REMHDCO
Racial and Ethnic Mental Health Disparities Coalition

May 10th, 2016

Carole D' Elia
Executive Director
Little Hoover Commission
925 L Street, Suite 805
Sacramento, CA 95814

Re: REMHDCO Letter to the Little Hoover Commission for Their Meeting of Thursday, May 26, 2016

Dear Ms. D' Elia:

The Racial and Ethnic Mental Health Disparities Coalition (REMHDCO) is once again indebted to the Little Hoover Commission (LHC) for continuing to review the progress of Proposition 63 or the Mental Health Services Act (MHSA). While REMHDCO continues to have concerns regarding the oversight and administration of the MHSA, we still believe this Act to be of great hope and promise to underserved racial and ethnic communities all over California in their quest for appropriate, equitable public mental health services.

The LHC report, "Promises Still to Keep: A Decade of the Mental Health Services Act," was stunning in the accuracy and depth of the analysis of a complex situation. REMHDCO has been asked about our perspective on the state's progress in addressing concerns raised in the 2015 LHC report, as well as what obstacles might be limiting progress and strategies to overcome them. We will comment on each recommendation, and then outline a few continuing concerns. A more detailed response including additional background and evidence for our statements will be completed by the time of the LHC meeting on May 26th, 2016.

LHC Recommendation 1: The Legislature should expand the authority of the Mental Health Services Oversight and Accountability Commission

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REMHDCO agrees with this recommendation, as we strongly believe the MHSOAC could be a more nimble and effective entity than the massive and bureaucratic Department of Health Care Services (DHCS). However, we have reservations in regards to the commitment and ability of the current Commission and staff to exercise more rigorous and thorough oversight and accountability over the administration of the MHSA.

While it is true that the MHSOAC should collaborate and support the counties in the administration of the MHSOAC, there is a vital role to ensure funds are allocated appropriately and for them to be the guardians of the Act's vision of transformational mental health services. REMHDCO does not recommend that the MHSOAC take a punitive approach to reviewing county plans and programs, but we would approve of them being able to impose sanctions or delay funds in serious cases. We would welcome the MHSOAC taking a stronger role in championing the concerns of consumers, families, and underserved communities of California, as well as facilitating systems change that is at the heart of the Act.

In addition, within the last year, there has been a loss of the most experienced and senior staff at the MHSOAC. REMHDCO would support any measures to facilitate the hiring of staff who are knowledgeable and experienced in the area of mental health in general, as well as those who have knowledge of cultural competence and reducing disparities. Also, with the re-organization of the MHSOAC committees and task forces, it is questionable whether adequate representation of people knowledgeable in reducing disparities for racial and ethnic communities will be present on these new structures.

REMHDCO believes that a new seat on the Commission for a person with knowledge, experience and commitment to *the reduction of mental health disparities* would certainly facilitate attention and action towards this goal that has here-to-fore been furthered more by Legislative action. We were grateful that a bill, AB 253 (Hernandez), was introduced last year to accomplish this but unfortunately, the bill died due to other factors this year.

- Strengthen the ability of the state to conduct up-front reviews of the more controversial programs funded by the act before funds are expended by requiring the oversight commission to review and approve county Prevention and Early Intervention plans annually, as it currently does for Innovation plans.

We support this specific recommendation, although we would not characterize the programs as "controversial". Oftentimes, the PEI programs most often criticized or questioned those that were targeted for underserved racial and ethnic communities. The vast majority of these "questionable" PEI programs were found to be effective, in line with MHSA PEI guidelines, and supported by both the community and county mental/behavioral health department.

- Refine the process by which the state responds to critical issues identified in county three-year plans or annual updates to ensure swift action. Empower the oversight commission to impose sanctions, including the ability to withhold part of the county's MHSA funds, if and when it identifies deficiencies in a county's spending plan. Decisions of the oversight commission should become mandatory unless they are overturned by the Department of Health Care Services within a reasonable period, such as 60 days.

REMHDCO strongly supports this portion of the LHC recommendation although the MHSOAC has not made any substantial moves towards developing or gaining more power and authority. While there has been a series of meetings by the MHSOAC in response to LHC report, no summary of these meetings has been released, and no actions have been taken by the MHSOAC in regards to this particular recommendation that we are aware of.

LHC Recommendation 2: To provide greater oversight and evaluation of the state administrative funds, the oversight commission should annually develop recommendations for and consult with the Department of Finance before the funds are allocated.

