing MHSA services data reporting burden, recommendations for financial incentives to counties for achievement on performance measures, and an analysis of the county and state workload associated with implementation of the requirements of this section.

(3) The workgroup shall develop the uniform elements for the county MHSA system improvement plans required in paragraph (3) of subdivision (d). The agency, in consultation with the workgroup, shall develop the uniform elements of the updates to those plans, as required pursuant to subparagraph (D) of paragraph (3) of subdivision (d).

(d) The MHSA-OAR shall consist of the following three components: performance indicators, a county MHSA self-assessment, and a county MHSA system improvement plan.

(1) (A) The MHSA-OAR performance indicators shall be consistent with programmatic goals for the MHSA, and shall include both process and outcome measures. These measures shall be established in order to provide baseline and ongoing information about how the state and counties are performing over time and to inform and guide each county behavioral health agency's MHSA self-assessment and MHSA system improvement plan.

(i) Process measures shall include measures of participant engagement, MHSA service delivery, and participation. Specific process measures shall be established by the agency, in consultation with the workgroup, and may include measures of engagement as shown by improvement in program participation, timeliness of service provision, rates of utilization of program components, and referrals and utilization of services.

(ii) Outcome measures shall include *measures of the reduction of the negative outcomes described in subdivision (d) of Section 5840, which address prevention and early intervention strategies for mental illness, and* measures of employment, educational attainment, program exits, and program reentries, adherence to treatment plans, attainment of housing, reduction in contacts with law enforcement, reduction in hospitalizations, and may include other indicators of well-being as determined by the agency, in consultation with the workgroup.

(B) Performance indicator data available in existing county data systems shall be collected by counties and provided to the agency, and performance indicator data available in existing state agency data systems shall be collected by the agency and provided to the counties. These data shall be reported in a manner, and on a schedule, determined by the agency, in consultation with the workgroup, but no less frequently than semiannually.

(C) (i) During the first five-year MHSA-OAR cycle, performance indicator data reported by each county, shall be used to establish both county and statewide baselines for each of the process measures. After the first review cycle, the agency shall, in consultation with the workgroup, establish standard target thresholds for each of the process measures established by the workgroup.

(ii) The agency, in consultation with the workgroup, shall develop a process for resolving any disputes regarding the establishment of standard process thresholds pursuant to clause (i).

(D) For subsequent reviews, and based upon availability of additional data through interagency data-sharing agreements, the workgroup shall convene, as necessary, to consider whether to establish additional performance indicators that support the programmatic goals for the MHSA. Additional performance indicators established shall also be subject to the process described in subparagraph (C) and shall include consideration of when data on the additional performance indicators would be available for reporting, if not already available.

(E) If, during subsequent reviews, there is sufficient reason to establish statewide performance standards for one or more outcome measures, the agency may, in consultation with the workgroup, establish those standards for each of the agreed-upon outcome measures.

(2) (A) The county MHSA self-assessment component of the MHSA-OAR, as established by the workgroup, shall require the county behavioral health agencies to assess their performance on the established process and outcome measures that comprise the performance indicators, identify the strengths and weaknesses in their current practice and resource deployment, identify and describe how local operational decisions and systemic factors affect program outcomes, and consider areas of focus that may be included in the county MHSA system improvement plan, as described in paragraph (3). The county MHSA self-assessment process shall be designed to identify areas of best practices for replication and for system improvement at the county level, and shall guide the development of the county MHSA system improvement plan.

(B) (i) The county MHSA self-assessment process shall be completed every five years by the county, in consultation and collaboration with local stakeholders, and submitted to the agency.

(ii) Local stakeholders shall include county behavioral health directors, supervisors, and caseworkers; current and former MHSA service recipients; and county behavioral health agency partners. To the extent possible and relevant, local stakeholders shall also include representatives of tribal organizations and the local

behavioral health board. Additional specific county behavioral health agency partners shall be determined by the county and may include, but are not limited to, adult education providers, providers of services for survivors of domestic violence, the local housing continuum of care, county human service departments, county drug and alcohol programs, community-based service providers, and organizations that represent MHSA recipients, as appropriate.

(3) (A) (i) The county MHSA system improvement plan shall, at a minimum, describe how the county will improve its MHSA program performance in strategic focus areas based upon information learned through the county MHSA self-assessment process. The county MHSA system improvement plan shall include the uniform elements established by the workgroup pursuant to paragraph (3) of subdivision (c).

(ii) The county MHSA system improvement plan shall be completed every five years by the county, approved in public session by the county's board of supervisors or, as applicable, chief elected official, and be submitted to the agency.

(B) The county MHSA system improvement plan shall include an MHSA services peer review element, the purpose of which shall be to provide additional insight and technical assistance by peer counties.

(C) Strategic focus areas for the county MHSA system improvement plan shall be determined by the county, informed by the county MHSA self-assessment process, as described in paragraph (2), with targets for improvement based upon what is learned in the county MHSA self-assessment process.

(D) The county behavioral health agency shall complete an annual progress report on the status of its system improvement plan and shall submit these reports to the agency.

(e) (1) The agency shall receive, review, and, based on its determination of whether the county MHSA system improvement plan meets the required elements, certify as complete all county-submitted performance indicator data, county MHSA self-assessments, county MHSA system improvement plans, and annual progress reports, and shall identify and promote the replication of best practices in MHSA service delivery to achieve the established process and outcome measures.

(2) The agency shall monitor, on an ongoing basis, county performance on the measures developed pursuant to subdivision (d).

(3) The agency shall make data collected pursuant to this section publicly available on its internet website.

(4) The agency shall, on an annual basis, submit a report to the Legislature that summarizes county performance on the established process and outcome measures during the reporting period, analyzes county performance trends over time, and makes findings and recommendations for common MHSA services improvements identified in the county MHSA self-assessments and county MHSA system improvement plans, including information on common statutory, regulatory, or fiscal barriers identified as inhibiting system improvements and any recommendations to overcome those barriers.

(5) (A) The agency shall provide or facilitate the provision of technical assistance to county behavioral health agencies as part of the peer review that supports the county's selected areas for improvement, as described in its system improvement plan.

(B) If, in the course of its review of county MHSA system improvement plans and annual updates, or, in the course of its review of regularly submitted performance indicator data, the agency determines that a county is consistently failing to make progress toward its strategic focus areas for improvement or is consistently failing to meet the process measure standard target thresholds established pursuant to subparagraph (C) of paragraph (1) of subdivision (d), the agency shall engage the county in a process of targeted technical assistance and support to address and resolve the identified shortcomings.

(f) A county shall execute and fulfill components of its MHSA system improvement plan that can be accomplished with existing resources.

SEC. 3. Section 5847 of the Welfare and Institutions Code is amended to read:

5847. (a) Each county mental health program shall prepare and submit a five-year program and expenditure plan, and annual updates, adopted by the county board of supervisors, to the Mental Health Services Oversight and Accountability Commission and the State Department of Health Care Services within 30 days after adoption.

(b) The five-year program and expenditure plan shall be based on available unspent funds and estimated revenue allocations provided by the state and in accordance with established stakeholder engagement and planning requirements, as required in Section 5848. The five-year program and expenditure plan and annual updates shall include all of the following:

(1) A program for prevention and early intervention in accordance with Part 3.6 (commencing with Section 5840).

(2) A program for services to children in accordance with Part 4 (commencing with Section 5850), to include a program pursuant to Chapter 4 (commencing with Section 18250) of Part 6 of Division 9 or provide substantial evidence that it is not feasible to establish a wraparound program in that county.

(3) A program for services to adults and seniors in accordance with Part 3 (commencing with Section 5800).

(4) A program for innovations in accordance with Part 3.2 (commencing with Section 5830).

(5) A program for technological needs and capital facilities needed to provide services pursuant to Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850). All plans for proposed facilities with restrictive settings shall demonstrate that the needs of the people to be served cannot be met in a less restrictive or more integrated setting, such as permanent supportive housing.

(6) Identification of shortages in personnel to provide services pursuant to the above programs and the additional assistance needed from the education and training programs established pursuant to Part 3.1 (commencing with Section 5820).

(7) Establishment and maintenance of a prudent reserve to ensure the county program will continue to be able to serve children, adults, and seniors that it is currently serving pursuant to Part 3 (commencing with Section 5800), the Adult and Older Adult Mental Health System of Care Act, Part 3.6 (commencing with Section 5840), Prevention and Early Intervention Programs, and Part 4 (commencing with Section 5850), the Children’s Mental Health Services Act, during years in which revenues for the Mental Health Services Fund are below recent averages adjusted by changes in the state population and the California Consumer Price Index.

(8) Certification by the county behavioral health director, which ensures that the county has complied with all pertinent regulations, laws, and statutes of the Mental Health Services Act, including stakeholder participation and nonsupplantation requirements.

(9) Certification by the county behavioral health director and by the county auditor-controller that the county has complied with any fiscal accountability requirements as directed by the State Department of Health Care Services, and that all expenditures are consistent with the requirements of the Mental Health Services Act.

