Mental Health Services Act: Then and Now

By Rusty Selix

For a variety of reasons, I am being asked much more than ever about the thinking behind various provisions of the Mental Health Services Act when we are writing it in 2003 and how that relates to some of the challenges we now have.
The act still looks like it correctly identified what was needed to fulfill our goals. But many parts of it have not been implemented the way they were envisioned and a lot has changed from what we knew in 2003 when it was written.

In this blog, I will speak to some of the issues and some of the solutions. Mostly what is required is a recognition that we have not revisited the guidelines (which led to regulations), all of which were developed before the applicable parts of the act had been implemented.
Now that we have had many years of implementing each part of the act, it is time to revisit the guidance (leading eventually to updated regulations) through a series of separate workgroups, that can move us more firmly in the direction in which I think we all know we need to go.

Key Recommendations:
Separate children system of care from the adults and older adult system of care dividing the funding now known as community service and supports into the two system of care programs and completely re-write the guidelines for each.
For children, focus on the uses of funds for services that are not covered by EPSDT or AB 114 to support families. For adults and older adults, clarify the different levels of need within full-service partnerships, the relationship to housing and homeless outreach and best cost-effective uses of funds not expended for full-service partnerships. For both ensure that there are performance outcome systems comparing all providers (not just counties) to identify the best approaches (for each of the many different types of problems and populations being served) that others should replicate. For both identify how to incorporate the alcohol and drug organized delivery system.

Identify core prevention and early intervention strategies most likely to make early identification a norm (schools, primary care, workplace, technology, youth centers, and others), using innovation funds to develop the models for replication and eventually steering the majority of prevention and early intervention funds to be used only for the proven most effective models. Ensure that each model addresses all behavioral health issues and creates warm handoffs to appropriate service providers.

Rewrite guidelines and regulations for the process to develop local plans. Ensure useful fiscal transparency for stakeholders, and a meaningful interactive process after a draft county spending plan has been developed. Focus on quality rather than quantity in measuring stakeholder participation, create local steering committees for prevention and early intervention and performance evaluation the bring in the diversity of outside interests similar to the OAC.

Develop a long-range workforce strategy that provides guidance to County plans and creates financial participation for employers of behavioral health professionals outside of the county systems.

Develop capital facilities strategies to **take SB 82 and children's crisis funding to scale** so that no one is taken to a jail or hospital simply because there was no alternative crisis care options. In anticipation of the election of a new governor, **develop clear roles and responsibilities for the OAC, DHCS, Planning Council** and other agencies that ensures there is a single specific place in state government that has clear authority, commitment and resources to address each major issue. Analysis that led to these recommendations is below.

STATE GOVERNANCE

The Oversight and Accountability Commission, primarily comprised of stakeholders outside of the mental health community (education, criminal justice, business and labor), was an idea that came from the original Little Hoover Commission reports in 2000. In addition, our campaign manager indicated that voters would not trust regular government agencies to properly spend the money. So, we had to have an independent commission overseeing the funds.

In the original drafts, the commission controlled all funds. But counties, the Department of Mental Health and the Mental Health Planning Council all objected. As a compromise we (primarily the CCCBHA board and Darrell Steinberg) agreed to give control of the children's and adult system of care money to the Department of Mental Health. This was based upon the fact that they had done a good job in implementing the children system of care program – and more importantly the AB 34 and 2034 programs which were expected to be the main programs funded by the initiative.

The initiative included state control of the funds and approval of County plans. The plan approvals were eliminated as they appear to reflect the worst of both worlds – drowning the counties and providers in extremely detailed paperwork and not providing oversight and guidance to promote best practices or collecting useful outcome data.
After the plan approvals were eliminated, all funds, including reserves, or set up to be transferred to counties on a regular ongoing basis by formula. The Little Hoover Commission reports in 2015 and 2016 documented the lack of strength and clarity in roles and responsibilities of the oversight commission and the Department of Health Care Services.

As we anticipate the election of a new governor in the fall of 2018, it is an appropriate time to evaluate what is working and what isn't, and what steps will get us where we need to go with the primary issue still being a lack of data that would allow for meaningful oversight.
In writing the act we envisioned that there would be adequate reporting of outcomes and expenditure patterns that would shine a light on the counties and providers that were performing the best in various categories. We envisioned that there would be reports identifying these practices so that other counties and providers make the changes necessary to

produce the best results. We envisioned that the funding formulas would include incentives to promote those changes. We also envisioned that guidelines and regulations would regularly be updated to reflect what was working and what was not. None of that has happened and very little of it can – without addressing the performance outcome and expenditure reporting issues.

