

## Report to Council

Government Affairs Committee

October 13, 2022

### GAC meeting of October 11, 2022

1. **Welcome and Introductions:** The Co-chairs welcomed members to the committee
2. **Federal and APA Issues:**
  1. **Updates:** The committee did not discuss the updates. It was later noted that Laura Halpin will be attending on behalf of SCPS the APA State Advocacy Conference during the weekend of October 15.
3. **CSAP GAC (CGAC) Meeting of September 15, 2022:** SCPS GAC (SGAC) reps to CSAP GAC (CGAC) (Reba Bindra, Laura Halpin, Zeb Little, Rod Shaner, and Emily Wood) attended CGAC on June 16, 2022, and gave report to SGAC. Key parts of the CGAC agenda were:
  1. **Review of gubernatorial actions to this date on legislative bills passed at the close of the last legislative session:**

**Signed/Approved:**

    1. AB 2275 (Wood) Certification review w/i 7 days for back-to-back 5150s
    2. SB 528 (Jones) Juveniles medication orders include JV 220s
    3. SB 858 (Wiener) DMHC penalty increases for MCO med necessity foot-dragging
    4. SB 929 (Eggman) Community mental health services: data collection
    5. SB 988 (Bauer-Kahan) 988 Suicide and Crisis Lifeline funding infrastructure
    6. SB 1035 (Eggman) AOT medication adherence testimony can be in court record
    7. SB 1227 (Eggman) Second 5270 for intensive inpatient tx
    8. SB 1338 (Umberg) CARE program enacting legislation
    9. SB 1394, (Eggman) Temporary Conservatorship Time Extension to date of court disposition

**Vetoed:**

    1. SB 964 (Wiener) Leg report from UC on BH job descriptions, including scope
    2. SB 1143 (Roth) "Loan" fund for building inpatient psych beds, with sketchy repayment
    3. SB 1446 (Stern) Entitlements for mental health services and "Housing the Heals."

2. **Update on new CSAP Policy Platform:** The committee discussed possible recommendation to SCPS Council regarding adoption of the interim CSAP High-Level Policy Platform in light of Council's previous resolution to of September 8, 2022 to "Notify the CSAP Board that the SCPS Council would be satisfied with a draft interim CSAP High-Level Policy Platform that approximates the one in Attachment II, should it be recommended by the CSAP GAC, with the understanding that such acceptance is not binding on future SCPS acceptance of policy planks in the future complete CSAP Policy Platform."
  1. OCPS subsequently notified the other DBs that it would not adopt the platform unless the term "behavioral health care" was changed to "comprehensive psychiatric care" throughout the document that the SCPS Council had examined in attachment II (9/15) and that the CSAP Board had asked DBs to indicate approval by 10/13/2022.
  2. The question discussed by the committee was whether the term "comprehensive psychiatric care" sufficiently approximated "behavioral health care" to be acceptable to the SCPS Council. in the interests of facilitating CSAP consensus in time to meet the 10/31 deadline.
  3. Pro arguments for recommending that the Council accept the approximation are that it is in the interests of SCPS to take leadership in fostering sufficient flexibility among the DBs to achieve sufficient consensus to achieve a serviceable document by 10/31 and the beginning of the new legislative session, and to thereby defer discussion about terminology for a subsequent final document later.
  4. The con argument is that the word substitution is not in the interests of SCPS because, depending on what might be meant by the non-standard term "comprehensive psychiatric care," it could appear to either 1) inappropriately limits the scope of psychiatric advocacy to psychiatric practice rather than the behavioral health system generally, or 2) claim that all behavioral health care falls under "psychiatric care," thereby undermining credibility of CSAP among legislators and other advocacy groups.
  5. After discussion, the committee voted 10-3 to make the following motion at SCPS Council:

**Motion I: Approval of the CSAP interim High-Level Policy Platform (See attachment 1)**

4. **CSAP Board Meeting of September 15, 2022:** SCPS CSAP Board members (Zeb Little, Rod Shaner) reported that:
  1. The CSAP Board directed written communication to be sent to CMA requesting that CMA restore determinative representation by the great majority of APA psychiatrists in California in the CMA Council on Legislation by approving the CSAP representation to the CMA Legislative Council.

