California Council of Community of Behavioral Health Agencies

Mental Health America of California
Also known as the Mental Health Association in California

LITTLE HOOVER COMMISSION

HEARING ON MENTAL HEALTH SERVICES ACT (PROPOSITION 63 OF 2004)

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The money is going for its intended purposes and its core program is producing the desired outcomes, but there are lots of problems that require legislative action in order for the act to achieve its goals

Proposition 63 had two primary purposes. The first was to fully fund the ""whatever it takes model of care that had been proven to be successful in achieving recovery for people with severe mental illnesses. The second is to end the "fail first system" by investing in prevention and early intervention strategies that would get mental illnesses identified and treated early in their onset.

The "whatever it takes" model is now referred to as full service partnerships or FSPs. This program was previously known as AB 34 (Steinberg) or AB 2034 (Steinberg) for which annual reports showed that there were 70-80 % reductions in hospitalizations and incarcerations for those who got that model of care.

The FSPs are demonstrating the same results as the AB 2034 programs so the money is working as intended. The act has succeeded in making this the main model of care and that transformation would not have happened without Proposition 63, so in that regard a key objective has been achieved and is being demonstrated with good data across the state.

The goal was that everyone with a severe and disabling mental illness could get the benefits of this model of care and that has not happened.

The reason is that there is still not enough money to meet all needs.

It is annual funding not total raised since passage that is real measure

That must also factor in other funds and costs such as dramatically increased housing costs

The 2015 report talked about $13 Billion raised since the act was passed as if this was all new money and that the needs were one time. The reality is that the annual funding that started at under $1 Billion and is now nearly $2 Billion was intended to close a major gap in annual state mental health funding. The underlying state funding primarily consists of what are now mainly state realignment funds that total about $2 Billion. In writing the act we had assumed that those funds represented a stable and growing revenue source that would continue to serve the same percentage of the population as they had been serving prior to passage of the act. However, the revenue from those funds did not grow due to statutory prioritization of other programs when other caseloads grew. Moreover the funds experienced actual losses during the recent recession. Combined this reduced the revenues below our projections by about $700 million annually. As a result nearly all of the funds that came in from 2005 through 2012 simply backfilled losses and so it was unrealistic to expect these funds to show any meaningful reduction in the unmet need.

In the last two years state reports show that counties have seen meaningful increases in funding. Revenue forecasts show that continuing at least through 2017-18 so I think it would be realistic to see meaningful gains in reducing unmet needs within a few years. The best way to measure that is to see if there is capacity to find a full service partnership for everyone coming out of crisis care and for everyone who has been incarcerated who is identified as having a severe mental illness.

However, the gap is still quite large and the increased costs in housing, especially in the San Francisco Bay Area, means that the costs are now much higher for serving both the existing population being served already as well as reaching those not currently served.

Service providers and advocates are frustrated by the lack of county mental health budget information. Where is the growth money? Where are the plans to address unmet needs? How will counties address the workforce challenge- and do we still need a state workforce education and training set aside?

Los Angeles County produces a detailed annual mental health budget that is readily available to the mental health community and has annually increased contracts for its providers in each of the past three years reflecting the increased funding that state officials have reported that counties are receiving. However, in most other counties this information is not readily available and service contracts have not expanded. Everyone is wondering where is the growth money and county officials generally say that they don't have funds for growth. Something is not adding up and at least Orange County has recognized the problem and released a consulting contract to analyze both revenue trends and the unmet needs to assist the county and its stakeholders in understanding what the true budget picture is and to develop a plan to address the unmet needs.

The legislature should require all plans to provide this budget transparency and to develop plans to measure and address the unmet needs- most obviously the "street people" who cycle in and out of jails and hospitals when they can't get the care and housing they need, but also identifying other populations that are being missed.

The planning requirements should also address the continuum of care and the ability to reduce reliance and more restrictive placements such as hospitals and other locked facilities such as nursing homes as more community services become available.

As counties identify the unmet needs and the expected resources over the next several years they will also identify the workforce required to deliver the additional services. There are already shortages in most mental health professions. Is local planning enough to address this problem or is there a need to reinstate the state level workforce education and training program? The act set aside $450 million for a ten year state workforce program with one time money. That money is spent and the needs are now to be addressed locally. Will that be enough?

The mental health planning council should produce a report and legislative recommendations on how to ensure that our workforce needs will be addressed.

State level reporting does not allow for review of where the funding is going besides the full service partnerships and also does not provide meaningful comparison of the relative costs and results of each full service partnership program- we don't know who or what produces the best results and how the answers might vary based on age race, sex or ethnicity

The full service partnerships programs are the core Mental Health Service Act program. The state has required reports on those services and there are good outcome reports from most counties. There is progress being made on developing more comprehensive reports on these programs.