(c) The programs established pursuant to paragraphs (2) and (3) of subdivision (b) shall include services to address the needs of transition age youth 16 to 25 years of age. In implementing this subdivision, county mental health programs shall consider the needs of transition age foster youth.

(d) Each year, the State Department of Health Care Services shall inform the County Behavioral Health Directors Association of California and the Mental Health Services Oversight and Accountability Commission of the methodology used for revenue allocation to the counties.

(e) Each county mental health program shall prepare expenditure plans pursuant to Part 3 (commencing with Section 5800) for adults and seniors, Part 3.2 (commencing with Section 5830) for innovative programs, Part 3.6 (commencing with Section 5840) for prevention and early intervention programs, and Part 4 (commencing with Section 5850) for services for children, and updates to the plans developed pursuant to this section. Each expenditure update shall indicate the number of children, adults, and seniors to be served pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850), and the cost per person. The expenditure update shall include utilization of unspent funds allocated in the previous year and the proposed expenditure for the same purpose.

(f) A county mental health program shall include an allocation of funds from a reserve established pursuant to paragraph (7) of subdivision (b) for services pursuant to paragraphs (2) and (3) of subdivision (b) in years in which the allocation of funds for services pursuant to subdivision (e) are not adequate to continue to serve the same number of individuals as the county had been serving in the previous fiscal year.

(g) The department shall post on its internet website the five-year program and expenditure plans submitted by every county pursuant to subdivision (a) in a timely manner.

(h) (1) Notwithstanding subdivision (a), a county that is unable to complete and submit a three-year program and expenditure plan or annual update for the 2020–21 or 2021–22 fiscal years due to the COVID-19 Public Health Emergency may extend the effective timeframe of its currently approved three-year plan or annual update to include the 2020–21 and 2021–22 fiscal years. The county shall submit a three-year program and expenditure plan or annual update to the Mental Health Services Oversight and Accountability Commission and the State Department of Health Care Services by July 1, 2022.

(2) For purposes of this subdivision, "COVID-19 Public Health Emergency" means the federal Public Health Emergency declaration made pursuant to Section 247d of Title 42 of the United States Code on January 30, 2020, entitled "Determination that a Public Health Emergency Exists Nationwide as the Result of the 2019 Novel Coronavirus," and any renewal of that declaration.

(i) Notwithstanding paragraph (7) of subdivision (b) and subdivision (f), a county may, during the 2020–21 and 2021–22 fiscal years, use funds from its prudent reserve for prevention and early intervention programs created in accordance with Part 3.6 (commencing with Section 5840) and for services to persons with severe mental illnesses pursuant to Part 4 (commencing with Section 5850) for the children's system of care and Part 3 (commencing with Section 5800) for the adult and older adult system of care. These services may include housing assistance, as defined in Section 5892.5, to the target population specified in Section 5600.3.

(j) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, may implement, interpret, or make specific subdivisions (h) and (i) of this section and subdivision (i) of Section 5892 by means of all-county letters or other similar instructions.

SEC. 4. Section 5848 of the Welfare and Institutions Code is amended to read:

5848. (a) Each five-year program and expenditure plan and update shall be developed with local stakeholders, including adults

and seniors with severe mental illness, families of children, adults, and seniors with severe mental illness, providers of services, law enforcement agencies, education, social services agencies, veterans, representatives from veterans organizations, providers of alcohol and drug services, health care organizations, and other important interests. Counties shall demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation, and budget allocations. A draft plan and update shall be prepared and circulated for review and comment for at least 30 days to representatives of stakeholder interests and any interested party who has requested a copy of the draft plans.

(b) The mental health board established pursuant to Section 5604 shall conduct a public hearing on the draft five-year program and expenditure plan and annual updates at the close of the 30-day comment period required by subdivision (a). Each adopted five-year program and expenditure plan and update shall include any substantive written recommendations for revisions. The adopted five-year program and expenditure plan or update shall summarize and analyze the recommended revisions. The mental health board shall review the adopted plan or update and make recommendations to the local mental health agency or local behavioral health agency, as applicable, for revisions. The local mental health agency or local behavioral health agency, as applicable, shall provide an annual report of written explanations to the local governing body and the State Department of Health Care Services for any substantive recommendations made by the local mental health board that are not included in the final plan or update.

(c) The plans shall include reports on the achievement of performance outcomes for services pursuant to Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) funded by the Mental Health Services Fund and established jointly by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, in collaboration with the County Behavioral Health Directors Association of California.

(d) Mental health services provided pursuant to Part 3 (commencing with Section 5800) and Part 4 (commencing with

Section 5850) shall be included in the review of program performance by the California Behavioral Health Planning Council required by paragraph (2) of subdivision (c) of Section 5772 and in the local mental health board's review and comment on the performance outcome data required by paragraph (7) of subdivision (a) of Section 5604.2.

(e) The department shall annually post on its internet website a summary of the performance outcomes reports submitted by counties if clearly and separately identified by counties as the achievement of performance outcomes pursuant to subdivision (c).

(f) For purposes of this section, "substantive recommendations made by the local mental health board" means any recommendation that is brought before the board and approved by a majority vote of the membership present at a public hearing of the local mental health board that has established its quorum.

SEC. 5. Section 5891 of the Welfare and Institutions Code is amended to read:

5891. (a) The funding established pursuant to this act shall be utilized to expand mental health services. Except as provided in subdivision (j) of Section 5892 due to the state's fiscal crisis, these funds shall not be used to supplant existing state or county funds utilized to provide mental health services. The state shall continue to provide financial support for mental health programs with not less than the same entitlements, amounts of allocations from the General Fund or from the Local Revenue Fund 2011 in the State Treasury, and formula distributions of dedicated funds as provided in the last fiscal year which ended prior to the effective date of this act. The state shall not make any change to the structure of financing mental health services, which increases a county's share of costs or financial risk for mental health services unless the state includes adequate funding to fully compensate for the increased costs or financial risk. These funds shall only be used to pay for the programs authorized in Sections 5890 and 5892. These funds may not be used to pay for any other program. These funds may not be loaned to the General Fund or any other fund of the state, or a county general fund or any other county fund for any purpose other than those authorized by Sections 5890 and 5892.

(b) (1) Notwithstanding subdivision (a), and except as provided in paragraph (2), the Controller may use the funds created pursuant

to this part for loans to the General Fund as provided in Sections 16310 and 16381 of the Government Code. Any such loan shall be repaid from the General Fund with interest computed at 110 percent of the Pooled Money Investment Account rate, with interest commencing to accrue on the date the loan is made from the fund. This subdivision does not authorize any transfer that would interfere with the carrying out of the object for which these funds were created.

(2) This subdivision does not apply to the Supportive Housing Program Subaccount created by subdivision (f) of Section 5890 or any moneys paid by the California Health Facilities Financing Authority to the Department of Housing and Community Development as a service fee pursuant to a service contract authorized by Section 5849.35.

(c) Commencing July 1, 2012, on or before the 15th day of each month, pursuant to a methodology provided by the State Department of Health Care Services, the Controller shall distribute to each Local Mental Health Service Fund established by counties pursuant to subdivision (f) of Section 5892, all unexpended and unreserved funds on deposit as of the last day of the prior month in the Mental Health Services Fund, established pursuant to Section 5890, for the provision of programs and other related activities set forth in Part 3 (commencing with Section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), Part 3.9 (commencing with Section 5849.1), and Part 4 (commencing with Section 5850).

(d) Counties shall base their expenditures on the county mental health program's five-year program and expenditure plan or annual update, as required by Section 5847. This subdivision shall not affect subdivision (a) or (b).

SEC. 6. Section 5891.5 of the Welfare and Institutions Code is amended to read:

5891.5. (a) (1) The programs in paragraphs (1) to (3), inclusive, and paragraph (5) of subdivision (a) of Section 5890 may include substance use disorder treatment for children, adults, and older adults with cooccurring mental health and substance use disorders who are eligible to receive mental health services pursuant to those programs. The MHSA includes persons with a serious mental disorder and a diagnosis of substance abuse in the definition of persons who are eligible for MHSA services in

Sections 5878.2 and 5813.5, which reference paragraph (2) of subdivision (b) of Section 5600.3.

(2) Provision of substance use disorder services pursuant to this section shall comply with all applicable requirements of the Mental Health Services Act.

(3) Treatment of cooccurring mental health and substance use disorders shall be identified in a county's five-year program and expenditure plan or annual update, as required by Section 5847.

(b) (1) When a person being treated for cooccurring mental health and substance use disorders pursuant to subdivision (a) is determined to not need the mental health services that are eligible for funding pursuant to the MHSA, the county shall refer the person receiving treatment to substance use disorder treatment services in a timely manner.

(2) Funding established pursuant to the MHSA may be used to assess whether a person has cooccurring mental health and substance use disorders and to treat a person who is preliminarily assessed to have cooccurring mental health and substance use disorders, even when the person is later determined not to be eligible for services provided with funding established pursuant to the MHSA.

