Little Hoover Commission Hearing on Proposition 63

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As co-author of the Act, the Commission would like to know:

- How did you expect it would improve the state's mental health system and have your expectations been met? Please briefly explain how your expectations have been met, and if not, why.
- Unlike many other initiatives, Proposition 63 included a clause to allow the Legislature under certain circumstances to make amendments to the Act. How has this provision been used and what has resulted from the legislative changes?
- Proposition 63 also established a body to oversee implementation of the Mental Health Services Act. Are the appropriate oversight mechanisms in place to know how and where California is investing the Mental Health Services Act funds and to capture best practices at the county level? How have legislative changes impacted the role of the oversight commission and is it currently structured to achieve what voters intended? Are additional changes necessary for the state to provide better oversight of the use of these funds?

How did you expect it would improve the state's mental health system?

We had three goals and expectations for Proposition 63:

1. **Fully fund the Adult System of Care AB 34 Integrated Services Model**
2. **Protect Existing Funding- Especially MediCal (EPSDT) and Special Education (AB 3632) Entitlements for Children's Services**
3. **Make Prevention and early intervention the rule and not the exception- end the fail first system**.

Have these expectations been met? If not, why not?

1. **Fully fund the Adult System of Care AB 34 Integrated Services Model**

At the time of writing the act in early 2003 we had 5000 people being served in the AB 34/2034 integrated services pilot programs funded through 1999's AB 34 and 2000's AB 2034 legislation authored by then Assembly member Darrell Steinberg. This model had been initiated for people as an alternative to state hospitals in the late 1980s. The 1999 legislation took that concept and combined it with specialized outreach teams including former homeless and social workers to engage and serve people who were homeless with severe mental illnesses.

The success of this program in reducing incarcerations by 80% and hospitalizations by 67% led us to believe that the legislature would expand it each year to serve the estimated 50,000 people believed to be homeless with severe mental illnesses. At that time the average non-federal costs were $8000 per person. We estimated that there were another 50,000 people with comparable needs who were either incarcerated or living with some level of support but without services. We estimated that 80,000 of the 100,000 would seek care

but that 20,000 would either be veterans whose care would be provided by the VA or would be graduating out of the program freeing up new slots for others, meaning that we would need to serve 60,000 people every year.

We also estimated that there were 60,000 people currently receiving extensive community mental health outpatient services (calculated by taking the LA total of 20,000 people receiving $2000 or more of outpatient MediCal billed services and multiplying by three). We estimated that 10,000 of them were getting AB 2034 or comparable comprehensive care meaning that 50,000 might need more services than they were currently getting. We estimated the additional costs to convert those programs to being AB 2034 system of care programs (now known as Full Service Partnerships) to be $2000 per person.

The total costs for these efforts were estimated at $580 million annually. We estimated that after a three year phase in 70% of the funds from Proposition 63 would be available to meet these needs and the revenues would be about $900 million which we considered adequate to accomplish this purpose.

This expectation has not been met

Several factors have prevented us from meeting this primary objective. First and foremost has been the recession and the related loss in other state funding. While we knew this was a volatile funding source and that there would be economic downturns we underestimated the severity of the recession (which was greater than any economic downturn since the Depression of the 1930s). More importantly, we also were **unaware of the instability of the underlying state funding- primarily the 1991 Realignment Law that provided dedicated sales tax revenues to mental health social services and health.**

The losses from realignment negated virtually all of the funding under the act. Under that 1991 law all three programs got an equal 1/3 of the initial funds. However, in allocating growth the social services programs would get whatever it took to fulfill their caseload entitlement needs and health and mental health would share in the balance.

When Realignment was enacted and as we understood it while writing Proposition 63, the social service share would be higher in poor economic growth years and lesser in strong years as we estimated that caseloads for those programs would go up and down in reverse pattern to the economy.

During the 1990s this generally held true and mental health got a healthy share of growth. However, at the end of the 1990s the Legislature reformed the In Home Support Services Program (IHSS) reflecting its value to reduce nursing home use. The program quadrupled in size from about $500 million to over $2 Billion. This swallowed up virtually all growth in realignment limiting mental health's share of growth to at most 2% annually. As a result mental health's share of realignment went from 1/3 to 1/4 from 2001 to 2010. The loss due to this feature for mental health is estimated at $400 million annually. We did not learn of this problem until it after we had already finalized the language of Proposition 63 and had no idea it would eventually become so big. (The 2011 Realignment restructured this program and also MediCal changes that same year revised IHSS so that mental health should gradually regain its share of growth.)