2. The CSAP Bylaws review is still being planned, and recent events, including a report to the CSAP Board by representatives from Area 6 Council, suggests that they might include language regarding the structure for coordination with Area 6.

## 5. SCPS advocacy issues

1. The committee discussed advocacy coordination and projects among GAC and Access to Care, Private Practice, and Managed Care Committees (GAC Co-chairs, Dr. Goldenberg (Chair, PPPC), Dr. Friedman (Chair, ACC)). It was agreed that coordination would be useful. Additionally, the committee voted to move at Council that SCPS request CSAP specifically identify those advocacy efforts most likely to benefit private practice activities of psychiatrists.

### **Motion II: CSAP Identification of specific advocacy efforts supporting the private practice of psychiatry (See Attachment 2}**

2. The committee discussed the implications of various formats for a planned CSAP "Lobby Day," including implications for effectiveness and financial costs. CSAP has indicated that the traditional format of sending members to visit offices of various legislators might differ in effectiveness and cost with other potential formats, such as webinar-based meetings with groups of legislators for discussion of specific issues, using town hall formats. The sense of the committee was that SCPS representatives to CSAP should advocate full discussion of the alternatives before the formats are determined.
3. **Adolescent ECT Initiative:** Dr. Shaner reported on a request received from a UCLA faculty member for SCPS guidance regarding advocacy for clarification of regulatory language regarding approval of ECT for adolescence. Committee members will recommend at the CSAP GAC meeting that CSAP advocacy resources be devoted to a review of feasibility of such a project. (See attachment 3).
4. **LA County requirement for repeat Riese Hearings the successive WIC holds:** Dr. Shaner reported on a request from UCLA faculty for SCPS guidance on effective advocacy to modify the practice of requiring inpatient facilities to re-petition the Court each time the WIC code detention status for a patient changes, as such repetition creates clinically contraindicated discontinuities in medication treatment. Committee members will recommend at the CSAP GAC meeting that CSAP advocacy resources be devoted to a review of feasibility of such a project. Additionally, the

SCPS GAC committee will reach out to local DMH administrators seeking the basis for LPS designation requirements for inpatient facilities to conduct such re-petitions rather than allowing for one petition with a duration that is independent of the LPS regulatory section under which the patient may be detained. (See attachment 4).

**Dropbox:**

GAC Report to Council 2022-10-13

GAC Motion I

GAC Motion II

**Attachment 1: GAC Motion I: That Council shall adopt the following resolution regarding Acceptance of the CSAP interim High-Level Policy Platform:**

**RESOLUTION:**

**Whereas,**

The CSAP Board has requested that each CSAP DB indicate whether it approves the interim high level CSAP policy by 10/31 to have a document for use by CSAP legislative advocates in time for the critical beginning phase of the new legislative policy session; and

**Whereas,**

An interim CSAP High-Level Policy Platform, while not necessary fully detailed, would be extremely useful to SCPS advocacy efforts as an aid in CSAP communication with lawmakers and other stakeholders already planning legislation for introduction in the 2023-2024 legislative session;

**Whereas,**

It is in SCPS interests to take leadership in modeling and encouraging sufficient flexibility in its approval to best assure success in meeting the 10/31 deadline; and

**Whereas,**

OCPS subsequently notified the other DBs that it would not approve the platform unless most instances of the term “behavioral health care” were changed to “comprehensive psychiatric care;” and

**Therefore,**

Be it resolved that:

1. The SCPS Council approves the use of the current draft of the interim High-Level Policy Platform sent by the CSAP Board.
2. If consensus is not achieved by all DBs on the current draft of the interim High-Level Policy Platform sent by the CSAP Board, SCPS approves of any compromise interim High-Level Policy Platform that which is supported by a majority vote of the CSAP Board of Directors, including one that substitutes the term “Comprehensive Psychiatric Care” for the term “Behavioral Health Care” in a manner acceptable to the OCPS Council.