More work is needed so that we can learn who and what is achieving the best results with each population. Moreover, there is a lack of financial reporting to determine how much each program costs relative to how many people it serves. This information needs to be available not just at the county level but for each program and provider in order to see where the most effective and efficient programs are and what they are doing or spending that is different from others. The level of recovery for each person served still leaves room for improvement. Only by seeing the performance for each provider across specific populations can we learn what the best approach is for each specific population that may need specialized culturally competent services.

These programs are the only ones which lend themselves to meaningful outcome reports on what the funding is achieving. That is not possible for most other funds but what we should be able to see is what the money is being spent on year by year and county by county.

In addition there seems to be confusion about what is a full service partnership. Some believe that it always requires the most intensive services. An information notice should clarify that people who need less intensive services but are still significantly disabled due to a mental illness can still be in a full service partnership. Reporting need to clarify that there are different levels of full service partnerships with outcome reports that take these differentiations into account.

Moreover, one of the main purposes of the act is to reduce utilization of hospitals and other restrictive placements. Reports should document county comparisons and progress in reducing reliance on these types of placements generally referred to as IMDs (institutes for mental disease).

What is each county doing with its remaining funds?

We know that about 30% is for community services and supports for programs that are not full service partnerships that serve the needs of children with serious emotional disturbances and adults with severe mental illnesses. This spending is primarily for services for people who do not need a full service partnership or have brief need for non hospital crisis care. How much is each county spending from Proposition 63 for each of these services and how many people are served? How much other funding supports these services? How much of the funding is utilized for administration, outreach and engagement and other eligible purposes?

There is a clear need for the legislature to direct state officials to establish better reporting requirements so that comparative information county by county and year by year is readily available. Without that there is no way to know how well these funds are being spent. This requires a data system to be developed and it should be a priority state and county expenditure to develop this system.

Prevention and Early Intervention was included in the act to transform our system from fail first to help first. We need a more strategic approach to these funds in each county with state leadership

We don't have any useful information on the extent to which that is happening in each county or how the funds are being expended-

20% of Proposition 63 funds are reserved for prevention and early intervention. This is the only money set aside for such a purpose in any state mental health program and represents the thinking at the time of writing the act that investing in these programs would get people help before mental illnesses became severe and disabling. We knew in writing the act that there was an average of a six year delay between the first onset of a diagnosable condition and the time that people first got an actual diagnosis and treatment. That six year delay explains why we have a fail first system and why most people who access the public mental health system have already been in special education, child welfare, criminal justice or a hospital as a result of ignoring a mental health problem for many years.

When we wrote the act we listed the outcomes that we hoped the program would achieve which would be reductions in these placements and reduced periods of suffering without treatment. However, those long term goals do not translate into ways to measure the results of specific activities. They are the cumulative results that the program could achieve. We did not know how to prioritize investments or how to measure their effectiveness.

We also did not know which programs would be the most effective and deliberately did not write the guidance for this program in a prescriptive way – allowing all counties to experiment to see what would work best with an expectation that as we learned what worked best the state would step up to provide more specific guidance and direct the funding only to the programs proven to work best- much like the community services and supports can only be spent on the model children's and adults and older adults systems of care programs set forth in statute.

But like with the 30% of community services and supports not spent on full service partnerships we don't have the data on what the money is being spent on.

Also like the 30% of community services and supports very few of these programs lend themselves to specific outcome measures.

In the 13 years since we wrote the act, we have learned a lot and the planning for prevention and early intervention programs need to be updated to reflect that knowledge. In 2014 we prepared the attached paper called four core programs which the Prevention and Early Intervention system should be built around.

These programs are **multi tiered school mental health programs, primary care (and emergency room) integration of physical health with behavioral health, workplace mental health and the internet. Combined these four program areas can reach nearly everyone. These programs mostly pay for themselves in other systems so** mental health service act funds are mainly needed only to help get the programs started. Health Care, education and employer communities who invest in these programs generate savings that more than offset their costs. We also noted that significantly underserved racial and ethnic communities may still not be reached as easily as other populations and supplemental programs to see who we will miss and where we can reach them would also be needed. We noted that early psychosis programs represent a special population that is worthy of extraordinary extra efforts across all of these systems so that we identify and begin services for people in the early phases of schizophrenia on a consistent basis across the state.

There is progress in each of these areas but none are incorporated into a strategic framework to guide the use of the Prevention and Early Intervention Programs in each county. The legislature needs to authorize and direct state officials to develop a strategic planning framework with priority recommended or required county investment strategies and the partnerships required with other systems (health care education, racial and ethnic communities, and employers) to take the proven models to scale.

