Supreme Court Case No.

IN THE SUPREME COURT OF THE STATE OF CALIFORNIA

DISABILITY RIGHTS CALIFORNIA

PETITIONER,

V.

GAVIN NEWSOM, in his official capacity as Governor of the State of California; and MARK GHALY, in his official capacity as Secretary of the California Health and Human Services Agency.

RESPONDENTS

EXHIBITS IN SUPPOPRT OF PETITIONER'S REQUEST FOR JUDICIAL NOTICE
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Exhibit 12

Pages: RJN-0296 through RJN-0303

Human Rights Watch, Written Testimony dated April 12, 2022, submitted to Senators Umberg and Eggman, California State Senate

Legislative History Report and Analysis for Senate Bill 1338 (Umberg & Eggman – 2022) Chapter 319, Statutes of 2022

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April 12, 2022

Senator Tom Umberg
Senator Susan Talamantes Eggman
California State Senate
Sacramento, Ca. 95814

HUMAN RIGHTS WATCH

HRW.org

Re: Human Rights Watch's Opposition to CARE Court (SB 1338)

Dear Senators Umberg and Eggman:

Human Rights Watch has carefully reviewed SB 1338[1] and the proposed framework for the Community Assistance, Recovery and Empowerment (CARE) Court created by CalHHS,[2] and must respectfully voice our strong opposition. CARE Court promotes a system of involuntary, coerced treatment, enforced by an expanded judicial infrastructure, that will, in practice, simply remove unhoused people with perceived mental health conditions from the public eye without effectively addressing those mental health conditions and without meeting the urgent need for housing. We urge you to reject this bill and instead to take a more holistic, rights-respecting approach to address the lack of resources for autonomy-affirming treatment options and affordable housing.

CARE Court proponents claim it will increase up-stream diversion from the criminal legal and conservatorship systems by allowing a wide range of actors to refer people with schizophrenia and other psychotic disorders to the jurisdiction of the courts without an arrest or hospitalization. In fact, the bill creates a new pathway for government officials and family members to place people under state control and take away their autonomy and liberty.[3] It applies generally to those the bill describes as having a "schizophrenia spectrum or other psychotic disorder" and specifically targets unhoused people.[4] It seems aimed at facilitating removing unhoused people from public view without actually providing housing and services that will help to resolve homelessness. Given the racial

[1] California SB 1338, "Community Assistance, Recovery, and Empowerment (CARE) Court Program (Umberg, Eggman)," 2022, https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB1338 (accessed April 12, 2022).
[2] California Health & Human Services Agency, "CARE Court: A New Framework for Community Assistance, Recovery & Empowerment," March 2022, https://www.chhs.ca.gov/wp-content/uploads/2022/03/CARE-Court-Framework_web.pdf (accessed April 12, 2022).
[3] California SB 1338, "Community Assistance, Recovery, and Empowerment (CARE) Court Program (Umberg, Eggman)," 2022, https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB1338.
[4] Marisa Lagos, "Gov. Newsom on His Plan to Tackle Mental Health, Homelessness with 'CARE Courts'," *KQED*, March 16, 2022, https://www.kqed.org/forum/2010101888316/gov-newsom-on-his-new-plan-to-tackle-mental-health-homelessness-with-care-courts (accessed April 12, 2022).

demographics of California's homeless population[5], and the historic over-diagnosing of Black and Latino people with schizophrenia,[6] this plan is likely to place many, disproportionately Black and brown, people under state control.

CARE Court is Coerced Treatment

Proponents of the plan describe CARE Court in misleading ways as "preserving self-determination" and "self-sufficiency," and "empower[ing]."[7] But CARE Court creates a state-imposed system of coerced, involuntary treatment. The proposed legislation authorizes judges to order a person to submit to treatment under a CARE plan.[8] That treatment may include an order to take a given medication, including long-acting injections, and a housing plan.[9] That housing plan could include a variety of interim housing or shelter options that may be unacceptable to an individual and unsuited to their unique needs.[10]

A person who fails to obey court orders for treatment, medication, and housing may be referred to conservatorship, which would potentially strip that person of their legal capacity and personal autonomy, subjecting them to forcible medical treatment and medication, loss of personal liberty, and removal of power to make decisions over the conduct of their own lives.[11] Indeed, the court may use failure to comply with their court-ordered treatment, "as a factual presumption that no suitable community alternatives are available to treat the individual," paving the way for detention and conservatorship.[12] In practical effect, the mandatory care plans are simply pathways to the even stricter system of control through conservatorship.

This approach not only robs individuals of dignity and autonomy but is also coercive and likely ineffective.[13] Studies of coercive mental health treatment have generally not shown

[5] Los Angeles Homeless Services Authority, "Report and Recommendations of the Ad Hoc Committee on Black People Experiencing Homelessness," December 2018, https://www.lahsa.org/documents?id=2823-report-and-recommendations-of-the-ad-hoc-committee-on-black-people-experiencing-homelessness (accessed April 12, 2022).

[6] Charles M. Olbert, Arundati Nagendra, and Benjamin Buck, "Meta-analysis of Black vs. White racial disparity in schizophrenia diagnosis in the United States: Do structured assessments attenuate racial disparities?" *Journal of Abnormal Psychology* 127(1) (2018): 104-115, accessed April 12, 2022, doi: 10.1037/abn0000309; Robert C. Schwartz and David M. Blankenship, "Racial disparities in psychotic disorder diagnosis: A review of empirical literature," *World Journal of Psyciatry* 4 (2014): 133-140, accessed April 12, 20220, doi: 10.5498/wjp.v4.i4.133.

[7] "CARE (Community Assistance, Recovery and Empowerment) Court," California Health & Human Services Agency, March 14, 2022, Slides 5, 10 and 20, https://www.chhs.ca.gov/wp-content/uploads/2022/03/CARE-Court-Stakeholder-Slides-20220314.pdf (accessed April 12, 2022); Marisa Lagos, "Gov. Newsom on His Plan to Tackle Mental Health, Homelessness with 'CARE Courts'," *KQED*, March 16, 2022, https://www.kqed.org/forum/2010101888316/gov-newsom-on-his-new-plan-to-tackle-mental-health-homelessness-with-care-courts (accessed April 12, 2022).

[8] SB 1338, Section 59–82 (a)-(b).

[9] SB 1338, Section, 5982.

[10] SB 1338, Section 5982(c); "CARE (Community Assistance, Recovery and Empowerment) Court." The DHHS presentation discusses a range of housing possibilities including "interim or bridge housing," which in common usage means temporary shelter.

[11] SB 1338, Section 5979(a); California Welfare and Institutions Code Section 5350—5372, https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=5357 (accessed April 12, 2022).

[12] SB 1338, Section 5979(a).

[13] Sashidharan, S. P., Mezzina, R., & Puras, D., "Reducing coercion in mental healthcare," *Epidemiology and psychiatric sciences*, 28(6) (2019): 605–612, accessed April 12, 2022, https://doi.org/10.1017/S2045796019000350 ("Available research does not suggest that coercive intervention in mental health care "are clinically effective, improve patient safety or result in better clinical or social outcomes.").

positive outcomes.[14] Evidence does not support the conclusion that involuntary outpatient treatment is more effective than intensive voluntary outpatient treatment and, indeed, shows that involuntary, coercive treatment is harmful.[15]

Coerced Treatment Violates Human Rights

Under international human rights law, all people have the right to "the highest attainable standard of physical and mental health."[16] Free and informed consent, including the right to refuse treatment, is a core element of that right to health.[17] Having a "substitute" decision-maker, including a judge, or even a "supporter," make orders for health care can deny a person with disabilities their right to legal capacity and infringe on their personal autonomy.[18]

The Convention on the Rights of Persons with Disabilities establishes the obligation to "holistically examine all areas of law to ensure that the right of persons with disabilities to legal capacity is not restricted on an unequal basis with others. Historically, persons with disabilities have been denied their right to legal capacity in many areas in a discriminatory manner under substitute decision-making regimes such as guardianship, conservatorship and mental health laws that permit forced treatment."[19] The US has signed but not yet ratified this treaty, which means it is obligated to refrain from establishing policies and legislation that will undermine the purpose and object of the treaty, like creating provisions that mandate long-term substitute decision-making schemes like conservatorship or court-ordered treatment plans.

The World Health Organization has developed a new model that harmonizes mental health services and practices with international human rights law and has criticized practices promoting involuntary mental health treatments as leading to violence and abuse, rather than recovery, which should be the core basis of mental health services.[20] Recovery means

[14] Sashidharan, S. P., Mezzina, R., & Puras, D., "Reducing coercion in mental healthcare," *Epidemiology and psychiatric sciences*, *28*(6) (2019): 605–612, https://doi.org/10.1017/S2045796019000350 (accessed April 12, 2022); Richard M. Ryan, Martin F. Lynch, Maarten Vansteenkiste, Edward L. Deci, "Motivation and Autonomy in Counseling, Psychotherapy, and Behavior Change: A Look at Theory and Practice," *Invited Integrative Review* (2011), https://www.apa.org/education/ce/motivation-autonomy.pdf (accessed April 12, 2022); McLaughlin, P., Giacco, D., & Priebe, S., 2016, "Use of Coercive Measures during Involuntary Psychiatric Admission and Treatment Outcomes: Data from a Prospective Study across 10 European Countries," *PloS one*, *11*(12), https://doi.org/10.1371/journal.pone.0168720 ("All coercive measures are associated with patients staying longer in hospital, and seclusion significantly so, and this association is not fully explained by coerced patients being more unwell at admission.").

[15] Joseph P. Morrissey, Ph.D., *et al.*, "*Outpatient Commitment and Its Alternatives: Questions Yet to Be Answered*," Psychiatric Services (2014): 812 at 814 (2014); S.P. Sashidharan, Ph.D., *et al.*, "Reducing Coercion in Mental Healthcare," *Epidemiology and Psychiatric Sciences* 28 (2019): 605-612.

[16] International Covenant on Economic, Social and Cultural Rights, ("ICESCR"), adopted December 16, 1966, entered into force January 3, 1976, Art. 12(1), https://www.ohchr.org/en/professionalinterest/pages/cescr.aspx.

[17] Human Rights Council; United Nations, General Assembly, "Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health," March 28, 2017, https://undocs.org/en/A/HRC/35/21, para. 63. See also Convention on the Rights of Persons with Disabilities, art. 12 read in conjunction with art. 25; Committee on the Rights of Persons with Disabilities: General comment No. 1 (2014), May 19, 2014, https://documents-dds-ny.un.org/doc/UNDOC/GEN/G14/031/20/PDF/G1403120.pdf?OpenElement, para. 31, 41.

[18] Convention on the Rights of Persons with Disabilities, art. 12; Committee on the Rights of Persons with Disabilities: General comment No. 1 (2014), May 19, 2014, para. 7.

[19] Committee on the Rights of Persons with Disabilities: General comment No. 1 (2014), May 19, 2014, para. 7.

[20] Freedom from coercion, violence, and abuse. WHO Quality Rights core training: mental health and social services, 2019, https://apps.who.int/iris/bitstream/handle/10665/329582/9789241516730-eng.pdf?sequence=5&isAllowed=y, p. 2, 8, 22.

different things for different people but one of its key elements is having control over one´s own mental health treatment, including the possibility of refusing treatment.

To comport with human rights, treatment should be based on the will and preferences of the person concerned, and not defined by some other entity's conception of their best interest. Housing or disability status does not rob a person of their right to legal capacity or their personal autonomy, including the right to refuse treatment. In very narrow, exceptional circumstances, where a person poses a serious and imminent risk to themselves or a third party and a qualified healthcare professional has determined they lack capacity to give informed consent to treatment, a brief, temporary period of mandatory treatment may be permissible if strictly clinically necessary for the purpose of returning the person to a place of autonomy in which they can make decisions about their own welfare—and for no longer than that. The process envisioned by the CARE Court plan is far more expansive; by definition, involuntary; and, as discussed below, runs the risk of being abused by self-interested actors. This coerced process leading to "treatment" undermines any healing aim of the proposal.

CARE Court Denies Due Process

The CARE Court proposal authorizes family members, first responders, including police officers or outreach workers, the public guardian, service providers, and the director of the county behavioral health agency, to initiate the process of imposing involuntary treatment by filing a petition with the court.[21] These expansive categories of people with the power to embroil another person in court processes and potential loss of autonomy, many of whom lack any expertise in recognition and treatment of mental health conditions, reveals the extreme danger of abuse inherent in this proposal. For example, interpersonal conflicts between family members could result in abusive parents, children, spouses, and siblings using the referral process to expose their relatives to court hearings and potential coerced treatment, housing, and medication.

Law enforcement and outreach workers would have a new tool to threaten unhoused people with referral to the court to pressure them to move from a given area. These state actors could place those who disobeyed their commands into the CARE Court process and under the control of courts. Given the long history of law enforcement using its authority to drive unhoused people from public spaces, a practice that re-traumatizes those people and does nothing to solve homelessness, it is dangerous to provide them with additional powers to do so.[22]

The legislation does not set meaningful standards to guide judicial discretion and does not delineate procedures for those decisions.[23] It establishes a contradictory and unworkable procedure by which a petition may be made on an allegation that a person "lacks medical decision making capacity"[24] On a mere showing of "prima facie" evidence that the petition is

[21] SB 1338, Section 5974.
[22] Chris Herring, "Complaint-Oriented Policing: Regulating Homelessness in Public Space," *American Sociological Review* 1-32, (2019), https://static1.squarespace.com/static/5b391e9cda02bc79baffebb9/t/5d73e7609b56e748f432e358/1567876975179/complaint-oriented+policing_ASR.pdf.
[23] SB 1338, Section, 5972-5978
[24] SB 1338, Section 5972.

true, the person is then required to enter into settlement discussions with the county behavioral health agency.[25] If someone lacks decision-making capacity, they would not be able to enter a settlement agreement voluntarily. Unless the parties stipulate otherwise, failure to enter a settlement agreement results in an evaluation by that same behavioral health agency, which is used to impose a mandatory, court-ordered course of treatment.[26] This process is entirely involuntary and coercive. The role of the behavioral health agency poses a great potential for conflicts of interest, as they will presumably be funded to carry out the Care Plans that result from their negotiations and their evaluations.

The CARE Court plan threatens to create a separate legal track for people perceived to have mental health conditions, without adequate process, negatively implicating basic rights.[27] Even with stronger judicial procedures and required clinical diagnoses by mental health professionals, this program would remain objectionable because it expands the ability of the state to coerce people into involuntary treatment beyond the limited and temporary circumstances provided for under human rights law.

CARE Court will harm Black, brown, and Unhoused people

The CARE Court directly targets unhoused people to be placed under court-ordered treatment, thus denying their rights and self-determination. Governor Newsom, in pitching this plan, called it a response to seeing homeless encampments throughout the state of California.[28] CARE Court will empower police and homeless outreach workers to refer people to the courts and allow judges to order them into treatment against their will, including medication plans. Despite allusions to "housing plans," CARE Court does not increase access to permanent supportive housing and indeed, the bill prohibits the court from requiring the county to provide actual housing.[29]

Due to a long history of racial discrimination in housing, employment, access to health care, policing and the criminal legal system, Black and brown people have much higher rates of homelessness than their overall share of the population.[30] The CARE Court plan in no way addresses the conditions that have led to these high rates of homelessness in Black and brown communities. Instead, it proposes a system of state control over individuals that will compound the harms of homelessness.

[25] SB 1338, Section 5977.
[26] SB 1338, Section 5977.
[27] Committee on the Rights of Persons with Disabilities, "Guidelines on article 14 of the Convention on the Rights of Person with Disabilities: The right to liberty and security of persons with disabilities," (September 2015), para. 14 https://www.google.com/search?q=Guidelines+on+CRPD+article+14%2C+paragraph+21&rlz=1C1PRFI_enUS936US936&oq=Guidelines+on+CRPD+article+14%2C+paragraph+21&aqs=chrome..69i57j33i160.3045j0j7&sourceid=chrome&ie=UTF-8, para. 14.
[28] KQED, "Gov. Newsom on His Plan to Tackle Mental Health, Homelessness with 'CARE Courts.'"

[30] Kate Cimini, "Black people disproportionately homeless in California," *CalMatters*, February 27, 2021, https://calmatters.org/california-divide/2019/10/black-people-disproportionately-homeless-in-california/ ("about 6.5% of Californians identify as black or African American, but they account for nearly 40% of the state's homeless population"); Esmeralda Bermudez and Ruben Vives, "Surge in Latino homeless population 'a whole new phenomenon; for Los Angeles," *LA Times*, June 18, 2017, https://www.latimes.com/local/california/la-me-latino-homeless-20170618-story.html; Los Angeles Homeless Services Authority, "Report and Recommendations of the Ad Hoc Committee on Black People Experiencing Homelessness," December 2018, https://www.lahsa.org/documents?id=2823-report-and-recommendations-of-the-ad-hoc-committee-on-black-people-experiencing-homelessness.

Further, much research shows that mental health professionals diagnose Black and Latino populations at much higher rates than they do white people.[31] One meta-analysis of over 50 separate studies found that Black people are diagnosed with schizophrenia at a rate nearly 2.5 times greater than white people.[32] A 2014 review of empirical literature on the subject found that Black people were diagnosed with psychotic disorders three to four times more frequently than white people.[33] This review found large disparities for Latino people as well. CARE Court may place a disproportionate number of Black and Latino people under involuntary court control.

CARE Court Does Not Increase Access to Mental Health Care

The CARE plan would establish a new judicial infrastructure focused on identifying people with mental health conditions and placing them under state control for up to twenty-four months. While touted as an unprecedented investment in support and treatment for people with mental health conditions, in reality, the program provides no new funding for behavioral health care, instead re-directing money already in the budget for treatment to programs required by CARE Court.[34] According to the DHHS presentation on the proposal, the only new money allocated for the program will go to the courts themselves to administer this system of control.[35]

The court-ordered plans will include a "housing plan," but not a guarantee of, or funding for, permanent supportive housing.[36] The court may not order housing or require the county to provide housing.[37] The proposal seems to anticipate allowing shelter and interim housing to suffice if available, without recognizing the vast shortage of affordable housing, especially supportive housing, throughout most of California.[38] To the extent the proposal relies on state investment in housing already in existence, it will prioritize availability of that housing for people under this program, meaning others in need would have less access to that housing.

California Should Invest in Voluntary Treatment and Supportive Services

CARE Court shifts the blame for homelessness onto individuals and their vulnerabilities, rather than recognizing and addressing the root causes of homelessness such as poverty, affordable housing shortages, barriers to access to voluntary mental health care, and racial discrimination. CARE Courts are designed to force unhoused people with mental health conditions into coerced treatment that will not comprehensively and compassionately address their needs.

[31] https://pubmed.ncbi.nlm.nih.gov/29094963/; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4274585/
[32] https://pubmed.ncbi.nlm.nih.gov/29094963/
[33] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4274585/
[34] "CARE (Community Assistance, Recovery and Empowerment) Court," California Health & Human Services Agency.
[35] Ibid.
[36] Ibid.
[37] SB 1338, Section 5982(c).
[38] Ibid.; National Low Income Housing Coalition, "The Gap: A Shortage of Affordable Homes," March 2020, https://reports.nlihc.org/sites/default/files/gap/Gap-Report_2021.pdf, p. 2, 9; California Housing Partnership, "California Affordable Housing Needs Report," March 2020, https://1p08d91kdoc03rlxhmhtydpr-wpengine.netdna-ssl.com/wp-content/uploads/2020/03/CHPC_HousingNeedsReportCA_2020_Final-.pdf.

Californians lack adequate access to supportive mental health care and treatment.[39] However, this program does not increase that access. Instead, it depends on money already earmarked for behavioral health initiatives and layers harmful court involvement onto an already inadequate system. Similarly, the "Care plans" mandated by the CARE Courts do not address the shortage of housing.

Investing in involuntary treatment ties up resources that could otherwise be invested in voluntary treatment and the services necessary to make that treatment effective.[40] California should provide well-resourced holistic community-based voluntary options and remove barriers to evidence-based treatment to support people with mental health conditions who might be facing other forms of social exclusion. Such options should be coupled with investment in other social supports and especially housing, not tied to court-supervision.

Rather than co-opting the language used by movements supporting housing and disability rights and cynically parading the trauma of family members let down by the state mental health system, as proponents of CARE Courts have done, we instead ask that you reject the CARE Court proposal entirely and direct resources towards making voluntary treatment and other necessary services accessible to all who need it.

Sincerely,

Olivia Ensign
Senior Advocate, US Program
Human Rights Watch

John Raphling
Senior Researcher, US Program
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[39] Liz Hamel, Lunna Lopes, Bryan Wu, Mollyann Brodie, Lisa Aliferis, Kristof Stremikis and Eric Antebi, "Low-Income Californians and Health Care," *KFF*, June 7, 2019, https://www.kff.org/report-section/low-income-californians-and-health-care-findings/#:~:text=About%20half%20of%20Californians%20with%20low%20incomes%20%2852,not%20able%20to%20get%20needed%20services%20%28Figure%208%29. ("A majority of low-income Californians (56 percent) say their community does not have enough mental health care providers to serve the needs of local residents.")

[40] Physicians for Human Rights, *Neither Justice nor Treatment: Drug Courts in the United States*, June 2017, phr_drugcourts_report_singlepages.pdf, p. 3.

Exhibit 13

Pages: RJN-0304 through RJN-0323

Cal Voices, Written Testimony dated June 14, 2022, submitted to Assembly Judiciary Committee

Legislative History Report and Analysis for Senate Bill 1338 (Umberg & Eggman – 2022) Chapter 319, Statutes of 2022

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June 14, 2022

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

RE: SB 1338, (Umberg and Eggman). The Community Assistance, Recovery, and Empowerment (CARE) Court Program—Opposition

Dear Chair Stone,

Cal Voices opposes SB 1338 as it creates another system of involuntary treatment through judicial expansion without meeting the needs of California's most vulnerable populations. While we understand the concerns around California's crisis of unhoused individuals, SB 1338 runs afoul of Proposition 63: The Mental Health Services Act, by unconstitutionally amending the Act with services not intended to be funded through the voter initiative. California should focus its efforts on improving access to care, reducing health disparities for BIPOC communities, and ensuring statewide initiatives do not fund services that remain racially biased. CARE Court misses the mark and is not a viable solution to these complex issues. We urge the legislature to abandon this proposal and collaborate with stakeholders to develop a comprehensive strategy to address the root causes of homelessness and untreated mental illness/substance use.

SB 1338 Unconstitutionally Amends Proposition 63: The Mental Health Services Act

When voters approved the MHSA, they were told that funds generated from the tax could only be used for specified new county programs and the expansion of existing, proven voluntary community mental health services. The funds could not be diverted by the State and local stakeholders had an ongoing role in determining the use of the funds, which was based on their current needs and capacity. Therefore, we believe, using MHSA funds for the CARE Court program would be invalid as inconsistent with the MHSA because SB 1338 unconstitutionally amends the MHSA without voter approval.

A. Background

i. AB 3777— the Wright, McCroquodale, and Bronzan Act of 1988[1]

AB 3777 authorized two types of pilot programs for delivering mental health services to seriously mentally ill adults and older adults. One model, the integrated service agency approach, was a separate agency that contracted to provide comprehensive mental health and supportive services for clients for

[1] AB 3777 (C. Wright), Chapter 982, Statutes of 1988 ["An act to add Part 3 (commencing with section 5800) to Division 5 of the Welfare and Institutions code, relating to mental health."].

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a fixed annual rate. Two pilot locations tested this model, Modesto (Stanislaus County) and Long Beach (Los Angeles County). The second model, a system of care approach, was based on providing additional case management resources to better coordinate county mental health, physical health, and other services. This model was piloted in Ventura County. Both models represented an integrated approach to providing mental health services and were the first of their kind in California.

In both models, client outcomes (i.e., their self-reported functional status), not their clinical symptoms, were the focus of the programs. The three pilot programs were successful in:

- Lower inpatient hospital days;
- Fewer involuntary mental health treatment admissions and commitments;
- Reduced arrests and conviction rates;
- Improved access to physical health care and treatment;
- Increased income (from higher wages and greater SSI/SSP utilization); and
- More independent living.[2]

The AB 3777 pilot programs proved to be outstanding in providing innovative and unique treatments and approaches to persons with serious and persistent mental illness. The programs promoted client-oriented services, recovery, and empowerment for participants receiving treatment. Fiscally, the programs substantially reduced expensive acute hospital days, costly jail sentences, and lingering courtroom appearances. Through the services provided in the programs, clients reported starting and maintaining jobs in competitive employment settings, which before this time had not been documented for adults with serious mental illness.[3]

ii. SB 659—The Adult and Older Adult System of Care Act of 1996[4]

In 1996, as the AB 3777 demonstration projects were set to sunset, SB 659—the Adult and Older Adult Mental Health System of Care Act—was enacted to build on the success of the pilot programs. SB 659 codified and established the funding for the adult system of care (the Ventura model), in addition to continuing the funding for the three sites funded by AB 3777 (Ventura, Stanislaus, and Los Angeles), so long as they achieved client and cost outcome goals specified in their program.

iii. AB 34—Mental Health Funding: Local Grants[5]

Enacted in 1999, AB 34 established demonstration projects in several counties to provide mental health and related services to unhoused individuals experiencing mental illness. The bill specified that only those counties with an existing adult system of care were eligible to operate a demonstration project. The target population under the AB 34 demonstration projects were adults with serious mental illness

[2] SB 659, (C. Wright), Senate Appropriation Committee Analysis, hearing date of 1/29/06 [staff comments].
[3] SB 659, Senate Appropriation Committee Analysis, *supra*, note 19.
[4] SB 659 (C. Wright), Chapter 153, Statutes of 1996 ["An act to repeal and add Part 3 (commencing with section 5800) to Division 5 of the Welfare and Institutions code, relating to mental health."].
[5] AB 34, (D. Steinberg), Chapter 617, Statutes of 1999.

who are unhoused, recently released from a county jail or state prison, or others who are untreated, unstable, and at significant risk of incarceration or homelessness, unless treatment was provided. Through these pilot projects, counties were provided funds to establish outreach programs and to provide mental health services, related medication, substance abuse services, housing assistance, vocational rehabilitation, and other services.

