



CALIFORNIA COALITION FOR MENTAL HEALTH

APPENDIX

Background Information in Support for California Coalition for Mental Health Recommendations for State Administration of Community Mental Health

(Excluding Medi-Cal and State Hospitals)

Licensing and Certification

The purpose of licensing and certification is to create a safe therapeutic living environment in the community for persons with mental health challenges. Regulations set forth in California Code of Regulations Title 22 and Welfare and Institutions Code, Sections 4080 and 5768, govern the community based facilities that typically provide services to mental health consumers.

DMH currently licenses Psychiatric Health Facilities (PHF) and Mental Health Rehabilitation Centers (MHRC) and certifies other mental health treatment programs that function within other facilities that are licensed by the California Department of Social Services/Community Care Licensing (DSS/CCL). Adult Residential Facilities and Community Treatment Facilities are licensed by DSS/CCL. SNFs are licensed and monitored by the California Department of Public Health (DPH).

California made a commitment to promote community based alternatives to institutional care in 1978 with the passage of the Community Residential Treatment System Act (CRTS). These programs are the backbone of a system that facilitates building a person's ability to manage their psychiatric disability and to be able to live independently in the community. Along with the supported housing options we have developed, these programs are the foundation for our ability to meet our obligations under the federal Olmstead decision for persons with psychiatric disabilities.

Oversight and Evaluation of County Mental Health

The data the state collects and analyzes must be accessible for use by a variety of entities, including:

- The State Legislature
- Mental Health Services Oversight and Accountability Commission (MHSOAC)
- California Mental Health Planning Council (CMHPC)
- County mental health agencies
- Community-based agencies
- Mental health consumer and family member constituents



Under existing law, the CMHPC has responsibility for reviewing and approving performance indicators and at times, proposes performance indicators to use in evaluating the mental health system. It also works with local mental health boards and commissions on responsibilities they have to evaluate their local performance outcome data.

The MHSOAC was established by Welfare and Institution (W&I) Code Section 5845 to oversee the MHSA funded programs, Adult and Older Adult System of Care Act, and Children’s Mental Health Services Act.

The statute mandates that the MHSOAC evaluate how funding has been used including what outcomes have resulted from those investments, and how to improve the services and programs to maximize positive outcomes for the community and for all populations, including reducing disparities in access to services, quality of care and outcomes. (W&I 5845(d)(6). In addition, the Act mandates sufficient state-level administrative funds to ensure adequate research and evaluation (W&I Code Section 5892(d)).

The following data collection systems relate to non-Medi-Cal county mental health programs:

- Client Services and Information System—an encounter level data system for the entire public mental health system that collects demographic and service information every time a client receives services
- County Financial Reporting System—year-end cost report of all costs expended by county mental health programs
- Consumer Perception of Care—satisfaction and quality of life data collected on a statewide random sample of children, youth, adults, and older adults
- Data Collection and Reporting System—data collection on Full Service Partnerships pursuant to the Mental Health Services Act in domains, such as Housing, Employment, Education, Criminal Justice status, and Residential Status
- Approval of facility designation for involuntary holds and production of a statewide list
- Electroconvulsive Therapy (ECT) Treatments administered (Title 9, §838)
- Collect and publish annual quantitative information on involuntary holds and conservatorships (W&I Code 5402)
- Identification of person served in Institutions for Mental Disease (IMDs) (W&I Code 5901)
- Statistical data on reports required by the Department (Title 9, §642)
- Annual report to the legislation on county performance measures (W&I Code 5613)
- Annual county mental health services performance contracts (W&I Code 5650)
- Mental health master plan (W&I Code 5733)
- Summary of beneficiary grievance from each county mental health plan (Title 9, §1795)
- Complaints on patient rights violations (Title 9, §857)
- Use of seclusion and behavioral restraint and associated injuries and deaths [H&S Code 1180.2(d)(3)]

Pertaining to the “performance contract,” the state annually revises the required content of the contract to identify changes in the applicable laws and the information required to be submitted by counties to determine that each county is in compliance with each applicable law in its administration. A vital state function is to review these submittals and to certify that each county is in compliance. State statutes identify an additional state function in circumstances in which the state determines that a county is in serious violation of state or federal laws and corrective action is



required. State agency staff is required to evaluate when such action is warranted and what corrective action must be taken.

Interaction with Federal Government

SAMHSA and PATH Grant Administration

The Substance Abuse and Mental Health Services Act (SAMHSA) Block Grant provides flexible funding to states for the purpose of providing comprehensive community mental health services to children with serious emotional disturbances and adults with serious mental illnesses. California acts as a “pass-through agency, receiving federal funds and allocating them to counties through a formula. There is also a requirement that five percent of the programs be audited each year.