**Attachment II: Motion 2: That Council shall adopt the following resolution seeking CSAP Identification of specific advocacy efforts supporting the private practice of psychiatry:**

**Resolution:**

**Whereas,**

Psychiatrists in private practice have significant interest in specific legislative advocacy efforts that support the private practice of psychiatry; and

**Whereas,**

Psychiatrists working predominantly in private practice settings often have fewer opportunities to interface with health system administrators and executives and legislators to gain experience with administrative and legislative issues and actions related to machinery to gain firsthand experience in legislative agendas and advocacy than do psychiatrists in working in public systems or in administrative roles in private health organizations; and

**Whereas,**

Properly focused psychiatric advocacy efforts should be crafted with a comprehensive understanding of the effects of current regulation upon private practice;

**Therefore,**

Be it resolved that:

1. SCPS Council requests that its representatives to the CSAP GAC move at the next CSAP GAC meeting to direct the CSAP legislative advocacy resources to develop and deliver to the CSAP GAC, not later than December 31<sup>st</sup>, a concise list of regulations and potential actions, including legislative changes, suitable for distribution to district branches, that could:
  1. Meaningfully improve the abilities of psychiatrists in private practice to provide high quality, effective care to their patients, and
  2. Better focus SCPS and CSAP legislative advocacy efforts upon issues of critical concern to members in private practice.
2. SCPS requests that SYASL partner Paul Yoder join SCPS for a webinar based SCPS town hall meeting, hosted by the SCPS Private Practice Committee, to share information and ideas with SCPS general membership about advocacy opportunities of relevance to the support of private practice.

### **Attachment 3: Possible CSAP GAC referral regarding potential advocacy for clarification of WIC 5326.8**

WIC 5326.8.

Under no circumstances shall convulsive treatment be performed on a minor under 12 years of age. Persons 16 and 17 years of age shall personally have and exercise the rights under this article.

Persons 12 years of age and over, and under 16, may be administered convulsive treatment only if all the other provisions of this law are complied with and in addition:

(a) It is an **emergency situation** and convulsive treatment is deemed a **lifesaving treatment**.

(b) This fact and the need for and appropriateness of the treatment are unanimously certified to by a review board of three board-eligible or board-certified child psychiatrists appointed by the local mental health director.

(c) It is otherwise performed in full compliance with regulations promulgated by the Director of State Hospitals under Section 5326.95.

(d) It is thoroughly documented and reported immediately to the Director of Health Care Services.

*(Amended by Stats. 2012, Ch. 34, Sec. 90. (SB 1009) Effective June 27, 2012.)*

**Attachment 4: ARTICLE 7. Legal and Civil Rights of Persons Involuntarily Detained [5325 - 5337]**

*( Article 7 added by Stats. 1967, Ch. 1667. )*

**5332.**

(a) Antipsychotic medication, as defined in subdivision (l) of Section 5008, may be administered to any person subject to detention pursuant to Section 5150, 5250, 5260, or 5270.15, if that person does not refuse that medication following disclosure of the right to refuse medication as well as information required to be given to persons pursuant to subdivision (c) of Section 5152 and subdivision (b) of Section 5213.

(b) If any person subject to detention pursuant to Section 5150, 5250, 5260, or 5270.15, and for whom antipsychotic medication has been prescribed, orally refuses or gives other indication of refusal of treatment with that medication, the medication shall be administered only when treatment staff have considered and determined that treatment alternatives to involuntary medication are unlikely to meet the needs of the patient, and upon a determination of that person's incapacity to refuse the treatment, in a hearing held for that purpose.

(c) Each hospital in conjunction with the hospital medical staff or any other treatment facility in conjunction with its clinical staff shall develop internal procedures for facilitating the filing of petitions for capacity hearings and other activities required pursuant to this chapter.

(d) When any person is subject to detention pursuant to Section 5150, 5250, 5260, or 5270.15, the agency or facility providing the treatment shall acquire the person's medication history, if possible.

(e) In the case of an emergency, as defined in subdivision (m) of Section 5008, a person detained pursuant to Section 5150, 5250, 5260, or 5270.15 may be treated with antipsychotic medication over his or her objection prior to a capacity hearing, but only with antipsychotic medication that is required to treat the emergency condition, which shall be provided in the manner least restrictive to the personal liberty of the patient. It is not necessary for harm to take place or become unavoidable prior to intervention.

