



Little Hoover Commission
Follow-Up Hearing on Oversight of the Mental Health Services Act
May 26, 2016

In response to questions presented in the invitation from the Little Hoover Commission, the California Mental Health Planning Council submits the following testimony.

CHAIRPERSON
Josephine Black

EXECUTIVE OFFICER
Jane Adcock

**Thoughts on Obstacles Limiting Progress on Commission
Recommendations and Strategies to Overcome Them**

Several of the recommendations in the 2015 report direct the Mental Health Services Oversight and Accountability Commission (oversight commission) to take on functions that previously were handled by another entity such as the Department of Mental Health. Additionally, in recent years, legislation has passed that also directed additional functions to the oversight commission. The California Mental Health Planning Council (Council) respectfully points out the need to carefully consider who has what role, in the bigger picture, when assigning functions and responsibilities. Individually, each of the entities is very clear about their own responsibilities as set in law. However, when taking a global look, the roles are muddled resulting in divided (and weakened) leadership for key aspects of the public mental health system and no clear designation of authority. Who is to hold the system accountable? Who is to hold the oversight entities accountable?

- **Advocacy**
- **Evaluation**
- **Inclusion**

The Council recommends revisiting the recommendations to determine whether the functions are appropriately placed to ensure effective administration of oversight and clear designation of authority.

Role of the California Mental Health Planning Council

The California Mental Health Planning Council (Council) is established pursuant to both federal and state law. As far back as 1975, federal law (PL 94-63) required any state that accepts a SAMHSA Mental Health Block Grant to “establish and maintain a State mental health planning council”. Federal law goes on to specify the council duties including review of the state mental health plan; to serve as an advocate for individuals with

serious mental illness/children with severe emotional disturbance; and to annually monitor, review and evaluate the allocation and adequacy of mental health services within the State. It also specifies the membership including requiring that not less than 50% of the members be individuals who are not state employees nor providers of mental health services, thus, the Council has a majority of consumers and family members.

To understand the role of the Council, it is important to understand the history and evolution of the Council. The Citizens Advisory Council (CAC) was established pursuant to the Lanterman-Petris-Short Act, which was signed into law in 1967 and went into full effect on July 1, 1972. The CAC was created to advise and assist the Legislature and the Director of Mental Health. The CAC consisted of 15 members total, 3 each appointed by the Assembly Speaker and the Senate Pro Tem and 9 members appointed by the Governor.

Beginning in 1975, the CAC was also to act as the state council required by Public Law 94-63 to advise the Director of Mental Health on the development of the Community Mental Health Plan. The Director of Mental Health, or his designee, and the Secretary of the Health and Welfare Agency, or his designee, would serve on the Council to perform the plan development function only. Additional duties of the CAC included: to develop and implement procedure for conducting the annual review of, and for publicizing, the Community Mental Health Plan and to submit, as part of the state plan, the CAC's report resulting from such annual review.

As part of AB 2541 in 1985, the CAC name was changed from the Citizens Advisory Council to the California Council on Mental Health (CCMH) which remained in statute until it was sunset as part of the Realignment Act of 1991. Before it sunset, the CCMH advocated for the creation of a California Mental Health Master Plan. This was accomplished through the passage of legislation (AB 904) that mandated the creation of the Mental Health Master Plan. To achieve this effort, the "904 Planning Council" was established and members were appointed by the Director of Mental Health. The staff of the CCMH acted as staff to the "904 Planning Council".

As part of the Realignment Act of 1991, the current California Mental Health Planning Council was established. The composition of the Council was re-established in accordance with Public Law 102-321 which amended Public Law 94-63 in July 1992. In addition to the federal requirements of the Council, the previous duties of the CCMH were amended into the Welfare and Institutions Code (WIC). Additional authority was added that still applies today including but not limited to:

- To advocate for effective, quality mental health programs
- To review, assess and make recommendations regarding all components of California's mental health system, and to report as necessary to the Legislature, Department of Health Care Services (DHCS), local boards and local programs

- To advise the Legislature, DHCS and county boards on mental health issues and the policies and priorities that this state should be pursuing in developing its mental health system
- To conduct public hearings on the state mental health plan, the SAMHSA block grant, and other topics
- To assess periodically the effect of realignment of mental health services and any important changes in the mental health system, and to report its findings to the Legislature, DHCS, local programs and local boards

The current Council wrote a second Mental Health Master Plan which was released in 2003. Many of the recommendations in that Plan were included in Proposition 63. From this history, one can see that the Council has played a role in the development, implementation and evaluation of the public mental health system for decades.

Planning Council Role in Relation to Oversight of the MHSA

In addition to the above, Welfare and Institutions Code (WIC) Section 5772(c) authorizes the Council to review program performance by annually reviewing performance outcome data. The Council is to:

- Review and approve performance outcome measures
- Review the performance of programs based on outcome data and other reports from the DHCS and other sources
- Report findings and recommendations on programs' performance annually to the Legislature, DHCS and the local boards
- Identify successful programs for recommendation and for consideration of replication in other areas.

The MHSA added WIC Section 5848(d) which directs the Council to include programs funded by the MHSA in the above program performance reviews.

Further oversight of the MHSA, by the Council, is presented in WIC Sections 5820 and 5821 which relate to addressing California's mental health workforce needs and shortages. These sections direct the Office of Statewide Health Planning and Development (OSHPD) to develop a five-year education and training (WET) plan which the Council is to review and approve. Additionally, the Council is to provide oversight for the WET Plan development.