The Project for Assistance in Transition from Homelessness (PATH) provides flexible community based services for persons with serious mental illnesses and co-occurring substance abuse disorders who are homeless or at imminent risk of becoming homeless. This program is state administered and locally operated by a county or through county subcontractors.

The CMHPC through a Memorandum of Understanding is responsible for conducting the audits of SAMHSA-funded local programs.

Interaction with Other State Agencies

State-Level Representation on a Variety of State Boards and Commissions

Currently, the Director of the Department of Mental Health has a seat on many state boards and commissions developing policy on health and related subjects.

Coordination of Policy with other State Agencies on Related Issues

The Governor’s Cabinet, the Governor’s office and other forums for discussing broad policy and budget issues must be informed about mental health and people with mental illness. These issues are especially important in the over representation of people with mental illness in the criminal justice and child welfare systems and the 75% high school dropout rate of youth with serious emotional disturbances. These societal failures are extremely expensive to other state programs and could be reduced through the provision of prevention and early intervention in primary care and education and other state programs doing a better job of identifying and treating mental illnesses early in their onset.



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Department of Rehabilitation (DOR) Cooperative

The Department of Rehabilitation (DOR) Mental Health Cooperative programs were designed to build partnerships between local county mental health agencies and the DOR to improve employment outcomes for persons with psychiatric disabilities. The program was designed to utilize local resources (both cash and/or in-kind) to provide matching funds to allow California to take advantage of the federal funds set-aside for the state. These programs assist consumers to find, obtain, and keep meaningful community employment. Statewide, there are 26 Mental Health Cooperative programs administered through cooperative agreements with local county mental health agencies. An additional 44 contracts with private non-profit community programs are funded through these county mental health cooperative programs to provide vocational rehabilitation services.

Under these contractual agreements, the DOR assigns vocational rehabilitation counselors to be actively involved with the program. DOR opens cases and provides enhanced vocational rehabilitation services. A county mental health agency or a contracted private non-profit provides exclusive training and enhanced programming to enable consumers to achieve employment utilizing assessment, vocational and work-site training, job placement, and follow-up services to mutual county mental health agencies and DOR consumers.

Recommendations for MHSOAC Members and Selection of Mental Health Planning Council Members

The Mental Health Services Oversight and Accountability Commission (MHSOAC) and the California Mental Health Planning Council are two state commissions that make important state policy decisions. Appointments to the MHSOAC are made by the Governor, Attorney General, superintendent of Public Instruction, Senate pro Tempore, and Assembly Speaker.

Veterans

It is well documented that veterans have extensive needs for mental health and alcohol and drug services and that not all of these needs can be met through the services available through the Veterans Administration (VA). However, there is very limited understanding of which veterans are entitled to assistance and which services are available through the VA. In addition, it is not clear what other health insurance veterans have now and would have in the next few years through healthcare reform. This lack of clarity creates tension between veterans who demand services and local mental health systems with limited funding. It is a challenge to the state's health care departments, as well as veterans' service agencies.

Mental Health in the Private Sector: Parity

Both state and federal mental health parity laws were designed to reduced private sector disparities between health and mental health insurance benefits and services. Parity statutes require mental health and substance use benefits and services to be available to beneficiaries on the same terms and conditions as other health conditions. Some dimensions



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of those requirements include but are not limited to parity in financial requirements, treatment limitations, and both network capacity and out of network coverage.

The state is required to exercise oversight over health plan and insurer performance related to access and quality in addition to monitoring coverage and costs. Parity is relevant to public sector programs because of widespread reports that private patients needing mental health treatment who are unable to access treatments and services through their commercial health service plan or private health insurance must seek those services in the public mental health and substance use systems. County mental health services provide to individuals with private insurance or health service plans is often uncompensated. This creates a burden on county provided mental health resources.

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA, P.L. 110-343) expanded the parity requirements in the Mental Health Parity Act of 1996 (MHPA, P.L. 104-204) expands the reach of mental health parity requirements in several ways to California, most notably in application to The Patient Protection and Affordable Care Act; specifically in health exchange products and coverage.

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The parity workgroup should at a minimum look at the following specific issues:

- Health Service Plan network adequacy needs to be quantitatively measured, oversight taken over remedial action by plans found not to be meeting standards, and enforcement actions taken against plans whose networks consistently do not meet statutory requirements.
- Timely Access regulations promulgated by the Department of Managed Health Care need to be vigorously enforced.
- Enforcement of the Knox Keene statute requiring presumptive eligibility for inpatient psychiatric admissions when an individual meets WIC 5150 standards.