In 2000, after a year of implementation, AB 34 had provided funding for mental health outreach demonstration projects in Los Angeles ($4.8 million), Stanislaus ($2.8 million) and Sacramento ($1.9 million) counties.[6]

- ***Sacramento County***. Outreach teams went to parks, levees and other places to find homeless persons to whom they could offer services. The teams identified immediate needs and provided transportation to those services. Sacramento County enrolled 196 people in mental health services as a result of this program.

- ***Stanislaus County.*** 88 people were served by programs funded through AB 34. Stanislaus worked to serve adults who are periodically homeless, and young adults who are transitioning from foster care and the juvenile justice's system. The County also developed housing options for seriously mentally ill adults to best assist in providing mental health treatment.

- ***Los Angeles County.*** The County served 790 people with AB 34 demonstration dollars.[7]

The DMH's findings include the following:

- Fewer than 15% of eligible clients refused enrollment in the program;
- Less than 4% of those enrolled left the program;
- The percent of enrollees hospitalized dropped 64%;
- The number of days of incarceration dropped 74%; and
- The number of days of homelessness dropped 59%.[8]

Through these programs in Sacramento, Stanislaus, and Los Angeles over 900 severally mentally ill people received voluntary mental health services and were stabilized in their community.

iv. AB 2034—Mental Health: Community Services[9]

AB 2034 widened the provisions of the AB 34 demonstration projects. The broader statutory requirements permitted implementation in counties having the capacity to create these services rather

[6] AB 2034 (D. Steinberg), Senate Floor Analysis, 8/25/00, [AB 34 Background].
[7] *Ibid.*
[8] Grantland Johnson, Secretary, Health and Human Services, A Report to the Legislature as Required by Assembly Bill (AB) 2034, "Effectiveness of Integrated Services for Homeless Adults with Serious Mental Illness", May 2000.
[9] AB 34, (D. Steinberg), Chapter 518, Statutes of 2000.

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than being limited only to counties that could expand certain existing programs to include these services. These new requirements, coupled with the additional state funding, enabled a total of 32 county and city programs to implement AB 34's successful programs.[10]

From November 1, 1999, to January 31, 2001 (fifteen months), the data from these programs revealed the following success:

- Less than 20% of clients enrolled in programs chose to leave the program;
- The percentage of days hospitalized dropped 77.7%;
- The number of days incarcerated dropped 84.6%; and
- The number of days spent homeless dropped 69%.[11]

The data shows that program participants remained engaged throughout the length of the program, experienced less hospitalization, reduced days of incarceration, and spent less days homeless. The success of these programs was due to the intensive, integrated outreach, and community-based services that helped people find recovery. By reducing symptoms that impaired their ability to work, maintain community supports, remain healthy, and avoid crime, community mental health services demonstrated their success.[12] Key among these approaches was the very close collaboration at the local level among service providers, including mental health services, law enforcement, and other community agencies—building on the framework established by AB 3777 and SB 659.

B. Proposition 63: The Mental Health Services Act (MHSA)

Building on the success of AB 34 and AB 2034, in November 2004, California voters approved Proposition 63: the Mental Health Services Act (MHSA). The MHSA imposed a new state income tax surcharge to finance the expansion of mental health services in the state. The Analysis, prepared by the Legislative Analyst in the Ballot Pamphlet for the MHSA, described the initiative, in relevant parts, as follows:

> **BACKGROUND**
>
> ***County Mental Health Services.*** Counties are the primary providers of mental health care in California communities for persons who lack private coverage for such care. Both children and adults are eligible to receive such assistance. Counties provide a range of psychiatric counseling, hospitalization, and other treatment services to patients. In addition, some counties arrange other types of assistance such as housing, substance abuse treatment, and employment services to help their clients. *A number of counties have established so called 'systems of care' to coordinate the provision of both medical and nonmedical services for persons with mental health problems*.

[10] "Effectiveness of Integrated Services for Homeless Adults with Serious Mental Illness", *supra*, note 24, at p. 7.
[11] *Ibid.*
[12] *Id*., at p. 3 ["*The data show that days spent homeless or incarcerated and days of inpatient hospitalization have been substantially reduced for enrollees*. The ability to maintain housing once enrolled continues to improve, and a notable increase in the level of employment among enrollees has been achieved."], emphasis added.

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PROPOSAL

This proposition establishes a state personal income tax surcharge of 1 percent on taxpayers with annual taxable incomes of more than $1 million. *Funds resulting from the surcharge would be used to expand county mental health programs*.

How This Funding Would Be Spent. Beginning in 2004-05, revenues deposited in the Mental Health Services Fund *would be used to create new county mental health programs and to expand some existing programs*. These funds would not be provided through the annual state budget act and thus *amounts would not be subject to change by actions of the Legislature and the Governor*. Specifically, the funds could be used for the following activities:

- **Adult System of Care**. *Expansion of existing county system of care services for adults with serious mental disorders* or who are at serious risk of such disorders if they do not receive treatment.

Other Fiscal Provisions. The proposition specifies that the revenues generated from the tax surcharge *must be used to expand mental health services and could not be used for other purposes*. In addition, the state and counties would be prohibited from redirecting funds now used for mental health services to other purposes.

The state would also be prohibited from changing mental health programs to increase the share of their cost borne by a county or to increase the financial risk to a county for the provision of such services unless the state provided adequate funding to fully compensate for the additional costs or financial risk …[13]

C. Operative SB 1338 Amendments

The Legislative Counsel's Digest for SB 1338 states "[t]his bill would clarify that MHSA funds may be used to provide services to individuals under a CARE agreement or a CARE plan."[14] The bill does this by amending sections 5801(legislative findings and intent for Adult and Older Adult System of Care Act) and 5813.5 (financial participation for the Adult and Older Adult System of Care Act) and adding Part 8 (commencing with Section 5970) to division 5 of, the Welfare and Institutions Code, relating to mental health. The chart on the subsequent pages highlights the amendments made by SB 1338.

[13] Ballot Pamp., Gen Elec. (Nov. 2, 2004) Analysis by the Legislative Analyst of Prop. 63, pp 33-35, emphasis added.
[14] Legislative Counsel's Digest for SB 1338.

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Section 5801, subd. (a), para. (5) **In 2004, when MHSA was passed**	Section 5801, subd. (a), para. (5) **Current Law**	Section 5801, subd. (a), para. (5) **As amended by SB 1338**
(5) The client should be fully informed and volunteer for all treatment provided, unless danger to self or others or grave disability requires temporary involuntary treatment.	(5) The client should be fully informed and volunteer for all treatment provided, unless danger to self or others or grave disability requires temporary involuntary treatment, or the client is under a court order for assisted outpatient treatment pursuant to Section 5346 and, prior to the filing of the petition for assisted outpatient treatment pursuant to Section 5346, the client has been offered an opportunity to participate in a treatment plan on a voluntary basis and has failed to engage in treatment.	(5) The client should be fully informed and volunteer for all treatment provided, unless danger to self or others or grave disability requires temporary involuntary treatment, or the client is under a court order for assisted outpatient treatment pursuant to Section 5346 and, prior to the filing of the petition for assisted outpatient treatment pursuant to Section 5346, the client has been offered an opportunity to participate in ~~a treatment plan~~ treatment on a voluntary basis and has failed to engage in that ~~treatment.~~ treatment, or the client is under a court order for CARE pursuant to Part 8 (commencing with Section 5970) and, prior to the court-ordered CARE plan, the client has been offered an opportunity to enter into a CARE agreement on a voluntary basis and has declined to do so.

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Section 5813.5, subd. (f) **In 2004, when MHSA was passed**	Section 5813.5, subd. (f) **Current Law**	Section 5813.5, subd. (f) **As amended by SB 1338**
(f) Each county plan and annual update pursuant to Section 5847 shall consider ways to provide services similar to those established pursuant to the Mentally Ill Offender Crime Reduction Grant Program. Funds shall not be used to pay for persons incarcerated in state prison	(f) Each county plan and annual update pursuant to Section 5847 shall consider ways to provide services similar to those established pursuant to the Mentally Ill Offender Crime Reduction Grant Program. Funds shall not be used to pay for persons incarcerated in state prison. Funds may be used to provide services to persons who are participating in a presentencing or post sentencing diversion program or who are on parole, probation, post release community supervision, or mandatory supervision. When included in county plans pursuant to Section 5847, funds may be used for the provision of mental health services under Sections 5347 and 5348 in counties that elect to participate in the Assisted Outpatient Treatment Demonstration Project Act of 2002 (Article 9 (commencing with Section 5345) of Chapter 2 of Part 1).	(f) Each county plan and annual update pursuant to Section 5847 shall consider ways to provide services similar to those established pursuant to the Mentally Ill Offender Crime Reduction Grant Program. Funds shall not be used to pay for persons incarcerated in state prison. Funds may be used to provide services to persons who are participating in a presentencing or post sentencing diversion program or who are on parole, probation, post release community supervision, or mandatory supervision. When included in county plans pursuant to Section 5847, funds may be used for the provision of mental health services under Sections 5347 and 5348 in counties that elect to participate in the Assisted Outpatient Treatment Demonstration Project Act of 2002 (Article 9 (commencing with Section 5345) of Chapter 2 of ~~Part 1).~~ Part 1), and for the provision of services to clients pursuant to Part 8 (commencing with Section 5970).

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Section 5979, subd. (b) **In 2004, when MHSA was passed**	Section 5979, subd. (b) **Current Law**	Section 5979, subd. (b) **As added by SB 1338**
Not in existence.	Not in existence.	(b) If, at any time during the proceedings, the court finds that the county or other local government entity is not complying with court orders, the court may fine the county or other local government entity up to one thousand dollars ($1,000) per day for noncompliance. If a county is found to be persistently noncompliant, the court may appoint a receiver to secure court-ordered care for the respondent at the county's cost.

Section 5982, subd. (a), para. (1) **In 2004, when MHSA was passed**	Section 5982, subd. (a), para. (1) **Current Law**	Section 5982, subd. (a), para. (1) **As added by SB 1338**
Not in existence.	Not in existence.	5982. (a) The CARE plan may only include the following: (1) Behavioral health services funded through the 1991 and 2011 Realignment, Medi-Cal behavioral health, non-Medi-Cal behavioral health, commercial plans, and services supported by the Mental Health Services Act pursuant to Part 3 (commencing with Section 5800).

D. SB 1338 Amends Rather than Clarifies, the MHSA

The MHSA was passed through the initiative process under Section 8, Article II, of the California Constitution. Section 10(c) of Article II provides that "[w]hen a statute enacted by the initiative process is involved, the Legislature may amend it only if the voters specifically gave the Legislature that power, and then only upon whatever conditions the voters attached to the Legislature's amendatory powers."[15] Section 18 of the MHSA allows its provisions to be amended "by two-thirds vote of the Legislature so long as such amendments are consistent with and further the intent if this act." That same section allows the Legislature to "by majority vote add provisions to clarify procedures and terms" of the Act. While a "clarification" has yet to be defined, our High Court has held that an amendment is "[a] statute which adds to or takes away from an existing statute"[16] and the fundamental question is "whether [the statute] prohibits what the initiative authorizes or authorizes what the initiative prohibits."[17]

Here, after examining the Adult and Older Adult System of Care, the MHSA's plain language, and CARE Court's operative provisions, SB 1338 amends the MHSA. The statute (SB 1338)—by amending Sections 5801 and 5815.5 and adding Part 8 (commencing with Section 5970) to Division 5 of the Welfare and Institutions Code—authorizes what that initiative (Proposition 63) prohibits. It therefore amends, rather than clarifies, the MHSA.

i. Amendments to Sections 5801 and 5813.5 Amend the MHSA

SB 1338 claims it "clarifies"—rather than "amends"—the MHSA by inserting the CARE Court programmatic language into sections 5001[18] 5813.5[19] of the Adult and Older Adult System of Care. This cannot stand. Voters relied on the adult system of care—as it existed in 2004—and they did not know that CARE Court programs and services would be included in the adult system of care, nor did they authorize MHSA funds to be used for this purpose. The MHSA also specifically incorporated the Adult and Older Adult System of Care Act by specific reference and isolated the adult system of care from repeal or modifications that were inconsistent with and did not further the intent of the MHSA. For these reasons, SB 1338 amends, rather than clarifies, the MHSA.

In 1988, AB 3777 created the framework for the adult system of care with several community based mental health pilot projects for severely mentally ill adults. The bill created Part 3 (commencing with Section 5800) of Division 5 of the Welfare and Institutions Code. As the demonstration projects were set to expire, SB 659 repealed and replaced Part 3 (commencing with Section 5800) of Division 5 with the Adult and Older Adult System of Care Act in 1996. SB 659 codified this new and innovative "system of

[15] *Proposition 103 Enforcement Project v. Quackenbush* (1998) 64 Cal.App.4th 1473, 1483-1483 (*Quackenbush*).
[16] *People v. Kelly* (2010) 47 Cal.4th 1008, 1027 (*Kelly*).
[17] *People v. Superior Court* (2010) 48 Cal.4th 564, 571 (*Pearson*).
[18] Section 5801, subd. (a), para. (5), as amended by SB 1338 ["or the client is under a court order for CARE pursuant to Part 8 (commencing with Section 5970) and, prior to the court-ordered CARE plan, the client has been offered an opportunity to enter into a CARE agreement on a voluntary basis and has declined to do so"].
[19] Section 5813.5, subd. (f), as amended by SB 1338 ["and for the provision of services to clients pursuant to Part 8 (commencing with Section 5970)"].

care" model that coordinated the provision of both medical and nonmedical services for people with mental health challenges. Building on this coordinated approach, AB 34 and AB 2034 amended sections 5802, 5806, 5814, and 5814.5 to offer a greater range of comprehensive and coordinated continuum of individualized treatment and care for adults with serious mental illness. The success of the AB 34 and AB 2034 led to the MHSA, which provided additional funding for the programs provided in the adult system of care with the addition of Section 5813.5.

Section 5891 of the Act requires MHSA dollars to be used only for the services outlined in the initiative (i.e., those outlined in Sections 5890 and 5892 of the MHSA).[20] Sections 5890 and 5892 both make specific reference to "Part 3 (commencing with Section 5800), the Adult and Older Adult System of Care Act" and do not mention or reference anything related to CARE Court.[21] Neither does the MHSA voter guide prepared by the Legislative Analyst Office (LAO). As explained to voters, MHSA funds would be used to expand "*existing county system of care services for adults with serious mental disorders* or who are risk of such disorders if they do not receive treatment."[22] SB 1338 alters this promise. As amended by SB 1338, Sections 5801 and 5813.5 attempt to use MHSA funds for a new unproven court ordered behavioral health delivery model that voters did not contemplate, consider, or approve. By amending these sections, SB 1338 is authorizing what the MHSA prohibits. CARE Court services (i.e., those outlined in Sections 5970-5982) which were not part of the "*existing county system of care*" when the MHSA was approved by voters and cannot be funded with MHSA dollars.

To find otherwise would be inconsistent with the well-settled presumptions that the California Supreme Court has established concerning initiatives adopted by voters. First, is the presumption that voters who approve an initiative "have voted intelligently upon an amendment to their organic law, the whole text of which was supplied [to] each of them prior to the election and which they must be assumed to have duly considered."[23] The second presumption, which is also applied to the Legislature, is that voters, in adopting an initiative, did so being "aware of existing laws at the time the initiative was enacted."[24] These presumptions apply with equal force and effect here. Voters were explicitly told that MHSA funding for the adult system of care would be used to *expand existing services for adults* with serious mental illness or at risk of serious mental illness, which SB 1338 does not do.

SB 1338 overlooks the rule of statutory construction discussed by our Supreme Court in *Palermo v. Stockton Theatres, Inc.*[25] The *Palermo* rule provides where a statute adopts by specific reference the provisions of another statute, such provisions are incorporated in the form they existed and not as later modified.[26] Under this rule, the Adult and Older Adult System of Care Act was adopted by specific reference by the MHSA with the phrases "Adult and Older Adult System of Care Act," "adult and older adult system of care," and "Part 3 (commencing with Section 5800)" that are repeatedly cited

[20] WIC § 5891.
[21] WIC §§ 5890 and 5892 [programs and services to be funded by the Act].
[22] See, *supra*, note 21, LAO Analysis of Proposition 63, at p. 33 ["Adult System of Care"].
[23] *People v. Valencia* (2017) 3 Cal.5th 347, 369.
[24] *Ibid.*
[25] (1948) 32 Cal.2d 53, 58-59 (*Palermo*).
[26] *Id.*, at pp. 58–59.

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throughout the various provisions of the MHSA. In other words, by applying *Palermo*, the adult system of care (commencing with section 5800) was frozen in time when the MHSA was passed and cannot be amended without also amending the MHSA.

An illustration of *Palermo* reveals why this rule applies here. In *Palermo*, the plaintiff entered into a lease agreement with a Japanese national under the Alien Land Act, which allowed agreements that were made in accordance with "any treaty now existing" between the United States and Japan.[27] When the treaty with Japan was later abrogated, the plaintiff sought to invalidate the lease.[28] The court held the lease was still valid because the reference in the Alien Land Act ("any treaty now existing") was to the treaty as it existed when the act was passed.[29] The court stated a principle of statutory law: "where a statute adopts by specific reference the provisions of another statute, regulation, or ordinance, such provisions are incorporated in the form in which they exist at the time of the reference and not as subsequently modified, and that the repeal of the provisions referred to does not affect the adopting statute, in the absence of a clearly expressed intention to the contrary."[30]

However, "the *Palermo* rule is not to be applied in a vacuum. The determining factor is legislative intent.[31] The Legislature and the constituency is presumed to have meant what it said and "the plain meaning of the language governs."[32] Here, like *Palermo*, the MHSA did purport to adopt the Adult and Older Adult System of Care Act as "now existing." Section 5895 of the MHSA provides, in its entirety: "In the event any provisions of Part 3 (commencing with Section 5800), or Part 4 (commencing with Section 5850) of this division, *are repealed or modified so the purposes of this act cannot be accomplished, the funds in the Mental Health Services Fund shall be administered in accordance with those sections as they read on January 1, 2004*."[33] This section expressly indicated that the MHSA intended to incorporate "Part 3 (commencing with Section 5800) . . . as they read on January 1, 2004." Indeed, that is what the LAO told voters in their analysis that voters read prior to passing the MHSA. The funds created by the Act would be used for the *"[e]xpansion of existing county system of care services for adults with serious mental disorders* or who are at serious risk of such disorders if they do not receive treatment" and the "revenues generated from the tax surcharge . . . *could not be used for other purposes*."[34]

The legislative intent of the MHSA is clear: the Act incorporated Part 3 (commencing with Section 5800) of Divisions 5 of the Welfare and Institutions Code as it existed in 2004 when the MHSA was passed, not as CARE Court attempts to modify. The Act does not allow MHSA dollars allocated for the adult system of care to be diverted for an unproven court ordered program that was not approved or concerned the voters. SB 1338 thus authorizes what the initiative prohibits and amends, rather than clarifies, the MHSA.

[27] *Id.*, at p. 55.
[28] *Id.*, at pp. 56–57.
[29] *Id.*, at p. 60.
[30] *Id.*, at pp. 58–59.
[31] *In re Jovan B.* (1993) 6 Cal.4th 801, 816.
[32] See e.g., *People v. Pecci* (1999) 72 Cal.App.4th 1500, 1505.
[33] WIC § 5895, emphasis added.
[34] Prop 63: MHSA, Analysis by LAO, *supra*, note 32, at pp. 34-35.

ii. SB 1338's Addition of Sections 5979 and 5982 Amend the MHSA

Section 5891, subdivision (a), of the MHSA provides that 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 such increased costs or financial risk*."[35] CARE Courts provisions run afoul of this protection.

As amended, section 5979, subdivision (b) of SB 1338 states, in its entirety, the following:

> (b) If, at any time during the proceedings, the court finds that the county or other local government entity is not complying with court orders, *the court may fine the county or other local government entity up to one thousand dollars ($1,000) per day for noncompliance*. If a county is found to be persistently noncompliant, the court may appoint a receiver to secure court-ordered care for the respondent at the county's cost.

And section 5892, subdivision (a), paragraph (1) reads:

> The CARE plan may only include the following:
>
> (1) Behavioral health services funded through the 1991 and 2011 Realignment, Medi-Cal behavioral health, non-Medi-Cal behavioral health, commercial plans, and services supported by the Mental Health Services Act pursuant to Part 3 (commencing with Section 5800).

The plain language of section 5892 requires counties to fund CARE Court treatment services with their existing behavioral health funding streams. This section, on its face, violates section 5891's financial structure requirement. By adding Part 8 (commencing with Section 5970) to the Welfare and Institutions Code, the State has increased the counties share of costs and financial risks for the behavioral health services mandated by the CARE Court program. Section 5891's plain language prohibits this without additional funding from the State, which has not occurred. In SB 1338, the State creates a new statewide court ordered behavioral health program that mandates county compliance and implementation, without providing additional funding.

The civil penalty, articulated in section 5979, subdivision (b), also violates section 5891. The possibility of a fine, in the amount of $1,000 a day for noncompliance, undeniably increases a county's "financial risk" to operate the CARE Court program. Again, section 5891 prohibits the State from doing this. Without adequate funding, the State cannot create civil liability for a county's failure to provide court ordered behavioral health services. If the state wants to increase the county's financial risk or hold a county financially responsible for noncompliance, the statute is clear: There must be adequate funding to fully compensate for such increased costs or financial risk. The State has not done so. To date, the State has not allocated or proposed any additional behavioral health funding to implement the CARE

[35] WIC § 5891, subd. (a), emphasis added.

Court proposal. Therefore, by authorizing what the MSHA specifically prohibits, SB 1338 is an amendment of the MHSA.

E. SB 1338 Exceeds the Legislature's Authority Under Article II, Section 10, Subdivision (c) of the California Constitution and Section 18 of the MHSA

As noted above, the MHSA states that the Legislature may amend the provisions of the MHSA by a two-thirds vote so long as the amendments are "consistent with and further the intent of" the Act. In reviewing any proposed amendments, courts generally strictly construe this type of limitation on the Legislature, but they also must ensure that the voter's restrictions are given the effect that the voters intended them to have.[36] The purpose of this limitation on the Legislature's power is to "protect the people's initiative powers by precluding the Legislature from undoing what the people have done, without the electorate's consent."[37]

In *Amwest*, the Supreme Court considered whether a legislative amendment to Proposition 103, the Insurance Rate Reduction and Reform Act, was valid pursuant to the terms of the initiative. With Proposition 103, Section 8(b), the electorate had limited the Legislature's ability to amend the initiative to those amendments that "furthered its purposes." The Supreme Court determined that it would uphold the validity of the challenged amendment if "by any reasonable construction, it can be said that the statute furthers the purposes of Proposition 103."[38] To determine the purposes of Proposition 103, the Supreme Court was "guided by, but not limited to, the general statement of purpose found the initiative." The Court also looked at context within which Proposition 103 was passed as instructive in evaluating the Proposition's purposes.

The plain language of the MHSA, which was described in general terms to the voters by the LAO[39] reflect themes of county responsibility, an emphasis on voluntary, community-based, individualized treatment services, and insulation of MHSA funds from diversion by the Governor and the Legislature. The Act specified that the funding shall be used to expand the existing county services for adults[40] and children[41] and to create new programs including services for children with serious mental illness,[42]county services for prevention and early intervention,[43] innovative county programs,[44] and a new program with

[36] Amwest Surety Ins. Co. v. Wilson (1995) 11 Cal.4th 1243, 1255 (Amwest).
[37] Proposition 103 Enforcement Project v. Charles Quackenbush (1998) 64 Cal.App.4th 1473, 1484.
[38] Id., at p. 1256. We note, however, that the restriction in Proposition 63 represents a more rigorous test that the Court considered in Amwest. The MHSA requires a two-prong evaluation as to whether the amendment is both consistent with and furthers the intent of the Act, whereas Proposition 103 requires only that the amendment "furthers its purposes." (See Stats. 1988, p A-290.)
[39] See excerpts from LAO's Analysis in Point Heading B ["Proposition 63: the Mental Health Services Act], at pp. 9-10.
[40] WIC §§ 5813.5, 5847, 5892, and 5897.
[41] WIC §§ 5847, 5892, and 5897.
[42] WIC §§ 5878.1-5878.3.
[43] WIC §§ 5840-5840.2, 5847, 5892, and 5897.
[44] WIC §§ 5830, 5847, 5892, and 5897.