How the Council performs these duties.

The Council identified the workforce shortage crisis in the public mental health system in 1999. In 2000, the Council held a Human Resources Summit that resulted in recommendations and an action plan. The work of the Council in this area led to the inclusion of the Education and Training piece in the MHSA. Several of the issues and recommendations identified by the Council ultimately became activities funded in both the first (2008-2013) and second (2014-2019) WET Five Year Plans. The Council continues its oversight of the development and implementation of the Five Year Plan. Council members and staff also serve on many of OSHPD's advisory committees as well as a workforce ad hoc committee at the Council.

In 2010, the Council released an initial, minimum set of performance indicators. This proposed set of performance indicators resulted from a stakeholder process to develop guidelines for the MHSA Annual Plan Updates and the Integrated Plan requirements. The goal was to streamline Integrated Plan requirements so that accountability was measured by performance indicators. While guidelines for Integrated Plans have not been issued, the performance indicators have been utilized in evaluation efforts by the MHSOAC and in data system development by DHCS and the County Behavioral Health Directors Association.

Program performance outcome data has not been readily available in recent years. So the Council has become creative in accomplishing this function. For example, 2016 will be the third year in a row that the Council will be issuing a Data Notebook to the local mental health boards/commissions. Each local board is statutorily-required to annually review its county's performance and report their findings to the Council. In an effort to coordinate that reporting to ensure consistent depth and scope of information, the Council develops a Data Notebook which strives to provide customized county-specific data regarding designated aspects of the service system. From the returned responses, Council staff compile the input and issue a summary report. Last year, 52 of 58 counties returned their Data Notebook. Prior Data Notebooks have contained county-specific demographic and service data extracted from External Quality Review Organization (EQRO) reports, substance use service data from DHCS, Consumer Perception Survey data and has also requested counties to fill-in their data, when available. This year we are hoping to include data from the DHCS Performance Outcomes System (POS) for children/youth as well as the county-designed Measurements, Outcomes and Quality Assessment (MOQA) data system. While the Council has not yet achieved the full vision of the project to provide comprehensive county-specific performance outcome data in each Notebook, there is hope for the future.

The Council holds public forums to hear from stakeholders about the impact of changes in the public mental health services over the last decade, about access to and effectiveness of services for un- and under-served populations and to educate the public and mental health constituency. Additionally, the Council periodically holds panel discussions in counties around

the state to assess the impact of more recent realignment actions such as the Criminal Justice and Student Mental Health Services Realignment that were part of the Budget Act of 2011-12. The Council has issued a number of reports subsequent to these activities.

How Does the Council Coordinate with Other Agencies Responsible for Oversight of the MHSA

To be honest, there is room for growth in this area. The Council meets with each of the other agencies occasionally. The Council becomes actively involved when either of the others embarks on design of new performance outcome measures or changes existing approved performance indicators.

Council Recommendations to Help the Public Understand How the MHSA is Implemented and the Outcomes Achieved

The beginning and the end of this issue is Data. Data regarding demographics, services, outcomes, revenues, costs and expenditures must be made available to the public in an easy to understand format and in real time. Evaluation cannot occur without this data. Quality improvement or identification of best practices cannot occur without this data. Decisions to expand or start anew cannot be made without this data. Effective use of limited resources cannot be done without this data. And questions, scrutiny, doubt and suspicion will continue to occur without this data.

The MHSA intended for services to reach un- and under-served populations such as ethnic groups including non-English speakers and refugees, cultural groups such as LGBTQ and veterans and the marginalized groups such as the homeless. Where is the data on penetration rates for these populations over the last several years of MHSA implementation to show progress in improving access and reducing disparities? Where is the retention data to prove that MHSA-funded programs that promote wellness, recovery and resiliency keep people in services long enough to achieve their goals and end negative consequences such as hospitalization or incarceration? We have many individual stories of success and they are extremely important and put a human face on the progress. However, data is the fundamental and universally-accepted evidence of progress.

We cannot answer the question of whether the current design of the public mental health system is meeting the needs of Californians experiencing severe mental illness. There are separate efforts occurring that collect data for a specific segment of the system such as Specialty Mental Health through EQRO which uses Medi-Cal claims data, Specialty Mental Health Services POS for Medi-Cal-funded services for children and youth, and MOQA for Full Service Partnerships but nothing and no one has a data system that can provide, or show publicly, information about the mental health service system as a whole. The lack, and de-

centralization, of data makes it extremely difficult for the oversight entities to perform their mandated functions. Services and programs are rarely implemented as a single stand-alone; rather the funding is blended so as to provide a full array of services, regardless of fund source, to meet individual needs. Each data system currently only depicts a snippet of the whole.

DHCS inherited the problem of the lack of data from the prior Department of Mental Health in 2012. They have worked within the limits of the state bureaucracy to shore up the legacy systems and have been working for over three years to implement the first phase of the Children's Specialty Mental Health Performance Outcomes System (EPSDT POS). But, as stated previously, this new system only captures a fraction of the overall picture.

The Council recommends that the DHCS be given permission and authority to step outside the box; to step outside the burdensome state government processes for technology projects. Given permission and resources to seek out the latest technology that will finally answer these, and more, questions and will give California the information it needs and deserves. We need technology that can create a web-based real-time data system that will undeniably prove the efficacy of the overall public mental health system and end the scrutiny, end the doubt and end the suspicion. The Council recommends that implementation, including county-wide training and necessary support, occur within three years.