- A reliable and enforceable claims process needs to be established to reimburse counties for mental health and substance abuse services rendered to individuals with private insurance and health service plans.

Mental Health Prevention & Early Intervention in Schools

The Early Mental Health Initiative, currently funded by the Department of Mental Health (DMH), demonstrates that modest mental health services of five to ten sessions per child is successful in alleviating the symptoms of mild to moderate mental health problems in children grades K-3. DMH reports that those children “Never show up in the system” meaning they do not wind up being students requiring special education due to a serious emotional disturbance or wind up in the child welfare or juvenile justice system and requiring out of home services. Conversely, a survey by the California Council of Community Mental Health Agencies among its members identifies that 90% of the youth that they see come from child welfare, special education, or juvenile justice “Fail First” circumstances. Similarly, a study by the Los Angeles County Department of Health indicated that where services for children requiring mental health care is identified and offered on campus by schools nearly all families will seek and utilize that care. Conversely, where the school simply informs that family of the need for care and urges the family to navigate the private health insurance system and find the care on their own, hardly any families will seek and utilize that care.

With schools now financially responsible for mental health services for non Medi-Cal students in special education there is, for the first time, a meaningful financial incentive for schools to identify students needing such care. However, such care is also a reimbursable service under health plans and work is required to identify means of getting health plans to reimburse for that care on campus (as is often the case for Medi-Cal students due to partnerships between the schools and a county or community mental health provider). Moreover, studies show that people with untreated mental health problems account for a disproportionate percentage of people in the prison system, high school drop outs and child welfare caseloads. In addition positive behavioral supports programs are recommended as a best practice for schools to address disciplinary problems. Many of those children will have diagnosable mental health disorders and the same supports can help address the mental health needs of those children.

Early Mental Health Initiative (EMHI)

EMHI is a \$15 million grant program to school districts to provide early mental health screening services to children in grades K-3. Last year EMHI funded projects (on average \$42,000) in 415 school sites in 71 school districts.

The 1992 legislation was intended to seed early mental health services in schools and after 3 years schools would continue their programs using their own funding. The program is not in every one of the 1,039 school districts in California and there is no data as to how many school districts have continued the EMHI program after the state grant ended.



Co-Occurring Disorders in the Public and Private Sector

Integrated Mental Health and Substance Use Disorder Services

Current state governance is inadequate to address the needs of individuals with co-occurring mental health and substance use disorders defined as the coexistence of two or more disorders, at least one of which relates to the use of alcohol and/or other drugs and at least one of which is a mental health disorder. Representing a significant policy issue for California, approximately one half of the people who have one of these conditions – a mental illness or a substance use disorder – also have the other condition; and, this proportion is believed to be even higher for adolescent populations. They are among California's most underserved and disproportionately represented among arrestees, incarcerated youth and adults, foster care placements, veterans, hospitalizations and the homeless. Touching every part of California's system the co-occurring population is more expensive to treat, has more medical problems, poorer treatment outcomes, more negative social consequences and lower quality of life.

Special Programs and Business Functions

Multicultural Programs and Cultural Competency

Reducing disparities in accessing mental health services and improving cultural competence are important policies that must be advanced to achieve the progress in mental health services needed to address the needs of this ever increasing percentage of Californians. Moreover the California Reducing Disparities Project (CRDP) is a multi-year program to identify needs and best practices. This project has garnered national attention as the most comprehensive compilation of community-defined practices and approaches that will served underserved racial, ethnic, and cultural (LGBT) communities in the country. This final plan is not due to be complete until late 2012. This is the final statewide project funded by MHSAs Prevention and Early Intervention monies.

Cultural Competence Plan Requirements (CCPR) Reports are required from each of the counties and is the only comprehensive report on cultural competence for mental health services at the state level. This vital and informative report has been the most effective way to measure cultural competence in mental health ever developed.

Support for Policy Input/Review and Program Oversight by Mental Health Consumers and Their Families

The active involvement of individuals who have received public mental health services and their family members is mandated by legislation and essential to the effective design and provision of mental health services. This requirement inheres in both state programs such as the MHSAs (see below) as well as Medicaid funded services statewide. Accomplishing this and ensuring clients have the tools and resources to be effective in review and development of such requires functionaries at the state level as well as the county level. Currently many counties have such functionaries. Previously the state DMH employed a Consumer as a community liaison officer. Similarly, the federal



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Center for Mental Health Services employs a consumer to coordinate and provide direction as well as performing liaison functions with state level programs such as client advocate, family and child mental health advocates.