(c) A county shall report to the department, in a form and manner determined by the department, both of the following:

(1) The number of people assessed for cooccurring mental health and substance use disorders.

(2) The number of people assessed for cooccurring mental health and substance use disorders who were ultimately determined to have only a substance use disorder without another cooccurring mental health condition.

(d) The department shall by January 1, 2022, and each January 1 thereafter, publish on its internet website a report summarizing county activities pursuant to this section for the prior fiscal year. Data shall be reported statewide and by county or groupings of counties, as necessary to protect the private health information of persons assessed.

(e) (1) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of plan or county letters, information notices,

plan or provider bulletins, or other similar instructions, without taking any further regulatory action.

(2) On or before July 1, 2025, the department shall adopt regulations necessary to implement this section in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

SEC. 7. Section 5892 of the Welfare and Institutions Code is amended to read:

5892. (a) In order to promote efficient implementation of this act, the county shall use funds distributed from the Mental Health Services Fund as follows:

(1) In the 2005–06, 2006–07, and 2007–08 fiscal years, 10 percent shall be placed in a trust fund to be expended for education and training programs pursuant to Part 3.1 (commencing with Section 5820).

(2) In the 2005–06, 2006–07, and 2007–08 fiscal years, 10 percent for capital facilities and technological needs shall be distributed to counties in accordance with a formula developed in consultation with the County Behavioral Health Directors Association of California to implement plans developed pursuant to Section 5847.

(3) Twenty percent of funds distributed to the counties pursuant to subdivision (c) of Section 5891 shall be used for prevention and early intervention programs in accordance with Part 3.6 (commencing with Section 5840). *Commencing with the 2024–25 fiscal year, the percentage requirement in this paragraph shall not apply.*

(4) The expenditure for prevention and early intervention may be increased in any county in which the department determines that the increase will decrease the need and cost for additional services to persons with severe mental illness in that county by an amount at least commensurate with the proposed increase.

(5) The balance of funds shall be distributed to county mental health programs for services to persons with severe mental illnesses pursuant to Part 4 (commencing with Section 5850) for the children's system of care and Part 3 (commencing with Section 5800) for the adult and older adult system of care. These services may include housing assistance, as defined in Section 5892.5, to the target population specified in Section 5600.3.

(6) Five percent of the total funding for each county mental health program for Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850), shall be utilized for innovative programs in accordance with Sections 5830, 5847, and 5848. *Commencing with the 2024–25 fiscal year, the percentage requirement in this paragraph shall not apply.*

(b) (1) In any fiscal year after the 2007–08 fiscal year, programs for services pursuant to Part 3 (commencing with Section 5800) and Part 4 (commencing with Section 5850) may include funds for technological needs and capital facilities, human resource needs, and a prudent reserve to ensure services do not have to be significantly reduced in years in which revenues are below the average of previous years. The total allocation for purposes authorized by this subdivision shall not exceed 20 percent of the average amount of funds allocated to that county for the previous five fiscal years pursuant to this section.

(2) A county shall calculate an amount it establishes as the prudent reserve for its Local Mental Health Services Fund, not to exceed 33 percent of the average community services and support revenue received for the fund in the preceding five years. The county shall reassess the maximum amount of this reserve every five years and certify the reassessment as part of the five-year program and expenditure plan required pursuant to Section 5847.

(3) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the State Department of Health Care Services may allow counties to determine the percentage of funds to allocate across programs created pursuant to Part 4 (commencing with Section 5850) for the children's system of care and Part 3 (commencing with Section 5800) for the adult and older adult system of care for the 2020–21 and 2021–22 fiscal years by means of all-county letters or other similar instructions without taking further regulatory action.

(c) The allocations pursuant to subdivisions (a) and (b) shall include funding for annual planning costs pursuant to Section 5848. The total of these costs shall not exceed 5 percent of the total of annual revenues received for the fund. The planning costs shall include funds for county mental health programs to pay for the costs of consumers, family members, and other stakeholders to participate in the planning process and for the planning and

implementation required for private provider contracts to be significantly expanded to provide additional services pursuant to Part 3 (commencing with Section 5800) and Part 4 (commencing with Section 5850).

(d) Prior to making the allocations pursuant to subdivisions (a), (b), and (c), funds shall be reserved for the costs for the State Department of Health Care Services, the California Behavioral Health Planning Council, the Office of Statewide Health Planning and Development, the Mental Health Services Oversight and Accountability Commission, the State Department of Public Health, and any other state agency to implement all duties pursuant to the programs set forth in this section. These costs shall not exceed 5 percent of the total of annual revenues received for the fund. The administrative costs shall include funds to assist consumers and family members to ensure the appropriate state and county agencies give full consideration to concerns about quality, structure of service delivery, or access to services. The amounts allocated for administration shall include amounts sufficient to ensure adequate research and evaluation regarding the effectiveness of services being provided and achievement of the outcome measures set forth in Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850). The amount of funds available for the purposes of this subdivision in any fiscal year is subject to appropriation in the annual Budget Act.

(e) In the 2004–05 fiscal year, funds shall be allocated as follows:

(1) Forty-five percent for education and training pursuant to Part 3.1 (commencing with Section 5820).

(2) Forty-five percent for capital facilities and technology needs in the manner specified by paragraph (2) of subdivision (a).

(3) Five percent for local planning in the manner specified in subdivision (c).

(4) Five percent for state implementation in the manner specified in subdivision (d).

(f) Each county shall place all funds received from the State Mental Health Services Fund in a Local Mental Health Services Fund. The Local Mental Health Services Fund balance shall be invested consistent with other county funds and the interest earned on the investments shall be transferred into the fund. The earnings

on investment of these funds shall be available for distribution from the fund in future fiscal years.

(g) All expenditures for county mental health programs shall be consistent with a currently approved plan or update pursuant to Section 5847.

(h) (1) Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county that have not been spent for their authorized purpose within three years, and the interest accruing on those funds, shall revert to the state to be deposited into the Reversion Account, hereby established in the fund, and available for other counties in future years, provided, however, that funds, including interest accrued on those funds, for capital facilities, technological needs, or education and training may be retained for up to 10 years before reverting to the Reversion Account.

(2) (A) If a county receives approval from the Mental Health Services Oversight and Accountability Commission of a plan for innovative programs, pursuant to subdivision (e) of Section 5830, the county's funds identified in that plan for innovative programs shall not revert to the state pursuant to paragraph (1) so long as they are encumbered under the terms of the approved project plan, including any subsequent amendments approved by the commission, or until three years after the date of approval, whichever is later.

(B) Subparagraph (A) applies to all plans for innovative programs that have received commission approval and are in the process at the time of enactment of the act that added this subparagraph, and to all plans that receive commission approval thereafter.

(3) Notwithstanding paragraph (1), funds allocated to a county with a population of less than 200,000 that have not been spent for their authorized purpose within five years shall revert to the state as described in paragraph (1).

(4) (A) Notwithstanding paragraphs (1) and (2), if a county with a population of less than 200,000 receives approval from the Mental Health Services Oversight and Accountability Commission of a plan for innovative programs, pursuant to subdivision (e) of Section 5830, the county's funds identified in that plan for innovative programs shall not revert to the state pursuant to paragraph (1) so long as they are encumbered under the terms of

the approved project plan, including any subsequent amendments approved by the commission, or until five years after the date of approval, whichever is later.

(B) Subparagraph (A) applies to all plans for innovative programs that have received commission approval and are in the process at the time of enactment of the act that added this subparagraph, and to all plans that receive commission approval thereafter.

(i) Notwithstanding subdivision (h) and Section 5892.1, unspent funds allocated to a county, and interest accruing on those funds, which are subject to reversion as of July 1, 2019, and July 1, 2020, shall be subject to reversion on July 1, 2021.

(j) If there are revenues available in the fund after the Mental Health Services Oversight and Accountability Commission has determined there are prudent reserves and no unmet needs for any of the programs funded pursuant to this section, including all purposes of the Prevention and Early Intervention Program, the commission shall develop a plan for expenditures of these revenues to further the purposes of this act and the Legislature may appropriate these funds for any purpose consistent with the commission's adopted plan that furthers the purposes of this act.

SEC. 8. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

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SENATE BILL No. 1035

Introduced by Senator Eggman

February 15, 2022

An act to amend Section 5346 of the Welfare and Institutions Code, relating to mental health.

LEGISLATIVE COUNSEL'S DIGEST

SB 1035, as introduced, Eggman. Mental health services: assisted outpatient treatment.

The Assisted Outpatient Treatment Demonstration Project Act of 2002, known as Laura's Law, as of July 1, 2021, requires a county or group of counties to provide mental health programs, as specified, unless a county or group of counties opts out by a resolution passed by the governing body stating the reasons for opting out and any facts or circumstances relied on in making that decision. Existing law authorizes participating counties to pay for the services provided from moneys distributed to the counties from various continuously appropriated funds, including the Mental Health Services Fund, when included in a county plan, as specified. Existing law authorizes a court to order a person who is the subject of a petition filed pursuant to specified requirements to obtain assisted outpatient treatment if the court finds, by clear and convincing evidence, that various conditions are met. Existing law requires that an order issued pursuant to those provisions state the categories of assisted outpatient treatment that the person who is the subject of the petition is to receive.

