

Dear Commission Members--

As a advocate for those with a serious mental illness I am very concerned about the misuse of MHSA funds meant for treatment and care of the seriously mentally. In our county's System of Care there is not parity for those who seek treatment for a mental illness. People with a serious mental illness only receive the care that the county has funding for--not what is required for their treatment.

Our Mental Health Commission has voted to send the attached White Paper to our Board of Supervisors. The MHSA/Finance committee of the CCCounty MH Commission also felt that there was not accountability on how the MHSA funding in our county was spent so we devised a Program & Fiscal Review that I brought to the MHSOAC over a year ago. In our county I am still very concerned that programs receiving MHSA funds do not have outcomes as required by law.

As an advocate who is very concerned about housing with supportive care, I am therefore concerned about the \$2 billion *No Place Like Home* initiative that is being supported by the Steinberg Institute. I know they have the best of intentions in solving homelessness, but the funds for Prop 63 are to be used for the treatment and care of the severely mentally ill not as a means to combat the homeless problem in our major cities. Many of those who are homeless are not severely mentally ill. By removing a percentage of the MHSA funds from each county the State is weakening the ability of each county to care for those who are seriously mentally ill.

My hope is that the Little Hoover Commission takes a serious look at the White Paper that is attached. I hope that it takes the time to visit with the Mental Health Boards and Commissions throughout our state.

---Lauren Rettagliata

Mental Health System and Budget Crisis In Contra Costa County, FY/16/17

Executive Summary

This White Paper is a collaborative effort of the Contra Costa County Mental Health Commission (MHC) and Behavioral Health Services (BHS) with the support of the Behavioral Health Care Partnership (BHCP) to encourage discussion around the current crisis in the county public mental health care system and deficits in the county mental health budget process that contribute to this crisis. The paper's objective is to 1) focus attention on key symptoms of the crisis, and 2) inspire collaborative, creative problem-solving and solutions that build on our many strengths while overcoming budgeting challenges for the greatest impact on the well-being of people with a serious mental illness. This paper is presented to the Board of Supervisors for consideration during the current budget planning cycle for 2016-17 as well as future cycles as we strive to provide the best mental health care possible for those most in need in Contra Costa County.

Key points of this White Paper describe:

- The wake-up call of the crisis at Psychiatric Emergency Services (PES) that points to an impacted system that is unable to provide the right treatment at the right moment in time and is therefore struggling to truly meet the needs of people with a serious mental illness;
- The compromised ability of the Adult clinics and Child/Adolescent clinics to meet the needs of patients due to understaffing as evidenced by three to four month wait times and a migration of patients in crisis to PES for intervention that is not meant to be a stand-in for treatment;
- The adverse lack of support for families, who are so critical to diagnosis, support and treatment, due to the absence of Family Partner positions in the Children/Adolescent clinics and unfilled positions in the adult clinics;
- The deficit of treatment capacity for children and adolescents due to the lack of in-patient and residential beds (lack of contracts), an insufficient number of clinics, and understaffing, and the resulting increase in the number of children presenting at PES, cases of children staying at PES for multiple weeks and months, and cases of children placed in treatment far from home and their families;
- The underlying theme of inadequate staffing levels due to the inability of treatment facilities to attract and keep high quality psychiatrists and nurses because of uncompetitive compensation and such practices as the closing of lists; and
- The underlying theme of dedicated, quality staff struggling to offer excellent care but undercut by budgets that are generated by a formulaic, top down process rather than a process that builds up a budget from program needs.

In considering these challenges, perhaps the most critical step in solving our county's mental health crisis is to allocate funding in a way that meets patient needs at every level along the continuum of care. With program needs driving the budgeting process, we will create fiscal and human savings through our ability to treat illness before it enters the crisis state.

Taking a Close Look

In accordance with our state mandated duties outlined in WIC 5604.2, the Contra Costa County Mental Health Commission has performed due diligence in reviewing the traditional budget process for the Mental Health system. Through our committee work, site visits and collaborative efforts we have studied fiscal documents, outcome based data and received testimony from consumers, families and providers. We have also read numerous reports, articles and studies on the complexity of financing the California mental health system. Based on this collective learning, the Contra Costa County Mental Health Commission requests that the Board of Supervisors rethink the traditional budget process for the public mental health system of Contra Costa County and recognize the existing system crisis.