In addition the recession also reduced the total realignment (sales and vehicle license fee revenues) that cost an additional $300 million annually. **The combined $700 million loss in**

revenues was as much as the total average annual Proposition 63 funding available for AB 2034 type services. Accordingly virtually all of the funds went to back fill these losses and hardly any was available to expand care as the act had envisioned.

In addition the passage of time has meant that the cost of providing care has gone up. So instead of it costing $8000 per person it now costs $15,000 to $20,000 per person. Thus the needs now are considerably greater than the $580 million originally estimated. Moreover, virtually all of the non Prop 63 funding for the 60,000 people getting community mental health care at the time of the act has gone mostly to mandated services such as hospitals and the base funding for other MediCal services to youth. (EPSDT)

Accordingly the population needing to be served has grown from 60,000 to at least 100,000 and the costs to at least $1.5 Billion and probably more than $2 Billion which would require that the act have available funding of more than $2 Billion and probably closer to $3 Billion – unless new funding can be generated from other sources (which the Affordable Care Act helps with and the recently enacted federal Excellence in Mental Health Act helps even more if California is selected and if funding can be expanded beyond the current authorized two years). In addition we should soon begin to see savings from the Prevention and Early Intervention Programs initiated under the Act.

What has been achieved

On the other hand, the funding that the act has made available has been expended exactly how we envisioned. **Tens of thousands of people are getting care in the AB 2034 model (now known as Full Service Partnerships or FSP). That is now the main model of care in every county and that represents a transformation for how services are provided**. That was also a main goal of the act so that instead of it being 10,000 out of 60,000 when the act was written who get this proven model of care, I would estimate that now the majority of people getting extensive community mental health care are getting it under this model, which is undoubtedly reducing their homelessness, hospitalizations and incarcerations as we knew this model program would do.

2. Protect Existing Funding- Especially MediCal (EPSDT) and Special Education (AB 3632) Entitlements for Children's Services

The act had several provisions to protect existing funding. The most important said that existing entitlements must be protected. This has largely been respected, although the legislature in 2011 realigned both of the most important children's mental health entitlements.

The MediCal EPSDT (early and periodic screening diagnosis and treatment) program went from having the state pay 90% of the federal funds to having it realigned to counties with a funding formula as part of other programs. While the guidance from the state says that EPSDT will have first call on growth so that the entitlement nature is respected there are concerns that many counties are acting as though funding is capped even though it is not. This is an issue requiring further monitoring but as long as the state guidance remains strong the act's requirements are being complied with.

The special education mental health services program was transferred from being a reimbursable state mandate for counties to a school program with its own dedicated funds. While the funds allocated to the schools have been equal or greater than what the state had paid counties there are concerns that not all school districts are providing all of the necessary

services (even though it is a federal law requirement and entitlement). This program also requires monitoring although as long as the dedicated funding is maintained the act's requirements are being complied with.

Where we have lost funding is outside of entitlements regarding a clause that said that the state could not reduce mental health funding. Two years after the act passed Governor Schwarzenegger used his line item veto authority to eliminate $55 million in funding for the original AB 2034 program. We challenged that in court and lost because the court ruled that the language of the act requiring protection of existing funding applied to total state $$ for mental health and not to individual programs.

There was also language requiring that counties use the funding to expand and not to replace existing discretionary funding used for mental health. While there was only a small amount of such funding it appears as though most of it has been retained.

3. **Make Prevention and early intervention the rule and not the exception- end the fail first system**

When we began the campaign we convened focus groups to help guide us in how to draft the measure. In each group we asked what people thought of when they saw or heard the phrase "mental health". In each group the first response was "street people". As the discussion continued, people also said, "but why do people have to become homeless before they get help? Why can't we identify and treat mental illness earlier in its onset?

From these conversations we developed the idea of having at least 20% of the funds go to prevention and early intervention programs designed to identify people who could develop a severe and disabling mental illness but to get them help before that happened. We coined the campaign phrase of going from "fail first to help first". This meant ending the pattern whereby children have to fail in school or at home or in society and wind up in special ed or child welfare or juvenile justice before their mental health problem is identified and treated. For adults it meant before someone dropped out of college or lost their job.

The programs to accomplish these goals were brand new for counties and so there were only a few proven models to build on. This included so called early psychosis programs to identify people in the first few months of experiencing the most severe symptom of schizophrenia. It finds them and gets them into treatment programs that have been proven to get people back to normal living within a year or two. This success contrasts with a lifetime of disability that most with schizophrenia have faced when their illness goes the current average of six years before treatment.