REMHDCO supports this LHC recommendation. However, we are most concerned about the oversight and accountability of the 95% of MHSA funds not encompassed by the 5% State Administration. We recall that this was the sentiment of many participants at the meetings held by the MHSOAC on the LHC recommendations. In order to best show the overall success of the MHSA, it is imperative that we track and highlight how these funds are spent.

LHC Recommendation 3: To make MHSA finances more transparent and make it easier for voters, taxpayers and mental health advocates, consumers and their

families to see how and where the money is spent and who benefits from its services, the Mental Health Services Oversight and Accountability Commission should add to and update material on its website to include: [see attached for complete list]

REMHDCO strongly supports this recommendation and notes that the MHSOAC supported it also. It appears that the MHSOAC has just redesigned their website and a great deal of information has been added although we have not yet had the time to determine whether all the information below is available there.

- Data about who benefits from the act, including the number of individuals served, their ages, gender, racial and ethnic background and language spoken.

It is certain that the above data is NOT yet available because the counties are not collecting basic demographic data in a way that can be easily compiled by the state. For REMHDCO, it is particularly frustrating to not have basic racial and ethnic information on who is being served by "Full Service Partnerships" (FSP's) in the Community Services and Supports (CSS) component of the MHSA. The majority of MHSA funds go towards FSP's and anecdotal information indicates that people from underserved racial and ethnic communities are likewise, also underserved by this program. After ten years of the Act being in place, we are frustrated that there is not more leadership and movement by the governmental entities (DHCS, MHSOAC, or the counties) to collect disaggregated demographic information for this major component of the MHSA.

    - Other relevant mental health reports, such as county cultural competence plans that describe how a county intends to reduce mental health service disparities identified in racial, ethnic, cultural, linguistic and other unserved and underserved populations.

REMHDCO also remains concerned with the lack of movement by DHCS on the development of the county cultural competence plan (CCP) requirements. We have met regularly with DHCS since they were given responsibility for the CCPs in 2012 to urge them to release their new revised requirements for the counties. The CCP is a tool that would provide information and guidance to both state and local community advocates to work together with counties in addressing mental health disparities. The counties have not had a CCP

reviewed by a state entity since 2010. At our last meeting with DHCS leadership on November 13th, 2015, we were told that the staff already had a great deal of work to do and that there was just not enough time to prioritize this. Additionally, at a recent DHCS Behavioral Health Forum it was announced that DHCS will not be grading the CCPs. We believe it is important for local Stakeholder involvement that CCPs are reviewed and graded in a format as was recommended by the County Ethnic Services Managers and approved by the former State Department of Mental Health.

LHC Recommendation 4: To promote meaningful accountability of the MHSA, the state needs access to reliable, timely information that allows it to monitor effective progress toward the act's goals. The Mental Health Services Oversight and Accountability Commission and Department of Health Care Services should:

- Immediately develop a formal plan and timeline to implement a comprehensive, statewide mental health data collection system capable of incorporating data for all MHSA components, as well as other state behavioral and mental health programs.

- This plan should address how the development of such a data collection system would be funded and should use a portion of the MHSA state administrative funds to support the effort.

- Regularly report to the Legislature on the progress made in developing this data system and identify challenges that arise.

REMHDCO strongly supports this LHC recommendation. We are concerned about the lack of progress and reluctance of some government entities to work towards collecting this data. We are also concerned about the lack of leadership and collaboration among the government entities to design and agree on a statewide mental health data collection system.

Last year, we were advised by MHSOAC staff that it would take somewhere in the neighborhood of seven years for a new coordinated data collection system to be developed by the state. REMHDCO was dismayed but not surprised by such a prediction, although we are unsure about how much coordination is taking place between DHCS, MHSOAC, and counties (CBHDA) to come to agreement on a standardized system and on what data is

required to be collected for the MHSA. Also, we feel there are more efficient data collection strategies that will be less expensive and more functional for all stakeholders.

CBHDA has touted its MOQA program, yet this project does not attempt to standardize or collect disaggregated data on race and ethnicity, nor sexual orientation and gender identity.