This bill would specify that court order also include medication when included in the treatment plan.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 5346 of the Welfare and Institutions Code is amended to read:

5346. (a) In any county or group of counties where services are available as provided in Section 5348, a court may order a person who is the subject of a petition filed pursuant to this section to obtain assisted outpatient treatment if the court finds, by clear and convincing evidence, that the facts stated in the verified petition filed in accordance with this section are true and establish that all of the requisite criteria set forth in this section are met, including, but not limited to, each of the following:

(1) The person is 18 years of age or older.

(2) The person is suffering from a mental illness as defined in paragraphs (2) and (3) of subdivision (b) of Section 5600.3.

(3) There has been a clinical determination that, in view of the person's treatment history and current behavior, at least one of the following is true:

(A) The person is unlikely to survive safely in the community without supervision and the person's condition is substantially deteriorating.

(B) The person is in need of assisted outpatient treatment in order to prevent a relapse or deterioration that would be likely to result in grave disability or serious harm to the person or to others, as defined in Section 5150.

(4) The person has a history of lack of compliance with treatment for the person's mental illness, in that at least one of the following is true:

(A) The person's mental illness has, at least twice within the last 36 months, been a substantial factor in necessitating hospitalization, or receipt of services in a forensic or other mental health unit of a state correctional facility or local correctional facility, not including any period during which the person was hospitalized or incarcerated immediately preceding the filing of the petition.

(B) The person's mental illness has resulted in one or more acts of serious and violent behavior toward themselves or another, or threats, or attempts to cause serious physical harm to themselves or another within the last 48 months, not including any period in

which the person was hospitalized or incarcerated immediately preceding the filing of the petition.

(5) The person has been offered an opportunity to participate in a treatment plan by the director of the local mental health department, or the director's designee, provided the treatment plan includes all of the services described in Section 5348, and the person continues to fail to engage in treatment.

(6) Participation in the assisted outpatient treatment program would be the least restrictive placement necessary to ensure the person's recovery and stability.

(7) It is likely that the person will benefit from assisted outpatient treatment.

(b) (1) A petition for an order authorizing assisted outpatient treatment may be filed by the county behavioral health director, or the director's designee, in the superior court in the county in which the person who is the subject of the petition is present or reasonably believed to be present.

(2) A request may be made only by any of the following persons to the county mental health department for the filing of a petition to obtain an order authorizing assisted outpatient treatment:

(A) A person 18 years of age or older with whom the person who is the subject of the petition resides.

(B) A person who is the parent, spouse, or sibling or child 18 years of age or older of the person who is the subject of the petition.

(C) The director of a public or private agency, treatment facility, charitable organization, or licensed residential care facility providing mental health services to the person who is the subject of the petition in whose institution the subject of the petition resides.

(D) The director of a hospital in which the person who is the subject of the petition is hospitalized.

(E) A licensed mental health treatment provider who is either supervising the treatment of, or treating for a mental illness, the person who is the subject of the petition.

(F) A peace officer, parole officer, or probation officer assigned to supervise the person who is the subject of the petition.

(G) A judge of a superior court before whom the person who is the subject of the petition appears.

(3) Upon receiving a request pursuant to paragraph (2), the county behavioral health director shall conduct an investigation

into the appropriateness of filing of the petition. The director shall file the petition only if the director determines that there is a reasonable likelihood that all the necessary elements to sustain the petition can be proven in a court of law by clear and convincing evidence.

(4) The petition shall state all of the following:

(A) Each of the criteria for assisted outpatient treatment as set forth in subdivision (a).

(B) Facts that support the petitioner's belief that the person who is the subject of the petition meets each criterion, provided that the hearing on the petition shall be limited to the stated facts in the verified petition, and the petition contains all the grounds on which the petition is based, in order to ensure adequate notice to the person who is the subject of the petition and that person's counsel.

(C) That the person who is the subject of the petition is present, or is reasonably believed to be present, within the county where the petition is filed.

(D) That the person who is the subject of the petition has the right to be represented by counsel in all stages of the proceeding under the petition, in accordance with subdivision (c).

(5) (A) The petition shall be accompanied by an affidavit of a licensed mental health treatment provider designated by the local mental health director who shall state, if applicable, either of the following:

(i) That the licensed mental health treatment provider has personally examined the person who is the subject of the petition no more than 10 days prior to the submission of the petition, the facts and reasons why the person who is the subject of the petition meets the criteria in subdivision (a), that the licensed mental health treatment provider recommends assisted outpatient treatment for the person who is the subject of the petition, and that the licensed mental health treatment provider is willing and able to testify at the hearing on the petition.

(ii) That, no more than 10 days prior to the filing of the petition, the licensed mental health treatment provider, or the provider's designee, has made appropriate attempts to elicit the cooperation of the person who is the subject of the petition, but has not been successful in persuading that person to submit to an examination, that the licensed mental health treatment provider has reason to

believe that the person who is the subject of the petition meets the criteria for assisted outpatient treatment, and that the licensed mental health treatment provider is willing and able to examine the person who is the subject of the petition and testify at the hearing on the petition.

(B) An examining mental health professional in their affidavit to the court shall address the issue of whether the defendant has capacity to give informed consent regarding psychotropic medication.

(c) The person who is the subject of the petition shall have the right to be represented by counsel at all stages of a proceeding commenced under this section. If the person so elects, the court shall immediately appoint the public defender or other attorney to assist the person in all stages of the proceedings. The person shall pay the cost of the legal services if able to do so.

(d) (1) Upon receipt by the court of a petition submitted pursuant to subdivision (b), the court shall fix the date for a hearing at a time not later than five days from the date the petition is received by the court, excluding Saturdays, Sundays, and holidays. The petitioner shall promptly cause service of a copy of the petition, together with written notice of the hearing date, to be made personally on the person who is the subject of the petition, and shall send a copy of the petition and notice to the county office of patient rights, and to the current health care provider appointed for the person who is the subject of the petition, if the provider is known to the petitioner. Continuances shall be permitted only for good cause shown. In granting continuances, the court shall consider the need for further examination by a physician or the potential need to provide expeditiously assisted outpatient treatment. Upon the hearing date, or upon any other date or dates to which the proceeding may be continued, the court shall hear testimony. If it is deemed advisable by the court, and if the person who is the subject of the petition is available and has received notice pursuant to this section, the court may examine in or out of court the person who is the subject of the petition who is alleged to be in need of assisted outpatient treatment. If the person who is the subject of the petition does not appear at the hearing, and appropriate attempts to elicit the attendance of the person have failed, the court may conduct the hearing in the person’s absence. If the hearing is conducted without the person present, the court

shall set forth the factual basis for conducting the hearing without the person's presence. The person who is the subject of the petition shall maintain the right to appear before the court in person, but may appear by videoconferencing means if they choose to do so.

(2) The court shall not order assisted outpatient treatment unless an examining licensed mental health treatment provider, who has personally examined, and has reviewed the available treatment history of, the person who is the subject of the petition within the time period commencing 10 days before the filing of the petition, testifies at the hearing. An examining mental health professional may appear before the court by videoconferencing means.

(3) If the person who is the subject of the petition has refused to be examined by a licensed mental health treatment provider, the court may request that the person consent to an examination by a licensed mental health treatment provider appointed by the court. If the person who is the subject of the petition does not consent and the court finds reasonable cause to believe that the allegations in the petition are true, the court may order any person designated under Section 5150 to take into custody the person who is the subject of the petition and transport the person, or cause the person to be transported, to a hospital for examination by a licensed mental health treatment provider as soon as is practicable. Detention of the person who is the subject of the petition under the order may not exceed 72 hours. If the examination is performed by another licensed mental health treatment provider, the examining licensed mental health treatment provider may consult with the licensed mental health treatment provider whose affirmation or affidavit accompanied the petition regarding the issues of whether the allegations in the petition are true and whether the person meets the criteria for assisted outpatient treatment.

(4) The person who is the subject of the petition shall have all of the following rights:

(A) To adequate notice of the hearings to the person who is the subject of the petition, as well as to parties designated by the person who is the subject of the petition.

(B) To receive a copy of the court-ordered evaluation.

(C) To counsel. If the person has not retained counsel, the court shall appoint a public defender.

(D) To be informed of the right to judicial review by habeas corpus.

(E) To be present at the hearing unless the person waives the right to be present.

(F) To present evidence.

(G) To call witnesses on the person's behalf.

(H) To cross-examine witnesses.

(I) To appeal decisions, and to be informed of the right to appeal.

(5) (A) If after hearing all relevant evidence, the court finds that the person who is the subject of the petition does not meet the criteria for assisted outpatient treatment, the court shall dismiss the petition.