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dedicating funding for human resources, education, and training to remedy the shortage of qualified service providers.[45]

In addition, the MHSA clearly reflected an intent to isolate MHSA revenue, designate the specified uses for the dollars, eliminate the ability of the Legislature and the Governor from diverting the funds for non-specified uses, and make counties and local stakeholders responsible for both developing and implementing the specified programs. For example, the Mental Health Services Fund (MHSF) is continuously appropriated by the Act for the designated purposes described above, which means the Legislature and the Governor do not control the expenditure of funds though the annual state budget.[46]

To the extent that the MHSA established broad categories of programs to be funded, the development and implementation of the programs rest primarily at the local level. Counties are required to develop three-year program and expenditure plans for programs receiving MHSA funds within the designated categories, with the plan to be updated at-least annually.[47] Each plan and update must be developed with local stakeholders, including circulation of a draft, notice and comment period, and a public hearing.[48]

Having reviewed the context and plain language of the MHSA, the issues and concerns with the CARE Court program become apparent. The primary concerns consist of the following:

i. Use of MHSA funds for CARE Court is Not Listed as An Approved Use and is Inconsistent with the Dynamic Nature of Three-Year Plans

In this case, neither the plain language nor the ballot information mentions the use of the MHSA revenue for court ordered mental health services, such as those required by CARE Court. Thus, the voters were not put on notice that the funds would be used for this purpose and are prohibited from withdrawing or changing their vote now. This notice is critical for programs funded through tax revenues, because the electorate's right to repeal or suspend a tax cannot be surrendered or suspended by a grant or contract under the constitution.[49]

Under the MHSA, the program is structured to allow flexibility over time. Counties are required to develop three-year plans that are updated annually. This dynamic feature of the proposal was touted as evidence that the MHSA "requires strict accountability" because "to ensure accountability, they can cut off programs that aren't effective."[50] This type of accountability is identified as one of the purposes and intentions of the MHSA in the Proposition itself.[51]

[45] WIC §§ 5820-5822, 5892, and 5897.
[46] WIC § 5890.
[47] WIC § 5847.
[48] WIC § 5848.
[49] California Constitution, Article XIII, section 31.
[50] Ballot Pamp., Gen. Elec. (Nov. 2, 2004) Rebuttal to Argument Against Prop. 63, p 37
[51] Proposition 63, Section 3 Purpose and intent, subsection (e): "To ensure that all funds are expended in the most cost-effective manner and services are provided in accordance with recommended best practices subject to local and state oversight to ensure accountability to the taxpayers and to the public."

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SB 1338 has indicated that the CARE Court program would need to be included in a county's three-year plan, but this is deceptive given the State mandate. Local stakeholders cannot repeal CARE Court's provisions or tell their counties to not implement the program. SB 1338 requires CARE Court to be implemented in all of California's counties within their existing behavioral health budgets. Even if stakeholders do not want funds used for CARE Court, the county may be required to use these funds to comply with the mandate. The $1,000 dollar fine for each day of noncompliance makes this reality quite possible. To avoid civil penalties, counties will need to use whatever funds they have to comply with this new obligation, even if that means using MHSA funds against stakeholder's requests.

The MHSA was premised on the ability of each county, in each year, to evaluate the county's capacity to serve, relative to its unmet need, in the context of the amount of funding available and whether the county can serve that need. All these indices will change for each county on an annual basis. A long-term commitment to CARE Court, as a result of a state mandate may limit a county's ability to comply with the MHSA's requirement to be responsive to the unmet needs. As unmet needs change over time, CARE Court respondents will be prioritized over non-CARE Court clients. That prioritization cuts against the dynamic nature of three-year plans aimed at identifying and serving those with unmet needs in a particular county. As a result, SB 1338 is inconsistent with and does not further the intent of the MHSA.

ii. The Creation of a New, Unproven Involuntary Program Was Never Proposed to Voters and Is Inconsistent with the Initiatives on the Expansion of Proven County Services and the Prohibition Against State Diversion for Unspecified Purposes.

As described above, the focus of the MHSA based on the context of the initiative and its plain language is an increase in funding of designated county mental health services, as proposed and implemented at the local level, and restrictions on the ability of the state to alter the priorities specified in the law. Both Proposition 63 and the Ballot Pamphlet emphasize the notion that the funding would be used to expand community-based programs that have already demonstrated success.[52]

[52] Proposition 63, Section 2, Findings and Declarations, subdivision (e), "With effective treatment and support, recovery from mental illness is feasible for most people. The State of California has developed effective models of providing services to children, adults and seniors with serious mental illness. A recent innovative approach, begun under Assembly Bill 34 in 1999, was recognized in 2003 as a model program by the President's Commission on Mental Health. This program combines prevention services with a full range of integrated services to treat the whole person, with the goal of self-sufficiency for those who may have otherwise faced homelessness or dependence on the state for years to come. Other innovations address services to other underserved populations such as traumatized youth and isolated seniors. These successful programs, including prevention, emphasize client-centered, family focused and community-based services that are culturally and linguistically competent and are provided in an integrated services system."

Section 3, Purpose and Intent, "The people of the State of California hereby declare their purposes and intent in enacting this act to be as follows: (c) To expand the kind of successful, innovative service programs for child, adults and seniors begun in California, including culturally and linguistically competent approaches for underserved populations. These programs have already demonstrated their effectiveness in providing outreach and integrated services, including medically necessary psychiatric services, and other services to individuals most severely affected by or at risk of serious mental illness."

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The rebuttal to Argument Against Proposition 63 in the Ballot Pamphlet makes a forceful statement regarding these points. It stated, in part, as follows.

> PROPOSITION 63 EXPANDS A PROGRAM THAT WORKS.
>
> After decades of neglecting mental illness, California began an experimental, community-based mental health program five years ago. It helps teenagers and adults get the care they need from one place. Special community teams offer treatment, medicines, housing, job training, and other assistance. The program has been studied extensively. (See www.AB34.org.) The results show that three times more people found employment than had worked previously. Those enrolled had a 66% reduction in hospital days, and an 81% reduction in jail days. A panel of nationally recognized experts calls this program a model for the nation.
>
> PROPOSITION 63 REQUIRES STRICT ACCOUNTABILITY.
>
> Under Proposition 63:
> 1. Funding goes only to these proven, new programs.
> 2. Bureaucrats can't redirect the funding.
> 3. An oversight panel of independent, unpaid members supervise expenditures.
> 4. To ensure accountability, they can cut off programs that aren't effective.[53]

Reducing homelessness and serious mental illness are mentioned in both the initiative and the Ballot Pamphlet as an issue for California. However, the "proven, new" programs being promoted are generally described as "community based" programs which provide a variety of integrated services, without a court order. Even a casual review of the AB 34 and AB 2034 programs provides no indication that these programs required a court to order them nor any other involuntary component. At all times the services and supports were optional, irrespective of their mental illness, level of care, or risk of noncompliance with a treatment program.

The MHSA also has numerous controls on the use of revenue, including continuous appropriation of the fund to avoid state diversion, a detailed inventory of the activities to be funded, and an explicit statement that the funding can only be used for those specifically designated purposes. On this point, the MHSA's legislative history[54] provides guidance. Following early drafts of the MHSA,[55] stakeholders expressed concerns that MHSA funds may be diverted from services created by the Act to fund other

[53] Ballot Pamp., Gen. Elec. (Nov. 2, 2004) Rebuttal to Argument Against Prop. 63, at p. 37

[54] The documents cited in this section were provided to the author of this letter by Sherman Russell Selix Jr. (Rusty Selix), the Co-Author of Proposition 63. He sent them via email prior to his death. The documents have since been uploaded to a google drive to be shared with the public. Each document has its own google drive link for ease of accessibility.

[55] See Revised Draft of the MHSA, 07/02/03, at sections 5890, 5891, *et seq*., accessible at https://drive.google.com/file/d/1segxUeRtOXADRGqCoB9V83n4e3eY5SI9/view?usp=sharing

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purposes.[56] This was a major concern for additional MHSA revenue. And to address these concerns, the MHSA was revised[57, 58] and a "Guide to the MHSA" was drafted and shared, explaining the "fiscal parts of the measures" to stakeholders.[59]

The guide stated that revisions were made to the MHSF to do the following.

1. Establish this fund as a special fund independent from the State General Fund *so that all of its funds are reserved for this purpose and not subject to appropriation for any other state purposes*.

2. Ensure that these *funds are only utilized to fund the programs that are set forth in the ballot measure*.

3. Make sure that these *funds are designed to supplement and not replace any existing state and county funding* that is currently available.[60]

Section 5891, as it appeared in the Voter Information Guide, reflected these changes.[61] Even as the structure of the MHSA's funding source was criticized and described as "fatally flawed" by the measure's opponents, voters were assured otherwise by Ballot Pamphlet. [62] Voters were told that "bureaucrats [could not] redirect the funding"[63] and that the "funding goes *only* to these proven, new programs."[64] MHSA dollars would be used to expand "*existing county system of care services for adults with serious mental disorders*" only and not for funding other existing mental health services, such as holds and conservatorships under the LPS Act.[65] Instead, they would "supplement," rather than "replace" existing state and county behavioral health funding streams. As explained to voters, "*Proposition 63 makes this*

[56] Email to Rusty Selix, Comments Received on Draft Versions of the MHSA, accessible https://drive.google.com/file/d/1F2nbwRcWtuXAcUDM13dJcZSH7tgUoafs/view?usp=sharing

[57] MHSA Revised Draft, 08/01/03, Composite of All Input, at sections 5891, 5892, and 5893, accessible at https://drive.google.com/file/d/1IZwFbtlT8xZj8IM7oitZUcL9-Oxe8oLg/view?usp=sharing

[58] MHSA Revised Draft, 08/05/03, Composite of All Input, at sections 5891, 5892, and 5893, accessible at https://drive.google.com/file/d/1nU3DUmvVrSX-Ho6Fbq0Tgm3Ptz2018QY/view?usp=sharing

[59] Guide to the MHSA, drafted by Rusty Selix, the Co-Author of the MHSA, on 8/08/03, at p. 6, accessible at https://drive.google.com/file/d/1hLxLRjZJPUW-2B1GpjYgUShXNHTIqE7q/view?usp=sharing

[60] *Id.*, at pp. 5-6 [Mental Health Services Fund explanation], emphasis added.

[61] Voter Information Guide, Gen. Elec. (Nov. 2, 2004), Text of Proposed Laws, at p. 107 ["The funding established pursuant to this act shall be utilized to expand mental health services. These funds shall not be used to supplant existing state or county funds utilized to provide mental health services. . .. 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 such increased costs or financial risk. These funds shall only be used to pay for the programs authorized in Section 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 Section 5892."], emphasis added.

[62] *Id.*, at p. 37 [Argument Against Proposition 63 and Rebuttal to Argument Against Proposition 63].

[63] *Ibid.*

[64] *Ibid*., emphasis added.

[65] *Ibid.*

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new model program available to the thousands now turned away" because "[r]ight now the program is small, reaching *fewer* than 10% of those who could benefit. [66]

By amending sections 5801 and 5813.5, SB 1338 clashes with and does not further the intent of the MHSA. CARE Court seeks to use MHSA funds for the very same involuntary services that the MHSA sought to avoid, and in fact, did. The MHSA was based on the overwhelming success of the voluntary mental health services and supports created by the AB 34 and AB 2034, which built on the pilot programs created by AB 3777 and SB 659. This is not what SB 1338 seeks to do. The bill does not expand the "these proven" new and innovative programs. Using MHSA funds for involuntary services means less funding for voluntary treatment—a gross deviation of the Act's purpose and intent—which was to increase voluntary mental health care for those who were being "turned away."

From the plain language of the initiative, the voter information guide, and the MHSA's legislative history, MHSA revenue was never intended to be used for CARE Court. The plain language of the Act restricts the state's ability to divert funds for unspecified programs and limits the state's use of MHSA dollars for unspecified uses. There is no indication that voters contemplated the creation of a new, complex, state-controlled court ordered mental health treatment program which would divert funding from the specified priorities into perpetuity, particularly when the MHSA's legislative history does not support the use of MHSA funds for this purpose. SB 1338 is therefore inconsistent with the purpose and does not further the intent of the MHSA.

Conclusion

CARE Court is bad policy, as it fails to address Californians' evolving behavioral health needs, the widening chasm between these needs and the services provided through the state's public behavioral health system, and the economic factors contributing to the ongoing homelessness crisis. CARE Court essentially concedes California lacks the ingenuity, vision, and commitment to solve the real problems its citizens are facing. Forcing people into treatment or conservatorships because we are unable to meet their health care and housing needs is a sad reflection on California's state and local governments. Rather than blaming the victims of our failures, let's work together on real solutions.

If you have any questions, feel free to contact me at mgallagher@calvoices.org or (916) 792-1425. We welcome all opportunities to work together to identify viable alternatives to CARE Court that address the causes of homelessness, strengthen the Public Behavioral Health System, and preserve individuals' civil liberties.

Sincerely,

/s/ ***Matt Gallagher***

Matthew R. Gallagher, Esq.
Assistant Director

[66] *Ibid*., emphasis in original.

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Cc: Senator Umberg
Senator Eggman
Leora Gershenzon, Deputy Chief Counsel to the Assembly Judiciary Committee
Toby Ewing, Executive Director, MHSOAC
Chair Madrigal-Weiss, MHSAOC

Exhibit 14

Pages: RJN-0324 through RJN-0337

Assembly Committee on Appropriations, Analysis, Date of Hearing: August 3, 2022

Legislative History Report and Analysis for Senate Bill 1338 (Umberg & Eggman – 2022) Chapter 319, Statutes of 2022

Date of Hearing: August 3, 2022

ASSEMBLY COMMITTEE ON APPROPRIATIONS
Chris Holden, Chair
SB 1338 (Umberg) – As Amended June 30, 2022

Policy Committee:	Judiciary	Vote:	9 - 1
	Health		14 - 0

Urgency: No State Mandated Local Program: Yes Reimbursable: Yes

SUMMARY:

This bill establishes the Community Assistance, Recovery, and Empowerment (CARE) court program (CARE court or CARE Act) and the CARE Act to provide comprehensive treatment, housing, and support services to Californians with complex behavioral health care needs.

Specifically, this bill:

1) Requires the CARE Act to be implemented, with technical assistance and continuous quality improvement, as follows:

   a) A first cohort of counties, representing at least half of the population of the state, will begin no later than July 1, 2023, with additional funding provided to support the earlier implementation date.

   b) A second cohort of counties, representing the remaining population of the state, will begin no later than July 1, 2024.

2) Requires a respondent qualify for CARE proceedings only if all of the following criteria are met:

   a) The person is 18 years of age or older.

   b) The person is currently experiencing a serious mental illness, as defined, and has a diagnosis of schizophrenia spectrum or other psychotic disorder as defined in the most current version of the Diagnostic and Statistical Manual of Mental Disorders, provided that nothing is construed to establish a respondent's eligibility based upon a psychotic disorder that is due to a medical condition or is not primarily psychiatric in nature, including but not limited to physical health conditions such as traumatic brain injury, autism, dementia, or neurologic conditions.

   c) The person is not clinically stabilized in on-going treatment.

   d) At least one of the following is true: (i) the person is unlikely to survive safely in the community without supervision and the person's condition is substantially deteriorating, or, (ii) the person is in need of services 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.

e) Participation in the CARE proceedings would be the least restrictive alternative necessary to ensure the person's recovery and stability.

f) It is likely that the person will benefit from CARE proceedings.

2) Prohibits a person who has a current diagnosis of substance use disorder (SUD), as defined, but who does not meet the required criteria above, from qualifying for CARE court proceedings.

3) Permits proceedings to commence in any of the following locations:

a) The county in which the respondent resides.

b) The county where the respondent is found, except as specified.

c) The county where the respondent is facing criminal or civil proceedings.

4) Allows a petition to initiate a CARE proceedings to be brought by:

a) A person 18 years of age or older with whom the respondent resides or a spouse, parent, adult sibling, adult child, or grandparent of the respondent, or another adult who stands *in loco parentis* to the respondent.

b) The director of a hospital, or their designee, in which the respondent is hospitalized, or the director of a public or charitable organization, agency, or home, or their designee, that is currently, or within the previous 30 days, providing behavioral health services to the respondent or in whose institution the respondent resides.

c) A licensed behavioral health professional, or their designee, who is treating, or treated the respondent within the last 30 days.

d) A first responder, including a peace officer, firefighter, paramedic, emergency medical technician (EMT), mobile crisis response worker, or homeless outreach worker who has had repeated interactions with the respondent in the form of multiple arrests, multiple detentions, and transportation under the Lanterman-Petris-Short (LPS) Act, multiple attempts to engage the respondent in voluntary treatment or other repeated efforts to aid the respondent in obtaining professional assistance.

e) The public guardian or public conservator of the county in which the respondent is present or reasonably believed to be present (a respondent may be referred from conservatorship proceedings).

f) The director of a county behavioral health agency, or their designee, of the county in which the respondent resides or is found (a respondent may be referred from assisted outpatient treatment (AOT) proceedings).

g) The director of the county adult protective services or their designee of the county in which the respondent resides or is found.

h) The director of a California Indian health services program, California tribal behavioral health department, or their designee.

i) The judge of a tribal court that is located in California, or their designee.

j) A prosecuting attorney (a respondent may be referred from misdemeanor proceedings, as provided).

k) The respondent.

5) Requires the CARE court petition to be signed under penalty of perjury and contain all of the following:

a) The name of the respondent, their address, if known, and the petitioner's relationship with the respondent.

b) Facts that support petitioner's allegation that the respondent meets the criteria of the CARE court, as defined above.

c) Either of the following:

i) An affidavit of a licensed behavioral health professional stating that the health professional or their designee has examined the respondent within 60 days of the submission of the petition, or has made multiple attempts to examine, but has not been successful in eliciting the cooperation of the respondent to submit to an examination, within 60 days of submission of the petition, and that the licensed behavioral health professional has determined that the respondent meets, or has reason to believe, explained with specificity in the affidavit, that the respondent meets, the diagnostic criteria for CARE proceedings.

ii) Evidence that the respondent was detained for a minimum of two intensive treatments pursuant to the LPS Act, the most recent of which must be within 60 days from the date of the petition.

6) Requires, upon receipt of a CARE court petition, the court to promptly review the petition to determine if it meets the requirements of CARE Court, as stated above.

7) States the following about the petition:

a) If the court finds the petition does not meet the requirements of CARE court, the court shall to dismiss without prejudice, except as specified.

b) If the court finds that the petition may meet the requirements of CARE court, the court shall order a county agency, or its designee, as determined by the judge, to investigate as necessary and file a written report with the court within 21 days.

c) Requires the written report to include a determination as to whether the respondent meets, or is likely to meet, the criteria for CARE court, and the outcome of efforts made to voluntarily engage the respondent during the 21-day report period.

d) Requires the court to provide notice to the respondent and petitioner that a report has been ordered.

8) Allows the court, at any point in the proceedings, if it determines, by clear and convincing evidence, that the respondent, after receiving notice, is not participating in the CARE proceedings, to terminate respondent's participation in the CARE program and allows the court to make a referral under the LPS Act, as provided.

9) Allows the court, at any time in the proceeding, if it finds that the county, or other local government entity, is not complying with its orders, to fine the county, or other local government entity, up to $1,000 per day for noncompliance.

10) Allows the court, if a county is found to be persistently noncompliant, to appoint a receiver to secure court-ordered care for the respondent at the county's cost.

11) Establishes the CARE Act Accountability Fund (fund) in the State Treasury to receive penalty payments from each county as collected. Requires that all monies in the fund are reserved and continuously appropriated, without regard to fiscal years.

12) Requires, subject to approval from the Department of Finance, the Department of Managed Health Care (DMHC), to determine how funds may be used to support local government efforts that will serve individuals who have schizophrenia or other psychotic disorders who experience or are at risk of homelessness, criminal justice involvement, hospitalization or conservatorship.

13) Requires individuals who are CARE court participants to be prioritized for any appropriate bridge housing funded by the Behavioral Health Bridge Housing program.

14) Requires no later than July 1, 2023, DMHC and California Department of Insurance (CDI) to issue guidance to health plans or insurers regarding compliance with the CARE Act. Exempts the guidance from being subject to the Administrative Procedure Act (APA) and that such guidance is effective only until DMHC and CDI adopt regulations under the APA.

FISCAL EFFECT:

1) Costs (General Fund (GF)) in the tens of millions of dollars to Judicial Council of California (JCC) for courts to operate the CARE Act. The 2022 Budget allocates $39.5 million from the GF in fiscal year (FY) 2022-23 and $37.7 million ongoing for the courts to conduct CARE court hearings and provide resources for self-help centers. According to the Administration, it is continuing to work with the JCC and counties to estimate costs associated with this new process. JCC estimates costs of approximately $40 million to $50 million related to conducting additional hearings, expanding self-help centers, and updating court case management systems.

2) Possibly reimbursable costs (GF and local funds) in the hundreds of millions of dollars to low billions of dollars to counties, including local behavioral health departments, to provide services to CARE court participants. According to the California State Association of Counties (CSAC), costs include as much as $40,000 per participant for at least 12,000 participants (although county offices believe the number of participants could be much higher - as high as 50,000 participants), court-ordered investigations, evaluations, and

reporting requirements, and one-time start-up costs. Costs to the GF will depend on whether the duties imposed by this bill constitute a reimbursable state mandate, as determined by the Commission on State Mandates.

3) Possible cost pressure (GF) to the California Department of Health and Human Services (CHHSA), possibly in the millions of dollars to engage in an independent, research-based entity to advise on the development of data-drive processes and outcome measure for the CARE Act and provide support and coordination between stakeholders during the implementation process.

4) Costs (GF) possibly in the tens of millions of dollars to the Department of Health Care Services (DHCS) to provide training to support to people enrolled in CARE court. Costs include providing technical assistance to counties and contractors, overseeing stakeholder engagement on the CARE Court model, developing guidance for counties on CARE Court responsibilities; implementing processes to support ongoing data collection and reporting; analyzing data and developing an annual legislative report; and, publishing an independent evaluation. Costs may also result from increased Medi-Cal utilization rates by individuals referred to the CARE court program, who otherwise may not have been existing beneficiaries. Possible cost savings to state public health systems to the extent that peer support services provide support and assistance to Medi-Cal beneficiaries with mental illness and reduce the need for more expensive downstream services, such as inpatient hospitalizations or incarceration.

5) Possibly reimbursable costs (GF and local funds) in the millions of dollars to counties for public defender services. This bill requires a person to receive counsel before ruling on a CARE court petition. Section 5977, subdivision (a)(5)(A)(ii)(II) requires a court to appoint a qualified legal services project to represent any person in the CARE court program that does not already have counsel. If a legal services project declines representation, the public defender is appointed. Only 14 counties have legal services organizations and most do not have enough attorneys to handle even their existing workload. Therefore, it seems far more likely this bill will result in increased duties on county public defenders. Existing law already requires public defenders to represent individuals in LPS and other conservatorships. The

6) Cost pressure (GF), possibly in the hundreds of millions of dollars on state and local housing programs, to the extent this bill increases utilization of the specified housing programs, including the Bridge Housing program, HOME Investment Partnership Program, Housing and Urban Development (HUD) Continuum of Care program, and emergency housing vouchers, among other programs identified in this bill. In addition, as this bill reprioritizes CARE plan program participants in the Behavioral Health Bridge Housing program, it does not increase the funding for Bridge Housing in this bill. The 2021 Budget Act allocated a $12 billion multi-year investment for local governments to build housing and provide critical supports and homelessness services. The 2022 Budget Act includes an additional $3.4 billion GF over three years to continue the state's efforts by investing in immediate behavioral health housing and treatment, as well as encampment cleanup grants, and extends for an additional year support for local government efforts. It is unknown whether existing allocations for housing will be sufficient.

7) Costs (GF) to the Department of Insurance (CDI) of $17,000 in FY 2022-23 and $12,000 FY 2023-24.

8) California Department of Social Services (CDSS) reports no costs. However, this bill may result in considerable cost pressures, possibly in the millions of dollars, downstream to local county welfare departments. The Care Act will likely result in increased use of several programs such as the CalWORKS Housing Support Program, SSI/SSP, Cash Assistance Program for immigrants, CalWORKs, CalFresh, and homeless housing assistance and prevention. This bill may generate costs in the form of local assistance, as county welfare departments will have to conduct participant eligibility, redetermination, and screening for programs. While the bill would be implemented on a county-level, the workload for CDSS to provide technical assistance, program monitoring, and to issue new or updated guidance or all county letters to implement the bill may result in the need for GF money.