COUNTY GOVERNANCE, FINANCIAL TRANSPARENCY AND STAKEHOLDER PROCESS

Over the course of the past 10 years I have heard more complaints about this than just about any other part of the act. The two most common problems are lack of access to all of the relevant budget details in terms of available revenues relative to past and projected expenditures, and lack of an interactive process with stakeholders after the county has developed its draft spending plan.

In addition it is clear that the stakeholder process only works in relationship to community services and supports and that the key other interests necessary to get to the best prevention and early intervention programs are not generally part of the process.

Is clear that the best prevention and early intervention programs happen outside of the public mental health system. Getting major changes in these other systems requires engagement at higher levels of leadership such as County supervisors, County executives and sheriffs interacting with their counterparts in schools, health plans, cities and other key partners.

ADULT AND OLDER ADULT SYSTEM OF CARE

The phrase "community services and supports" does not exist in the act. The phrase "full-service partnerships" does not exist either. The Department of Mental Health invented these phrases in its initial guidelines believing that they would help counties understand the "*whatever it takes*" concepts with these labels. The act refers to the children's system of care and the adult and older adult system of care. The adult and older adult system of care was the AB 2034 program. We expected 100% of the funding for adults and older adults to go to this model. Counties wanted flexibility to gradually improve all of their programs so that eventually they could all meet the comprehensive *whatever it takes* model. Accordingly the regulations allowed up to 50% of the funds to be spent on "system development".

We still don't have information on how that money has been spent. Our definition of *whatever it takes* did not require that everyone had to stay at a very high level of service in order to continue to be eligible for services. As people progressed along the milestones of recovery we expected lower levels of care that would still be part of the services for people with severe and disabling mental illnesses unless and until the recovery led to full-time employment in which case we expected they would leave the system of care, and presumably Medi-Cal.

CHILDREN'S SYSTEM OF CARE

The primary goals of children's providers and advocates were to protect the two main entitlements: EPSDT and AB 3632. The non-supplantation clause was written to serve that purpose. In addition, there were examples of services that children with serious emotional

disturbance as needed and which would not be covered under those two programs. The children system of care was expected to be used to provide supplemental funding to eliminate those gaps so the children and families also received the same whatever it takes concept.

Keeping children at home was reinforced by requiring every county to implement wraparound as an alternative to out of home placement and adding language to provide that it would pay for any services necessary to prevent a family from choosing to give up custody of their child in order to access mental health services.

Nothing has gone according to plan. The two entitlement programs remain in place but the state has realigned them to counties and schools with evidence that fewer children are being served under EPSDT (penetration rate went from 5.7% to 4.8% in first two years) and many schools are providing less comprehensive services to children with serious emotional disturbances and counties have been doing under AB 3632.

The merging of the children's and adult systems of care under community services and supports led counties to believe that full-service partnerships for children were to be freestanding separate programs rather than limited supplemental services to children already being served through the entitlement programs.

SUBSTANCE USE DISORDERS

In developing the scope of the act, voters were clear that they only wanted to pay for people with severe mental illnesses and for prevention and early intervention. They did not support funding for less severe mental illness or for substance use disorders except when those conditions needed to be treated incidental to a severe and disabling mental illness or the prevention of a severe mental illness.

From the outset of AB 34 (which became full-service partnerships) it was recognized that many of the people to be served would have co-occurring substance use disorders and that the funding was intended to pay for those services to the extent that other funding was not available. This appears to have worked as intended but we don't have good data on the extensiveness of the use of these funds for that purpose and how consistently this is being done. With the development of the county organized delivery system there should be a better way to more broadly get federal financial participation for the services.

The application of prevention and early intervention for people with substance use disorders has not been identified as a separate priority and as best as we can tell none of the funds have been expended to support substance use disorder treatment.

HOUSING

The housing bond measure approved by the Legislature in 2016 was viewed by many as a major departure from the original purposes of Proposition 63. That is not correct. As we were writing the measure, we recognized that a significant portion of the target population was homeless

and that using MHSA funds to leverage other housing funds through a bond measure was anticipated something we would do after the measure was passed. We did not highlight it in the text of the measure because we feared that it could create a NIMBY backlash, but we did have legal opinions telling us that it would be a proper use of the funds.

Like any major new effort, the No Place Like Home housing program will present challenges that will have to be worked out over the many years of its implementation that depend upon many variables such as:

- transitional housing for those for whom permanent supportive housing is not the right approach
- unknown amounts of housing that can be leveraged from other funding sources that reduces the cost per unit from MHSA funds
- unknown rates of growth of MHSA funds that will be needed to ensure services to those newly housed to not displace services to others
- uncertainty of other funding sources

WORKFORCE EDUCATION AND TRAINING

The act set aside $450 million for this program to remedy the shortage of qualified individuals to provide services. That money is nearly all spent, but the shortages are not gone, and if anything are greater now than when the act was written.