Most of the larger counties have started this program under the Act and the Mental Health Services Oversight and Accountability Commission (MHSOAC) has just begun a study of these programs to measure their results. That should lead to expansion of these programs to the rest of the counties and should dramatically reduce the number of people with schizophrenia who become disabled hospitalized and homeless. However, we don't yet have measures of our success.

Other programs have focused on schools, youth drop in centers, primary care and community centers or other places where people who are at high risk of developing mental health problems are likely to go for any sort of problem. Many recognize our diversity and reflect specialized

outreach and engagement efforts for specific ethnic communities and the places they would be likely to engage, which is seldom a mental health center.

These programs did not start until 2009 and measurement of their success can only be done over many years because what we are looking for is not direct results but a reduction in the number of people who "fail first". Due to the economic downturn and reduced overall funding for community mental health, we would have expected a significant increase in homelessness and hospitalization without these programs. That did not generally happen so we know we are making progress. However, we need to see the results of these programs combined with increased funding for the community care programs for several years before we will know how successful we can be with what was started in 2009.

In addition some of the most promising strategies require partnerships with schools and health plans and employers. The act's funding alone cannot make this happen although it can incentivize it. Much more work is needed to further develop these leveraging opportunities.

The act itself says that the 20% funding for prevention and early intervention is a minimum. In writing the act we envisioned that we would learn that the value of these programs produced savings in extensive care to people with disabling mental illness that justified expanding them beyond the 20% minimum. We still don't have the data to prove that so our results on this aspect of our goals are incomplete at this time.

Allowing the Legislature to Amend the Act

As a lawyer and lobbyist for 36 years I have drafted legislation many times. However, drafting an initiative is a very different experience because once you hit print on the computer and take the language to the Attorney General, that language is final and can never be changed without a vote of the people. Knowing that these provisions would govern the public mental health system permanently, we did not have enough confidence that we could be sure we got it right and so we wanted to allow amendments.

There are two types allowed. By majority vote the legislature can clarify terms. By a two thirds vote it can amend other provisions so long as they are consistent with the purpose and intent of the act and help accomplish its purposes.

In my view there have only been two significant amendments. The first was to eliminate state approval of county spending plans under the act- allowing the counties to "self certify" compliance but also providing for review and comment and informal certification of compliance by the Oversight and Accountability Commission. This has served to streamline administration at both the state and local level. If it has resulted in changes in county funding allocations, and if such changes were beneficial or detrimental are both unknown. But the OAC review assures us that the funds are still being spent in accordance with the legal requirements of the act.

The other significant change was to transfer to the Oversight Commission the authority to promulgate regulations for the Prevention and Early Intervention Program that previously appeared to be the responsibility of the Department of Health Care Services. That also appears beneficial as the Commission is best suited to this task since its composition is meant to mirror the interests who will be most affected by our success or failure (schools, criminal justice, employers and employees, health plans and people with mental illnesses and their families).

There have been several other amendments. At this time I believe that all of them have improved the functioning of the act so that makes this a good concept- so far. However, it should be noted that all of them were enacted while my co-author Darrell Steinberg was President Pro Tem of the Senate and so it may be premature to declare that this authority is necessarily good.

Are appropriate oversight mechanisms in place?

This was a most important issue to us in drafting the act. We reserved up to 5% of the funds for state administration and specifically stated that the amounts appropriated for this purpose needed to be "*sufficient to ensure adequate research and evaluation regarding the effectiveness of services being provided and achievement of the outcome measures set forth in Parts 3, 3.6 and 4."* (these are the Adults and Children's systems of care and the Prevention and Early Intervention parts of the act.)

The problem with implementation of this section is that after ten years we still don't have all of the outcome measure reporting and data that is needed to accomplish this objective. Most of that is due to a series of missteps by the State Department of Mental Health and the authority for this function has now been shifted to the Oversight Commission which is working to address the many failings in the early years of the act's implementation.

The problem is best illustrated by comparing the act to what we had before it. One of the best features of the AB 2034 program that was the basis for the Act was its outcome reporting system which measured each provider's progress in reducing hospitalizations, incarcerations and homelessness and increasing housing independence and employment. This system allowed everyone to see where the best results were being achieved and allowed those whose results were not as good to see what they needed to change to match the results of the best performers. We had assumed that the outcome measures already in place for the AB 2034 programs would simply be expanded and used as they were. While counties and providers did provide that information the state did not invest in appropriate staff or consultants to collect that data and provide the analysis needed.

That responsibility has been shifted to the Oversight Commission which has made considerable progress but there is still a long way to go.

This has been one of the most frustrating parts of the implementation of the Act and Senate President Pro Tem Steinberg has generally shared my frustrations.