9) Department of Managed Health Care (DMHC) reports costs (GF) to draft regulations and provider technical assistance will be minor and absorbable.

COMMENTS:

1) **Purpose.** This bill is sponsored by the Governor and is intended to address the homelessness crisis in California. Multiple large cities and business groups support this bill while numerous civil rights and mental health assistance advocates remain strongly opposed. According to Governor Newsom in a June 28, 2022 press release:

> Californians understand that we need a paradigm shift to help the thousands of individuals in crisis suffering with untreated psychosis and too often living on the streets. The passage of CARE Court will not only bring relief to those in dire need of care in the community, but it will also bring hope to their friends and family members who feel helpless under today's status quo.

According to the author:

> County behavioral health departments provide Medi-Cal specialty mental health services to those who are enrolled in Medi-Cal and have severe mental illness. However, many of the most impaired and vulnerable individuals remain under or un-served because: (a) the individual is so impaired they do not seek out services, (b) the necessary services are not available at the right time due to administrative complexities and/or legal barriers, (c) client care lacks coordination among providers and services, resulting in fragmentation among provided services, and (d) little accountability at various levels of the system results in poor outcomes for the client, who is often living on the streets. This legislation seeks to overcome these barriers by connecting individuals to services, requiring coordination, and adding a necessary layer of accountability through the courts.

2) **Housing First.** California law requires that any proposed homelessness solution focus on "Housing First." SB 1380 (Mitchell) Chapter 847, Statutes of 2016, created the California Interagency Council on Homelessness to oversee implementation of Housing First regulations and coordinate the state's response to homelessness, as well as create

partnerships among state agencies and departments, local government agencies, nonprofits, and federal agencies to prevent and end homelessness in California. SB 1380 also aligned the Housing First guidelines with any state program that provides housing and supportive services to people experiencing homelessness. Housing First is an evidence-based model that uses housing as a tool, rather than a reward, for recovery and that centers on providing or connecting homeless people to permanent housing as quickly as possible. Housing First providers offer services as needed and requested on a voluntary basis and do not make housing contingent on participation in services.

This bill does not mandate housing for CARE court participants, but identifies numerous state and federal housing programs that may be used to provide housing to CARE court participants. It grants housing priority for any *"appropriate bridge housing funded by the Behavioral Health Bridge Housing program."* However, it does not require a person be placed in supportive housing before being enrolled in CARE court. Opponents of this bill argue that any mental health assistance will likely be unsuccessful until a person is provided safe and stable housing. According to Housing California:

> Instead of allocating vast sums of money towards intimidating and likely unsuccessful court-ordered treatment that does not guarantee housing, the state should expend its resources on a proven solution to houselessness for people living with mental health disabilities: guaranteed housing with voluntary services. Given that housing reduces both utilization of emergency services and contacts with the criminal legal system, a team of UC Irvine researchers concluded that it is 'fiscally irresponsible, as well as inhumane' not to provide permanent housing for Californians experiencing houselessness. To effectuate guaranteed housing, California should invest in low-barrier, deeply affordable (15% of area median income or less), accessible, integrated housing for people experiencing houselessness.

The Governor's Summary of the 2022 Budget Act states:

> The Administration continues to work with the Judicial Council and counties to estimate costs associated with this new court process. In addition, the Budget includes significant investments in community treatment and care for individuals suffering from mental illness who are deemed incompetent to stand trial. The Budget also allocates opioid settlement funds, expands medication assisted treatment, and expands community-based mobile crises services. All of these investments will better serve individuals experiencing mental illness and substance use disorders. To support the implementation of these and other efforts, the Budget also includes $1.5 billion to invest in a multi-pronged effort to develop and train thousands of new care economy workers, including various mental health professionals and 25,000 new community health workers.

It is unclear whether this bill is contrary to California's Housing First policy because it does not mandate housing to any person referred to CARE court. According to the CHHSA discussion of CARE court on its website, "A person should be offered housing before they can reasonably be expected to engage in intensive mental health services." Existing evidence suggests mental health treatment is best achieved after a person is placed in stable housing. According to a study on Housing First principles in Santa Clara County published in the National Library of Medicine, permanent supportive housing (which incorporates Housing First principles) combined with intensive case management, significantly reduced psychiatric emergency room visits and increased the rate of scheduled outpatient mental health visits compared to the control group.

3) **Disparate Impact.** Opponents of this bill allege it will result in racially disparate impacts to communities of color, and in particular, Black Californians. AB 3121 (Weber), Chapter 319, Statutes of 2020, created the Task Force to Study and Develop Reparation Proposals for African Americans. The Taskforce issued its first report in June 2022 wherein it detailed historical and continued discrimination against Black Californians in, among other things, housing and medical services. As a result, Black Californians suffer a disproportionate rate of homelessness and are more likely to receive an inaccurate mental health diagnosis. According to the Racial and Ethnic Mental Health Disparities Coalition:

> The Reparations Report recounts the history of racial discrimination enacted against Black people in the health care system over centuries, including the weaponizing of a mental health diagnosis to force sterilization and treatment. Research demonstrates that Black, Indigenous, and People of Color (BIPOC) and immigrant racial minorities are more likely to be diagnosed, and misdiagnosed, with psychotic disorders than white Americans because of clinicians' prejudice and misinterpretation of patient behaviors. In California, rates of those living with mental health disabilities requiring intense support vary considerably by racial and ethnic groups, with American Indian and Alaska Native and Black Californians experiencing the highest rates of diagnosis for serious mental health disabilities. For unhoused LGBTQIA+ people of color, the intersecting identities can result in even more significant mental health struggles and intensified discrimination.

The World Journal of Psychiatry published a report in December 2014 entitled, "Racial disparities in psychotic disorder diagnosis: A review of empirical literature," which found:

> The preponderance of literature clearly shows how African Americans are more frequently misdiagnosed than Euro-Americans, with research findings initially gaining momentum since the early 1980's. In particular, African Americans are disproportionately diagnosed with Schizophrenia with estimates ranging from three to five times more likely in receiving such a diagnosis. … Clinician-perceived honesty was lower for African American consumers, a factor found to be a significant correlate of increased Schizophrenia diagnoses among African Americans.

> Conversely, increased distrust and a poorer clinical relationship were reported by African American consumers.

Opponents further argue that CARE court will result in higher rates of involuntary detention because any person who does not participate in court when eligible may be referred to LPS conservatorship proceedings, which includes involuntary detention and may include forced medication. Additionally, and as explained in greater detail below, it is unclear how a person will get to court to determine eligibility. This bill allows peace officers to file CARE court petitions. If law enforcement is responsible for rounding up possible CARE court candidates, members of a community that already do not trust law enforcement because of centuries of oppression, may react aggressively out of fear, leading to possibly deadly and tragic consequences.

While the opponents do not suggest the status quo is sufficient, several racial justice organizations have expressed serious concern that this bill may result in forced incarceration and even institutionalization of people of color. California has enacted several laws to root out institutional racism, including AB 2542 (Kalra), Chapter 317, Statutes of 2020, which allows a defendant to file a motion in court requesting re-sentencing where there is evidence of racial discrimination, and, as noted above, AB 3121. The opponents contend this bill is in diametric opposition to existing efforts to end institutional racism.

4) **Due Process**. In addition to a "Housing First" policy in response to homelessness, existing law also requires that any person placed in a mental health treatment program or conservatorship be placed in the least restrictive environment. This bill does not provide the CARE court recipient a choice about which mental health treatment program they wish to participate in. If the person refuses to comply with CARE court, they may be referred to LPS conservatorship – which is not voluntary. Moreover, it is not clear how a person referred to CARE court will receive notice of the petition. Opponents contend this may constitute a violation of state and federal due process protections. This bill also has no clear appeals process for any person who disputes eligibility or does not believe they failed the requirements of the program.

5) **Practical Concerns.** CSAC, the Urban Counties Association, the Rural Counties Association, and several individual counties have expressed concerns about how this bill will be implemented. Both opponents and county agencies claim this bill requires referral to extensive mental health services that do not currently exist and are not funded in this bill. First, the County Behavioral Health Directors Association (CBHDA) notes there is a stunning lack of mental health care service providers now. In smaller counties that have suffered multiple wildfires – there are no treatment providers at all. CBHDA contends there are not enough mental health care providers statewide to handle the requirements of this bill. The 2022 Budget Act allocates funds to, among other things, address the shortage of mental health staff. CBHDA also notes this bill may result in having to prioritize people with health insurance over indigent patients because a county is legally obligated to provide specific services to a person in CARE Court regardless if they have insurance. Since the counties do not have sufficient resources to provide full service to both CARE court recipients and people relying on other county services, indigent people using other county services may be short-changed.

Second, as noted above, it is not clear how a person will actually get to court. If, for example, a paramedic identifies a person through multiple contacts, as possibly being eligible for CARE court (although the paramedic likely would not know for sure if a person suffers from schizophrenia spectrum or other psychotic disorder), and the person is not transported to a hospital or otherwise detained, it is unclear how that person will appear in court unless law enforcement forces them to court or county behavioral health providers try to persuade a person to come to court. This bill allows a court to dismiss a petition for referral if a person does not show to court. Given it is not clear how a person would actually get to court in the first place, it is unknown how the court will properly consider a petition for a person that is not present. This bill also allows the court to hold the initial hearing without the person being present if "*appropriate attempts to elicit the attendance"* have been made. Again, opponents contend this may result in law enforcement "rounding up" people who may be eligible for CARE court.

Also, as alluded to above, county agencies allege this bill may cost as much as $1.3 billion to counties, assuming an enrollment of 7,000 to 12,000 participants. CSAC and others contend:

> As currently drafted, SB 1338 would require that a CARE Act court be established in all 58 counties, which would be the venue for a new civil court process designed to provide effective treatment and long-term plans for those suffering with psychotic disorders. Counties would play a key and substantial role in implementation under SB 1338 as the state's partners in providing critical behavioral health assessments and care, social services, and housing resources. SB 1338 imposes new mandated activities on counties, including but not limited to county behavioral health agencies, which will require both one-time and ongoing resources and funding in order to implement the CARE Act. While the overall impact to counties will depend on factors yet to be determined such as the annual number of CARE Act petitions submitted and the number of qualifying participants, an initial fiscal estimate developed in coordination with affected county departments reflects county costs upon full implementation could range between approximately $780 million to $1.3 billion annually.

CSAC and other county representatives are seeking amendments to this bill including a deliberate phase-in implementation schedule, more funding for increased duties, a showing of deliberate and chronic deficiencies before sanctions may be used, and additional funds for Bridge Housing to service the CARE court population. The Behavioral Health Bridge Housing Program allocated $1.5 billion to address housing and treatment needs of people suffering serious mental health issues. However, counties note that this plan program was just implemented and may DHCS additional time to allocate funds to counties. Moreover, housing should be available to all unhoused people with mental health needs, not just those referred to CARE court. Counties further argue that other budget allocations in past two years are one-time funds and do not include funds for mental health services.

6) **Alternatives.** Opponents of this bill concede that homelessness is a serious problem in this state and greater mental health assistance is needed. The organizations and coalitions opposed to this bill all prioritize funding for stable housing. Opponents of this bill contend that once a person's housing is stable, care providers can meaningfully engage with people struggling with mental health issues. Addressing mental health issues is virtually impossible while a person remains homeless. Additionally, advocates propose expanded supported decision-making. According to Disability Rights California:

> Supported Decision Making (SDM) is a practice recognized and endorsed by the Administration for Community Living of the U.S. Department of Health and Human Services (which funds the National Resource Center for Supported Decision-Making), the American Bar Association Commission on Law and Aging, and the United Nations Convention on Rights of Persons with Disabilities. These entities have all used the term SDM to refer to a model or practice that enables individuals to make choices about their own lives with support from a team of people they choose. With SDM, individuals choose people they know and trust to be part of a support network that helps them understand their issues, options, and choices. Disability Rights California, Disability Rights Education and Defense Fund and California Advocates for Nursing Home Reform are sponsors of AB 1663 (Maienschein), the Probate Conservatorship Reform and Supported Decision-Making Act, which seeks to codify SDM as part of the Probate Code.

According to an article in the Los Angeles Times on July 11, 2022, entitled "Cause of homelessness? It's not drugs or mental illness, researchers say," about a recent study on homelessness, the root cause of homelessness is spiraling housing costs or the lack of any available housing:

> By looking at the rate of homeless per 1,000 people, [the authors] found communities with the highest housing costs had some of the highest rates of homelessness, something that might be overlooked when looking at just the overall raw number of homeless people. As an example, the 2019 count of people in shelters and on the street found a homeless population of 56,000 in Los Angeles County; 11,200 in King County, Wash.; 9,700 in Santa Clara County, Calif.; and 4,000 in Multnomah County, Ore. The homeless populations became similar when looking at per capita rates, with Los Angeles having six homeless people for every 1,000 residents and the other three, smaller counties having five homeless people for every 1,000. What they had in common was a lack of affordable housing.

Finally, centers statewide that assist people struggling with homelessness and mental health issues are closing. In Santa Ana, the city filed suit to close a public drop-in center for homeless people with mental illness or other disorders. In the city's lawsuit against

the non-profit Mental Health Association, it asked a court to declare the Homeless Multi-Service Center a public nuisance, seeking to at least temporarily – if not permanently – shut the center down.

Supporters of this bill, including numerous cities, particularly in historically underserved parts of the state, allege law enforcement and mental health resources are stretched to the breaking point by the homelessness crisis. As a result, a new approach is necessary. According to the Cities across the Coachella Valley, which supports the bill:

> As mayors representing cities across the Coachella Valley, we are writing to express our strong support for SB 1338 that will establish the Community Assistance, Recovery and Empowerment (CARE) Court. Solving the homelessness crisis and addressing mental health continues to be a top priority for our cities. Under CARE Court, we can bring an end to the cycle of homelessness, incarceration, and hospitalization due to mental health challenges. SB 1338 is a bold step toward meaningful reform. The issues for us in the Coachella Valley are heightened. We have experienced a higher percentage of homelessness in our communities and our region has been historically underserved. With CARE Court, our cities will now have a new set of tools to connect a person struggling with an untreated mental illness, to the care and treatment they deserve.

7) **Argument in Support.** According to the California Professional Firefighters:

> While we recognize the complexity and concerns that come with court ordered treatment, the current system is clearly failing this population and that is why we believe that CARE Court provides a real pathway to care and healing while balancing individual rights and the need for care. Moreover, this model will reduce the need for more restrictive conservatorships while establishing a clear pathway for treatment. We recognize that this measure is the start of a robust dialogue on how to implement this vision and paradigm shift, and has already sparked wider discussions on the most effective way to implement not only the intent of this bill but also a more comprehensive and holistic mental healthcare system.

8) **Argument in Opposition.** According to Cal Voices:

> The recently enacted AB 178, a budget trailer bill with $39.5 in court funding contingent on enactment of policy changes, appears to fall far short. Recent amendments to SB 1338 add legal services attorneys to the mix, with funding by the Judicial Council. Public defenders are to serve as a backup. It is unclear how the bill contemplates deploying this mix of services but the costs will still be great. A better use of these significant funds will be to invest in a robust housing framework for this target population and provide

services, the ultimate solution to homelessness. The bill targets bringing 7,000 to 12,000 people with severe mental illness into court but it is unclear how they will be found, how they will get to court, and how much will be spent on care teams of providers through county behavioral health departments. Services will require extensive staffing. Ongoing costs could be at least in the hundreds of millions of dollars statewide. Current funding for mental health services, already insufficient to meet needs, will likely be diverted to pay for CARE Court, risking services for others, including children and youth. In addition, much of CARE Court will not be reimbursable through Medi-Cal.

9) Related Legislation.

a) AB 2242 (Santiago) permits county mental health providers, to the extent otherwise permitted under state and federal law and consistent with the Mental Health Services Act, to pay for the provision of services for individuals placed in involuntary detentions and conservatorship using funds distributed from the Mental Health Subaccount, among others. AB 2242 is pending in the Senate Appropriations Committee. According to the opponents of SB 1338, AB 2242 will allow counties to use Proposition 63 money to fund CARE court at the expense of other clients.

b) AB 2830 (Bloom) is very similar to SB 1338 in that it creates a CARE court with similar requirements. AB 2830 was referred to the Assembly Judiciary Committee, but never heard.

Analysis Prepared by: Kimberly Horiuchi / APPR. / (916) 319-2081

Exhibit 15

Pages: RJN-0338 through RJN-0340

Monterey County, Written Testimony dated May 10, 2022, submitted to Assembly Member Umberg, California State Assembly

Legislative History Report and Analysis for Senate Bill 1338 (Umberg & Eggman – 2022) Chapter 319, Statutes of 2022

MONTEREY COUNTY

BOARD OF SUPERVISORS

May 10, 2022

The Honorable Tom Umberg
California State Assembly
1021 O Street, Room 6730
Sacramento, CA 95814

Re: SB 1338 (Umberg): Community Assistance, Recovery, and Empowerment (CARE) Court Program – LETTER OF CONCERNS

Dear Senator Umberg:

On behalf of the County of Monterey, I write to express our concerns regarding SB 1338 as amended on April 7.

The measure as amended reflects Governor Newsom's vision for creating a new civil court process to reach and treat individuals living with untreated schizophrenia spectrum and psychiatric disorders. These new Community Assistance, Recovery, and Empowerment (CARE) Courts would work with public defenders, county behavioral health, and trained "supporters" to assist individuals with treatment, medication, and housing.

We understand that the language within SB 1338 represents a work in progress, and we appreciate the ongoing conversations with this Committee, the Newsom Administration, and other stakeholders on the details. We share in the concerns raised below by the California State Association of Counties (CSAC); Urban Counties of California (UCC); Rural County Representatives of California (RCRC); County Behavioral Health Directors Association of California (CBHDA); California Association of Public Administrators, Public Guardians, and Public Conservators (CAPAPGPC); and the County Welfare Directors of California (CWDA).

Below, we provide the top five priorities for our County as SB 1338 continues to be negotiated.

- **Funding:** SB 1338 does not include funding for county public defender and behavioral health costs. The Governor has said he intends to sponsor a Budget Trailer Bill to fund new court costs but has not yet committed to providing funding for the significant county role within CARE Courts. New expectations, whether for CARE Court or other programs, require new resources to meet them, and counties are working on two tracks: estimating the costs associated with CARE Courts and advocating for new state funding to cover those costs.

- **Sanctions:** Counties cannot bear sanctions related to an entirely new program in which we lack the authority and funding, not to mention the workforce, to implement. If sanctions are preferred by the legislature, counties will suggest that other entities should also be subject to sanctions. Additionally, sanctions would exacerbate the issues our overloaded and underfunded county public defenders and behavioral health departments are already experiencing – including a severe workforce shortage.

- **Housing:** Housing is foundational for addressing homelessness. While SB 1338 avoids housing mandates, legislators have made it clear that ensuring housing for CARE Court participants is a top priority. To address these concerns, the county coalition is exploring a requirement to prioritize CARE Court participants within any local government homeless and housing programs that receive state funding. This includes programs administered by counties, cities, and Continuums of Care.

- **Eligibility:** Estimates for the number of people eligible for CARE Court vary from a low of 7,000 to 12,000 to a high of well above six figures statewide. Eligibility and processes for CARE Court petitions must be refined to align potential resources and timelines with the number of those who could be eligible.

- **Funding for Existing Services:** We are seeking additional state support for proven county services that serve or could serve the population identified in SB 1338, including:
    - County Public Guardians/Conservators
    - Assisted Outpatient Treatment (Laura's Law)
    - Peer Support Specialists
    - Operating & Workforce Costs
    - Outreach and Engagement efforts – which are the only evidence-based methods known to help transition people from the streets into care

For these reasons, Monterey County appreciates your consideration of our concerns on SB 1338. Should you have any questions, please feel free to contact Monterey County's Public Policy Advisor, Ashley Walker of Nossaman LLP at 916-442-8888.

Sincerely,

Mary L. Adams
Chair, Monterey County Board of Supervisors

Cc: Hon. Anna Caballero, 12th Senate District
Hon. John Laird, 17th Senate District
Hon. Mark Stone, 29th Assembly District
Hon. Robert Rivas, 30th Assembly District
California State Association of Counties (CSAC)
Rural County Representatives of California (RCRC)

Exhibit 16

Pages: RJN-0341 through RJN-0354

ACLU et al., Written Testimony dated June 14, 2022, submitted to Assembly Judiciary Committee

Legislative History Report and Analysis for Senate Bill 1338 (Umberg & Eggman – 2022) Chapter 319, Statutes of 2022

June 14, 2022

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

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

Dear Assemblymember Stone:

The organizations sending this letter advance and protect the civil rights of Californians living with disabilities, experiencing houselessness, and involved in the criminal legal system. Respectfully, we **oppose SB 1338**.

The CARE Court framework that SB 1338 seeks to establish is unacceptable for a number of reasons:

- It perpetuates institutional racism through a system of coerced treatment and worsens health disparities, directly harming Black, Indigenous and People of Color;
- It denies a person's right to choose and have autonomy over personal healthcare decisions;
- It does not guarantee housing provided with fidelity to principles that prioritize voluntary services, an approach that is backed by evidence;
- Community evidence-based practices and scientific studies show that adequately-resourced intensive voluntary outpatient treatment is more effective than court-ordered treatment; and
- It will not matter that the terms used are called "Supportive Decision-Making" and "Supporter" because the Supporter's role is to implement an involuntary medical plan ordered by a civil court, and disregards the importance of voluntary decisions in mental health treatment; and

Because CARE Court will harm Californians with disabilities, we strongly oppose this bill. Instead, we would welcome a proposal developed with input from the people CARE Court seeks to help. We believe a community-based approach would be far more likely to succeed. This approach would expand resources for permanent affordable housing with voluntary supports and increase early access to voluntary, community-based treatment based on principles of trauma-informed care and the complete removal of law enforcement and the courts from the process.

I. Background

The California Legislature has declared that, "[i]n the absence of a controversy, a court is normally not the proper forum in which to make health care decisions."[1] Yet, SB 1338 seeks to establish a new court system in which health care decisions will be made. Despite SB 1338's use of the terms "recovery" and "empowerment," CARE Court is a system of

[1] Probate Code § 4650(c). "Return to Main Document"

coerced, court-ordered treatment that strips people with mental health disabilities of their right to make their own decisions about their lives.

CARE Court is antithetical to recovery principles, which are based on self-determination and self-direction.[2] The CARE Court proposal is based on stigma and stereotypes of people living with mental health disabilities and experiencing houselessness. CARE Court is not voluntary if it begins with court involvement – a petition filed against the person supposedly being helped – and conditions compliance for specific treatment under court orders.

While the organizations submitting this letter agree that State resources must be urgently allocated towards addressing houselessness and care for Californians living with mental health disabilities with intense requirements of support, CARE Court is the wrong framework. The right framework allows people with disabilities to retain autonomy over their own lives by providing them with meaningful and reliable access to affordable, accessible, integrated housing combined with voluntary services.