The Crisis at Psychiatric Emergency Services: A Wake-up Call

Over the last decade, even with the additional prevention/intervention and full service partnership funding through the MHSA funding stream, there has been a dramatic rise in the number of patients accessing Psychiatric Emergency Services (PES). This is ground zero for crisis and the Contra Costa County behavioral health system barometer. It has reached a breaking point.

The average number of patients being seen in PES now averages nine hundred per month. This includes one hundred to one hundred and fifty children and adolescents per month. The PES physical plant is designed for fourteen to twenty patients; however, it routinely holds double this amount -- thirty to forty patients. This number had already sharply increased before the Affordable Care Act became operational and has not subsided with integrated services in several of our county health and mental health centers. While there was hope that the Miller Wellness Center would relieve the stress on PES, this has not occurred.

Behavioral Health Administration points out the pressing need for access to key outpatient services that are critical for discharge planning from both PES and the inpatient unit of the hospital (4C). These services include active case management, adult mobile response teams, drop-in services (e.g. a sobering center), and dual diagnosis treatment. It is essential to expand capacity for moderate to severely impaired mentally ill patients in behavioral health clinics while at the same time increasing psychiatric support for primary care providers so that stable patients in the behavioral health clinics may be transitioned to primary care providers.

The Impact of Chronic Understaffing

Each of the Children and Adult Specialty Mental Health Clinics are understaffed. The East clinic, for example, is operating with a deficit of three psychiatrists. At the adult clinics, a patient seeking psychiatric services may have "rapid access" to having a file opened, but the intake including the psychiatric evaluation and necessary treatment is delayed for two to four months. Children are seen for an intake appointment within ten days, but it may take two to three months for an initial psychiatry appointment. Patients have no other option but to access PES or the Miller Wellness Center. In order to provide needed care and prevent unnecessary hospitalizations, the clinics must maintain sufficient staffing levels. This is the first step in fighting the firestorm of over 900 patients that request treatment at PES each month.

This chronic understaffing is not a human resource problem. It is a failure to think creatively and to raise the level of pay to attract quality psychiatrists. We need to review the entire compensation packet for this pivotal position to see if we are aligned with other Bay Area counties. If not, we need to make competitive compensation a top priority.

Miller Wellness: Filling In For Clinics

The Miller Wellness Center Behavioral Health was intended as a Mental Health Urgent Care for patients with mild to moderate mental health conditions for up to 60 days, and a possible preventative service for voluntary-only severely mentally ill or severely emotionally disturbed patients presenting at PES. It is not a specialty mental health clinic, and it cannot replace the psychiatric evaluations that are deemed medically necessary for disabled, severely mentally ill patients. Due to the markedly reduced access to mental health services through the county clinics, Miller Wellness Center has become the substitute for the behavioral health clinics, serving the moderate to severely impaired mentally ill population for substantially longer than the originally intended sixty days.

Providing For Family Support

Providing adequate support for families of both children and adults can also help prevent the avalanche of patients now being seen at PES. The Family Partner positions must be fully funded in each Children's Clinic and the Family Service Coordinator positions that have remained unfilled for five years must be filled in each of the Adult Clinics. These positions ensure that the families of seriously mentally patients can be educated to give vital information to health care professionals. They also support continuity of community-based and home care. These front line positions are essential and have remained unfilled for years, leading to crisis management in higher, more expensive levels of care.

Caring For Our Children

Since the AB 3632 mandate was suspended in 2011, severely emotionally disturbed children have been known to spend more than the statutorily allowed twenty three hours at PES waiting hospitalization or residential placement. Some children have spent months in PES awaiting an inpatient or residential placement. This puts additional stress on the patient and the staff. While this is a statewide and national problem, we have a legal and moral obligation to ensure the development of appropriate in-patient resources and facilities. Currently, freestanding hospitals are able to deny admittance to our most difficult young patients. Appropriate contracts need to be in place for high risk, difficult-to-place youth. The children's mental health clinics must be restored to the previous staffing levels of 2008. All front line positions should be filled, especially psychiatrists, nurses, and clinicians in order to alleviate the crisis. The Behavioral Health Administration also sees a great need for additional night and weekend clinics to augment the Miller Wellness Center and PES.

The county needs to work closely with First Hope to make a First Break program available for children and youths who are experiencing the initial effects of psychosis. This is one example of why it is essential to keep the "lists" open for hiring mental health specialists. Closing the list (as mentioned in the CAO handout on the Budget) prevents our clinics and hospital from acquiring the best and the brightest new graduates in the fields of Psychiatry and Psychology. Creative solutions such as internship programs with UC Davis and UCSF should be explored.