*(Amended by Stats. 2001, Ch. 506, Sec. 9. Effective January 1, 2002.)*

**5333.**

(a) Persons subject to capacity hearings pursuant to Section 5332 shall have a right to representation by an advocate or legal counsel. "Advocate," as used in this section, means a person who is providing mandated patients' rights advocacy services pursuant to Chapter 6.2 (commencing with Section 5500), and this chapter. If the State Department of State Hospitals provides training to patients' rights advocates, that training shall include issues specific to capacity hearings.

(b) Petitions for capacity hearings pursuant to Section 5332 shall be filed with the superior court. The director of the treatment facility or his or her designee shall



personally deliver a copy of the notice of the filing of the petition for a capacity hearing to the person who is the subject of the petition.

(c) The mental health professional delivering the copy of the notice of the filing of the petition to the court for a capacity hearing shall, at the time of delivery, inform the person of his or her legal right to a capacity hearing, including the right to the assistance of the patients' rights advocate or an attorney to prepare for the hearing and to answer any questions or concerns.

(d) As soon after the filing of the petition for a capacity hearing is practicable, an attorney or a patients' rights advocate shall meet with the person to discuss the capacity hearing process and to assist the person in preparing for the capacity hearing and to answer questions or to otherwise assist the person, as is appropriate.

*(Amended by Stats. 2012, Ch. 24, Sec. 129. (AB 1470) Effective June 27, 2012.)*

### **5334.**

(a) Capacity hearings required by Section 5332 shall be heard within 24 hours of the filing of the petition whenever possible. However, if any party needs additional time to prepare for the hearing, the hearing shall be postponed for 24 hours. In case of hardship, hearings may also be postponed for an additional 24 hours, pursuant to local policy developed by the county mental health director and the presiding judge of the superior court regarding the scheduling of hearings. The policy developed pursuant to this subdivision shall specify procedures for the prompt filing and processing of petitions to ensure that the deadlines set forth in this section are met, and shall take into consideration the availability of advocates and the treatment needs of the patient. In no event shall hearings be held beyond 72 hours of the filing of the petition. The person who is the subject of the petition and his or her advocate or counsel shall receive a copy of the petition at the time it is filed.

(b) Capacity hearings shall be held in an appropriate location at the facility where the person is receiving treatment, and shall be held in a manner compatible with, and the least disruptive of, the treatment being provided to the person.

(c) Capacity hearings shall be conducted by a superior court judge, a court-appointed commissioner or referee, or a court-appointed hearing officer. All commissioners, referees, and hearing officers shall be appointed by the superior court from a list of attorneys unanimously approved by a panel composed of the local mental health director, the county public defender, and the county counsel or district attorney designated by the county board of supervisors. No employee of the county mental health program or of any facility designated by the county and approved by the department as a facility for 72-hour treatment and evaluation may serve as a hearing officer. All hearing officers shall receive training in the issues specific to capacity hearings.

(d) The person who is the subject of the capacity hearing shall be given oral notification of the determination at the conclusion of the capacity hearing. As soon thereafter as is practicable, the person, his or her counsel or advocate, and the

director of the facility where the person is receiving treatment shall be provided with written notification of the capacity determination, which shall include a statement of the evidence relied upon and the reasons for the determination. A copy of the determination shall be submitted to the superior court.

(e) (1) The person who is the subject of the capacity hearing may appeal the determination to the superior court or the court of appeal.

(2) The person who has filed the original petition for a capacity hearing may request the district attorney or county counsel in the county in which the person is receiving treatment to appeal the determination to the superior court or the court of appeal, on behalf of the state.

(3) Nothing shall prohibit treatment from being initiated pending appeal of a determination of incapacity pursuant to this section.

(4) Nothing in this section shall be construed to preclude the right of a person to bring a writ of habeas corpus pursuant to Section 5275, subject to the provisions of this chapter.

(f) All appeals to the superior court pursuant to this section shall be subject to de novo review.

*(Added by Stats. 1991, Ch. 681, Sec. 5.)*

**5336.**

Any determination of a person's incapacity to refuse treatment with antipsychotic medication made pursuant to Section 5334 shall remain in effect only for the duration of the detention period described in Section 5150 or 5250, or both, or until capacity has been restored according to standards developed pursuant to subdivision (c) of Section 5332, or by court determination, whichever is sooner.

*(Added by Stats. 1991, Ch. 681, Sec. 6.)*