II. CARE Court will perpetuate institutional racism and worsen health disparities.

Due to a long and ongoing history of racial discrimination in housing, banking, employment, policing, land use, and healthcare systems, Black people experience houselessness at a vastly disproportionate level compared to the overall population of the state. In 2020, California established the Task Force to Study and Develop Reparation Proposals for African Americans, with a Special Consideration for African Americans Who are Descendants of Persons Enslaved in the United States.[3] AB 3121 directed the Reparations Task Force to study the institution of slavery and its lingering negative effects on living Black Americans. On June 1, 2022, the Task Force issued its initial findings.[4] The Reparations Report details

[2] Substance Abuse and Mental Health Services Administration, *SAMHSA's Working Definition of Recovery* (https://store.samhsa.gov/sites/default/files/d7/priv/pep12-recdef.pdf). "Return to Main Document"

[3] AB 3121 (S. Weber) Chapter 319, Statutes of 2020. "Return to Main Document"

[4] State of California's Department of Justice – Office of the Attorney General, *California Task Force to Study and Develop Reparation Proposals for African Americans: Interim Report* (AB 3121), dated June 2022 (2022 - AB3121 Full Interim Report (ca.gov)), *Chapter 11: An Unjust Legal System* at pp. 390-391. "Return to Main Document"

the pervasive effects of racial discrimination in these systems resulting in serious harm to the health and welfare of Black Californians.[5]

These racial disparities are reflected in California's acute houselessness problem, which places a particularly heavy burden on Black Californians. In Los Angeles County alone, Black people make up 8% of the population, but 34% of people experiencing houselessness.[6] Statewide statistics are even more dire: 6.5% of Californians identify as Black or African-American, but they account for nearly 40% of the state's unhoused population.[7]

Moreover, the Reparations Report recounts the history of racial discrimination enacted against Black people in the health care system over centuries, including the weaponizing of a mental health diagnosis to force sterilization and treatment.[8] Research demonstrates that Black, Indigenous, and People of Color (BIPOC) and immigrant racial minorities are more likely to be diagnosed, and misdiagnosed, with psychotic disorders than white Americans because of clinicians' prejudice and misinterpretation of patient behaviors.[9, 10,11] In California, rates of those living with mental health disabilities requiring intense support vary considerably by racial and ethnic groups, with American Indian and Alaska Native and Black Californians experiencing the highest rates of diagnosis for serious mental health disabilities.[12] For unhoused LGBTQIA+ people of color, the

[5] Id., *Chapter 1: Introduction*, at 40-41. "Return to Main Document"

[6] Steve Lopez, *Column: Black people make up 8% of L.A. population and 34% of its homeless. That's unacceptable.*, Los Angeles Times, June 13, 2020 (https://www.latimes.com/california/story/2020-06-13/column-african-americans-make-up-8-of-l-a-population-and-34-of-homeless-count-heres-why). "Return to Main Document"

[7] Kate Cimini, *Black people disproportionately homeless in California*, Cal Matters, October 5, 2019 (updated February 27, 2021) (https://calmatters.org/california-divide/2019/10/black-people-disproportionately-homeless-in-california/). "Return to Main Document"

[8] *See* fn. 4, *Chapter 12: Mental and Physical Harm and Neglect* at 406-436. "Return to Main Document"

[9] Robert C. Schwartz, Ph.D., *et al*., *Racial disparities in psychotic disorder diagnosis: A review of empirical literature*, World Journal of Psychiatry 2014: 4:4, 133-140. "Return to Main Document"

[10] *See* fn. 4, *Chapter 12: Mental and Physical Harm and Neglect* at 422-423, fn. 408 ("White mental health staff at federally-funded clinics and hospitals often diagnosed Black patients with schizophrenic, when they should have been diagnosed with depression.") "Return to Main Document"

[11] California Health Care Foundation, *Health Disparities by Race and Ethnicity in California: Pattern of Inequity* (October 2021) at 33 (https://www.chcf.org/wp-content/uploads/2021/10/DisparitiesAlmanacRaceEthnicity2021.pdf). "Return to Main Document"

[12] *Id.* "Return to Main Document"

intersecting identities can result in even more significant mental health struggles and intensified discrimination.[13]

The civil legal system can play a role in ameliorating discriminatory effects in health care, housing and government services but has historically been used to subjugate Black people.[14] The negative impact of the civil legal system on Black Californians continues today.[15]

Here, the consequences for being found "non-compliant" with a CARE plan or not attending court hearings are serious: a possible referral to Lanterman-Petris-Short Act (conservatorship) proceedings with a presumption that there is no suitable community-based alternative for the person. This creates a direct route to conservatorship – a legal determination that deprives a person of the right to choose where to reside, to make medical decisions, to vote, to decide social and sexual contacts and relationships, and other fundamental rights. By targeting unhoused people with diagnoses of schizophrenia and other psychotic disorders, CARE Court will only repeat California's racially discriminatory history.

Instead, California should use the resources earmarked for CARE Court to invest in systems that will eliminate racial disparities in the healthcare, housing and other contributing systems to address houselessness. The first step would be to create and fund truly voluntary services, starting with housing, outside of the pressure of a court process. A fully funded system would permit a person to choose their services without fear of adverse legal consequences if they are found to be "non-compliant" with treatment.

III. Ending houselessness for all Californians living with mental health disabilities requires guaranteed housing provided with fidelity to principles that prioritize voluntary services.

Evidence shows that involuntary, coercive treatment is harmful.[16,17] Instead of allocating vast sums of money towards intimidating and likely

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[13] Brodie Fraser et al., *LGBTIQ+ Homelessness: A Review of the Literature*, National Institutes of Health: National Library of Medicine, National Center for Biotechnology Information, July 26, 2019 (LGBTIQ+ Homelessness: A Review of the Literature - PMC (nih.gov)). "Return to Main Document"

[14] *See* fn. 4, *Chapter 11: An Unjust Legal System* at pp. 390-391. "Return to Main Document"

[15] *Id.* "Return to Main Document"

[16] Joseph P. Morrissey, Ph.D., *et al*., *Outpatient Commitment and Its Alternatives: Questions Yet to Be Answered*, Psychiatric Services 2014:812 at 814 (2014). "Return to Main Document"

[17] S.P. Sashidharan, Ph.D., *et al.*, *Reducing Coercion in Mental Healthcare*, Epidemiology and Psychiatric Sciences 2019: 28, 605-612 (All forms of coercive practices are inconsistent with human rights-based

unsuccessful court-ordered treatment that does not guarantee housing, the state should expend its resources on a proven solution to houselessness for people living with mental health disabilities: guaranteed housing with voluntary services.

Given that housing reduces both utilization of emergency services and contacts with the criminal legal system, a team of UC Irvine researchers concluded that it is "fiscally irresponsible, as well as inhumane" not to provide permanent housing for Californians experiencing houselessness.[18]

To effectuate guaranteed housing, California should invest in low-barrier, deeply affordable (15% of area median income or less), accessible, integrated housing for people experiencing houselessness. This housing should be made available with access to voluntary, trauma-informed, culturally-responsive, evidence-based services such as Assertive Community Treatment, Intensive Case Management, Peer Support, and substance use disorder services that follow the Harm Reduction approach. In addition, an intersectional system thinking approach to BIPOC and LGBTQIA+ houselessness would usher inclusive policies that can be used to develop "well-informed, culturally sensitive support programs."[19,20,21]

mental healthcare); Daniel Werb, Ph.D., *et al.*, *The Effectiveness of Compulsory Drug Treatment: A Systematic Review*, International Journal of Drug Policy 2016: 28, 1-9 (Because evidence, on the whole, does not suggest improved outcomes related to compulsory drug treatment approaches and some studies suggest potential harms, non-compulsory treatment modalities should be prioritized by policymakers seeking to reduce drug-related harms). "Return to Main Document"

[18] David A. Snow and Rachel E. Goldberg, *Homelessness in Orange County: The Costs to Our Community* (June 2017) at 43 (https://www.unitedwayoc.org/wp-content/uploads/2017/08/united-way-cost-study-homelessness-2017-report.pdf). "Return to Main Document"

[19] *LGBTQ Equity and Housing Fact Sheet: Research is Increasingly clear that Stable, Affordable Housing is a Critical Driver of Positive Outcomes in Many Areas of Life, But Such Housing is Much Less Assured for the LGBTQ Community*, Opportunity Starts at Home (LGBTQ Equity and Housing Fact Sheet - Opportunity Starts at Home (opportunityhome.org)). "Return to Main Document"

[20] Brodie Fraser et al., *LGBTIQ+ Homelessness: A Review of the Literature*, National Institutes of Health: National Library of Medicine, National Center for Biotechnology Information, July 26, 2019 (LGBTIQ+ Homelessness: A Review of the Literature - PMC (nih.gov)). "Return to Main Document"

[21] Iore m. dickey, Ph.D. et al., *Mental health considerations with transgender and gender nonconforming clients*, University of California San Francisco: Transgender Care, dated May 28, 2016 (Mental health considerations with transgender and gender nonconforming clients | Gender Affirming Health Program (ucsf.edu)). "Return to Main Document"

Existing law requires Housing First in programs addressing houselessness.[22,23] California has recognized that it is crucial to use housing as a tool rather than a reward for recovery, and to provide or connect unhoused people to permanent housing as quickly as possible. Housing First principles, as an evidence-based model, require offering services as needed and requested on a voluntary basis, and not making housing contingent on participation in services.[24]

Evidence shows that housing provided with fidelity to Housing First principles leads to the types of positive outcomes for unhoused people that the state is misguidedly proposing to attain via CARE Court. For example, a recent UCSF randomized controlled study of unhoused high utilizers of public systems in Santa Clara County found that permanent supportive housing (which incorporates Housing First principles) combined with intensive case management, significantly reduced psychiatric emergency room visits and increased the rate of scheduled outpatient mental health visits compared to the control group.[25] In addition, Housing First programs that closely adhere to the evidence-based model result in positive housing and substance use outcomes for chronically houseless people with substance use disorders.[26]

As the Health and Human Services Agency recognizes, "finding stability and staying connected to treatment, even with the proper supports, is next to impossible while living outdoors, in a tent or a vehicle."[27] On this premise, a person should be offered housing before they can reasonably be expected to engage in intensive mental health services.

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[22] Welf. & Inst. Code § 8255, et seq. "Return to Main Document"

[23] Welf. & Inst. Code § 8256(a). SB 1338's stated plan to give CARE Court participants priority for the "Behavioral Health Bridge Housing" proposed in the Governor's Budget violates the State's commitment to Housing First as codified here. CARE Court is *not* a Housing First program because it will likely require participants to comply with a program or services as a condition of tenancy. "Return to Main Document"

[24] Welf. & Inst. Code § 8255(d)(1). "Return to Main Document"

[25] Maria C. Raven, M.D., M.P.H., M.Sc., *et al*., *A Randomized Trial of Permanent Supportive Housing for Chronically Homeless Persons with High Use of Publicly Funded Services*, Health Services Research 2020;55 (Suppl. 2): 797 at 803. "Return to Main Document"

[26] Clare Davidson, M.S.W., *et al*., *Association of Housing First Implementation and Key Outcomes Among.0124 Homeless Persons with Problematic Substance Use*, Psychiatric Services 2014; 65:1318 at 1323. "Return to Main Document"

[27] California Health and Human Services Agency, *CARE Court: A New Framework for Community Assistance, Recovery, and Empowerment* (https://www.chhs.ca.gov/wp-content/uploads/2022/03/CARE-Court-Framework_web.pdf) (accessed April 10, 2022). "Return to Main Document"

V. Evidence shows that adequately-resourced intensive voluntary outpatient treatment is more effective than court-ordered treatment.

In 2000, when the State was first considering adopting Assisted Outpatient Treatment (AOT), the California Senate Committee on Rules commissioned the RAND Institute to develop a report on involuntary outpatient treatment, with a primary objective to identify and synthesize empirical evidence on the effectiveness of involuntary outpatient treatment and its alternatives.[28] The findings of the RAND report remain relevant today. Then and now, no studies exist to prove that a court order for outpatient treatment *in and of itself* has any independent effect on client outcomes.[29]

In comparison, the RAND study provided strong evidence of the effectiveness of voluntary Assertive Community Treatment (ACT), a multidisciplinary, community-based intervention that combines the delivery of clinical treatment with intensive case management.[30] The report's authors concluded that there is clear evidence that, when implemented with fidelity to evidence-based models, community-based mental health interventions like ACT can produce good outcomes for people living with mental health disabilities with intense requirements of support.[31] Rather than funneling money into a new court system, the State's resources would be better utilized to expand and strengthen the availability of ACT and other intensive evidence-based treatment modalities throughout California.[32] In addition, the State should incentivize communities to implement

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[28] M. Susan Ridgely, *et al.*, *The Effectiveness of Involuntary Outpatient Treatment: Empirical Evidence and the Experience of Eight States*, RAND Health and RAND Institute for Civil Justice, 2001 (https://www.rand.org/pubs/monograph_reports/MR1340.html). "Return to Main Document"

[29] *Id*. at xvi. "Return to Main Document"

[30] *Id*. at 29. The primary difference between California's Full Service Partnerships (FSP) and ACT is that there is no evidence-based model that FSPs must follow. There is significant variation in FSP delivery across counties. Some counties have ACT programs as part of their FSP offerings. When offered as part of an FSP, ACT generally provides a more engaged level of service than the standard FSP. "Return to Main Document"

[31] *Id*. at 32. "Return to Main Document"

[32] The recent behavioral health needs assessment published by DHCS found that ACT is not yet available with fidelity on the scale necessary to support optimal care for people who could benefit from the level of engagement that it offers. State of California, Department of Health Care Services, *Assessing the Continuum of Care for Behavioral Health Services in California: Data, Stakeholder Perspectives, and Implications* (January 10, 2022) at 60 (https://www.dhcs.ca.gov/Documents/Assessing-the-Continuum-of-Care-for-BH-Services-in-California.pdf) "Return to Main Document"

community-defined evidence practices specifically developed to meet the needs of California's diverse populations.[33]

VI. Use of the terms "Supported Decision-Making" and "Supporter" in the context of a coercive court-involved treatment scheme reflects a serious misunderstanding of the concepts behind the terms and obscures the involuntary nature of CARE Court.

SB 1338's use of the terms "Supported Decision-Making" and "Supporter" to describe certain court-ordered components of the CARE Court process is inconsistent with well-established definitions of those concepts. The inconsistency is not just inaccurate, it is misleading and damaging to future implementation of these healthy practices.

Supported Decision Making (SDM) is a practice recognized and endorsed by the Administration for Community Living of the U.S. Department of Health and Human Services (which funds the National Resource Center for Supported Decision-Making),[34] the American Bar Association Commission on Law and Aging,[35] and the United Nations Convention on Rights of Persons with Disabilities.[36] These entities have all used the term SDM to refer to a model or practice that enables individuals to make choices about their own lives with support *from a team of people they choose*. With SDM, individuals *choose people they know and trust* to be part of a support network that helps them understand their issues, options, and choices. The role of the supporter is to offer guidance and advice, but to ultimately honor

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[33] California Pan-Ethnic Health Network, *Concept Paper: Policy Options for Community-Defined Evidence Practices* (April 14, 2021) (https://cpehn.org/publications/concept-paper-policy-options-for-community-defined-evidence-practices-cdeps/). "Return to Main Document"

[34] American Bar Association, *Guardianship and Supported Decision-Making* (https://www.americanbar.org/groups/law_aging/resources/guardianship_law_practice/). "Return to Main Document"

[35] National Center on Law & Elder Rights, *Legal Basics: Supported Decision-Making* (https://ncler.acl.gov/pdf/Legal-Basics-Supported-Decision-Making1.pdf). "Return to Main Document"

[36] United Nations Department of Economic and Social Affairs/Disability, *Handbook for Parliamentarians on the Convention on the Rights of Persons with Disabilities Chapter Six: From Provisions to Practice: Implementing the Convention – Legal Capacity and Supported Decision-Making* (https://www.un.org/development/desa/disabilities/resources/handbook-for-parliamentarians-on-the-convention-on-the-rights-of-persons-with-disabilities/chapter-six-from-provisions-to-practice-implementing-the-convention-5.html). "Return to Main Document"

and help carry out the choices made by that individual, regardless of whether the supporter thinks they are in the person's best interest.[37]

Contrary to SB 1338's statement of findings and declarations, the new "CARE Supporter" role will not advance and protect self-determination and civil liberties of Californians living with mental health disabilities with intense requirements of support. More troubling, the "CARE Supporter" does not just act within a coercive system but also has the potential to be an agent of that system. If a person "fails" or does not comply with their "CARE plan," they risk being forced into a conservatorship perhaps based on reports from the "CARE Supporter" about whether the person followed their plan.

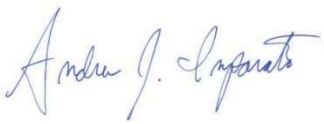
Disability Rights California is a sponsor of AB 1663 (Maienschein), the Probate Conservatorship Reform and Supported Decision-Making Act, which seeks to codify SDM as part of the Probate Code. AB 1663 passed out of the Assembly and will soon be heard in the Senate. The bill makes clear that SDM allows a person with a disability to choose *voluntary supports* to help them with decisions, *as requested*. SB 1338's misappropriation of these concepts and proposed statutory language from AB 1663, without using the appropriate definitions of the terms, undermines the true meaning and value of SDM.

VII. Conclusion

CARE Court is not the appropriate tool for providing a path to wellness for Californians living with mental health disabilities who face houselessness, incarceration, hospitalization, conservatorship, and premature death. Instead, California should invest in community evidence-based practices that are proven to work and that will actually empower people living with mental health disabilities on their paths to recovery and allow them to retain full autonomy over their lives without the intrusion of a court.

[37] Center for Public Representation, *About Supported Decision Making* (https://supporteddecisions.org/about-supported-decision-making/) (accessed April 8, 2022). "Return to Main Document"

Sincerely,



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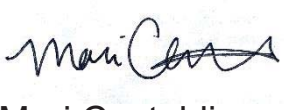

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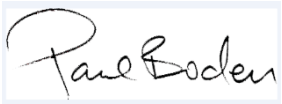

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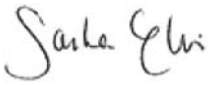

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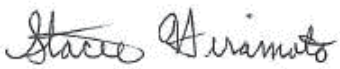

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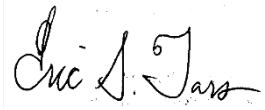

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(Individual)

David Mauroff, CEO
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Diversion Project

Khalil Ferguson, Secretary
California Democratic Party Black
Caucus Legislative Committee

Tak Allen, Chair
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Amanda Andere
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Funders Together to End
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Larry Dodson
Pastor
New Life Ministries
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Tony Chicotel
California Advocates
for Nursing Home Reform

Paula Lomazzi
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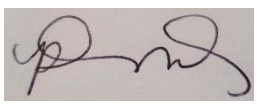
Stuart Seaborn
Managing Dir., Lit.
Disability Rights
Advocates

Maribel Nunez
Executive Director
Inland Equity Partnership

Melissa A. Morris
Staff Attorney
Public Interest Law Project

Jessica Lehman
Executive Director
Senior & Disability Action



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Cal Voices

cc: The Honorable Members, Assembly Judiciary Committee
Zach Keller, Legislative Director, Office of Senator Umberg
Leora Gershenzon, Deputy Chief Counsel, Assembly Judiciary Committee
Gary Olson, Consultant, Republican Assembly Caucus Committee

Exhibit 17

Pages: RJN-0355 through RJN-0363

Mental Health Advocacy Services, Written Testimony dated June 23, 2022, submitted to Assembly Health Committee

Legislative History Report and Analysis for Senate Bill 1338 (Umberg & Eggman – 2022) Chapter 319, Statutes of 2022

MENTAL HEALTH ADVOCACY SERVICES
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MHAS-LA.ORG

A nonprofit organization protecting and advancing the legal rights of people with mental disabilities.

June 23, 2022

Honorable Jim Wood
Chair, Assembly Health Committee
1020 N Street, Room 390
Sacramento, CA 95814

RE: SB 1338 (UMBERG) as amended June 16, 2022 - OPPOSE

Dear Assemblymember Wood:

I am writing on behalf of Mental Health Advocacy Services ("MHAS"), a legal aid organization serving Los Angeles County whose mission is to protect and advance the legal rights of low-income adults and children with mental health disabilities and empower them to assert those rights in order to maximize their autonomy, achieve equity, and secure the resources they need to thrive. Respectfully, **MHAS opposes SB 1338**. The CARE Court framework that SB 1338 seeks to establish is unacceptable for a number of reasons:

- It perpetuates institutional racism through a system of coerced treatment and worsens health disparities, directly harming Black and Brown community members;
- It denies a person's right to choose and have autonomy over personal healthcare decisions;
- It does not guarantee affordable permanent housing provided with fidelity to principles that prioritize voluntary services, an approach that is backed by evidence;
- Community evidence-based practices and scientific studies show that adequately-resourced intensive voluntary outpatient treatment is more effective than court-ordered treatment; and
- Use of the terms "Supportive Decision-Making" and "Supporter" disregards the importance of voluntary decisions in mental health treatment and does not mask the involuntary nature of CARE Court; and

Because CARE Court will harm Californians with mental health disabilities, we strongly oppose this bill. Instead, we would welcome a proposal developed with input from the people CARE Court seeks to help. We believe a community-based approach would be far more likely to succeed. This approach would expand resources for permanent affordable housing with voluntary support and increase early access to voluntary, community-based treatment based on principles of trauma-informed care and the complete removal of law enforcement and the courts from the process.

/ / /

I. Background

The California Legislature has declared that, "[i]n the absence of a controversy, a court is normally not the proper forum in which to make health care decisions."[1] Yet, SB 1338 seeks to establish a new court system in which health care decisions will be made. Despite SB 1338's use of the terms "recovery" and "empowerment," CARE Court is a system of coerced, court-ordered treatment that strips people with mental health disabilities of their right to make their own decisions about their lives.

CARE Court is antithetical to recovery principles, which are based on self-determination and self-direction.[2] The CARE Court proposal is based on stigma and stereotypes of people living with mental health disabilities and experiencing houselessness. CARE Court is not voluntary if it begins with court involvement – a petition filed against the person supposedly being helped – and conditions compliance for specific treatment under court orders.

While the organizations submitting this letter agree that State resources must be urgently allocated towards addressing houselessness and care for Californians living with mental health disabilities with intense requirements of support, CARE Court is the wrong framework. The right framework allows people with mental health disabilities to retain autonomy over their own lives by providing them with meaningful and reliable access to affordable, accessible, integrated housing combined with voluntary services.

II. CARE Court will perpetuate institutional racism and worsen health disparities.

Due to a long and ongoing history of racial discrimination in the housing, banking, employment, policing, land use, and healthcare systems, Black people experience houselessness at a vastly disproportionate level compared to the overall population of the state. In 2020, California established the Task Force to Study and Develop Reparation Proposals for African Americans, with a Special Consideration for African Americans Who are Descendants of Persons Enslaved in the United States.[3] AB 3121 directed the Reparations Task Force to study the institution of slavery and its lingering negative effects on living Black Americans. On June 1, 2022, the Task Force issued its initial findings.[4] The Reparations Report details the pervasive effects of racial discrimination in these systems resulting in serious harm to the health and welfare of Black Californians.[5]

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[1] Probate Code § 4650(c). "Return to Main Document"

[2] Substance Abuse and Mental Health Services Administration, *SAMHSA's Working Definition of Recovery* (https://store.samhsa.gov/sites/default/files/d7/priv/pep12-recdef.pdf). "Return to Main Document"

[3] AB 3121 (S. Weber) Chapter 319, Statutes of 2020. "Return to Main Document"

[4] State of California's Department of Justice – Office of the Attorney General, *California Task Force to Study and Develop Reparation Proposals for African Americans: Interim Report* (AB 3121), dated June 2022 (2022 - AB3121 Full Interim Report (ca.gov)), *Chapter 11: An Unjust Legal System* at pp. 390-391. "Return to Main Document"

[5] Id., *Chapter 1: Introduction*, at 40-41. "Return to Main Document"

These racial disparities are reflected in California's acute houselessness problem, which places a particularly heavy burden on Black Californians. In Los Angeles County alone, Black people make up 8% of the population, but 34% of people experiencing houselessness.[6] Statewide statistics are even more dire: 6.5% of Californians identify as Black or African-American, but they account for nearly 40% of the state's unhoused population.[7]

Moreover, the Reparations Report recounts the history of racial discrimination enacted against Black people in the health care system over centuries, including the weaponizing of a mental health diagnosis to force sterilization and treatment.[8] Research demonstrates that Black, Indigenous, and People of Color (BIPOC) and immigrant racial minorities are more likely to be diagnosed, and misdiagnosed, with psychotic disorders than white Americans because of clinicians' prejudice and misinterpretation of patient behaviors.[9, 10,11] In California, rates of those living with mental health disabilities requiring intense support vary considerably by racial and ethnic groups, with American Indian and Alaska Native and Black Californians experiencing the highest rates of diagnosis for serious mental health disabilities.[12] For unhoused LGBTQIA+ people of color, the intersecting identities can result in even more significant mental health struggles and intensified discrimination.[13]

The civil legal system can play a role in ameliorating discriminatory effects in health care, housing and government services but has historically been used to subjugate Black people.[14] The negative impact of the civil legal system on Black Californians continues today.[15]

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[6] Steve Lopez, *Column: Black people make up 8% of L.A. population and 34% of its homeless. That's unacceptable.*, Los Angeles Times, June 13, 2020 (https://www.latimes.com/california/story/2020-06-13/column-african-americans-make-up-8-of-l-a-population-and-34-of-homeless-count-heres-why). "Return to Main Document"

[7] Kate Cimini, *Black people disproportionately homeless in California*, Cal Matters, October 5, 2019 (updated February 27, 2021) (https://calmatters.org/california-divide/2019/10/black-people-disproportionately-homeless-in-california/). "Return to Main Document"

[8] *See* fn. 4, *Chapter 12: Mental and Physical Harm and Neglect* at 406-436. "Return to Main Document"

[9] Robert C. Schwartz, Ph.D., *et al*., *Racial disparities in psychotic disorder diagnosis: A review of empirical literature*, World Journal of Psychiatry 2014: 4:4, 133-140. "Return to Main Document"

[10] *See* fn. 4, *Chapter 12: Mental and Physical Harm and Neglect* at 422-423, fn. 408 ("White mental health staff at federally-funded clinics and hospitals often diagnosed Black patients with schizophrenic, when they should have been diagnosed with depression.") "Return to Main Document"

[11] California Health Care Foundation, *Health Disparities by Race and Ethnicity in California: Pattern of Inequity* (October 2021) at 33 (https://www.chcf.org/wp-content/uploads/2021/10/DisparitiesAlmanacRaceEthnicity2021.pdf). "Return to Main Document"

[12] *Id*. "Return to Main Document"

[13] Brodie Fraser et al., *LGBTIQ+ Homelessness: A Review of the Literature*, National Institutes of Health: National Library of Medicine, National Center for Biotechnology Information, July 26, 2019 (LGBTIQ+ Homelessness: A Review of the Literature - PMC (nih.gov)). "Return to Main Document"

[14] *See* fn. 4, *Chapter 11: An Unjust Legal System* at pp. 390-391. "Return to Main Document"

[15] *Id.* "Return to Main Document"

Here, the consequences for being found "non-compliant" with a CARE plan or not attending court hearings are serious: a possible referral to Lanterman-Petris-Short Act (conservatorship) proceedings with a presumption that there is no suitable community-based alternative for the person. This creates a direct route to conservatorship – a legal determination that deprives a person of the right to choose where to reside, to make medical decisions, to vote, to decide social and sexual contacts and relationships, and other fundamental rights. By targeting unhoused people with diagnoses of schizophrenia and other psychotic disorders, CARE Court will only repeat California's racially discriminatory history.