Housing That Heals

The number of persons with a serious mental illness who are homeless and in county shelters is rising. All MHSA-funded supportive housing for those with a serious mental illness is at capacity and our in-patient psychiatric unit is full. There is tremendous unmet need for mental health residential treatment and long-term supportive housing, yet we are holding millions of dollars in unspent MHSA funds.

More alternative treatment residential programs that lead to permanent, service-enriched housing models for people with a serious mental illness need to be explored, invested in, and implemented. Although “Housing First” was been adopted and promoted in our county several years ago, it cannot be effectively implemented without an adequate inventory of housing that is embedded with services that support consumers in developing skills to maintain their health and recovery. A true supportive housing model that includes teaching many consumers “direct skills” to maintain their health and recovery will prevent many high costs and reduce out-of-county placements.

The housing needs of our consumers and families present many challenges that follow a continuum from least restrictive to locked settings. Some see a need for more permanent supportive and shared housing; others see a need for more shelters; while others are calling for more residential alternative treatment settings. There may be a need for all. Behavioral Health is committed to working with stakeholders to look at the whole picture and to define solutions to the housing crisis, but planning meetings without action plans that are implemented remain only a dream, not a needed solution.

Creating a well-planned system for moving those with serious mental illness into the most appropriate housing model will be a savings to the county. There will always be a need for locked facilities and skilled nursing facilities, but many patients could be more effectively served in alternative residential treatment programs and permanent supportive housing in this county. Permanent supportive housing will also give those living in shelters or transitional housing a better path to optimal health. The county budget process must take a deep look at the funding streams that could make supportive housing a reality for people with serious mental illnesses.

Funding Our Solutions

Although the above problems can be classified as “Quality of Care” or “Human Resource” issues, in reality they are “Budget” problems. They are local, state and national problems that we must tackle. They are not problems without solutions. Creativity and collaboration must be employed to use the various braided budget streams to protect and augment resources. Budgets must be built based on program needs defined by people in the trenches rather than generated by a formulaic, top down process that is not always sensitive to the harsh realities on the ground.

California has more mental health funding available than any other state in the union. Yet we do not demonstrate the best outcomes for our communities. While Contra Costa County has the tools to create the best mental health system in the state, we must break through bureaucratic and budgeting barriers in order to maximize our strengths. Funding must be allocated to meet patient needs at the clinic level and every level along the continuum of care. This will create fiscal and human savings because we will be treating illness before it enters the critical or crisis state. We have learned to do this routinely with heart disease, lung disease, cancer, and diabetes. Why not with the brain disease of mental illness?

Respectfully submitted,

Contra Costa County Mental Health Commission

In collaboration with the *Behavioral Health Administration*

And in consultation with the *Behavioral Health Care Partnership*

April, 2016

APPENDIX

Source Reports and Articles to Consider

Financing mental health care

<http://dover-files.com/66/A-Model-for-California-Community-Mental-Health-Programs.pdf>

A report prepared in 1981 (still relevant today) at a time when legislature was aware of the underfunding of community mental health and asked the community to develop a report estimating how big the underfunding was and what would be needed.

http://www.mhac.org/pdf/mh_funding.pdf

Underfunded from the Start-2000-2001

http://histpubmh.semel.ucla.edu/sites/default/files/story-flipbooks/funding_publicmental_health/files/dmh_funding.pdf

www.chcf.org/.../download.aspx?id...

[Public Mental Health Delivery and Financing in California](#)

The lack of hospital beds; impact on Psychiatric Emergency Services

<http://m.eastbayexpress.com/oakland/overwhelmed/Content?oid=4705660>

http://www.treatmentadvocacycenter.org/storage/documents/the_shortage_of_publichospital_beds.pdf

<http://www.medpagetoday.com/Psychiatry/GeneralPsychiatry/44008>

<http://www.psychiatrictimes.com/psychiatric-emergencies/dearth-psychiatric-beds?GUID=EB5182F5-3FB6-4E50-A0B8-3E20501364F7&rememberme=1&ts=27022016>

<http://www.modernhealthcare.com/article/20131116/magazine/311169992>

The rapid rise of Psychiatric Emergency Services

<http://www.psychiatrictimes.com/psychiatric-emergencies/rise-emergency-psychiatry/page/0/1>

Rise in Latino youth hospitalizations; comparative numbers for other youth groups

<http://californiahealthline.org/news/latino-youth-in-california-see-significant-rise-in-psychiatric-hospitalizations/>

A special "thank you" to Kristine Girard, M.D.