Although some of this work can be completed regionally, much of it will require targeted organizational support at the local level with oversight by the State. This reorganization provides an opportunity to not simply preserve the function of consumer and family member involvement but the chance to reinforce participation by establishing concrete mechanisms specifically designed to advance consumer and family member contribution throughout the state. Part of this reinforcement includes effectively utilizing the findings and recommendations of the California Reducing Disparities Project in order to effectively reach out to and engage representatives of underserved communities.

Careful consideration must be given to state functions that deal with consumer and family member protections in the form of oversight, accountability, protection, and advocacy. Mechanisms for consumer and family member involvement are best utilized for proactive purposes, such as policy advocacy and community planning. Since AB 100 terminated state review of county plans, which had been one way to monitor the inclusion of consumer and family stakeholders from diverse racial, ethnic, cultural and age groups, the explicit need to protect this inclusion remains, along with the need to standardize stakeholder engagement processes. When proactive support is not enough, there is also the essential need to support the rights of consumers and family members in processes of issue resolution.

Finally progress in evidence-based mental health supportive services has identified the need to deploy Peer Specialist (peer support) programs broadly in order to provide positive long-term outcomes for illness management and sustained recovery among mental health service recipients. These specialized service programs, which have been prioritized for development under state Medicaid waivers through the federal Center for Medicaid Services, require guidance and structure for integration across the range of service systems, as well as an informed centralized authority to establish standards for certification and training to ensure quality and success that is not bound by county or municipality.

Contracts

Currently, there are several state organizations with contracts to provide education training and advocacy support for the California Institute of Mental Health and organizations of clients, family members and other small nonprofit organizations who serve important mental health policy development and education functions to support the public mental health system. There are contracts with statewide organizations which comprise significant portions of the budgets of these organizations and which require timely contract execution and payment of invoices for these organizations to remain viable.

Ombudsman Program, Complaint, Grievance

The ombudsman program, and the complaint and grievance system, is part of the Medi Cal specialty mental health program. These programs should be consolidated with the other Medi-Cal programs in the Department of Health Care Services.



Human Rights, Including Electroconvulsive Therapy (ECT) Data Collection

ECT data collection, seclusion and restraint data collection, and denial of patients' rights data collection should be housed in one department. Because so much of the data comes from state hospitals, the Department of State Hospitals would be an appropriate place.

Mental Health Services Act (MHSA)

MHSA Regulations and State Guidance

The MHSA and other laws governing community mental health require regulations and informational guidance from the state. The MHSA requires a review of regulations to revise and streamline requirements in light of AB 100 and to set forth revisions reflecting health care reform, integrated county plans, an issue resolutions process for both local and state decision making and the capacity to provide information and guidance on other laws and policies. All of these need to be updated frequently reflecting problems identified through review of current practices and changes in state and federal laws and funding that affect mental health services.

State Office of Suicide Prevention

The Office of Suicide Prevention serves as a statewide resource center and technical assistance unit on suicide prevention in California. Its activities, guided by the California Strategic Plan on Suicide Prevention, include: disseminating and monitoring the implementation of the California Strategic Plan on Suicide Prevention and providing technical assistance on the Plan; convening and facilitating monthly conference calls with county suicide prevention liaisons and crisis centers; developing and maintaining the Office of Suicide Prevention website; developing and updating county level suicide data profiles that are distributed broadly across the state; coordinating activities with the CalMHSA Statewide Project on Suicide Prevention; coordinating occasional trainings and conferences; responding to request for information from a broad range of stakeholders; and serving as a liaison to national suicide prevention partners.

Programs for Reduction of Stigma

California Welfare Institutions Code § 5845(d)(8) directs the Mental Health Services Oversight and Accountability Commission (MHSOAC) to develop strategies to overcome stigma. The OAC steers counties to address stigma throughout all Mental Health Services Act (MHSA) projects. Specifically, using pooled Prevention and Early Intervention (PEI) funds from forty-one counties the California Mental Health Services Authority (CalMHSA) has awarded a number of contracts explicitly to reduce mental health stigma and discrimination.



MHSA Workforce Education and Training (WET)

The MHSA Workforce, Education and Training component provides dedicated funding to remedy the shortage of qualified individuals to provide services to address serious mental illness.

State Level Programs:

The Mental Health Loan Assumption Program (MHLAP) is administered by the Health Prof. Foundation. \$2.5 million in awards are made annually to repay educational loans for mental health professionals who are in hard to fill or hard to retain positions. Awardees are obligated to work in public mental health for a year.