Instead, California should use the resources earmarked for CARE Court to invest in systems that will eliminate racial disparities in the healthcare, housing and other contributing systems to address houselessness. The first step would be to create and fund truly voluntary services, starting with permanent affordable housing, outside of the pressure of a court process. A fully funded system would permit a person to choose their services, including mental health services, without fear of adverse legal consequences if they are found to be "non-compliant" with treatment.

III. Ending houselessness for all Californians living with mental health disabilities requires guaranteed permanent affordable housing provided with fidelity to principles that prioritize voluntary services.

Evidence shows that involuntary, coercive treatment is harmful.[16,17] Instead of allocating vast sums of money towards intimidating and likely unsuccessful court-ordered treatment that does not guarantee housing, the state should expend its resources on a proven solution to houselessness for people living with mental health disabilities: guaranteed permanent affordable housing with voluntary services.

Given that housing reduces both utilization of emergency services and contacts with the criminal legal system, a team of UC Irvine researchers concluded that it is "fiscally irresponsible, as well as inhumane" not to provide permanent housing for Californians experiencing houselessness.[18]

To effectuate guaranteed permanent affordable housing, California should invest in low-barrier, deeply affordable (15% of area median income or less), accessible, integrated housing for people experiencing houselessness. This housing should be made available with access to voluntary,

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[16] Joseph P. Morrissey, Ph.D., *et al*., *Outpatient Commitment and Its Alternatives: Questions Yet to Be Answered*, Psychiatric Services 2014:812 at 814 (2014). "Return to Main Document"

[17] S.P. Sashidharan, Ph.D., *et al*., *Reducing Coercion in Mental Healthcare*, Epidemiology and Psychiatric Sciences 2019: 28, 605-612 (All forms of coercive practices are inconsistent with human rights-based mental healthcare); Daniel Werb, Ph.D., *et al*., *The Effectiveness of Compulsory Drug Treatment: A Systematic Review*, International Journal of Drug Policy 2016: 28, 1-9 (Because evidence, on the whole, does not suggest improved outcomes related to compulsory drug treatment approaches and some studies suggest potential harms, non-compulsory treatment modalities should be prioritized by policymakers seeking to reduce drug-related harms). "Return to Main Document"

[18] David A. Snow and Rachel E. Goldberg, *Homelessness in Orange County: The Costs to Our Community* (June 2017) at 43 (https://www.unitedwayoc.org/wp-content/uploads/2017/08/united-way-cost-study-homelessness-2017-report.pdf). "Return to Main Document"

trauma-informed, culturally-responsive, evidence-based services such as Assertive Community Treatment, Intensive Case Management, Peer Support, and substance use disorder services that follow the Harm Reduction approach. In addition, an intersectional system thinking approach to BIPOC and LGBTQIA+ houselessness would usher inclusive policies that can be used to develop "well-informed, culturally sensitive support programs.[19,20,21]

Existing law requires Housing First in programs addressing houselessness.[22,23] California has recognized that it is crucial to use housing as a tool rather than a reward for recovery, and to provide or connect unhoused people to permanent affordable housing as quickly as possible. Housing First principles, as an evidence-based model, require offering services as needed and requested on a voluntary basis, and not making housing contingent on participation in services.[24]

Evidence shows that housing provided with fidelity to Housing First principles leads to the types of positive outcomes for unhoused people that the state is misguidedly proposing to attain via CARE Court. For example, a recent UCSF randomized controlled study of unhoused high utilizers of public systems in Santa Clara County found that permanent supportive housing (which incorporates Housing First principles) combined with intensive case management, significantly reduced psychiatric emergency room visits and increased the rate of scheduled outpatient mental health visits compared to the control group.[25] In addition, Housing First programs that closely adhere to the evidence-based model result in positive housing and substance use outcomes for chronically houseless people with substance use disorders.[26]

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[19] *LGBTQ Equity and Housing Fact Sheet: Research is Increasingly clear that Stable, Affordable Housing is a Critical Driver of Positive Outcomes in Many Areas of Life, But Such Housing is Much Less Assured for the LGBTQ Community*, Opportunity Starts at Home (LGBTQ Equity and Housing Fact Sheet - Opportunity Starts at Home (opportunityhome.org)). "Return to Main Document"

[20] Brodie Fraser et al., *LGBTIQ+ Homelessness: A Review of the Literature*, National Institutes of Health: National Library of Medicine, National Center for Biotechnology Information, July 26, 2019 (LGBTIQ+ Homelessness: A Review of the Literature - PMC (nih.gov)). "Return to Main Document"

[21] Iore m. dickey, Ph.D. et al., *Mental health considerations with transgender and gender nonconforming clients*, University of California San Francisco: Transgender Care, dated May 28, 2016 (Mental health considerations with transgender and gender nonconforming clients | Gender Affirming Health Program (ucsf.edu)). "Return to Main Document"

[22] Welf. & Inst. Code § 8255, et seq. "Return to Main Document"

[23] Welf. & Inst. Code § 8256(a). SB 1338's stated plan to give CARE Court participants priority for the "Behavioral Health Bridge Housing" proposed in the Governor's Budget violates the State's commitment to Housing First as codified here. CARE Court is *not* a Housing First program because it will likely require participants to comply with a program or services as a condition of tenancy. "Return to Main Document"

[24] Welf. & Inst. Code § 8255(d)(1). "Return to Main Document"

[25] Maria C. Raven, M.D., M.P.H., M.Sc., *et al*., *A Randomized Trial of Permanent Supportive Housing for Chronically Homeless Persons with High Use of Publicly Funded Services*, Health Services Research 2020;55 (Suppl. 2): 797 at 803. "Return to Main Document"

[26] Clare Davidson, M.S.W., *et al*., *Association of Housing First Implementation and Key Outcomes Among.0124 Homeless Persons with Problematic Substance Use*, Psychiatric Services 2014; 65:1318 at 1323. "Return to Main Document"

As the Health and Human Services Agency recognizes, "finding stability and staying connected to treatment, even with the proper support, is next to impossible while living outdoors, in a tent or a vehicle."[27] On this premise, a person should be offered housing before they can reasonably be expected to engage in intensive mental health services.

V. Evidence shows that adequately-resourced intensive voluntary outpatient treatment is more effective than court-ordered treatment.

In 2000, when the State was first considering adopting Assisted Outpatient Treatment (AOT), the California Senate Committee on Rules commissioned the RAND Institute to develop a report on involuntary outpatient treatment, with a primary objective to identify and synthesize empirical evidence on the effectiveness of involuntary outpatient treatment and its alternatives.[28] The findings of the RAND report remain relevant today. Then and now, no studies exist to prove that a court order for outpatient treatment *in and of itself* has any independent effect on client outcomes.[29]

In comparison, the RAND study provided strong evidence of the effectiveness of voluntary Assertive Community Treatment (ACT), a multidisciplinary, community-based intervention that combines the delivery of clinical treatment with intensive case management.[30] The report's authors concluded that there is clear evidence that, when implemented with fidelity to evidence-based models, community-based mental health interventions like ACT can produce good outcomes for people living with mental health disabilities with intense requirements of support.[31] Rather than funneling money into a new court system, the State's resources would be better utilized to expand and strengthen the availability of ACT and other intensive evidence-based treatment modalities throughout California.[32] In addition, the State should incentivize

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[27] California Health and Human Services Agency, *CARE Court: A New Framework for Community Assistance, Recovery, and Empowerment* (https://www.chhs.ca.gov/wp-content/uploads/2022/03/CARE-Court-Framework_web.pdf) (accessed April 10, 2022). "Return to Main Document"

[28] M. Susan Ridgely, *et al.*, *The Effectiveness of Involuntary Outpatient Treatment: Empirical Evidence and the Experience of Eight States*, RAND Health and RAND Institute for Civil Justice, 2001 (https://www.rand.org/pubs/monograph_reports/MR1340.html). "Return to Main Document"

[29] *Id*. at xvi. "Return to Main Document"

[30] *Id*. at 29. The primary difference between California's Full Service Partnerships (FSP) and ACT is that there is no evidence-based model that FSPs must follow. There is significant variation in FSP delivery across counties. Some counties have ACT programs as part of their FSP offerings. When offered as part of an FSP, ACT generally provides a more engaged level of service than the standard FSP. "Return to Main Document"

[31] *Id*. at 32. "Return to Main Document"

[32] The recent behavioral health needs assessment published by DHCS found that ACT is not yet available with fidelity on the scale necessary to support optimal care for people who could benefit from the level of engagement that it offers. State of California, Department of Health Care Services, *Assessing the Continuum of Care for Behavioral Health Services in California: Data, Stakeholder Perspectives, and Implications* (January 10, 2022) at 60 (https://www.dhcs.ca.gov/Documents/Assessing-the-Continuum-of-Care-for-BH-Services-in-California.pdf) "Return to Main Document"

communities to implement community-defined evidence practices specifically developed to meet the needs of California's diverse populations.[33]

VI. Use of the terms "Supported Decision-Making" and "Supporter" in the context of a coercive court-involved treatment scheme reflects a serious misunderstanding of the concepts behind the terms and obscures the involuntary nature of CARE Court.

Though the June 16 amendments make having a "CARE Supporter" optional and allow a person subject to CARE Court to choose their own "CARE Supporter," SB 1338's use of the terms "Supported DecisionMaking" and "Supporter" in the context of coercive, court-involved treatment is inconsistent with well-established definitions of those concepts. The inconsistency is misleading and damaging to future implementation of these healthy practices.

Supported Decision Making (SDM) is a practice recognized and endorsed by the Administration for Community Living of the U.S. Department of Health and Human Services (which funds the National Resource Center for Supported Decision-Making),[34] the American Bar Association Commission on Law and Aging,[35] and the United Nations Convention on Rights of Persons with Disabilities.[36] These entities have all used the term SDM to refer to a model or practice that enables individuals to make choices about their own lives with support *from a team of people they choose*. With SDM, individuals *choose people they know and trust* to be part of a support network that helps them understand their issues, options, and choices. The role of the supporter is to offer guidance and advice, but to ultimately honor and help carry out the choices made by that individual, regardless of whether the supporter thinks they are in the person's best interest.[37]

AB 1663 (Maienschein), the Probate Conservatorship Reform and Supported Decision-Making Act, seeks to codify SDM as part of the Probate Code. AB 1663 passed out of the Assembly and will soon be heard in the Senate. The bill makes clear that SDM allows a person with a disability to choose *voluntary supports* to help them with decisions, *as requested*. SB 1338's misappropriation of these concepts and proposed statutory language from AB 1663, without using the appropriate definitions of the terms, undermines the true meaning and value of SDM.

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[33] California Pan-Ethnic Health Network, *Concept Paper: Policy Options for Community-Defined Evidence Practices* (April 14, 2021) (https://cpehn.org/publications/concept-paper-policy-options-for-community-defined-evidence-practices-cdeps/). "Return to Main Document"

[34] American Bar Association, *Guardianship and Supported Decision-Making* (https://www.americanbar.org/groups/law_aging/resources/guardianship_law_practice/). "Return to Main Document"

[35] National Center on Law & Elder Rights, *Legal Basics: Supported Decision-Making* (https://ncler.acl.gov/pdf/Legal-Basics-Supported-Decision-Making1.pdf). "Return to Main Document"

[36] United Nations Department of Economic and Social Affairs/Disability, *Handbook for Parliamentarians on the Convention on the Rights of Persons with Disabilities Chapter Six: From Provisions to Practice: Implementing the Convention – Legal Capacity and Supported Decision-Making* (https://www.un.org/development/desa/disabilities/resources/handbook-for-parliamentarians-on-the-convention-on-the-rights-of-persons-with-disabilities/chapter-six-from-provisions-to-practice-implementing-the-convention-5.html). "Return to Main Document"

[37] Center for Public Representation, *About Supported Decision Making* (https://supporteddecisions.org/about-supported-decision-making/) (accessed April 8, 2022). "Return to Main Document"

VII. Conclusion

CARE Court is not the appropriate tool for providing a path to wellness for Californians living with mental health disabilities who face houselessness, incarceration, hospitalization, conservatorship, and premature death. Instead, California should invest in community evidence-based practices that are proven to work and that will actually empower people living with mental health disabilities on their paths to recovery and allow them to retain full autonomy over their lives without the intrusion of a court.

Sincerely,

Pavithra Menon
Supervising Attorney
Mental Health Advocacy Services

cc: The Honorable Members, Assembly Health Committee
Zach Keller, Legislative Director, Office of Senator Umberg
Judith Babcock, Senior Consultant, Assembly Health Committee
Leora Gershenzon, Deputy Chief Counsel, Assembly Judiciary Committee
Gino Folchi, Consultant, Assembly Republican Caucus Committee

Exhibit 18

Pages: RJN-0364 through RJN-0368

Drug Policy Alliance, Written Testimony dated April 20, 2022, submitted to Assembly Judiciary and Health Committees

Legislative History Report and Analysis for Senate Bill 1338 (Umberg & Eggman – 2022) Chapter 319, Statutes of 2022

April 20, 2022

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

Honorable Assemblymember Wood
Chair, Assembly Health Committee
1020 N Street, Room 390
Sacramento, CA, 95814

We are the Drug Policy Alliance.

RE: Opposition to AB 2830 (Bloom) The Community Assistance, Recovery, and Empowerment (CARE) Court Program.

Dear Chair Stone and Wood,

The Drug Policy Alliance regretfully must oppose AB 2830 (Bloom), a bill to create the CARE Court program which while well intended, raises multitudinous questions and concerns.

Drug Policy Alliance is a national organization advocating for drug policies grounded in science, compassion, health and human rights. The CARE Court proposal would compel vulnerable people in need of supportive services to undergo an involuntary court process and treatment plan. We strongly oppose any legislation that results in expansion of involuntary treatment of people who are grappling with problematic drug use and co-occurring behavioral and mental health challenges. California should invest in tested and proven methods for supportive services and voluntary treatment that focus on the autonomy, health, and safety of the person receiving that treatment, not abridging people's personal liberty with unsound policies.

As the nation's leading organization working to advance policies and attitudes to best reduce the harms of both drug use and drug prohibition, the Drug Policy Alliance strongly believes that mandating someone to involuntarily treatment of any kind will not decrease drug use or solve the problem of behavioral and mental health challenges; in fact, it may make them worse. While we encourage the legislature to work to address the dual crises of addiction and lack of access to behavioral health and mental health care, we caution that policies resulting in involuntary treatment will undoubtedly cause more harm than good.

While AB 2830 does not name substance use as a criterion for qualification for CARE Court, both the Governor's statements and information about the plan released by California's Health and Human Services notably do. Regardless, despite not articulating people using drugs as a target population for CARE Court, people on the streets dealing with addiction will almost certainly be swept into these proceedings. This inevitability is due in large part to the broad category of people who can petition to force an individual into CARE Court proceedings as well as the incredibly low threshold for triggering an initial hearing on the petition.

The current process outlined in the CARE Court proposal will lead to people who have no expertise in healthcare attempting to make complex medical determinations – which they will undoubtedly get wrong at least some, if not most, of the time. Therefore, instead of the person who has been forced into CARE Court getting treated with true care, dignity, and properly tailored support, they will undergo the stressful experience of undergoing a confusing and intimidating court process. CARE Court sends a message to

vulnerable people dealing with myriad struggles that they are wrong – because things don't end up in court when they are right. California can and must do better.

Involuntary treatment has been proven to be ineffective. In scientific studies directly comparing involuntary and voluntary drug treatment, involuntary treatment does not produce better outcomes in terms of sustained abstinence – and some studies have found negative effects from involuntary treatment. Involuntary treatment methods are ineffective, with a large majority of people placed in these programs continuing their drug use afterward.[1] [2]

Involuntary treatment is also a violation of personal liberty. Without any clear guidelines or standards for treatment, we are concerned that many people who are grappling with problematic drug use and behavioral health challenges will be subject to punitive, stigmatizing, and potentially harmful practices under the CARE Court proposal.

The standards for ordering the proposed involuntary commitment are substantially less rigorous than what is required under the current mental hygiene law, creating a significant risk of abuse, conflict of interest, and lack of review by individuals competent to make a medical determination that an individual is a risk to themselves or speculate about an individual's potential future risk.

Additionally, the parameters and terms in the CARE Court proposal are overly vague, reflect a misunderstanding of the concepts behind the terms, obscures the involuntary nature of CARE Court and may not lead to an appropriate level of treatment.

CARE Court will also perpetuate and exacerbate the overrepresentation of people of color in involuntary treatment programs. This is perhaps best evidenced by the allegations of racial disparities that plague Alameda County's application of the California law that allows police first responders to remove people who they think are a danger to themselves or others to a mental health facility. These significant racial disparities are magnified at each stage of the process – from assessment to involuntary hold to forced treatment.

A lawsuit over the Alameda County involuntary hold policy includes disturbing findings of racial disparities:

- Black people make up over 30% of those brought to the hospital's emergency psychiatric ward, but just 10% of the county population overall, in Alameda County, which has the highest rate of psychiatric holds in all of the California.[3]
- Black men are significantly more likely than other groups to end up "involuntarily institutionalized in the wake of a mental health crisis call."
- Of the more than 350 people who had been held in Alameda County's John George Psychiatric Hospital emergency unit at least 10 times, over half were Black; some had been hospitalized more than 85 times.[4]

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[1] Szalavitz, Maia (2012). TIME Magazine. "Should States Let Families Force Addicts Into Rehab?" https://healthland.time.com/2012/10/03/should-states-let-families-force-adults-into-rehab.
[2] James A. Inciardi, "Some Considerations on the Clinical Efficacy of Compulsory Treatment: Reviewing the New York Experience," at 126-138 *in* National Institute on Drug Abuse, Research Monograph Series 86, *Compulsory Treatment of Drug Abuse: Research and Clinical Practice* (1988).
[3] Thompson, Christie. (2020) "When Going to the Hospital Is Just as Bad as Jail" The Marshall Project. https://www.themarshallproject.org/2020/11/08/when-going-to-the-hospital-is-just-as-bad-as-jail.
[4] Disability Rights California. "DRC Lawsuit against Alameda County." https://www.disabilityrightsca.org/cases/drc-lawsuit-against-alameda-county.

- These are not isolated incidents: a supervisor of the mental health unit for the Oakland Police Department revealed that approximately half of the mental health calls that officers respond to each day end in an involuntary hold (40 to 50 calls per day).[5]

Additionally, people in Alameda County who have been subjected to short-term hospital holds under the so-called kinder, gentler policies say "the experience of being held against their will in a psychiatric ward was as traumatizing as being arrested, and didn't connect them with any follow-up treatment."[6] Expanding the processes that lead to involuntary treatment and civil commitment while doing nothing to address the structural root causes driving racial disparities is wholly unacceptable.

The above documentation of extreme disparities in involuntary holds mirrors national trends on racial disparities in behavioral health treatment. Research has indicated Black Americans are overrepresented in psychiatric emergency rooms and under-served by voluntary, community-based mental health support.[7] Data analyzed by the Substance Abuse and Mental Health Services Administration (SAMHSA), the federal agency responsible for behavioral health issues, found racial disparities in substance use disorder treatment for people with co-occurring disorders.[8]

The recently published SAMHSA report highlights disparities[9] including:

- African Americans have worse mental health outcomes following inpatient treatment than Whites.
- African Americans are less likely than Whites to receive continuing care (e.g., medication management, outpatient visits/follow-up services) following hospital discharge.
- African Americans are more likely than Whites to get higher doses of antipsychotics and are less likely to be prescribed newer generation antipsychotics (which have fewer side effects).

Finally, California should invest in housing and supportive services not costly court programs. A great deal of focus within the current debate CARE Court has centered on people who are experiencing homelessness, with media portrayals grossly stoking fears of violence among people who are on the streets. The unfortunate reality is people who are homeless are subject to violent attacks on them by vigilantes and daily abuse and trauma in myriad forms that can compound risk factors for overdose and serious mental health episodes.

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[5] Thompson, Christie. (2020) "When Going to the Hospital Is Just as Bad as Jail" The Marshall Project. https://www.themarshallproject.org/2020/11/08/when-going-to-the-hospital-is-just-as-bad-as-jail.

[6] Thompson, Christie. (2020) "When Going to the Hospital Is Just as Bad as Jail" The Marshall Project. https://www.themarshallproject.org/2020/11/08/when-going-to-the-hospital-is-just-as-bad-as-jail.

[7] Snowden, Lonnie R., Julia F. Hastings, Jennifer Alvidrez. (2009) "Overrepresentation of Black Americans in Psychiatric Inpatient Care" Psychiatric Services. https://doi.org/10.1176/ps.2009.60.6.779.

[8] Substance Abuse and Mental Health Services Administration. (2020) "Substance Use Disorder Treatment for People With Co-Occurring Disorders." Treatment Improvement Protocol 42. https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-004_Final_508.pdf.

[9] Substance Abuse and Mental Health Services Administration. (2020) "Substance Use Disorder Treatment for People With Co-Occurring Disorders." Treatment Improvement Protocol 42. https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-004_Final_508.pdf.

Access to permanent, affordable housing is a critical component of maintaining the health and stability of people actively engaged in drug use and those in recovery. Homelessness and unstable housing often co-occur with substance use disorder. Indeed, policies and practices that force people who use drugs out of their home can contribute to homelessness.

For many people, stabilizing their housing situation is associated with decreases in drug use and decreased use of emergency psychiatric services.[10] Current policy frequently bars the population most in need of services from accessing crucial temporary shelter and housing. Without access to stable housing, people who use drugs can find themselves caught in the cycle of repeat incarceration and dependency on emergency medical service. In the absence of significant housing access reform, we will continue to be stuck in a vicious cycle where people who use drugs cannot secure housing because of their substance use, and yet, without housing, they will face undue challenges to adequately address the risks or harms of their substance use.

Proposals that invest state money to expand costly court processes that lead to involuntary treatment will not address this disparity in resources nor improve access to proven behavioral health care. Instead of relying on coercive involuntary tactics that are unproven, punitive, rife with racial disparities and will further compound what hardest-hit communities are facing, California must rapidly scale up resources and funding for proven public health responses.

For these reasons, we urge your NO vote when AB 2830 (Bloom) comes before you in committee. If you have any questions about our position, please contact me directly at 707.386.7142 or our legislative advocate, Danica Rodarmel at danica@wholeconsulting.org Thank you for all your work on behalf of all Californians.

Respectfully,

Jeannette Zanipatin, Esq.
State Director, Drug Policy Alliance

cc: Honorable Members, Assembly Judiciary Committee
Honorable Members, Health Committee
Office of Assemblymember Bloom

[10] Kerman, N., Sylvestre, J., Aubry, T. et al. (2018) The effects of housing stability on service use among homeless adults with mental illness in a randomized controlled trial of housing first. BMC Health Serv Res 18, 190. https://doi.org/10.1186/s12913-018-3028-7; Gulcur, Leyla & Stefancic, Ana & Shinn, Marybeth & Tsemberis, Sam & Fischer, Sean. (2003). "Housing, Hospitalization, and Cost Outcomes for Homeless Individuals with Psychiatric Disabilities Participating in Continuum of Care and Housing First Programmes." Journal of Community & Applied Social Psychology 13(2). doi:10.1002/casp.723.

Exhibit 19

Pages: RJN-0369 through RJN-0375

California Council of Community Behavioral Health Agencies, et al., Written Testimony dated April 19, 2022, submitted to Assembly Judiciary and Health Committees

Legislative History Report and Analysis for Senate Bill 1338 (Umberg & Eggman – 2022) Chapter 319, Statutes of 2022

April 19, 2022

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

The Honorable Jim Wood, DDS
Chair, Assembly Health Committee
1020 N Street, Room 390
Sacramento, CA 95814

RE: AB 2830 (Bloom) Community Assistance, Recovery, and Empowerment Court Program–CONCERNS
As amended April 7th, 2022

Dear Chair Stone and Wood:

On behalf of the undersigned statewide provider advocacy associations, which combined represent the backbone of the public behavioral health system, we respectfully express significant concerns with AB 2830 (Bloom) as amended on April 7th, 2022. While we support the intention of the proposal to connect individuals with untreated schizophrenia and psychotic disorders to care, we believe that SB 1338 as drafted does not provide adequate services or housing, does not provide for sufficient due process protections, and has the potential to harm individuals who, given the opportunity, would engage in care and housing voluntarily outside of CARE Court.

While we appreciate that the bill language has answered some questions we raised in our preliminary letter regarding the CARE Court proposal, our coalition still has significant questions and concerns that need to be addressed before being able to fully weigh in.