Chief Psychiatrist, Contra Costa Regional Medical Center

For her contribution of several excellent resources

Mental Health Services Act (MHSA)

Program and Fiscal Review

- I. **Date of On-site Review:**
Date of Exit Meeting:
- II. **Review Team:**
- III. **Name of Program/Plan Element:**
- IV. **Program Description.**
- V. **Purpose of Review.** Contra Costa Mental Health is committed to evaluating the effective use of funds provided by the Mental Health Services Act. Toward this end a comprehensive program and fiscal review was conducted of the above program/plan element. The results of this review are contained herein, and will assist in a) improving the services and supports that are provided, b) more efficiently support the County's MHSA Three Year Program and Expenditure Plan, and c) ensure compliance with statute, regulations and policy. In the spirit of continually working toward better services we most appreciate this opportunity to collaborate together with the staff and clients participating in this program/plan element in order to review past and current efforts, and plan for the future.
- VI. **Summary of Findings.**
- VII. **Review Results.** The review covered the following areas:
 1. **Deliver services according to the values of the Mental Health Services Act** (California Code of Regulations Section 3320 – MHSA General Standards). Does the program/plan element collaborate with the community, provide an integrated service experience, promote wellness, recovery and resilience, be culturally competent, and be client and family driven.
Method. Consumer, family member and service provider interviews and consumer surveys.
Results.
Discussion.

Attachment 1 – Program and Fiscal Review Report Template

- 2. Serve the agreed upon target population.** For Community Services and Supports, does the program serve adults with a serious mental illness or children or youth with a serious emotional disturbance. For Prevention and Early Intervention, does the program prevent the development of a serious mental illness or serious emotional disturbance, and help reduce disparities in service. Does the program serve the agreed upon target population (such as age group, underserved community).

Method. Compare the program description and/or service work plan with a random sampling of client charts or case files.

Results.

Discussion.

- 3. Provide the services for which funding was allocated.** Does the program provide the number and type of services that have been agreed upon.

Method. Compare the service work plan or program service goals with regular reports and match with case file reviews and client/family member and service provider interviews.

Results.

Discussion.

- 4. Meet the needs of the community and/or population.** Is the program or plan element meeting the needs of the population/community for which it was designed. Has the program or plan element been authorized by the Board of Supervisors as a result of a community program planning process. Is the program or plan element consistent with the MHSA Three Year Program and Expenditure Plan.

Method. Research the authorization and inception of the program for adherence to the Community Program Planning Process. Match the service work plan or program description with the Three Year Plan. Compare with consumer/family member and service provider interviews. Review client surveys.

Results.

Discussion.

- 5. Serve the number of individuals that have been agreed upon.** Has the program been serving the number of individuals specified in the program description/service work plan, and how has the number served been trending the last three years.

Method. Match program description/service work plan with history of monthly reports and verify with supporting documentation, such as logs, sign-in sheets and case files.

Attachment 1 – Program and Fiscal Review Report Template

Results.

Discussion.

6. **Achieve the outcomes that have been agreed upon.** Is the program meeting the agreed upon outcome goals, and how has the outcomes been trending.

Method. Match outcomes reported for the last three years with outcomes projected in the program description/service work plan, and verify validity of outcome with supporting documentation, such as case files or charts. Outcome domains include, as appropriate, incidence of restriction, incidence of psychiatric crisis, meaningful activity, psychiatric symptoms, consumer satisfaction/quality of life, and cost effectiveness. Analyze the level of success by the context, as appropriate, of pre- and post-intervention, control versus experimental group, year-to-year difference, comparison with similar programs, or measurement to a generally accepted standard.

Results.

Discussion.

7. **Quality Assurance.** How does the program/plan element assure quality of service provision.

Method. Review and report on results of participation in County's utilization review, quality management incidence reporting, and other appropriate means of quality of service review.

Results.

Discussion.

8. **Ensure protection of confidentiality of protected health information.** What protocols are in place to comply with the Health Insurance Portability and Accountability Assurance (HIPAA) Act, and how well does staff comply with the protocol.

Method. Match the HIPAA Business Associate service contract attachment with the observed implementation of the program/plan element's implementation of a protocol for safeguarding protected patient health information.

Results.

Discussion.

9. **Staffing sufficient for the program.** Is there sufficient dedicated staff to deliver the services, evaluate the program for sufficiency of outcomes and continuous quality improvement, and provide sufficient administrative support.