(B) If after hearing all relevant evidence, the court finds that the person who is the subject of the petition meets the criteria for assisted outpatient treatment, and there is no appropriate and feasible less restrictive alternative, the court may order the person who is the subject of the petition to receive assisted outpatient treatment for an initial period not to exceed six months. In fashioning the order, the court shall specify that the proposed treatment is the least restrictive treatment appropriate and feasible for the person who is the subject of the petition. The order shall state the categories of assisted outpatient treatment, *including medication when included in the treatment plan,* as set forth in Section 5348, that the person who is the subject of the petition is to receive, and the court may not order treatment that has not been recommended by the examining licensed mental health treatment provider and included in the written treatment plan for assisted outpatient treatment as required by subdivision (e). If the person has executed an advance health care directive pursuant to Chapter 2 (commencing with Section 4650) of Part 1 of Division 4.7 of the Probate Code, any directions included in the advance health care directive shall be considered in formulating the written treatment plan.

(6) If the person who is the subject of a petition for an order for assisted outpatient treatment pursuant to subparagraph (B) of paragraph (5) refuses to participate in the assisted outpatient treatment program, the court may order the person to meet with the assisted outpatient treatment team designated by the director of the assisted outpatient treatment program. The treatment team shall attempt to gain the person's cooperation with treatment ordered by the court. The person may be subject to a 72-hour hold pursuant to subdivision (f) only after the treatment team has

attempted to gain the person's cooperation with treatment ordered by the court, and has been unable to do so.

(e) Assisted outpatient treatment shall not be ordered unless the licensed mental health treatment provider recommending assisted outpatient treatment to the court has submitted to the court a written treatment plan that includes services as set forth in Section 5348, and the court finds, in consultation with the county behavioral health director, or the director's designee, all of the following:

(1) That the services are available from the county, or a provider approved by the county, for the duration of the court order.

(2) That the services have been offered to the person by the local director of mental health, or the director's designee, and the person has been given an opportunity to participate on a voluntary basis, and the person has failed to engage in, or has refused, treatment.

(3) That all of the elements of the petition required by this article have been met.

(4) That the treatment plan will be delivered to the county behavioral health director, or to the director's appropriate designee.

(f) If, in the clinical judgment of a licensed mental health treatment provider, the person who is the subject of the petition has failed or has refused to comply with the treatment ordered by the court, and, in the clinical judgment of the licensed mental health treatment provider, efforts were made to solicit compliance, and, in the clinical judgment of the licensed mental health treatment provider, the person may be in need of involuntary admission to a hospital for evaluation, the provider may request that persons designated under Section 5150 take into custody the person who is the subject of the petition and transport the person, or cause the person to be transported, to a hospital, to be held up to 72 hours for examination by a licensed mental health treatment provider to determine if the person is in need of treatment pursuant to Section 5150. Any continued involuntary retention in a hospital beyond the initial 72-hour period shall be pursuant to Section 5150. If at any time during the 72-hour period the person is determined not to meet the criteria of Section 5150, and does not agree to stay in the hospital as a voluntary patient, the person shall be released and any subsequent involuntary detention in a hospital shall be pursuant to Section 5150. Failure to comply with an order of assisted outpatient treatment alone may not be grounds for involuntary

civil commitment or a finding that the person who is the subject of the petition is in contempt of court.

(g) If the director of the assisted outpatient treatment program determines that the condition of the patient requires further assisted outpatient treatment, the director shall apply to the court, prior to the expiration of the period of the initial assisted outpatient treatment order, for an order authorizing continued assisted outpatient treatment for a period not to exceed 180 days from the date of the order. The procedures for obtaining an order pursuant to this subdivision shall be in accordance with subdivisions (a) to (f), inclusive. The period for further involuntary outpatient treatment authorized by a subsequent order under this subdivision may not exceed 180 days from the date of the order.

(h) At intervals of not less than 60 days during an assisted outpatient treatment order, the director of the outpatient treatment program shall file an affidavit with the court that ordered the outpatient treatment affirming that the person who is the subject of the order continues to meet the criteria for assisted outpatient treatment. At these times, the person who is the subject of the order shall have the right to a hearing on whether or not the person still meets the criteria for assisted outpatient treatment if they disagree with the director's affidavit. The burden of proof shall be on the director.

(i) During each 60-day period specified in subdivision (h), if the person who is the subject of the order believes that they are being wrongfully retained in the assisted outpatient treatment program against their wishes, the person may file a petition for a writ of habeas corpus, thus requiring the director of the assisted outpatient treatment program to prove that the person who is the subject of the order continues to meet the criteria for assisted outpatient treatment.

(j) A person ordered to undergo assisted outpatient treatment pursuant to this article, who was not present at the hearing at which the order was issued, may immediately petition the court for a writ of habeas corpus. Treatment under the order for assisted outpatient treatment may not commence until the resolution of that petition.

(k) This section shall become operative on July 1, 2021.

O

SENATE BILL No. 1154

Introduced by Senator Eggman

February 16, 2022

An act to add Article 7.1 (commencing with Section 1323.2) to Chapter 2 of Division 2 of the Health and Safety Code, relating to health and care facilities.

LEGISLATIVE COUNSEL'S DIGEST

SB 1154, as introduced, Eggman. Facilities for mental health or substance use disorder crisis: database.

Existing law generally requires the State Department of Public Health to license, inspect, and regulate health facilities, defined to include, among other types of health facilities, an acute psychiatric hospital. Existing law generally requires the State Department of Social Services to license, inspect, and regulate various types of care facilities, including, among others, a community crisis home. Existing law requires the State Department of Health Care Services to license and regulate facilities that provide residential nonmedical services to adults who are recovering from problems related to alcohol, drug, or alcohol and drug misuse or abuse, and who need alcohol, drug, or alcohol and drug recovery treatment or detoxification services.

This bill would require, by January 1, 2024, the State Department of Public Health, in consultation with the State Department of Health Care Services and the State Department of Social Services, and by conferring with specified stakeholders, to develop a real-time, internet-based database to collect, aggregate, and display information about beds in inpatient psychiatric facilities, crisis stabilization units, residential community mental health facilities, and licensed residential alcoholism or drug abuse recovery or treatment facilities in order to facilitate the identification and designation of facilities for the temporary treatment

of individuals in mental health or substance use disorder crisis. The bill would require the database to include a minimum of specific information, including the contact information for a facility's designated employee, and have the capacity to, among other things, enable searches to identify beds that are appropriate for the treatment of individuals in a mental health or substance use disorder crisis.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Article 7.1 (commencing with Section 1323.2) is added to Chapter 2 of Division 2 of the Health and Safety Code, to read:

Article 7.1. Availability of Inpatient Care for Mental Health or Substance Use Disorder Crisis

1323.2. (a) The State Department of Public Health, in consultation with the State Department of Health Care Services and the State Department of Social Services, shall develop a real-time, internet-based database to collect, aggregate, and display information about beds in inpatient psychiatric facilities, crisis stabilization units, residential community mental health facilities, and licensed residential alcoholism or drug abuse recovery or treatment facilities in order to facilitate the identification and designation of facilities for the temporary treatment of individuals in mental health or substance use disorder crisis. The database shall be operational by January 1, 2024.

(b) (1) Except as described in paragraph (3), the database created pursuant to subdivision (a) shall include, at a minimum, all of the following:

(A) The contact information for the facility's designated employee.

(B) The facility's license type.

(C) Whether the facility provides substance use disorder, mental health, or medical treatment.

(D) Whether the bed is secure for the treatment of a person who, as a result of a mental health disorder, is a danger to others, or to themselves, or gravely disabled, pursuant to Part 1 (commencing

with Section 5000) of Division 5 of the Welfare and Institutions Code.

(E) The types of diagnoses for which the bed is appropriate.

(F) The age ranges for which the bed is appropriate.

(G) Whether the bed is available.

(2) The database created pursuant to subdivision (a) shall have the capacity to do both of the following:

(A) Collect data.

(B) Enable searches to identify beds that are appropriate for the treatment of individuals in a mental health or substance use disorder crisis.

(3) The database shall not include any information relating to state hospitals under the jurisdiction of the State Department of State Hospitals.

(c) The department shall confer with stakeholders to inform the development of the database. Stakeholders represented in this process shall include, but not be limited to, the State Department of Health Care Services, State Department of Social Services, County Behavioral Health Directors Association of California, and organizations that have experience providing inpatient psychiatric care, organizations that have experience providing psychiatric crisis stabilization, organizations that have experience providing residential community mental health services, and organizations that have experience providing residential alcoholism or drug abuse recovery or treatment services. The department and stakeholders shall consider strategies for facility use of the database.

O

AMENDED IN SENATE MARCH 15, 2022

SENATE BILL No. 1227

Introduced by Senator Eggman

February 17, 2022

An act to amend ~~Section 5150~~ *Sections 5270.35 and 5270.55* of the Welfare and Institutions Code, relating to mental health.