Even with further detail, we request additional discussion via the stakeholder workgroups and other communication mechanisms before registering a position. In this vein, we offer the following questions, considerations, and concerns that we believe should guide the development of this new program. Our organizations and the members we represent stand ready to engage and lend our expertise as you continue to further develop the CARE Court framework.

While we are generally supportive of providing a robust and accountable system of care and we applaud the intention of this legislation, we do have high level concerns. Individuals coerced into treatment experience these services as trauma, not "care." Though we understand that the Administration's goal is not to look to conservatorship, 5150's and other types of mandated treatment as a first option, the fact that these may ultimately be a part of some individuals' treatment plans during CARE Court is concerning. Research shows that coerced treatment is also ineffective treatment and there are numerous studies demonstrating this with respect to services for individuals experiencing mental health and substance use conditions. Accordingly, coerced treatment should be a last resort, and only used in those instances where there is an immediate threat to life or risk of serious harm. This is a value shared in common by all four state associations and our member organizations.

We remain concerned that CARE Court does not include some critical protections and safeguards outlined in Assisted Outpatient Treatment (AOT). AOT authorizes a court to order an individual with a mental illness in counties that have not opted-out onto court-ordered services. AOT eligibility criteria is more specific than CARE Court and critically requires that an individual "has been offered an opportunity to participate in a treatment plan… and the person continues to fail to engage in treatment" and "Participation in the assisted outpatient treatment program would be the least restrictive placement necessary to ensure the person's recovery and stability," pursuant to Welfare and Institutions Code (WIC) 5346 (a)(5-6). Within CARE Court, the petition to place the individual into CARE Court only needs to include an affirmation or affidavit of a qualified behavioral health person that the person has examined, or has made attempts to examine, the respondent in the last three months and that the professional has determined that the person meets or is likely to meet the diagnostic for CARE Court proceedings, pursuant to WIC 5975(g)(1). The qualified behavioral health professional does not need to have offered services to the individual nor even actually evaluated the person in order for a petition to be filed with CARE Court. We find this problematic, as individuals who would otherwise engage in voluntary services will be pulled into an unnecessary legal proceeding which provides them no benefit. We believe that moving forward, CARE Court needs to address these key protections. Without a proper evaluation and service options clients could be faced with further barriers to care.

It is important to note that when it comes to the proposed target population for CARE Court, those individuals experiencing co-occurring mental health and substance use disorders might be the majority group as they are more likely to come to the attention of those who might make referrals into the CARE Court process. Additionally, we remain concerned about clients who never have had contact with the legal system but through this initiative would be experiencing it through this new program. This is why it is of utmost importance to ensure that the CARE Court referral and treatment process is comprehensive and attends to the various impacts of the social determinants of health on this population.

During our conversations with CalHHS staff, we understand the Administration's commitment to focusing on the least restrictive treatment environments and allowing as

much individual choice in the CARE Court process. However, many of our members continue to react to the messaging around CARE Court which seems to feed into stigma-based beliefs around violence and incompetence on the part of those that CARE Court would look to serve. This messaging can and will have an impact on those who might participate in CARE Court, and "care" and "court" are two words that don't make much sense when combined.

With respect to timeline, we believe the January 2023 start date for CARE Court implementation is overly ambitious for an effort with this level of complexity. Additionally, the bill does not require health care service plans and health insurers to cover services for their enrollees that are in CARE Court until July 1, 2023. We are concerned that the ambitious timeline may leave many important details and questions unresolved, and ultimately fail the individuals the proposal aims to help. For example, if critical resources such as workforce for treatment settings and housing do not exist, an individual is bound to fail. As such, we request consideration of a pilot program of several select counties for the next three years beginning January 1 2024, with a sunset, and a robust evaluation conducted by a university. This will allow the state to test the effectiveness of this new court model and correct unforeseen challenges with the program prior to statewide rollout.

Below, we outline additional feedback from our members:

How does the Administration envision substance use disorder conditions to be included in CARE Court? Methamphetamine-induced psychosis, a transient condition, is included under a psychotic disorder although the strategies and involuntary treatment are not effective for this condition. Additionally, individuals with co-occurring conditions will be included under CARE Court and the services described do not match what is needed for an individual with a substance use disorder condition. Access to MAT, recovery residences, harm reduction services, contingency management, and individualized treatment are critical for individuals with substance use disorders. Additionally, what will prevent CARE Court from being used to further criminalize or coerce substance use disorders? How will additional treatment capacity be funded for substance use disorder care? Drug Medi-Cal alone cannot meet the full needs. Since a high percentage of the population in question are co-occurring, there is a significant capacity shortage today to meet the need of this population.

There will need to be a new workforce of evaluators for CARE Court that is trained specifically on the eligible diagnoses and impairment criteria. From conversations regarding alienist evaluations for felony incompetent to stand trial (IST) evaluations, there is not sufficient training or an adequate number of evaluators leading to delays before evaluation and inappropriate evaluations leading to individuals who are competent being placed on the IST waitlist. It is unclear in the bill's language who is qualified to do these evaluations and there is no definition in the bill of a "qualified behavioral health professional." How will the state prevent something similar from happening with CARE Court? One potential solution could include adapting the Massachusetts model for IST evaluations which includes workshops for evaluators, individual mentoring, review of reports, written examination and an ongoing quality improvement process overseen by the

state mental health agency. Additionally, it is imperative that the CARE Court process include protections for underserved, underrepresented and under-resourced communities that have been historically targeted by law enforcement for crimes at a higher rate than other communities.

Given that there is an existing behavioral health staffing shortage, what will prevent CARE Court from draining staff from community-based programs into a costly and time-consuming court process where individuals are already receiving services? We hear from provider agencies that the critical barrier that prevents them from offering additional services is the lack of ability to hire and retain qualified workforce. One specific example is when San Francisco City and County declared a local state of emergency in December regarding the situation in the Tenderloin, allowing them to waive the government hiring process and fill nearly all of the hundreds of vacant and funded positions within the behavioral health branch of the Department of Public Health. However, doing this gutted the vital workforce from local CBOs. While we appreciate that the Administration has proposed a Care Economy Workforce request in the Fiscal Year 2022-23 State Budget, workforce development will take time and the immediate need is far greater than what is proposed to meet the needs of Californians with mental health and substance use conditions.

While considering workforce shortages, we are also uneasy about deadlines listed in the bill. Between 56 distinct county systems this program will be implemented in many different ways. This could prove to be problematic when mandating each client receive a hearing no later than 30 days. If hearings are delayed for more than 30 days the "defendant is released on their own recognizance" and, without a transition plan, returns to the community. Not only do we think it would be feckless to let someone simply lapse out of care due to a missed deadline but without an appropriate transition plan further homelessness and churn is inevitable.

While we understand that CARE Court is not intended to be a silver bullet solution to homelessness, likely a significant portion of the individuals in CARE Court will be experiencing homelessness or housing insecurity. How does CARE Court intend to operate when we are experiencing a general lack of housing services for individuals with behavioral health conditions? We have members that are currently doing a superb job of engaging predominantly individuals experiencing homelessness with both mental health and substance use conditions, but are having a difficult time linking individuals to housing and services particularly for individuals with co-occurring conditions because these options simply do not exist. Clients are able to take a shower, access harm reduction services, and get short-term services, but there remains a need for more housing options for individuals with behavioral health conditions.

It is also important to note that research from Dr. Margot Kushel of UC San Francisco indicates that half of all individuals experiencing homeless today are over the age of 50 with half of this population having their first experience of homelessness after they turned 50 years old. There is a significant percentage of this population who have geriatric conditions beyond their biological age including urinary incontinence, hearing impairment

and mobility impairment. As such, access to services, including housing needs to be designed to address these needs. Does the CARE Plan designed within the CARE Court model include adequate access to primary care and physical health care services?

Our members raised several questions about the mechanics of CARE Court and how it will actually be operationalized. The pathway of Referral, Clinical Evaluation, Care Plan, Support, and Success is highly aspirational and does not reflect all of the possible situations that could occur including refusal of treatment. As well as the successful examples outlined in the materials we have seen, is it possible to see a diagram or decision tree that reflects a person refusing or failing out of CARE Court, at each point in the pathway, in order to better understand their treatment options and what happens to them if they refuse or drop out of the process prior to the "end?"

Lastly, our members are also concerned about the role that different system representatives play in the CARE Court model. What will happen if a homeless outreach worker or a police officer refers an individual to be evaluated and placed into CARE Court, but the individual refuses? To what location are the notices served when the individual is unhoused? Will the person be arrested or detained by law enforcement? Further, how does the person actually get to the court? Are they transported? Where will the person be detained until they are evaluated? We believe that jails are not the appropriate place for individuals with behavioral health conditions and psychiatric hospitals are already at capacity. What protections will exist for situations where an inappropriate referral is made? How will individuals who lack medical decision-making capacity also be required to complete an advanced health care directive?

Our organizations combined represent the community-based providers on the ground serving individuals that could potentially be ordered into CARE Court. We have provided commentary and questions reflecting fundamental details that need to be resolved prior to CARE Court passing the Legislature, being signed by the Governor, and implemented.

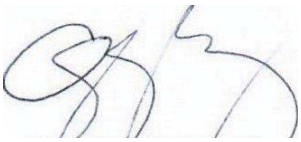
We are committed to continuing discussions with our respective members, with the Legislature, and with the CalHHS team. If you have any questions, please do not hesitate to outreach to any of our organizations.

Sincerely,

Le Ondra Clark Harvey, Ph.D., Chief Executive Officer, California Council of Community Behavioral Health Agencies

Chad Costello, CPRP, Executive Director, California Association of Social Rehabilitation Agencies

Tyler Rinde, Executive Director, California Association of Alcohol and Drug Addiction Program Executives



Christine Stoner-Mertz, LCSW, Chief Executive Officer, California Alliance of Child and Family Services

CC: Honorable Members, Assembly Judiciary Committee
Honorable Members, Assembly Health Committee
The Honorable Richard Bloom, 50th Assembly District
Richard Figueroa, Deputy Cabinet Secretary, Office of Governor Newsom
Tam Ma, Deputy Legislative Secretary, Office of Governor Newsom
Kim McCoy Wade, Senior Advisor, Office of Governor Newsom
Dr. Mark Ghaly, Secretary, CalHHS
Marko Mijic, Undersecretary, CalHHS
Stephanie Welch, Deputy Secretary of Behavioral Health, CalHHS
Corrin Buchannan, Deputy Secretary for Policy and Strategic Planning, CalHHS
Michelle Baass, Director, Department of Health Care Services (DHCS)
Jacey Cooper, Chief Deputy Director and State Medicaid Director, DHCS
Dr. Kelly Pfeifer, Deputy Director, Behavioral Health, DHCS
Susan DeMarois, Director, Department of Aging
Martin Hoshino, Administrative Director, Judicial Council of California
Agnes Lee, Policy Consultant, Office of Assembly Speaker Rendon
Leora Gershenzon, Deputy Chief Counsel, Assembly Judiciary Committee
Judy Babcock, Senior Consultant, Assembly Health Committee
Scott Bain, Principal Consultant, Assembly Health Committee
Andrea Margolis, Consultant, Assembly Budget Committee
Eusevio Padilla, Chief of Staff, Office of Assemblymember Joaquin Arambula
Liz Snow, Chief of Staff, Office of Assemblymember Jim Wood
Guy Strahl, Chief of Staff, Office of Assemblymember Richard Bloom

Exhibit 20

Pages: RJN-0376 through RJN-0441

Certified Hearing Transcript of California Senate Hearing, dated May 25, 2022, re: SB 1388

Legislative History Report and Analysis for Senate Bill 1338 (Umberg & Eggman – 2022) Chapter 319, Statutes of 2022

Community Assistance, Recovery and Empowerment (CARE)

Senate Floor (5/25)

RE SB 1338 Bill

SENATE PRESIDENT: Members, we are going to move forward to File Item 110, Senator Umberg. Madam Secretary, please read.

SECRETARY: Senate Bill 1338 by Senator Umberg, an act relating to mental health.

SENATE PRESIDENT: Senator Umberg.

SENATOR THOMAS UMBERG: Thank you, Madam President.

Colleagues, I'm pleased to present SB-1338 along with my joint author, my colleague -- our colleague from Stockton.

Colleagues, there are 7,000 to 12,000 Californians who are afflicted with schizophrenia or schizophrenia-like illnesses. The families of those who are afflicted, they know the pain and suffering of schizophrenia and the schizophrenia-like illnesses.

They know the turmoil of getting phone calls at 3:00 in the morning notifying them that their loved one is incarcerated, and actually feeling a sense of relief because they know their loved one at least is someplace where they can be found and is presumably relatively well as opposed to other phone calls that they may get.

The governor has proposed a bold new

paradigm shift which is the Community Assistance Recovery Empowerment (CARE) Court program. This is a proposed framework that is intended to address the needs to stabilize those 7,000 to 12,000 Californians and address the needs of their families as well.

This comprehensive program provides for a structure where there is a court who has accountability, where there is a supporter who provides assistance to those who are ill, a public defender if necessary, but it is not a collaborative court. It is akin to one. It doesn't provide for incarceration. What it does is it provides an alternative, for example, to conservancy. It provides individuals with clinically appropriate community-based services and supports that are clinically, and logistically, and culturally competent.

Appropriations Committee provided two important amendments to strengthening the housing compound of the CARE Courts because you can't get well unless you have a stable location from which you can thrive and survive. Are there going to be additional amendments? There are going to be additional amendments.

The CARE Court program is one that is innovative, and as I mentioned at the outset is a paradigm shift but one that's necessary to address those that we've had a very difficult time reaching who have so impacted of course themselves, their families, and the communities in where they -- where they resign -- reside.

Thank you, Madam President.

SENATE PRESIDENT: Thank you, Senator Umberg.

Senator Eggman.

SENATOR SUSAN EGGMAN: Thank you, Madam President.

Members, I am proud to rise as a co-author in support of my colleague. You have the care, you have the court, so we feel like we are -- we're excited to be working together on this and really bringing together we think a comprehensive team. We're very grateful to the governor's office for coming up with this new concept.

You've all heard me talk a lot about our broken mental health system. I know I have been focusing on this pretty intently this year. Neither my eight-bill package that we need to

pass or this bill will solve all of our issues, but it will go a long way towards doing that, especially for those who have been the hardest to treat.

And some people say, "You're putting them at the front of the line." Yes, kind of, because right now they're not even in line. They're too hard to treat.

So as we said before, this should only impact between 7,000 and 12,000 people. Will it solve homelessness? No, it will not. But are the majority of these people that we are talking about suffering from homelessness? Yes, they are.

This again comes with three core components, that one being care, being provided a treatment plan, having a supporter, a medication plan, as well as a housing plan.

As I think about what we all experienced yesterday, and the helplessness and hopelessness that maybe you all felt as I did in thinking about those children gunned down, and we think we need to do more, and you feel frustrated in California because we've passed some of the most stringent. We can't fix our country's gun

laws today, but we can stop people dying on our streets, and languishing in our jails, and languishing in our emergency rooms, and families who are living in fear every single day of that phone call they're going to get, and praying that it's their person's been taken somewhere safely.

So this is a new and innovative new onramp into our mental health system. It is innovative. As we all know, our LPS laws were passed in the '60s. We've way advanced through there. And while we need to continue to strengthen and fix those, this is a new onramp for those very chronic folks who so desperately need care, and I would respectfully ask for your aye vote.

SENATE PRESIDENT: Thank you, Senator Eggman.

Senator Borgeas.

SENATOR ANDREAS BORGEAS: Madam President, I want to commend both senators, both authors for this bill, and I certainly would've supported it in (indiscernible) if the Chair hadn't closed the roll. I think this is an important development, and I want to congratulate you -- both of you -- for the hard work that

you've done.

SENATE PRESIDENT: Thank you, Senator Borgeas.

Senator Pan.

SENATOR RICHARD PAN: Thank you, Madam President, senators. Actually, a question for the author.

SENATE PRESIDENT: Senator Umberg, will you take a question?

SENATOR THOMAS UMBERG: Well, if it's a hard question, my colleague from Stockton said she'd like to take it.

SENATE PRESIDENT: Beautiful.

SENATOR THOMAS UMBERG: Either one.

SENATE PRESIDENT: Senator Pan?

SENATOR THOMAS UMBERG: I'll take a shot first.

SENATOR RICHARD PAN: Sure. Yes. So I appreciate that.

And first of all, I want to thank you for -- both you and the senator from Stockton for bringing this forward. You know, we had I think a very thorough hearing in Health Committee, and heard from the administration.

A couple of key points came out. I do

want to ask you about one of them because you made references to amendments taken in appropriations.

So I think both the administration acknowledged and I think you understand that housing is going to be very important, and the bill, at least as it came through Health Committee, we did not have the requirement for housing. I think I raised the issue about priority for housing at least, and can you speak to -- at this point in time, now it's on the floor -- what the -- I don't want to say requirements but what's being done to assure that people going through CARE Court will have housing? Because without housing, it's going to be very difficult to deliver these services. And if it's not in the form that's on the floor, what do you anticipate? Are you committing to in the Assembly to try to address the housing issue? So you said -- did say you accepted some amendments in appropriations, and maybe you can elaborate on that.

SENATE PRESIDENT: Senator Umberg.

SENATOR THOMAS UMBERG: Thank you. thank you, Senator Pan.

So currently, there's a $12 billion investment in housing here in this year's budget. There's also a $1.5 billion investment in housing to support behavioral health challenges. And one of the attributes of the CARE Courts is that you have a judge. And to the extent that the county has the capacity to provide housing, Court can actually order -- at least that's my vision -- can order the county to provide that housing.

There are still some challenges. We recognize that there are still some challenges that need to be addressed as this bill moves forward, but I know it's the governor's intent, and it is certainly our intent to make sure that we provide a stable environment for those who have been identified and are within the jurisdiction of the CARE Court. And I'll turn to my --

SENATE PRESIDENT: Thank you, Senator Umberg. I think Senator Eggman would also like to answer part of your question, Senator Pan.

SENATOR SUSAN EGGMAN: And if it's all right with Senator Umberg, just to further add to that, as Senator Umberg said, over $12 billion we have provided for housing through last year's

budget. More will be provided in this year's budget.

And as you know, Dr. Pan, one size does not fit all with the population we're talking about. So it is very difficult to try to say what it will be because, as we said, an individual will have a developed plan, and then the judge will be able to say, "Is that adequate what you're planning for their housing, or is it not?" and for the Court to be able to order that.

But as you know, some people might go to a sober living, some people might go -- be able to live with their family who'd now be willing to have them back at the house if they're under medication and under care.

So we realize more needs to be done, but with the over $12 billion investments that we have sent out and more coming in this year, we know that there's out -- the funding exists currently. And because we're only talking between 7,000 and 12,000 people that will each be -- have an individualized plan that this -- that the judge -- the Court will be able to order what is appropriate for each individual person.

SENATOR RICHARD PAN: I appreciate the

answers, and I do want to of course also recognize the investments that are being made in the budget.

So I'm -- I want -- I'm going to support the bill today to continue to move forward. I think I've -- I sort of indicated this in the committee, but I'm going to reiterate this is that -- and I really appreciate my good friend from Stockton saying that the issue is that oftentimes they're not even on the line, and I think that's also what the secretary of Health and Human Services said as well.

That's my concern is that although we're investing all this money in housing, I also want to be sure that by the time someone ends up in CARE Court, technically it's of the CARE Court. They should be at the front of the line for whatever housing is consistent with their housing plan.

Now maybe we don't have it ready yet and we're still -- but if it's there, they shouldn't be waiting, and waiting, and waiting. They should be at the front of the line. Okay.

So I'm going to make that pitch so when it heads over to Assembly to be a little more

explicit about that, that if you are so far that you're ending up in the CARE Court, and the judge comes up with a care -- has a housing plan which is required under your bill -- it's there, that if there's housing that fits the housing plan, they're in the front of the line to get that housing, that they don't have to keep waiting.

And I realize there may be other people in line, et cetera, but if you're at the point where you have to require CARE Court, you get to cut in front of the line because you're in considerable straits, as long as you're under the CARE Court. So I do want to say that.

The other thing I'm just going to say briefly which I know is a little beyond the purview but, you know, as we're talking about the budget, I think it's going to be important that our county behavioral health system -- which we're also counting on to be able to do a lot of different things to make the CARE Court work -- needs to get funding as well to be able to do those functions. And that's something that, you know, we have to be sure of that, again to make this successful.

So I know that's a little perhaps

beyond your bill, but as we're talking about the budget and so forth, we're going to have to be sure that they have the support, so the behavioral health system can also do their role that you're -- that the bill is going to require them.

So I appreciate the work. I know this is a -- there's a whole list of people who have concerns. It's going to be -- it's a very important conversation to keep moving forward. I appreciate your leadership in this, so I'm certainly going to be supporting the bill. I urge other people to support the bill, but I also think there's continuing work to do, and I know that you're going to carry that forward. Thank you.

SENATE PRESIDENT: Thank you, Senator Pan.

Senator Roth.

SENATOR RICHARD ROTH: Thank you, Madam President.

You know, folks down where I come from when they see me on the streets say, and they -- thinking about this CARE Court proposal -- they say it's about time.

So I want to certainly thank the governor. I want to thank the pro team. I want to thank the bill authors and others involved in this effort, commend them for the effort because I think it's an extraordinary one.

It's a critical component of our attempt to deal with a mental health crisis that's a longstanding crisis in this state.

I will note that due -- as you all know, due to the 1991 mental health and health realignment of funding in this state, there are significant funding inequities, county to county, north to south, east to west in this state. Those inequities remain, and so I've said this before. I'll say it again. In order for this program to be efficient, effective, and robust, we're going to have to figure out a way to deal with those funding inequities, perhaps not through restructuring the 1991 realignment but rather through augmentation from the general fund budget.

And it's essential that we do that because it's -- while we have appropriated billions of dollars for housing, this program is more than just housing. It's about mental health

treatment. It's about personnel at the county level to provide that sort of treatment. It's about acute care, subacute care, and sub-subacute care, mental health treatment facilities and beds, and we're going to have to have the funding to do that.

I'm confident that leadership, my budget leadership will pursue that during the budget negotiations. I look forward to seeing the results, and I certainly urge an aye vote on this measure.

SENATE PRESIDENT: Thank you, Senator Roth.

Senator Bates.

SENATOR PATRICIA BATES: Thank you, Madam President, and let me add my great appreciation to the authors of this measure. It is so very important.

And it was clear to all of us and all of our constituents that what we were doing on homelessness needs new approaches. We do need accountability for the resources we've expended, and we need resources for the programs. The governor's CARE Court proposal is absolutely a step in the right direction. It is a new

approach. And while I heartily support this bill moving forward, we do need to be certain not to set counties and courts up for the failure.

The CARE Court program includes new responsibilities and obligations imposed on counties and courts that require additional resources and ongoing funding. In order for the proposal to work and be implemented at the local level, the governor and the legislature need to commit to adequate and sustainable funding for our counties.

Given the magnitude of CARE Court proposal and capacity issues throughout the state around behavioral health infrastructure, workforce and housing, the best path to success for implementors should be grounded in a thoughtful, transparent, and incremental phase and model.

An 18-month implementation is just too short. However, we do need to get onto it. We can't have years of delay. This approach will afford stakeholders in all levels of government the opportunity to examine outcomes CARE Court participants -- for CARE Court participants, work through implementation hurdles, and develop a

robust and successful statewide rollout.

The CARE Court effort must be paired with treatment. There's no real path to solving our homelessness crisis that does not involve expanding treatment capacity. To that end, we need to establishing a mental health infrastructure fund that would provide access to care for individuals who are unable to care for themselves due to untreated illness or addiction and will provide -- most importantly will provide the resources our local county governments -- our local governments and county governments will need to meet the expectations that have placed on California CARE Court.

According to a recent report conducted by the Rand Corporation and financed by the California Mental Health Services Authority, California has a deficit of 4,700 subacute and acute psychiatric treatment beds, and if we add the lower acuity treatment beds in community residential facilities, that deficit increases to 7,700. The report's first recommendation is that a significant investment is needed in psychiatric bed infrastructure.

And we need to create new centers at

our state universities for behavioral-health-focused additional education and degrees in order to expand the treatment workforce.

In my own district, I will share about two years ago, we could not get psychiatrists available in our emergency rooms for 5150 folks brought there. It was really, really a crisis.

If we do not build the treatment capacity now, we'll never do it, and too many Californians will continue to needlessly suffer.

Again, I support moving SB-1338 forward, but it must be worked on in the Assembly to make sure that we are not setting our counties and courts up for failure. It must also be paired with expanded treatment capacity, and that can be funded by the establishment of mental health infrastructure fund, and I would like to share that's a budget proposal we recently submitted and discussed by the Republican caucus.

To that end, I again strongly support an aye vote on this measure.

SENATE PRESIDENT: Thank you, Senator Bates.

Senator Durazo.

SENATOR MARIA ELENA DURAZO: Thank you,

Madam President.