There is a continued need to do what the act requires, which is to have a state plan every five years to relies upon each county doing a needs assessment.

However, it is not just the public mental health system that has benefited from the funds already set aside and that is impacted by the shortages that still exist.

Schools, jails, prisons, and commercial health plans all employ individuals and compete with the public mental health system to hire and retain qualified individuals.

INNOVATIONS

We set aside funds for innovations so that there would be resources to identify the next generation of advances in care. We recognized that the children system of care and the adult system of care were started with new dedicated state funds and an evaluation of these pilot projects. Due to their success we were able to get additional funds to expand them to other counties.

This part of the act did not wind up being implemented until 2012. The way it was set up each county was on its own to identify new innovative projects. The first round of these projects are now completed. I would've thought that we would have a detailed report on the results and a series of new models that could be recommended for replication by other counties.

That has not happened. In the meantime several new innovations have emerged which include:

- Integrated crisis centers to divert people from both jails and hospitals
- School county multi-tiered partnerships
- College mental health systems

- Workplace mental health programs
- Prodromal phase "early psychosis" programs
- Youth centers

This program needs to be restructured so that counties can choose from a list of innovations for which the Oversight and Accountability Commission (OAC) has provided guidelines and a method by which to have a statewide evaluation that will allow all the other counties to benefit and learn how to implement the program. Allowing all counties to use innovation funds to implement the startup of any of these approved innovations should be an eligible use of funds for several years after the initial projects are completed.

As documented in our 2016 policy recommendations, the approved list should be developed to create an interactive process that collects the best ideas that come to counties locally, as well as those that come directly to the commission.

In addition, counties would be free to propose other projects with an understanding that they are not as likely to be approved unless they appear to be equally significant or the county has already implemented all the programs on the approved list that are feasible for County of its size.

PREVENTION AND EARLY INTERVENTION

This part of the act came largely from focus groups who clearly told us that we should only focus on people with severe mental illness but we should also have prevention programs so the people didn't have to become homeless before they could get help.

We knew very little about what would be the best strategies for this program, besides the value of school-based approaches to children and early psychosis programs. Nearly all counties now have some school-based approach as well as an early psychosis program. But there is also an enormous variety and how counties of approached this program.

I have often quoted a cardiologist who said that when he started practicing they did one hundred different things but by the time he retired there were only doing five because everyone learned what the most effective strategies were.

That is what needs to happen for the prevention and early invention program. We need to identify that small group of program elements that should be universal statewide. I wrote a paper in 2014 which identified four of them besides early psychosis:

- school multi-tiered approach reflecting school county partnerships with on-campus clinicians and a process to identify all at risk students as early as possible
- primary care and emergency room screening with immediate initiation of evaluation by a behavioral health professional
- workplace behavioral health programs that steer everyone to seeking help when a coworker or manager recognizes that something isn't right
- Internet strategies that steer people to getting help

Since writing that paper I've also become aware of youth centers and college programs that also should be promoted. The OAC should develop specific strategies to take each of these core prevention early intervention programs to scale as well as identifying others that should also become universal.

As this work is done the commission should rewrite the guidelines and regulations so that all counties are incentivized to implement those programs.

OUTCOME MEASURES

We wrote the act expecting the outcome measurement and collection system that had been in place for the children's and adults and older adult's systems of care to carry over and be collected in the same manner as had been done.

For the most part providers and counties have been inputting the data necessary to provide the outcome measures for full-service partnerships. We expected that to be the use of all community services and supports funds. The OAC has been able to provide occasional snapshot reports that provides overall information on the success of the programs. What it doesn't do is compare each provider on their achievement of desired outcomes relative to the amount of time and money expended in advancing someone on milestones of recovery.

For the 30% of community service and supports funds which do not go to full-service partnerships we need to find out what that money is being spent on and get a comprehensive report that allows us to determine what are the other purposes for which is being spent and how to do comparative outcome reporting.

For prevention and early intervention, the outcome measures listed in the act are the absence of bad outcomes which prevention and early intervention should make happen. As it turns out it is very hard to measure these outcomes in relationship to specific prevention and early intervention activities. A better approach is to focus on the core prevention and early intervention activities and measure the extensiveness of the implementation. What percentage of people are screened in primary care? Of those who screened positive what percentage get care that helps them? What percentage of schools have early identification systems? What percentage of workplaces have early identification systems?
These types of measurements would go a long way to demonstrating that we are making prevention and early intervention a norm instead of an exception.