LEGISLATIVE COUNSEL'S DIGEST

SB 1227, as amended, Eggman. Involuntary ~~commitment.~~ *commitment: intensive treatment.*

Existing law, the Lanterman-Petris-Short Act, provides for the involuntary commitment and treatment of persons with specified mental disorders for the protection of the persons committed. Under the act, when a person, as a result of a mental health disorder, is a danger to others, or to themselves, or gravely disabled, the person may, upon probable cause, be taken into custody and placed in a facility designated by the county and approved by the State Department of Health Care Services for up to 72 hours for evaluation and treatment. *Under existing law, if a person is detained for 72 hours under those provisions, and has received an evaluation, the person may be certified for not more than 14 days of intensive treatment, as specified. Existing law further authorizes a person to be certified for an additional period of not more than 30 days of intensive treatment if the person remains gravely disabled and is unwilling or unable to accept treatment voluntarily. Existing law requires the person to be released at the end of the 30 days, except under specified circumstances, including, but not limited to, when the patient is subject to a conservatorship petition filed pursuant to specified provisions. Existing law requires an evaluation to be made when a gravely disabled person may need to be detained*

beyond the initial 14-day period, as to whether the person is likely to qualify for appointment of a conservator, and, if so, requires that referral to be made, as specified.

This bill would authorize an additional 30-day period of treatment if the patient is still in need of intensive treatment and the certification for the additional 30-day treatment period has begun. The bill also would make conforming changes to the evaluation requirements for determining whether the patient is likely to qualify for appointment of a conservator.

~~This bill would make technical, nonsubstantive changes to those provisions.~~

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 5270.35 of the Welfare and Institutions Code is amended to read:

5270.35. (a) A certification pursuant to this article shall be for no more than 30 days of intensive treatment, *except as provided in paragraph (4) of subdivision (b),* and shall terminate only as soon as the psychiatrist directly responsible for the person's treatment believes, as a result of the psychiatrist's personal observations, that the person no longer meets the criteria for the certification, or is prepared to voluntarily accept treatment on a referral basis or to remain on a voluntary basis in the facility providing intensive treatment. However, in those situations in which both a psychiatrist and psychologist have personally evaluated or examined a person who is undergoing intensive treatment and there is a collaborative treatment relationship between the psychiatrist and the psychologist, either the psychiatrist or psychologist may authorize the release of the person but only after they have consulted with one another. In the event of a clinical or professional disagreement regarding the early release of a person who is undergoing intensive treatment, the person may not be released unless the facility's medical director overrules the decision of the psychiatrist or psychologist opposing the release. Both the psychiatrist and psychologist shall enter their findings, concerns, or objections into the person's medical record. If any other professional person who is authorized to release the person believes

the person should be released before 30 days have elapsed, and the psychiatrist directly responsible for the person's treatment objects, the matter shall be referred to the medical director of the facility for the final decision. However, if the medical director is not a psychiatrist, ~~he or she~~ *they* shall appoint a designee who is a psychiatrist. If the matter is referred, the person shall be released before 30 days have elapsed only if the psychiatrist believes, as a result of the psychiatrist's personal observations, that the person no longer meets the criteria for certification, or is prepared to voluntarily accept treatment on referral or to remain on a voluntary basis in the facility providing intensive treatment.

(b) Any person who has been certified for 30 days of intensive treatment under this article, shall be released at the end of 30 days unless one or more of the following is applicable:

(1) The patient agrees to receive further treatment on a voluntary basis.

(2) The patient is the subject of a conservatorship petition filed pursuant to Chapter 3 (commencing with Section 5350).

(3) The patient is the subject of a petition for postcertification treatment of a dangerous person filed pursuant to Article 6 (commencing with Section 5300).

(4) The patient is still in need of intensive services and the certification for an additional 30 days has begun. Under no circumstance shall a person be certified under this article for more than two consecutive periods of 30 days.

(c) The amendments to this section made by Assembly Bill 348 of the 2003–04 Regular Session shall not be construed to revise or expand the scope of practice of psychologists, as defined in Chapter 6.6 (commencing with Section 2900) of Division 2 of the Business and Professions Code.

SEC. 2. Section 5270.55 of the Welfare and Institutions Code is amended to read:

5270.55. (a) Whenever it is contemplated that a gravely disabled person may need to be detained beyond the end of the 14-day period of intensive treatment and prior to proceeding with an additional 30-day certification, *or beyond the end of an initial 30-day period of intensive treatment and prior to proceeding with a second consecutive 30-day certification,* the professional person in charge of the facility shall cause an evaluation to be made, based on the patient's current condition and past history, as to whether

it appears that the person, even after up to 30 days of additional treatment, is likely to qualify for appointment of a conservator. If the appointment of a conservator appears likely, the conservatorship referral shall be made during the ~~14-day~~ *current* period of intensive treatment.

(b) If it appears that with up to 30 days additional treatment a person is likely to reconstitute sufficiently to obviate the need for appointment of a conservator, then the person may be certified for the additional 30 days.

(c) ~~Where no conservatorship referral has been~~ *When a conservatorship referral has not been* made during the 14-day period and ~~where~~ *it appears* during the 30-day certification ~~it appears~~ that the person is likely to require the appointment of a conservator, *or when a conservatorship referral has not been made during the initial 30-day period and it appears during the second consecutive 30-day certification that the person is likely to require the appointment of a conservator,* then the conservatorship referral shall be made to allow sufficient time for conservatorship investigation and other related procedures. If a temporary conservatorship is obtained, it shall run concurrently with and not consecutively to the 30-day certification period. The conservatorship hearing shall be held by the 30th day of the certification period. The maximum involuntary detention period for gravely disabled persons pursuant to Sections 5150, 5250 and 5270.15 shall be limited to ~~47~~ *77* days. ~~Nothing in this section shall~~ *This section does not* prevent a person from exercising ~~his or her~~ *their* right to a hearing as stated in Sections 5275 and 5353.

All matter omitted in this version of the bill appears in the bill as introduced in the Senate, February 17, 2022. (JR11)

O

SENATE BILL No. 1238

Introduced by Senator Eggman

February 17, 2022

An act to add Section 5610.5 to the Welfare and Institutions Code, relating to mental health.

LEGISLATIVE COUNSEL'S DIGEST

SB 1238, as introduced, Eggman. Behavioral health services: existing and projected needs.

Existing law, the Bronzan-McCorquodale Act, contains provisions governing the operation and financing of community mental health services for the mentally disordered in every county through locally administered and locally controlled community mental health programs. Existing law further provides that the mission of California's mental health system is to enable persons experiencing severe and disabling mental illnesses and children with serious emotional disturbances to access services and programs that assist them, in a manner tailored to each individual, to better control their illness, to achieve their personal goals, and to develop skills and supports leading to their living the most constructive and satisfying lives possible in the least restrictive available settings.

This bill would require the State Department of Health Care Services, in consultation with each council of governments, to determine the existing and projected need for behavioral health services for each region in a specified manner and would require, as part of that process, councils of governments to provide the department-specified data. The bill would authorize a council of governments, within 30 days following notice of the determination from the department, to file with the department an objection to the department's determination of the region's existing and projected behavioral health need. The bill would

require the department to make a final written determination of the region's existing and projected behavioral needs within 45 days of receiving an object. By adding to the duties of councils of governments, this bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 5610.5 is added to the Welfare and Institutions Code, to read:

5610.5. (a) The State Department of Health Care Services, in consultation with each council of governments, where applicable, shall determine the existing and projected need for behavioral health services, for each region, in the following manner:

(1) The department's determination shall be based upon population projections produced by the Department of Finance, incidence of behavioral health issues within the region, including serious emotional disturbance among children and serious mental illness among adults, frequency of referrals for assisted outpatient treatment, frequency of psychiatric holds under Article 1 (commencing with Section 5150) of Chapter 1 of Part 1, frequency and duration of conservatorships under Chapter 3 (commencing with Section 5350) of Part 1, and an inventory of the continuum of behavioral health services provided by the county behavioral health department.

(2) Prior to developing the existing and projected behavioral health need for a region, the department shall meet and consult with the council of governments regarding the assumptions and methodology to be used by the department to determine the region's behavioral health needs. The council of governments shall provide behavioral health service access and utilization data for the region, including, but not limited to, the total number of beds

or slots, total utilization, and unmet need, in all of the following service categories:

(A) Prevention and wellness services for mental health and substance use issues, including, but not limited to, services, activities, and assessments that help identify individuals at risk of a mental health or substance use disorder; support for communities, families, and individuals in coping with stress and trauma; dissemination of information on ways to promote resiliency; and discouragement of risky behaviors.

(B) Outpatient services, including a variety of traditional clinical outpatient services such as individual and group therapy and ambulatory detoxification services.

(C) Peer and recovery services delivered in the community that can be provided by individuals with lived experience, including young adults and family members.

(D) Community supports, including flexible services designed to enable individuals to remain in their homes and participate in their communities, such as supportive housing, case management, supported employment, and supported education.

(E) Intensive outpatient treatment services, including services such as full-service partnerships, assertive community treatment (ACT), and substance use intensive outpatient services that are delivered using a multidisciplinary approach to support individuals living with higher acuity behavioral health needs.

(F) Residential treatment provided on a short-term basis to divert individuals from, or as a step down from, intensive services.

