California
Behavioral Health
Planning Council
ADVOCACY • EVALUATION • INCLUSION

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The Honorable Anna Caballero, Chair

Senate Committee on Appropriations

1021 O Street, Suite 7620

Sacramento, CA 95814

RE: Opposition for AB 416

Dear Senator Caballero:

On behalf of the California Behavioral Health Planning Council (CBHPC), I am writing to express our opposition to Assembly Bill (AB) 416 (Krell), which seeks to expand the eligibility of professionals authorized to place individuals on a 5150 involuntary hold to include emergency physicians

The CBHPC serves as an advisory body to the Legislature and the Administration on behavioral health policies and priorities, as outlined in Welfare and Institutions Code §§ 5771 and 5772. Our diverse membership includes individuals with lived experience of serious mental illness and substance use disorders, family members, service providers, professionals, and representatives from state departments whose work intersects with California's behavioral health system. Their perspectives are essential in our evaluation of the public behavioral health system and shape the Council's recommendations.

AB 416 is unnecessary and duplicative as the Lanterman-Petris-Short (LPS) Act already defines and designates the categories of professionals legally authorized to place individuals deemed a danger to themselves or others or identified as "gravely disabled" on a 72-hour 5150 hold. This includes professionals authorized by the County Board of Supervisors, which have the discretion to determine the need for emergency physicians to be designated within their jurisdiction.

Health and Safety Code § 1799.111 authorizes non-LPS designated facilities to initiate 5150 holds for up to 24 hours, provided all required

conditions are met; emergency physicians are among those permitted under this statue.

Expanding the list of professionals eligible to initiate a 5150 hold does not inherently improve the effectiveness of mental health services. Instead, we believe California should prioritize strengthening person-centered and holistic crisis intervention strategies that reduce involuntary holds, decrease emergency room visits, and improve systemic responses to behavioral health crises.

Effective alternatives, such as crisis mobile teams, play a crucial role in de-escalating crises and connecting individuals with appropriate community-based services, rather than defaulting to hospitalization or law enforcement involvement. Research[1] shows that 44 percent of adults who engaged with a mobile crisis team connected with mental health services within **30 days**, demonstrating their effectiveness in facilitating care. Mobile crisis teams help reduce emergency room visits and hospital admissions, as early intervention prevents unnecessary hospitalization.

For these reasons, the Council respectfully opposes AB 416. If you have any questions, please contact Jenny Bayardo, Executive Officer, at (916) 750-3778 or via e-mail at Jenny.Bayardo@cbhpc.dhcs.ca.gov.

Sincerely,

Tony Vartan, Chairperson

cc: The Honorable Assemblymember Maggy Krell
Honorable Members, Senate Committee on Appropriations
Melanie Morelos, Legislative Director
Alex Niles, Communications Director

[1] Kim, S. Kim, H. Determinants of the use of community-based mental health services after mobile crisis team services: An empirical approach using the Cox proportional hazard model. J Community Psychol. 2017;45:877–887: https://doi.org/10.1002/jcop.21899