There is a need for state leadership to bring together key stakeholders and experts to develop the guidance training and outreach to education health care, employer and racial and ethnic communities to develop the best practices and models and help counties get these programs focused on what we know works best.

The success of these programs can be measured through the extensiveness of putting in place these strategies. As these programs succeed we should also measure the extent to which counties show increased penetration rates in accessing mental health services – both in MediCal and for those in commercial plans. These strategies are also the best way to address the significant racial and ethnic disparities in accessing services and reports should highlight which counties are showing significant progress in reducing disparities.

Need more meaningful stakeholder process and state approval of county plans to ensure that they are in compliance with the law and regulations and provided stakeholders with all of the relevant information and meaningfully considered alternative expenditures to what county staff has proposed.

Proposition 63 included specific requirements that county spending plans be developed through a stakeholder process. Counties have complied with the state requirements. Unfortunately that guidance has missed the mark by measuring how many people attended meetings and how many groups the counties reached out to. The counties are not required to do the four things that the stakeholders all want:

1. Put all of the relevant dollars on the table (not just MHSA but all of the other funds that can support the same purposes- mainly realignment and federal funds). Clarifying how much the revenues are going up or down and describe how all of those funds have been spent and are proposed to be spent.

2. Have meaningful discussions welcoming stakeholder views on different priorities for those expenditures- both before AND AFTER the county staff has developed a draft spending plan.

3. Demonstrate that each significant substantive suggested change has been seriously considered by either revising spending priorities to accommodate it or providing a substantive reason why county officials believe other expenditures represent a higher priority.

4. Have an issues resolution process to bring together key stakeholders when major issues arise to attempt to resolve them and eliminate major areas of conflict if possible to do so within identified priorities.

Putting these requirements in place can be done through amendments to state regulations. If that does not happen the legislature needs to make sure these processes become uniformly adopted throughout the state.

In addition, there is no effective way to enforce these policies without state review. Presently the Mental Health Services Oversight and Accountability Commission reviews and approves county innovation proposals. However, the legislature amended the act several years ago to eliminate Commission approval of Prevention and Early Intervention Programs and to eliminate Department of Mental Health (now part of the Department of Health Care Services) approval of community services and supports. The elimination of the types of reviews and approvals that had been occurring was appropriate as state officials were drowning counties in too much detail that took too much local staff time to complete and too much state staff time to review.

But eliminating that review has had a negative consequence in the stakeholder process.

We hear this consistently from individuals and groups across the state and representing providers as well as advocates for consumers, family members and racial and ethnic communities.

Accordingly there is a now a need to reinstate a limited Oversight and Accountability Commission review and approval of county plans. This also needs to apply to statewide projects developed by the California Mental health Services Administration - CalMHSA

The review should not demand lengthy plans and micromanage details. Instead it should just insist upon receiving enough detail about each expenditure (both past and proposed) to ensure that they are in compliance with the law and that the three key stakeholder process elements are being properly executed.

Counties have recognized that some programs are better done collectively by a single statewide entity. CalMHSA is a joint powers authority created by the counties to administer such programs. However, when the funds are transferred to CalMHSA the local stakeholder process is no longer relevant. Instead CalMHSA

needs to have a similar state level process for interaction with stakeholders. Moreover, the spending plans of CalMHSA and the evaluation of these programs needs oversight from the MHSOAC.

This process can also enable state officials to assemble more current and complete information about county expenditures.

The Mental Health Services Oversight and Accountability Commission should be authorized to require reporting and development of a data system that tracks all of the past and proposed expenditures across each component of the act across all counties which should be presented to stakeholders as plan updates are occurring and submitted to the state annually as plans are adopted.

We also need appropriate processes at the state level and an issues resolution process to ensure that stakeholders' perspectives are being properly considered by the Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission

As a general rule there is much greater transparency with state agencies than is reported to be the case with county budget decisions. However, there are occasions when issues arise that require an issues resolutions process to address stakeholder concerns. Both DHCS and the MHSOAC should establish such processes and publish the ways that stakeholders can initiate it.

It has now been nearly twelve years since the passage of the act and ten years since counties began the programs that it funded. It is an appropriate time to examine what is working and what needs fine tuning. The core of the act is working as expected but we don't have enough information about what the rest of the act is doing and there is a growing disconnect between counties and stakeholder groups that requires better information and more meaningful engagement. We also need to be more strategic in our approach to prevention and early intervention based upon what we have learned over these past twelve years.

We have not achieved our primary goals and we know that the main reason is that we still don't have enough funds to close all of the gaps in service. But we can do a better job of identifying the magnitude of these gaps in each county and identifying the actions that we can take as funds grow to address them. We also know that over the long run this is a rapidly growing revenue source so counties should expect there to be growth and be planning to address the unmet needs.