Method. Match history of program response with organization chart, staff interviews and duty statements.

Attachment 1 – Program and Fiscal Review Report Template

Results.

Discussion.

10. **Annual independent fiscal audit.** Did the organization have an annual independent fiscal audit performed and did the independent auditors issue any findings.

Method. Obtain and review audited financial statements. If applicable, discuss any findings or concerns identified by auditors with fiscal manager.

Results.

Discussion.

11. **Fiscal resources sufficient to deliver and sustain the services.** Does organization have diversified revenue sources, adequate cash flow, sufficient coverage of liabilities, and qualified fiscal management to sustain program or plan element.

Method. Review audited financial statements (contractor) or financial reports (county). Review Board of Directors meeting minutes (contractor). Interview fiscal manager of program or plan element.

Results.

Discussion.

12. **Oversight sufficient to comply with generally accepted accounting principles.** Does organization have appropriate qualified staff and internal controls to assure compliance with generally accepted accounting principles.

Method. Interview with fiscal manager of program or plan element.

Results.

Discussion.

13. **Documentation sufficient to support invoices.** Do the organization's financial reports support monthly invoices charged to the program or plan element and ensure no duplicate billing.

Method. Reconcile financial system with monthly invoices. Interview fiscal manager of program or plan element.

Results.

Discussion.

14. **Documentation sufficient to support allowable expenditures.** Does organization have sufficient supporting documentation (payroll records and timecards, receipts, allocation bases/statistics) to support program personnel and operating expenditures charged to the program or plan element.

Attachment 1 – Program and Fiscal Review Report Template

Method. Match random sample of one month of supporting documentation for each fiscal year (up to three years) for identification of personnel costs and operating expenditures charged to the cost center (county) or invoiced to the county (contractor).

Results.

Discussion.

15. **Documentation sufficient to support expenditures invoiced in appropriate fiscal year.** Do organization's financial system year end closing entries support expenditures invoiced in appropriate fiscal year (i.e., fiscal year in which expenditures were incurred regardless of when cash flows).

Method. Reconcile year end closing entries in financial system with invoices. Interview fiscal manager of program or plan element.

Results.

Discussion.

16. **Administrative costs sufficiently justified and appropriate to the total cost of the program.** Is the organization's allocation of administrative/indirect costs to the program or plan element commensurate with the benefit received by the program or plan element.

Method. Review methodology and statistics used to allocate administrative/indirect costs. Interview fiscal manager of program or plan element.

Results.

Discussion.

17. **Insurance policies sufficient to comply with contract.** Does the organization have insurance policies in effect that are consistent with the requirements of the contract.

Method. Review insurance policies.

Results.

Discussion.

18. **Effective communication between contract manager and contractor.** Do both the contract manager and contractor staff communicate routinely and clearly regarding program activities, and any program or fiscal issues as they arise.

Method. Interview contract manager and contractor staff.

Results.

Discussion.

Attachment 1 – Program and Fiscal Review Report Template

VIII. Summary of Results.

IX. Findings for Further Attention.

X. Next Review Date.

XI. Appendices.

Appendix A – Program Description/Service Work Plan

Appendix B – Service Provider Budget (Contractor)

Appendix C – Yearly External Fiscal Audit (Contractor)

Appendix D – Organization Chart

XII. Working Documents that Support Findings.

Consumer Listing

Consumer, Family Member Surveys

Consumer, Family Member, Provider Interviews

County MHSA Monthly Financial Report

Progress Reports, Outcomes

Monthly Invoices with Supporting Documentation (Contractor)

Indirect Cost Allocation Methodology/Plan (Contractor)

Board of Directors' Meeting Minutes (Contractor)

Insurance Policies (Contractor)

MHSA Three Year Plan and Update(s)

Senate Housing Construction Plan Will Cost \$3.9 Billion to Repay \$2 Billion



Campaign. Mental Illness FACTS –Family And Community True Stories

For Immediate Release: Monday April 4, 2016 Contact: Rose King 916-768-8012; rking1@surewest.net