(G) Crisis services, including, but not limited to, a range of services and supports such as crisis call centers, mobile crisis services, and crisis residential services that assess, stabilize, and treat individuals experiencing acute distress who may require hospitalization.

(H) Intensive treatment services that are provided in structured, facility-based settings to individuals who require 24-hours-a-day, seven-days-a-week care, including inpatient psychiatric treatment and clinically managed inpatient services.

(I) School-based behavioral health services.

(3) The department may accept or reject the information provided by the council of governments or modify its own assumptions or methodology based on the information provided. After consultation with the council of governments, the department

shall make determinations, in writing, on the assumptions for each of the factors listed in paragraph (2) and the methodology it will use to determine the region's behavioral health needs and shall provide these determinations to the council of governments.

(4) (A) After consultation with the council of governments, the department shall make a determination of the region's existing and projected behavioral health need based upon the assumptions and methodology determined pursuant to paragraph (3). Within 30 days following notice of the determination from the department, the council of governments may file with the department an objection to the department's determination of the region's existing and projected behavioral health need.

(B) An objection shall be based on, and shall provide substantiation of, either of the following:

(i) The department failed to base its determination on the data for the region. If an objection is filed under this clause, the council of governments shall identify the data it believes should instead be used for the determination and explain the basis for its rationale.

(ii) The regional behavioral health need determined by the department is not a reasonable application of the methodology and assumptions determined pursuant to paragraph (3). If an object is filed under this clause, it shall include a proposed alternative determination of its regional behavioral health need based upon the determinations made in paragraph (3), including analysis of why the proposed alternative would be a more reasonable application of the methodology and assumptions determined pursuant to paragraph (3).

(C) If a council of governments files an objection pursuant to this paragraph and includes with the objection a proposed alternative determination of its regional behavioral health need, it shall also include documentation of its basis for the alternative determination. Within 45 days of receiving an objection filed pursuant to this section, the department shall consider the objection and make a final written determination of the region's existing and projected behavioral health need that includes an explanation of the information upon which the determination was made.

(b) For the purposes of this section, "council on governments" has the same meaning as in Section 65582 of the Government Code.

SEC. 2. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

O

AMENDED IN SENATE APRIL 7, 2022

SENATE BILL No. 1416

Introduced by Senator Eggman

February 18, 2022

An act *to amend Section 1799.111 of the Health and Safety Code, and* to amend Section 5008 of the Welfare and Institutions Code, relating to mental health.

LEGISLATIVE COUNSEL'S DIGEST

SB 1416, as amended, Eggman. Mental health services: gravely disabled persons.

Existing law, the Lanterman-Petris-Short Act, provides for the involuntary commitment and treatment of a person who is a danger to themselves or others or who is gravely disabled. Existing law also provides for a conservator of the person or estate to be appointed for a person who is gravely disabled. Existing law, for the purposes of involuntary commitment and conservatorship, defines "gravely disabled," among other things, as a condition in which a person, as a result of a mental health disorder, is unable to provide for the basic personal needs of food, clothing, or shelter.

This bill would also include under the definition of "gravely disabled" a condition in which a person, as a result of a mental health disorder, is unable to provide for the basic personal needs of ~~personal or~~ medical care or self protection and ~~safety.~~ *safety, as specified.* By increasing the level of service required of county mental health departments, this bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 1799.111 of the Health and Safety Code is amended to read:

1799.111. (a) Subject to subdivision (b), a licensed general acute care hospital, as defined in subdivision (a) of Section 1250, that is not a county-designated facility pursuant to Section 5150 of the Welfare and Institutions Code, a licensed acute psychiatric hospital, as defined in subdivision (b) of Section 1250, that is not a county-designated facility pursuant to Section 5150 of the Welfare and Institutions Code, licensed professional staff of those hospitals, or ~~any~~ *a* physician and surgeon, providing emergency medical services in any department of those hospitals to a person at the hospital is not civilly or criminally liable for detaining a person if all of the following conditions exist during the detention:

(1) The person cannot be safely released from the hospital because, in the opinion of the treating physician and surgeon, or a clinical psychologist with the medical staff privileges, clinical privileges, or professional responsibilities provided in Section 1316.5, the person, as a result of a mental health disorder, presents a danger to themselves, or others, or is gravely disabled. For purposes of this paragraph, "gravely disabled" ~~means an inability to provide for the person's basic personal needs for food, clothing, or shelter.~~ *has the same definition as in paragraph (1) of subdivision (h) of Section 5008 of the Welfare and Institutions Code.*

(2) The hospital staff, treating physician and surgeon, or appropriate licensed mental health professional, have made, and documented, repeated unsuccessful efforts to find appropriate mental health treatment for the person.

(A) Telephone calls or other contacts required pursuant to this paragraph shall commence at the earliest possible time when the

treating physician and surgeon has determined the time at which the person will be medically stable for transfer.

(B) ~~In no case shall the~~ *The* contacts required pursuant to this paragraph *shall not* begin after the time when the person becomes medically stable for transfer.

(3) The person is not detained beyond 24 hours.

(4) There is probable cause for the detention.

(b) If the person is detained pursuant to subdivision (a) beyond eight hours, but less than 24 hours, both of the following additional conditions shall be met:

(1) A discharge or transfer for appropriate evaluation or treatment for the person has been delayed because of the need for continuous and ongoing care, observation, or treatment that the hospital is providing.

(2) In the opinion of the treating physician and surgeon, or a clinical psychologist with the medical staff privileges or professional responsibilities provided for in Section 1316.5, the person, as a result of a mental health disorder, is still a danger to themselves, or others, or is gravely disabled, as defined in paragraph (1) of subdivision (a).

(c) In addition to the immunities set forth in subdivision (a), a licensed general acute care hospital, as defined in subdivision (a) of Section 1250, that is not a county-designated facility pursuant to Section 5150 of the Welfare and Institutions Code, a licensed acute psychiatric hospital, as defined by subdivision (b) of Section 1250, that is not a county-designated facility pursuant to Section 5150 of the Welfare and Institutions Code, licensed professional staff of those hospitals, or a physician and surgeon, providing emergency medical services in any department of those hospitals to a person at the hospital shall not be civilly or criminally liable for the actions of a person detained up to 24 hours in those hospitals who is subject to detention pursuant to subdivision (a) after that person's release from the detention at the hospital, if all of the following conditions exist during the detention:

(1) The person has not been admitted to a licensed general acute care hospital or a licensed acute psychiatric hospital for evaluation and treatment pursuant to Section 5150 of the Welfare and Institutions Code.

(2) The release from the licensed general acute care hospital or the licensed acute psychiatric hospital is authorized by a physician

and surgeon or a clinical psychologist with the medical staff privileges or professional responsibilities provided for in Section 1316.5, who determines, based on a face-to-face examination of the person detained, that the person does not present a danger to themselves or others and is not gravely disabled, as defined in paragraph (1) of subdivision (a). In order for this paragraph to apply to a clinical psychologist, the clinical psychologist shall have a collaborative treatment relationship with the physician and surgeon. The clinical psychologist may authorize the release of the person from the detention, but only after the clinical psychologist has consulted with the physician and surgeon. In the event of a clinical or professional disagreement regarding the release of a person subject to the detention, the detention shall be maintained unless the hospital's medical director overrules the decision of the physician and surgeon opposing the release. Both the physician and surgeon and the clinical psychologist shall enter their findings, concerns, or objections in the person's medical record.

(d) Notwithstanding any other law, an examination, assessment, or evaluation that provides the basis for a determination or opinion of a physician and surgeon or a clinical psychologist with the medical staff privileges or professional responsibilities provided for in Section 1316.5 that is specified in this section may be conducted using telehealth.

(e) This section does not affect the responsibility of a general acute care hospital or an acute psychiatric hospital to comply with all state laws and regulations pertaining to the use of seclusion and restraint and psychiatric medications for psychiatric patients. Persons detained under this section shall retain their legal rights regarding consent for medical treatment.

(f) A person detained under this section shall be credited for the time detained, up to 24 hours, if the person is placed on a subsequent 72-hour hold pursuant to Section 5150 of the Welfare and Institutions Code.

(g) The amendments to this section made by Chapter 308 of the Statutes of 2007 do not limit any existing duties for psychotherapists contained in Section 43.92 of the Civil Code.

(h) This section does not expand the scope of licensure of clinical psychologists.

~~SECTION 1.~~

SEC. 2. Section 5008 of the Welfare and Institutions Code is amended to read:

5008. Unless the context otherwise requires, the following definitions shall govern the construction of this part:

(a) "Evaluation" consists of multidisciplinary professional analyses of a person's medical, psychological, educational, social, financial, and legal conditions that appear to constitute a problem. Persons providing evaluation services shall be properly qualified professionals and may be full-time employees of an agency providing face-to-face, including telehealth, evaluation services, part-time employees, or persons employed on a contractual basis.

(b) "Court-ordered evaluation" means an evaluation ordered by a superior court pursuant to Article 2 (commencing with Section 5200) or by a superior court pursuant to Article 3 (commencing with Section 5225) of Chapter 2.