Physician Assistant Training: DMH has partnered with OSHPD to add a mental health track to the Residency Program for Physician Assistants as a strategy to address the shortage of individuals who can administer psychotropic medications. In 2008-09 five Physician Assistant programs that train a total of 383 second-year residents to specialize in mental health were awarded a total of \$500,000 (approximately \$100,000 per program); in 2009-10 three programs received \$100,000 each.

Psychiatric Residency Program: DMH contracted with the Regents of the University of California, Davis to develop a specialty Medical Psychiatric residency program, and with University of California, Los Angeles-Kern to expand their Child and Adolescent Fellowship program. DMH is working with the Regents of the University of California-San Francisco (Fresno Medical Education Program) to develop a new child and adolescent psychiatry fellowship program.

Stipend Programs: Ten higher educational entities are contracted to provide stipend programs for graduate students who plan to work in the public mental health system.

Statewide Technical Assistance Center: To promote the employment of mental health clients and family members in the mental health system. Working Well Together (WWT) is a statewide technical assistance center (a collaborative of four statewide mental health agencies - California Network of Mental Health Clients, NAMI California, United Advocates for Children and Families, and the California Institute of Mental Health).

Regional Partnerships - Five Regional Partnerships (RPs) have formed across the state to promote building and improving local workforce, education and training resources

County Level Programs:

Currently, 55 local mental health programs have submitted local workforce development plans and upon the subsequent submission by the other remaining counties, over 200 million dollars will be directed at the following local workforce activities: Workforce administration sustainability

- Financial incentive and relief programs for staff
- Career pathway development in educational programs, including secondary education
- Streamlining and updating the training and retraining of the public mental health workforce



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- The expansion of educational programs including certificated programs for individuals with lived experience and their families
- Creating and sustain internship and residency programs
- Promoting the inclusion of consumers and family members in all levels of development.

MHSA and Other Mental Health Housing Programs

The availability of decent, accessible and affordable housing is a cornerstone of our ability to address the needs of clients of the public mental health system. In recognition of this fact, \$ 400 million in Mental Health Services Act (MHSA) funds were made available to finance the capital costs associated with development, acquisition, construction and/or rehabilitation of permanent supportive housing for individuals with mental illness and their families, especially including homeless individuals with mental illness and their families. The program is called the MHSA Housing Program and funds for capitalized operating subsidies were included in the \$400 million that has been designated for the program. Executive Order S-07-06, signed by Governor Schwarzenegger on May 12, 2006, mandated the establishment of the MHSA Housing Program, with the stated goal of creating 10,000 additional units of permanent supportive housing for this population. The program is jointly administered by DMH and the California Housing Finance Agency (CalHFA). During the application review and evaluation process, CalHFA underwrites requests for capital funds and capitalized operating subsidies, while DMH evaluates each applicant's proposed target population and Supportive Services Plan. Once funds are awarded, CalHFA oversees all housing and financial aspects of the development and DMH oversees provision of services, including continuing assessment as to whether the services match tenant needs and support the individual's recovery.

The Lanterman-Petris-Short (LPS) and Related Programs

The Lanterman-Petris-Short Act, (LPS) California Welfare & Institutions Code, sec. 5000 et seq., (1967), governs involuntary civil commitment to mental health treatment in California. The goal of the LPS Act was to end inappropriate lifetime and/or indeterminate commitment of people with mental illness, to firmly establish civil rights of individuals, particularly the right to due process in the commitment process for patients, and to significantly reduce state institutional expense with a de facto presumption favoring voluntary community based care for individuals diagnosed with a severe and persistent mental illness whenever possible.

The state functions associated with this role are meant to enforce provisions of Act and to ensure Counties are in conformance with the Act. This requires that the State of California do a number of things not limited to the following:

- Approve county-designated LPS facilities for the detention, evaluation and treatment of individuals who may qualify for involuntary treatment;
- Approve county proposals for and oversight of outpatient civil commitment (AB 1421, Thomson, 2002) for conformance to statute;



- Develop and exercise oversight over the statutorily required forms which counties are required to use in the commitment process of individuals including those used for legal rights and civil rights notification and informed consent (W&I Codes 5325 & 5157);
- The development of written materials on the effects of medication addressing the probable effects and possible side-effects (WIC 5152);
- Collecting data on the use of seclusion and restraint incidents outside of state hospitals and data on the utilization of electroconvulsive therapy;
- Publicly reporting aggregate data related to specific statutorily designated categories of commitments;
- Approving waivers to counties allowing minors to be admitted to adult facilities (WIC 5751.7);
- Developing a booklet outlining the specific rights of minors in mental health facilities (WIC 6002.15);
- Adopting, overseeing and enforcing standards, rules and regulations for administration of the Act (WIC 5400).