Presently we have had a few reports from some of the counties and there are contracts to establish provider level reports that could become interactive and regularly updated but they are not yet available.

We also need to know where all of the funding not spent on comprehensive services has gone and how big the gap is in achieving our goals in each county. This is still a missing set of data.

In prevention and early intervention the progress is much more difficult to measure and it will take many years to see if the programs are reducing the numbers of people whose mental illnesses are allowed to become severe and disabling before they get help and which programs make the most difference.

There is clearly a lot of work to be done and the Oversight Commission is finally taking steps to put the oversight in place but we lost a lot of time.

It appears as though the Oversight Commission has the authority to require this information from counties. However, there might be a need to strengthen the authority of the commission to obtain the information it may need.

How have legislative changes impacted the role of the oversight commission and is it currently structured to achieve what voters intended?

Legislative changes have clarified the role of the commission and generally I believe they have benefited it. There is still some controversy over eliminating their approval of county Prevention and Early Intervention Plans but there is no clear evidence at this time that this change has created problems since the Commission still reviews those plans and has found all of them to be in accordance with the requirements of the Act. Other changes have given the commission clearer authority to enact regulations and request information both of which are beneficial.

As for its structure it is somewhat ironic to have the Little Hoover Commission ask about this as the composition is largely lifted from recommendations from the Little Hoover Commission in its 2000 report entitled "Being There- Making a Commitment to Mental Health". As the Commission observed in 2000 it was important for the oversight body to have non mental health interests who represented key stakeholders impacted by our success or failure in addressing mental health needs. These interests – education, law enforcement, employment, and health plans compliment the views of mental health professionals, consumers, families and legislators.

After ten years I still believe that we got this part of the Act right.

Are additional changes necessary for the state to provide better oversight of the use of these funds?

Oversight of the use of funds is a double edged sword as most forms of oversight result in taking funds out of direct care and into paperwork. Accordingly the most comprehensive possible oversight is never a good idea because it costs too much. My belief is that rather than drowning the system in detailed audits of how every dollar is spent that oversight should focus on measuring results and then finding out who was the best and why.

The state auditor did not find that funds were being misspent but did find that there was a lack of data to demonstrate that we were achieving results.

While there is a small group of critics, including some reporters, who question whether the funds are being spent as intended, every objective review has found those critics to be off base- generally reflecting a lack of appreciation of the value of prevention and early intervention versus focusing all funds on people who are already severely disabled.

At the state level there is more data analysis and reporting needed to develop the foundation to do the real work which is to shine a bright light on the counties and providers who are having the greatest success and educating the others on the changes they need to make.

Bigger changes seem needed at the local level where stakeholders complain about a lack of county budgeting transparency and a lack of meaningful engagement in decision making.

The local mental health boards seem to lack the funding and stature to carry out this role and their composition is too limited to include the views of key stakeholders. This is an area that requires significant change to have a truly open system of budget decision making and dialogue and access to data that allows all interests to know how their county and providers compare to others so that their advocacy can be better informed.

Some of these changes can be implemented through Oversight Commission reporting requirements. Others may be addressed by actions of counties on their own. However, it seems likely that there is a need for reform of the county decision making process and that may take legislation as it is a subject that we did not very fully address in drafting the initiative.

Additional Comments

This initiative was needed because it was clear that there was no way that mental health could ever become a sufficient legislative priority to achieve its needed funding in any other way. A 2000 Senate Budget Committee report called "Underfunded from the Start" explained the history of what Darrell Steinberg called the failed promise of community care after the state hospitals were emptied more than 40 years ago. The consequences of this neglect are visible on the downtown streets of every major city, in our jails, prisons and hospitals, and children failing in school.

It passed because the voters understood this neglect. A 1986 legislative poll asked whether voters would rather have a tax cut or an increase in spending on various programs. Mental health was second among 20 subjects (behind only helping the frail elderly and well ahead of public safety, education and other health programs) in the percentage of voters wanting more spending for that program.

Other more recent polls found the same recognition of the need to spend more on mental health even if it meant raising taxes.

After ten years I still believe that Proposition 63 represents one of the best ever uses of the Initiative Process accomplishing important public policy goals that could not have been enacted any other way.

It is disappointing that we are not further along in achieving our goals. However, that is not because the money has not been properly spent but due to other external factors we could not control. I still believe that we can get to our goal of a fully funded community mental health system and prevention and early intervention as a societal norm. However, it will take far longer than I had envisioned and will take help from many other sources.

The good news is that there is now much more support for taking those remaining necessary steps and we probably don't have to go back to the voters again to achieve our goals- but that always should remain an option.