(c) "Intensive treatment" consists of hospital and other services as indicated. Intensive treatment shall be provided by properly qualified professionals and carried out in facilities qualifying for reimbursement under the California Medical Assistance Program (Medi-Cal) set forth in Chapter 7 (commencing with Section 14000) of Part 3 of Division 9, or under Title XVIII of the federal Social Security Act and regulations thereunder. Intensive treatment may be provided in hospitals of the United States government by properly qualified professionals. This part does not prohibit an intensive treatment facility from also providing 72-hour evaluation and treatment.

(d) (1) "Referral" means referral of persons by each agency or facility providing assessment, evaluation, crisis intervention, or treatment services to other agencies or individuals. The purpose of referral is to provide for continuity of care, and may include, but need not be limited to, informing the person of available services, making appointments on the person's behalf, discussing the person's problem with the agency or individual to which the person has been referred, appraising the outcome of referrals, and arranging for personal escort and transportation when necessary. Referral shall be considered complete when the agency or individual to whom the person has been referred accepts responsibility for providing the necessary services. All persons shall be advised of available precare services that prevent initial

recourse to hospital treatment or aftercare services that support adjustment to community living following hospital treatment. These services may be provided through county or city mental health departments, state hospitals under the jurisdiction of the State Department of State Hospitals, regional centers under contract with the State Department of Developmental Services, or other public or private entities.

(2) Each agency or facility providing evaluation services shall maintain a current and comprehensive file of all community services, both public and private. These files shall contain current agreements with agencies or individuals accepting referrals, as well as appraisals of the results of past referrals.

(e) "Crisis intervention" consists of an interview or series of interviews within a brief period of time, conducted by qualified professionals, and designed to alleviate personal or family situations that present a serious and imminent threat to the health or stability of the person or the family. The interview or interviews may be conducted in the home of the person or family, or on an inpatient or outpatient basis with the therapy or other services, as appropriate. The interview or interviews may include family members, significant support persons, providers, or other entities or individuals, as appropriate and as authorized by law. Crisis intervention may, as appropriate, include suicide prevention, psychiatric, welfare, psychological, legal, or other social services.

(f) "Prepetition screening" is a screening of all petitions for court-ordered evaluation as provided in Article 2 (commencing with Section 5200) of Chapter 2, consisting of a professional review of all petitions; an interview with the petitioner and, whenever possible, the person alleged, as a result of a mental health disorder, to be a danger to others, or to themselves, or to be gravely disabled, to assess the problem and explain the petition; when indicated, efforts to persuade the person to receive, on a voluntary basis, comprehensive evaluation, crisis intervention, referral, and other services specified in this part.

(g) "Conservatorship investigation" means investigation by an agency appointed or designated by the governing body of cases in which conservatorship is recommended pursuant to Chapter 3 (commencing with Section 5350).

(h) (1) For purposes of Article 1 (commencing with Section 5150), Article 2 (commencing with Section 5200), and Article 4

(commencing with Section 5250) of Chapter 2, and for the purposes of Chapter 3 (commencing with Section 5350), "gravely disabled" means either of the following:

(A) A condition in which a person, as a result of a mental health disorder, is unable to provide for their basic personal needs for food, clothing, shelter, ~~personal or~~ medical care, or self protection and safety. *A person is unable to provide for their basic personal needs for medical care or self protection and safety when the person is at risk of substantial bodily harm, dangerous worsening of any concomitant serious physical illness, significant psychiatric deterioration, or mismanagement of their basic needs that could result in substantial bodily harm.*

(B) A condition in which a person, has been found mentally incompetent under Section 1370 of the Penal Code and all of the following facts exist:

(i) The complaint, indictment, or information pending against the person at the time of commitment charges a felony involving death, great bodily harm, or a serious threat to the physical well-being of another person.

(ii) There has been a finding of probable cause on a complaint pursuant to paragraph (2) of subdivision (a) of Section 1368.1 of the Penal Code, a preliminary examination pursuant to Section 859b of the Penal Code, or a grand jury indictment, and the complaint, indictment, or information has not been dismissed.

(iii) As a result of a mental health disorder, the person is unable to understand the nature and purpose of the proceedings taken against them and to assist counsel in the conduct of the person's defense in a rational manner.

(iv) The person represents a substantial danger of physical harm to others by reason of a mental disease, defect, or disorder.

(2) For purposes of Article 3 (commencing with Section 5225) and Article 4 (commencing with Section 5250), of Chapter 2, and for the purposes of Chapter 3 (commencing with Section 5350), "gravely disabled" means a condition in which a person, as a result of impairment by chronic alcoholism, is unable to provide for their basic personal needs for food, clothing, or shelter.

(3) The term "gravely disabled" does not include persons with intellectual disabilities by reason of that disability alone.

(i) "Peace officer" means a duly sworn peace officer as that term is defined in Chapter 4.5 (commencing with Section 830) of

Title 3 of Part 2 of the Penal Code who has completed the basic training course established by the Commission on Peace Officer Standards and Training, or a parole officer or probation officer specified in Section 830.5 of the Penal Code when acting in relation to cases for which the officer has a legally mandated responsibility.

(j) "Postcertification treatment" means an additional period of treatment pursuant to Article 6 (commencing with Section 5300) of Chapter 2.

(k) "Court," unless otherwise specified, means a court of record.

(*l*) "Antipsychotic medication" means medication customarily prescribed for the treatment of symptoms of psychoses and other severe mental and emotional disorders.

(m) "Emergency" means a situation in which action to impose treatment over the person's objection is immediately necessary for the preservation of life or the prevention of serious bodily harm to the patient or others, and it is impracticable to first gain consent. It is not necessary for harm to take place or become unavoidable prior to treatment.

(n) "Designated facility" or "facility designated by the county for evaluation and treatment" means a facility that is licensed or certified as a mental health treatment facility or a hospital, as defined in subdivision (a) or (b) of Section 1250 of the Health and Safety Code, by the State Department of Public Health, and may include, but is not limited to, a licensed psychiatric hospital, a licensed psychiatric health facility, and a certified crisis stabilization unit.

~~SEC. 2.~~

SEC. 3. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

O

Re: Resolution for Introduction - supporting Senator Eggman's legislation modernizing our behavioral health continuum

Thornhill, Jackie (BOS) <jackie.thornhill@sfgov.org>

Tue 4/12/2022 2:49 PM

To: BOS Legislation, (BOS) <bos.legislation@sfgov.org>

Cc: Mandelman, Rafael (BOS) <rafael.mandelman@sfgov.org>

Hi Jocelyn,

The California State Association of Counties and League of California Cities have not yet taken a position on these bills.

Best,
Jackie

Jackie Thornhill (she/her/hers)
Legislative Aide
Office of Supervisor Rafael Mandelman, District 8
Jackie.Thornhill@sfgov.org |(415) 554-4488

From: BOS Legislation, (BOS) <bos.legislation@sfgov.org>
Sent: Tuesday, April 12, 2022 2:46 PM
To: Thornhill, Jackie (BOS) <jackie.thornhill@sfgov.org>; BOS Legislation, (BOS) <bos.legislation@sfgov.org>
Cc: Mandelman, Rafael (BOS) <rafael.mandelman@sfgov.org>
Subject: RE: Resolution for Introduction - supporting Senator Eggman's legislation modernizing our behavioral health continuum

Hi Jackie,

Pursuant to Board Rule 2.8.2, please provide the following to complete this submission:

- confirm that organizations such as the California State Association of Counties and League of California Cities have *not* taken a position on these bills. If they have, please provide a copy of their statement for completeness of the file

Best regards,
Jocelyn Wong
San Francisco Board of Supervisors
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San Francisco, CA 94102
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(VIRTUAL APPOINTMENTS) To schedule a "virtual" meeting with me (on Microsoft Teams), please ask and I can answer your questions in real time.

Due to the current COVID-19 health emergency and the Shelter in Place Order, the Office of the Clerk of the Board is working remotely while providing complete access to the legislative process and our services

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From: Thornhill, Jackie (BOS) <jackie.thornhill@sfgov.org>
Sent: Tuesday, April 12, 2022 2:32 PM
To: BOS Legislation, (BOS) <bos.legislation@sfgov.org>
Cc: Mandelman, Rafael (BOS) <rafael.mandelman@sfgov.org>
Subject: Resolution for Introduction - supporting Senator Eggman's legislation modernizing our behavioral health continuum

Good afternoon,

Attached please find documents re: Supervisor Mandelman's introduction of a resolution urging the California State Legislature to pass SB 929, SB 965, SB 970, SB 1035, SB 1154, SB 1227, SB 1238, and SB 1416.

This resolution is routine, not contentious in nature, and of no special interest.

Supervisor Mandelman is the signatory and can confirm via email.

Best,
Jackie

Jackie Thornhill (she/her/hers)
Legislative Aide
Office of Supervisor Rafael Mandelman, District 8
Jackie.Thornhill@sfgov.org |(415) 554-4488