I too rise in support with concerns, and I'm sure I'm not the only who has concerns. Speaking of which with -- and I'm not opposed to the quickness of putting forward this framework. There are concerns that have been raised by a number of organizations who I believe are good allies of ours on all of the issues.

So one question I have, if I may, Madam President.

SENATE PRESIDENT: Will you take a question, Senator Umberg?

SENATOR THOMAS UMBERG: Yes.

SENATOR MARIA ELENA DURAZO: Is to address the remaining concerns, what do you see -- where is the engagement process that we can create or that you've already thought of creating?

Second, because we all -- we both work on the judicial issues in this state -- is what do you see as the capacity of the judicial system in light of so many other great needs that we have, like evictions or criminals? There are so many things that happen that cause a backlog.

And then three is because of the black

and brown being more misdiagnosed or over-diagnosed with these same mental illnesses, how do we make sure that this doesn't spill over into a new system that also becomes sort of a new way of incarcerating those individuals?

So if you could respond, I'd appreciate it.

SENATE PRESIDENT: Senator Umberg.

SENATOR THOMAS UMBERG: Sure. Thank you. Let me -- let me address those in reverse order if I can remember them.

First of all, in terms of incarceration, this is a court that is in the civil jurisdiction. It's not a criminal court. And I mentioned collaborative courts. It's not an -- it's a cousin of collaborative courts. Its purpose is to make sure that we get people back up on their feet, but there is no component of this that provides for incarceration, number one.

In terms of other issues that have been raised, our colleague and friend from Sacramento raised issues concerning prioritization of housing. That is in the bill, prioritizing housing. And in fact, if the county has the capacity, the Court can order the county to

provide that housing. And I believe that has been addressed, and we'll continue to address that.

In terms of my colleague from Riverside and funding, funding is obviously the underpinning of any policy, and there is significant funding that the governor has proposed, and I think that we are in agreement with in terms of providing housing.

In terms of the issue concerning potential racial disparity, that is clearly not the intent. The intent is to help all those, those 7,000 to 12,000 folks who are seriously afflicted with mental illness, particularly schizophrenia. That's the purpose is to address that universe irrespective of, you know, race.

The other issues raised in terms of the courts in judicial capacity, another important question, another important issue. Yes. There's additional funding that's provided to the courts to also make sure that we do things like we provide that additional capacity in the courts, and additionally training for judges. This is not something that might naturally come to someone who either is or aspires to be a judge,

so we do recognize that additional training is going to have to be provided to the judges. This is a different sort of animal for the courts but one I'm confident they'll handle.

And having a judge who has responsibility. Accountability is a critical component. I hope that's addressed at least some of your issues.

SENATOR MARIA ELENA DURAZO: Thank you.

SENATOR THOMAS UMBERG: Senator Eggman, did --

SENATE PRESIDENT: Senator Eggman?

SENATOR SUSAN EGGMAN: Yeah. I wanted to respond specifically to the issue of a black and brown. Historically, people of color have sought out mental health treatment less and have had less access to it. And we know that the best way to be able to treat somebody effectively is earlier intervention, and so oftentimes people don't get care, and then end up much more in severe circumstances than others.

And so the issues around access exist historically. This bill does not affect that at all, but it does move anybody who fits into this criteria to the very front of the line to make

sure they get the help they need. And again, it's civil. It is not about penalizing these folks at all. It's about getting them the care, the housing, and the treatment that they need.

SENATE PRESIDENT: Thank you all.

Senator Kamlager.

SENATOR SYDNEY KAMLAGER: Thank you, Madam President. I too rise in cautious support of this bill. I think it's incredibly audacious. I mean, this is not a bite at the apple. This is the entire orchard.

And I'm also hoping that the authors of this bill will take into consideration some of the very vocal and legitimate opposition that has been raised. I want to echo some of the concerns by the good senator from Los Angeles who also raised some of them.

You know, this bill as I read it impacts four different codes, the penal code, the insurance code, the welfare and institutions code, and health and safety. And sometimes those codes don't work together, and now we have created this very aspirational and dynamic overhaul of a system, and so I think we should be very rooted in reality that this is not going to

see success overnight because these are systems that have been in place for quite some time in terms of their development, how they've been operationalized, implemented, where they fail, and where they leave people out.

I -- you know, the reality is that you cannot legislate buy-in, and this proposal is going to require buy-in from both impacted communities, from the courts, from counties, and from systems.

And most importantly, it's going to require an infusion of human contact of people working with people, and what you don't want is to create a new system of chutes and ladders where people are funneled through new chaos that's been designed to help them get treatment or force them into treatment, and it doesn't work because there is not the human connection of like the check-ins and the understandings and the nonjudgmental support.

I caution that there are family members and friends of people who are impacted who are not interested in their people's wellbeing and success.

There are nefarious folks out there

interested in A, gaming systems, and B, taking advantage of people who need help. And how do we make sure when we're creating a system that we are not leaning -- you know, because you have to have the support from the family member, or this person is going to, you know, write in a letter, and they're involved in the decision-making of this person's health and wellbeing. What are the checks and balances to make sure that the folks that are really interested in that person's success are at the table.

And I also hope that this doesn't create a cottage industry for lawyers who are helping families and friends like navigate this new thing because we know where that can end up.

You know, lastly I just want to say that self-determination is incredibly important. It is primary for me, and it's primary for folks from the disability community. It's also really primary for folks who are mentally unwell, and for homeless folks, and for black and brown communities that find themselves in these systems disproportionately.

And I just want to share two stories that I think help resonate both my concern and my

support for this bill.

The first one is Fatima. Fatima is homeless. She has -- she has AIDS. She's blind. She's homeless. She was moved into Project Roomkey after living on the streets for a really long time. She has a caregiver, her boyfriend, who's also her dealer, and her parttime user friend, and her pimp. And they both ended up in Project Roomkey.

And she -- in sharing this story, I was like, "Well, you need to get away from this man." And the folks -- the healthcare provider said, "Yeah. We've been trying to do that, but she won't go." And I said, "This doesn't make any sense."

They both ended up in Project Roomkey. Then there was a series of events, and she got kicked out, and she ended up pitching a tent right next door to the facility so she could be close to her friend who was her caregiver, her pimp, her dealer.

Me and providers, now she's out. Get her -- now that she's out, how do we help her get away from this person? And they said, "Well, you know, her belief is that she would rather be

abused by the person that she knows who is getting money every month because he is her caregiver, so he's giving her her medication, he's getting her around because she is blind, and he's also abusing her. And she said she would rather be with that person than out on the street alone being abused and sexualized by so many other people.

Now is she defiant or is she self-determinant? And is it my right to determine that?

I still have conflict about this story about Fatima, but Fatima is not one person. There are thousands of Fatimas out there. And she pitched her tent next to where he was, to be close to a man who was abusing her.

The second story is David. David's sister babysat me when I was little. Close family friend. I had a -- David was smart and attractive and going places.

David took a trip and became schizophrenic. And David, his -- he would -- he got help when he wanted to, and he didn't when he didn't want to. And David was over 18, and so the doctors said to his mother, my good friend,

"We cannot mandate David to get help," so there were days when David would walk by his mother and did not notice her at all. Did not recognize her.

I went to visit them. David went into the room. He was talking to himself in a voice that was so demonic that it made me deeply afraid.

David tried to set their condo on fire, and he was -- they had to go.

David walked into Lake Michigan, and his mother had to identify him as a John Doe with a tag on his foot at the coroner's office.

I grew up with David. David deserved to get help. Maybe that help would have saved his life. But I don't know which voice or voices -- Francine, or the doctors, or David -- should've listened to.

David is why we need something like this. Fatima is why we need to be incredibly cautious and thoughtful about the opposition.

I don't talk much about David. But it is very hard, and oftentimes folks who are mentally unwell and have schizophrenia are left into the margins of our society, and they do have

a right. They have a right to be listened to.

And once again, did David abdicate or was it self-determination? These are so important questions that we need to really make sure we get right.

So I will be supporting this bill, but I will be thinking about both of those people while this makes its way to the other side because both of their stories are important.

SENATE PRESIDENT: Thank you, Senator Kamlager.

Senator Ochoa Bogh.

SENATOR ROSILICIE OCHOA BOGH: Thank you Madam President and members.

I wasn't planning on following senator from L.A., but I want to thank her thoughts -- for sharing her thoughts because I absolutely agree with them, and I also agree with many of the comments that have been made on this floor today.

I'd like to thank the authors for this bill because as our senator from Riverside mentioned, many have stated it's about time.

And while I'll be supporting this bill today, I do rise with concerns that have been

shared and some that haven't yet.

I have heard from many stakeholders that they need more time to implement the new process in this bill. Additionally, as mentioned, there are not enough resources currently committed in order to ensure the success of the system.

I do have a question to the author.

SENATE PRESIDENT: Senator Umberg, will you take a question?

SENATOR THOMAS UMBERG: Yes.

SENATE PRESIDENT: Senator Ochoa Bogh, please proceed.

SENATOR ROSILICIE OCHOA BOGH: Would you be willing to amend the bill in the Assembly to push the timeline because that is one of the concerns that have been raised?

SENATE PRESIDENT: Senator Umberg?

SENATOR THOMAS UMBERG: The proposal has a very aggressive timeline, as is appropriate for an issue that is as significant and as acute as it exists today in California. But we are mindful. I suppose I'll speak for my joint author. We are mindful of the fact that this aggressive timeline -- it's important that we

stay on track but that we do this right. And so yes, we are going to be flexible as to the timeline. We don't want to delay this too long, but we want to make sure we get it right. So the short answer is yes.

SENATOR ROSILICIE OCHOA BOGH: Thank you very much, senators, and I'll conclude with that.

SENATE PRESIDENT: Thank you very much, Senator Ochoa Bogh.

Senator Nielsen.

SENATOR JIM NIELSEN: Madam President, ladies and gentlemen of the senate, I want to record a little bit of history here just to ensure the confidence of where this is headed. A little bit different program maybe, but the pattern is one of success.

My staff were able to dig up an article and a picture about the signing of the GAIN program. In the picture, I am in it with Senator Garamendi, Assemblyman Konnyu, and Assemblyman Agnos in the mid '80s.

GAIN dramatically changed welfare in California, which was not about dependence but about empowerment, about help, like we do in

special ed in our schools, IEPs. Well, this was kind of like an IEP, individual treatment program, if you will, to assist an individual to redress the issues or address the issues that were plaguing them. And that then later began the drug court in California, and I helped Judge Darrell Stevens in Butte County start one of the first, if not the first, in California.

The drug court was not just about dependence. It was about accountability and health and empowerment, and it worked until Prop 47 destroyed the drug courts. I won't get into the whys it did, but it did.

Now drug court, which was immensely successful, has been replaced by individuals not having their needs met, but they get flash incarceration, which is nonsense.

Now what's the key here with this particular plan that is being proposed? It talks about recovery, assistance, empowerment. That is the pathway to success, not the pathway to dependence. And you probably heard me, at least some of you in committee and on the floor, talk about a kind of an individualized treatment plan for the homeless population because I say

historically all we've done about homeless is throw money at it, not accountability, not treatment, not assessment of needs and helping those individuals address their needs so they are not dependent on being homeless.

Well, this is such a pathway for particularly challenged individuals, and I believe it's helpful. It has incorporated into it assessment, treatment, accountability, and I will argue results. If we really want to do something about homelessness, shelter is a part of the deal, but unfortunately, that's all we've really focused on. This can be a pathway to that success of individuals who have challenges in their lives.

Now one of the aspects of this that must be addressed -- and I suggest we can take steps in this particular budget -- and Republicans have advocated for this in different ways maybe. Democrats have too, so there's room here for compromise and success. And as we finish up this year with our budget, this is one area that we most assuredly should focus on and address. Help those individuals who are homeless.

I think we all get tired of seeing the tents all over the place. I drive in four days a week in here to this capitol and see nothing but difficulty, and that's politely put.

We aren't helping those individuals by just throwing dollars at the wall and not really helping their individual needs, and they have many. All of them are not mental and all of the are not physical, but a heck of a lot of them are.

As I've said often here too, the constant in the lives of most criminals in California is a broken heart, which is where this all starts, sometimes in the womb, and then negative behavior that they resort to, to comfort themselves and to survive. That is a pathway to success and indeed a proven one.

As we proceed in this though, we cannot ignore -- we must focus on counties of California who are the vanguard through their behavioral health programs for the treatment and the assessment and the success of individuals to not be constrained and destroyed by their challenges. This is a positive pathway. I encourage it. I urge an aye vote, and I urge a sustained attempt

-- not an attempt, rather but a success of all of us to address these needs of individuals, in some cases before they end up out on the streets or deceased or other situations. I do urge an aye vote.

SENATE PRESIDENT: Thank you, Senator Nielsen.

Senator Portantino.

SENATOR ANTHONY PORTANTINO: Thank you, Madam President and members.

I rise to support SB-1338 and certainly appreciate the conversation that has happened and the perspectives. You know, this is a sensitive important problem to have across California, and it needs a sensitive implementation and, frankly, new ideas.

We've tried for decades to address mental health issues, homeless issues, and frankly have not had tremendous success. And we do need to try a new approach.

Whenever you try to bring something new to the table, there's a natural hesitancy and resistance, and I think it's important the -- certainly the concerns have been raised are the right questions to ask, and I have faith in the

authors, both of them, and the folks shepherding this to address them.

Sharing -- I mean, every family has been touched by a mental health issue, by a homeless person. This is not -- we're not immune to this.

Just in my own family situation, I had a sibling who went through three different county hospitals in California -- three different county hospitals, three different counties, and lo and behold on Day 14 was declared not a threat to himself.

And I don't want to believe that because he didn't have health insurance that the decision not to keep him was predicated on that situation. But lo and behold, on Day 14 in three different counties, he was sent home. And after the third time, he took his own life, and I just, you know, wish we had an opportunity at that point to see him get extended care and the love and opportunity to be with us today.

And so I strongly support SB-1338 and really appreciate the conversation and the concerns and definitely know the authors are going to be addressing them as we move forward.

SENATE PRESIDENT: Thank you, Senator Portantino.

Senator Becker.

SENATOR JOSH BECKER: Thanks, members.

I know this has been a long debate and probably can't say it better than my colleague. I just want to say -- I just want to really rise in gratitude because I know these issues are difficult. I know these issues are complex, and I also believe they are probably the most important that we will address this year. And so to have folks like the senator from Stockton and the senator from Santa Ana who are knowledgeable, are compassionate, I just know they're going to get us to the right place, and I am all in on whatever I can do in this legislation. I think it's that important, so thank you.

SENATE PRESIDENT: Thank you, Senator Becker.

Senator Allen.

SENATOR BENJAMIN ALLEN: Members, I'm so struck by how many of us have people we love and know -- our colleague from Los Angeles spoke so eloquently about David. There's someone in my life with a similar story, Danny, whose parents

were so desperate to help him and weren't able to find a way, and he ultimately took his life stepping into traffic.

Another friend I grew up with, went to high school with, Sean, still on the streets I believe but I'm not quite sure. It's very tough situations that I know would've -- he would've benefited from something like this, so I want to vote for this bill today in their honor.

SENATE PRESIDENT: Thank you, Senator Allen.

Senator Stern.

SENATOR HENRY STERN: Thank you, Madam President.

I rise as a co-author of this measure, and in light of the personal testimony delivered on the floor here today, I'll take a slightly less personal tack and talk about mechanics for a second.

The welfare and institutions code that this bill amends says that mental healthcare is a basic human service. I believe it ought to be a basic human right.

We currently treat housing that heals as something that's subject to appropriation,

something that's subject to the budget cycles. And if we're actually going to build this new infrastructure of care, the requirement and I believe the mandate on us is to say these resources will be there for you. If you're going to trust us enough to come into this care, we're not going to recycle you through the system like we do with so many people on the streets.

Our audit of L.A. County and San Francisco found that the average person living on the street right now is cycled 10 times through the system through 5150 holds, forced hospitalizations, expensive stints in jail systems, over, and over, and over again, cumulatively an incredibly expensive system that traumatizes and breaches our trust with people so they don't want to come into care anymore, and they don't want to go to a CARE Court, and that's some of the sensitivity you're hearing from the opposition to this legislation is that they just don't trust that it's going to be there for them.

The new provisions added even in appropriations say that the CARE plan may -- may -- include the following housing support systems and the following behavioral health systems.

Now, I recognize if that "may" became a "shall," that could be a very expensive proposition, and we debated some of this in Senate Health Committee, and I know that there have been dollars not properly tracked, wasted, unspent, but if we look at some analog out there -- say you have a disability of a different sort, not from a severe mental illness, say an intellectual or developmental disability here in the state of California. The state of California guarantees that you will have care.

Now, it's not always the best care, and we know there are challenges with our regional centers, but the state of California will guarantee you under the LPS Act that if you have an intellectual or developmental disability that was diagnosed at a young age, you will have access to that care. But if in your 20s you have a mental illness that is sparked sometimes by substance abuse disorders, sometimes by latent paranoid schizophrenia -- we know that these come -- these illnesses come on later in life, and it evades the system as a result.

And so people are left without anyone to back them up, without the government behind

them, and so -- you know, I'm a proud co-author of this measure because this is an indispensable piece of the puzzle. But I hope that as we go through our legislating this year -- and I'm working with the senator from Stockton on what I believe is a critical corollary to this, which is to actually provide a right to treatment in this process, to guarantee that right to the housing that goes along with it and to the treatment so that when the budget cycle is not good and we don't have a surplus, and we don't have one-time funding to throw at behavioral health infrastructure, even then we will be there for you.

And maybe if we can start to bridge that divide, those who have concerns, those who worry about rights being compromised will start to trust us. And more importantly, people on the streets who are literally dying -- five people a day last year in L.A. County alone -- literally dying on our doorsteps, the moral debt we owe those people will soon be repaid. So I think we can't afford not to make mental healthcare a basic human right.

And with that hopeful, hopeful vision

that we can get there, I ask for your aye vote.

SENATE PRESIDENT: Thank you, Senator Stern.

Senator Dahle.

SENATOR BRIAN DAHLE: Thank you, Madam President and members.

I rise -- I'm going to support the bill today.

And I served 16 years on the county board of supervisors, and one of the main reasons I ran for the legislature is because of unfunded mandates that come down to the counties, AB-109, those types of programs. I know there's money in the budget.

I have a great respect for both senators that are working on this bill, and I just wanted -- I just want to make sure that we communicate with the counties. They're the ones that are really going to be delivering these services at the end of the day. And they -- the one-size-fits-all -- it doesn't matter if you're in Yreka, California, the most southern town -- or northern town -- or San Diego. There are homeless people and schizophrenia and these issues across our state. But what works in

Siskiyou County or Modoc County may be -- look a lot different than it does in San Diego County or San Francisco County.

So I just want to reach out and say, you know, we need to communicate with those folks because at the end of the day, they're the ones that are really going to be delivering these services, and there are a lot of -- one size doesn't fit all in California, so I will be supporting the bill.

This is not easy. As you've heard, many members are talking on this bill today. this is not going to be easy, and we need to be able to accentology the fact that when we do it wrong, we need to be able to go back, and revisit it, and make it right because we're going to learn along the way. This is not something we got into overnight, and it's not something we're going to get out of anytime soon, and there are many issues.

I pray to God that he intervenes because a lot of this is just, I believe, evil. And drug addiction has to be addressed. They have to be clean and sober before we can actually start treating some of those.

If you visited any of your county facilities, I'm sure you're aware that a lot of times the reason they don't go into shelters is because there are people in those shelters that are abusing them worse than being out under the bridge where they feel safe. That's a fact, and we're going to have to figure out how to navigate that.

So I look forward to working with both the colleagues, and I know that the senator from Stockton, we came in together, and we've been talking about these issues for too damn long. But I look forward to seeing how this legislation works out, and I will be supporting SB-1338 today.

SENATE PRESIDENT: Thank you, Senator Dahle.

Seeing no further discussion or debate, Senator Umberg, you may close.

SENATOR THOMAS UMBERG: Thank you, Madam President.

Colleagues, thank you for sharing the pain of your own personal lived experience.

I began this by talking about an anecdote that is of my own lived experience

concerning a family member.

There are Californians right now at 5:32 on Wednesday that are looking for loved ones. They can't find them. And they're looking because they don't know what to do. Because they don't know what to do. They don't know how to find them help. We don't look for our loved one anymore because there's actually no need to

But I'm hopeful. And what gives me incredible hope is the breadth and scope of the support from our colleagues, Menlo Park, Los Angeles, to Tahoma, to Laguna Niguel, to Fresno. That breadth of support, that depth of support gives me hope.

Do we have work to do? We obviously have work to do. Do we have concerns about, for example, housing? Obviously we do. About making sure the counties can supply the support that this bill requires, that this bill calls for? Of course we have the concerns. But I do think that we have this unique opportunity, this unique time when we have the resources and the collective political will to make a huge difference, not just bipartisan but across the spectrum.

And so I am incredibly hopeful and

incredible grateful to all of you and the governor for putting this bold -- as we've said -- paradigm shift before all of us, so thank you, and I'll also defer.

All right. Thank you very much. I urge an aye vote.

SENATE PRESIDENT: Thank you, Senator Umberg.

Madam Secretary, please call the roll.

SECRETARY: Allen?

SENATOR BENJAMIN ALLEN: Aye.

SECRETARY: Aye. Archuleta?

SENATOR BOB ARCHULETA: Aye.

SECRETARY: Aye. Atkins?

SENATOR TONI ATKINS: Aye.

SECRETARY: Aye. Bates?

SENATOR PATRICIA BATES: Aye.

SECRETARY: Aye. Becker?

SENATOR JOSH BECKER: Aye.

SECRETARY: Aye. Borgeas?

SENATOR ANDREAS BORGEAS: Aye.

SECRETARY: Aye. Bradford?

SENATOR STEVEN BRADFORD: Aye.

SECRETARY: Aye. Caballero?

SENATOR ANNA CABALLERO: Aye.

SECRETARY: Aye. Cortese?
SENATOR DAVE CORTESE: Aye.
SECRETARY: Aye. Dahle?
SENATOR BRIAN DAHLE: Aye.
SECRETARY: Aye. Dodd?
SENATOR BILL DODD: Aye.
SECRETARY: Aye. Durazo?
SENATOR MARIA ELENA DURAZO: Aye.
SECRETARY: Aye. Eggman?
SENATOR SUSAN EGGMAN: Aye.
SECRETARY: Aye. Glazer?
SENATOR STEVEN GLAZER: Aye.
SECRETARY: Aye. Gonzalez?
SENATOR LENA GONZALEZ: Aye.
SECRETARY: Aye. Grove?
SENATOR SHANNON GROVE: Aye.
SECRETARY: Aye. Hertzberg? Hueso?
SENATOR BEN HUESO: Aye.
SECRETARY: Aye. Hurtado?
SENATOR MELISSA HURTADO: Aye.
SECRETARY: Aye. Jones?
SENATOR BRIAN JONES: Aye.
SECRETARY: Aye. Kamlager?
SENATOR SYDNEY KAMLAGER: Aye.
SECRETARY: Aye. Laird?

SENATOR JOHN LAIRD: Aye.
SECRETARY: Aye. Leyva?
SENATOR CONNIE LEYVA: Aye.
SECRETARY: Aye. Limon?
SENATOR MONIQUE LIMON: Aye.
SECRETARY: Aye. McGuire?
SENATOR MIKE MCGUIRE: Aye.
SECRETARY: Aye. Melendez?
SENATOR MELISSA MELENDEZ: Aye.
SECRETARY: Aye. Min?
SENATOR DAVE MIN: Aye.
SECRETARY: Aye. Newman?
SENATOR JOSH NEWMAN: Aye.
SECRETARY: Aye. Nielsen?
SENATOR JIM NIELSEN: Aye.
SECRETARY: Aye. Ochoa Bogh?
SENATOR ROSILICIE OCHOA BOGH: Aye.
SECRETARY: Aye. Pan?
SENATOR RICHARD PAN: Aye.
SECRETARY: Aye. Portantino?
SENATOR ANTHONY PORTANTINO: Aye.
SECRETARY: Aye. Roth?
SENATOR RICHARD ROTH: Aye.
SECRETARY: Aye. Rubio?
SENATOR SUSAN RUBIO: Aye.

SECRETARY: Aye. Skinner?

SENATOR NANCY SKINNER: Aye.

SECRETARY: Aye. Stern?

SENATOR HENRY STERN: Aye.

SECRETARY: Aye. Umberg?

SENATOR THOMAS UMBERG: Aye.

SECRETARY: Aye. Wieckowski?

SENATOR BOB WIECKOWSKI: Aye.

SECRETARY: Aye. Wiener?

SENATOR SCOTT WIENER: Aye.

SECRETARY: Aye. Wilk?

SENATE PRESIDENT: Please call the absent members one more time.

SECRETARY: Hertzerg. Wilk.

SENATE PRESIDENT: Okay. Ayes 38. Nos zero. The measure passes.

Members, we are going to break for a 30-minute dinner break.

C E R T I F I C A T I O N

I, Sonya Ledanski Hyde, certify that the foregoing transcript is a true and accurate record of the proceedings.

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