We were pleased that the MHSOAC had finalized the PEI regulations after several years of development. Except for several secret and closed-door meetings in early 2015 with the California Behavioral Health Directors Association (CBHDA), the MHSOAC staff conducted a very open and transparent process in developing these regulations. Community partners were regularly invited to all the meetings and MHSOAC staff was willing to meet with us on many occasions to answer questions and get input on these regulations. However, the counties have indicated willingness to file suit in case these regulations are not modified to their satisfaction. Although the MHSOAC has held a series of meetings around the state attended primarily by local county staff, the purpose of these meetings has not been clear. The MHSOAC has appeared to be willing to delay the implementation or make substantive changes as recommended by some local county staff.

In addition to our response to the LHC recommendations from your last report, REMHDCO would like to bring attention to the issue of reducing mental health disparities in regards to the MHSA. In our written testimony to the LHC in September of 2014, one of our major recommendations was that:

- **Government entities should develop independent and strong Community Advisory Committees, including a Cultural Competence or Reducing Disparities Committee, and be more open to listening to them and following their recommendations.**

We continue to strongly believe in this recommendation, but we are sad to report that the current situation at the state level is of concern. We seemed to have lost ground in regards to this situation in that:

- The current MHSOAC Cultural and Linguistic Competence Committee (CLCC) appears to be an extension of the MHSOAC Consumer and Family Leadership Committee (CFLC). While the CFLC is a vital committee, the

CLCC should have a different focus and different types of members. This committee has not done anything of substance that we are aware of in the area of reducing disparities in the past several years. We remain hopeful that this committee will provide more focused policy attention on reducing disparities and the needs of racial, ethnic and cultural communities.

- The current Cultural Competence, Equity, and Social Justice Committee (CCESJC) of the California Behavioral Health Directors Association is less powerful and more controlled now by County Behavioral Health Directors than the Ethnic Services Managers who, as their title suggests, should be more knowledgeable in regards to cultural competence and reducing disparities. For example, several months ago, CBHDA presented its policy priorities for the year to members of CCESJC, instead of consulting first with the committee so that those policies could include and incorporate cultural competence and reducing disparities for local mental health communities.

- The long standing Cultural Competence Advisory Committee of the California Institute of Behavioral Health Solutions was dismantled with little notice to its members in 2015. There has been no movement toward reforming a committee and it still remains unclear why this committee was discontinued.

- The California Mental Health Services Authority (CalMHSA) developed a community advisory committee that had all of six members from the community on it (and six members from County staff). There were never any meaningful or strong recommendations from this committee to CalMHSA on how to ensure cultural competence or reduce disparities in the statewide PEI programs that CalMHSA administered.

- The California Mental Health Planning Council dismantled their Cultural Competence Committee several years ago. We appreciate and applaud their recent outreach efforts to diverse communities, but we feel there must be a committee focused on cultural competence in order to address important policy issues

- There is currently no Cultural Competence Committee within the California Department of Health Care Services. REMHDCO has met with the Deputy Director of Behavioral Health and expressed our concerns about this more than once. It is not a priority for that department at this time. Also, as

mentioned previously, the revised County Cultural Competence Plan Requirements have not yet been released and the DHCS has been in charge of these since 2012.

- The Office of Health Equity (OHE) under the California Department of Public Health, has completed Phase 1 of the California Reducing Disparities Project (CRDP). Among the CRDP Phase 1 projects included the California MHSA Multicultural Committee (CMMC), which served as an important advisory body to the project. As the OHE begins Phase 2 of the CRDP there has been a lack of action to re-institute the CMMC, or form an advisory body to serve a similar function, as previously stated despite contact from representatives of the CMMC and REMHDCO.

Lastly, REMHDCO has reviewed the comments to the LHC for the May 26th hearing of both Dr. Deborah Lee, former staff to the MHSOAC, and Rusty Selix, co-author of the MHSA representing the California Coalition of Community Behavioral Health Agencies. REMHDCO supports the testimony and reports by these knowledgeable individuals who are committed to vision and success of the MHSA. We hope that the LHC pays particular attention to both of their comments and recommendations.

There has been one very positive development regarding reducing disparities at the state level that must be noted. Thanks to the Legislature (through last year's budget process) and efforts by the current MHSOAC Executive Director, there will be an advocacy contract put out to bid for an organization that represents underserved racial and ethnic communities. REMHDCO has been requesting this repeatedly from the MHSOAC for the past eight years. Although there is no guarantee that this contract will go to REMHDCO, we are extremely grateful for this new opportunity for more equitable representation of people from underserved racial, ethnic, and cultural communities throughout the state.

Sincerely,

Stacie Hiramoto, MSW
Director

cc: Tamar Lazarus