FROM FACTS: COSTLY and UNLAWFUL SENATE HOUSING PLAN TO RAID PROP 63

We Cannot Click Our Ruby Slippers and Do Away with Homelessness

1. The California Senate has announced an initiative to tackle homelessness. There is a plan now called “*No Place Like Home*” that creates a \$2 billion bond to build between 10,000-14,000 housing units for the homeless throughout the state. This sounds very commendable. Who doesn’t want to end homelessness—but there are **serious flaws** with this plan.
2. **It is securitized by MHPA funds.** Californians voted for Prop 63 funds to be used only for the treatment and care of people with serious mental illnesses—not to combat homelessness. Not all people who are homeless have a serious mental illness. Taking these funds to build homes for all homeless would be a misappropriation of these funds. An established Attorney General Opinion confirms how this plan violates MHPA provisions and voter intent.
3. **\$130 million in MHPA funds would be taken each year** to securitize this bond measure. Think about this—over the life of the 30 year bond that is securitized at \$130 million a year, as the Darrell Steinberg Foundation has envisioned, the MHPA fund will be paying back \$3.9 billion to use \$2 billion!
4. The plan places decisions in the hands of a **new layer of bureaucracy** that decides which counties get to use the funds. Wouldn’t the wise approach allow each county to use its MHPA funding to provide housing that fits its community’s needs? A new level of bureaucracy means less money spent on direct treatment for serious mental illnesses.
5. The Fair Housing Act of 1968 was meant to tackle homelessness and associated issues, and it failed. “No Place Like Home” is this same well-intended, but failed idea, at the expense of Californians denied essential treatment for serious mental illnesses.
6. The plan is to award the new \$2 billion in bond funds through a competitive grant process. **All counties would be giving up their portion** of the MHPA funds, but only some counties would be receiving funds. Counties with good grant writing ability would be unfairly favored—and without regard to need. Some **counties could pay into this for years and never be awarded any funding** or receive their fair share.

Lauren Rettagliata, family member, Contra Costa Advocate, Email: rettagliata@sbcglobal.net

Right to Treatment campaign challenges “No Place Like Home”

Contact: Rose King 916-768-8012; rking1@surewest.net Teresa Pasquini tcpasquini@gmail.com

Senate “Housing First” Is Unlawful and Unfunded—State Must Fund Mental Health “Parity First”

The Senate “housing first” plan is unaffordable and unlawful, according to Rose King, a co-author of Prop 63, and local and national advocate Teresa Pasquini, founders of Mental Illness FACTS, Family And Consumer True Stories. Senators want to borrow and spend more Prop 63 funds for other social problems, and construct housing for all homeless Californians. They want to “Repurpose” mental health money and transfer it to developers.

“Do Senators believe that Prop 63 has fulfilled its purpose?” King asks. “They should take a look at the increased number of suicide deaths and the increased rate of criminalization of people with serious mental illnesses.” A 2015 Stanford Law report co-published by Darrell Steinberg told us that 45% of all state prison inmates are treated for serious mental illnesses—an inhumane and fiscally irresponsible substitute for a functional treatment system. Investigative news reports say consumers wait months for an appointment and psychiatrists carry caseloads of hundreds of people with serious mental illnesses.

Steinberg and Senate supporters ignore the Attorney General Opinion that explains why Prop 63 funds may not be used to fund housing construction. The 2016 plan goes beyond the earlier violations identified by the AG opinion that cites the provisions that dedicate funding for Systems of Care treatment for children, adults, and older adults. The proposal by Senate President Pro-Tem Kevin DeLeon further violates provisions of the law, proposing to take money from the mental health system to fund housing development that does not even target the Prop 63 population or guarantee essential wraparound treatment services.

The federal government just adopted a rule to apply parity to Medicaid Managed Care Plans; people insured by MediCal will be entitled to access and quality of care. *“Senators should focus on funding this equal right. They can see the need with just one visit to a public clinic in their districts—talk to any consumer or family member or psychiatrist to know the tragic results of discrimination,”* King said. Federal Rules announced in March 2016 call for a major transformation of public mental health services.

Consider: the Mental Health Services Act/MHSA fund will be **paying back \$3.9 Billion to use \$2 Billion for the Steinberg – DeLeon ‘housing first’ plan**, an idea to reduce homelessness already tried and failed. California mental health systems have no money to spare for this unlawful plan. The state must develop and fund “medically necessary treatment” for serious mental illnesses under the same terms as that for physical illnesses and disabilities.

MENTAL HEALTH PARITY FOR THOSE INSURED BY MEDI-CAL will be guaranteed for serious mental illnesses when California complies with the federal Mental Health Parity and Addiction Equity Act (MHPAEA)—AND implements a federal ruling by the Centers for Medicare and Medicaid Services. Prop 63 revenue must lawfully be dedicated to expanding Systems of Care for serious mental illnesses, meeting community needs, and funding full parity for Medicaid-insured and uninsured.