

California's Mental Health System-Underfunded from the Start

I. BACKGROUND

A. Mental Health Needs in California: The scope and range of mental health needs in California is difficult to assess. According to the Department of Mental Health (DMH) several prevalence mental disorder rates are used, contingent on the diagnostic types, level of impairment, and the duration of the disorder.

For example, using a broad measure of mental disorder, national studies indicate rates of 20 percent of children and 22 percent of adults have a diagnosable mental disorder during the course of a year. This would mean 6.2 million Californians. These numbers include individuals with moderate depression, panic disorder, obsessive-compulsive disorder, and others that may be somewhat disabling but are not generally viewed as having a high level of functional impairment.

By using analyses conducted by the Center for Mental Health Services that used the most serious diagnoses and impairment levels, as well as synthesized data from several studies on children, the DMH states that:

- 2 to 3 percent of the state's adult population (about 486,000 to 728,000) have a severe and persistent mental illness (schizophrenia, bipolar disorder, and major depression).
- 5.4 percent (about 1.3 million) of the state's adult population has serious mental illness.
- 5 to 9 percent of the state's children aged 9 through 17 (212,000 to 382,000) have a serious emotional disturbance with extreme functional impairment. (The studies indicate that higher numbers should be used for areas of higher poverty.)
- 9 to 13 percent of the state's children aged 9 to 17 (382,000 to 551,000) have a serious emotional disturbance with substantial functional impairment.
- 50 to 67 percent of the children in foster care have been estimated to have a serious emotional disturbance with substantial functional impairment.
- About 60 percent of the adults also have a substance abuse problem.

Individuals obtain mental health services through general medical providers, mental health specialty providers, such as psychologists and psychiatrists, human service providers, such as social workers and the clergy, and self-help resources. Treatment needs, when identified through individualized assessment plans, vary with the individual and over time. How treatment needs are addressed depends on a number of factors, including the availability of community mental health services and other support resources. Several studies have attempted to measure mental health service use.

The California Needs Assessment Survey found that about one-third of the prevalence rate for schizophrenia was treated, about 15 percent for bipolar disorder, 3 percent for major depression, 4 percent

for antisocial personality disorder, and less than one percent for anxiety disorder. The DMH notes that the differences in these rates are consistent with services in the public mental health program, since schizophrenia is the most disabling of conditions. Further, the California Household survey found that about one-third of both children and adults received some services through the public mental health system.

Based on 1997-98 DMH data, almost 500,000 individuals received services via the state's publicly funded mental health system. Of these, about 50,000 individuals received acute inpatient care with the remainder of these individuals receiving residential, day treatment, or outpatient services. The majority of individuals served have a diagnosis of serious mental illness, such as schizophrenia, affective disorders, and other psychotic disorders.

Of the almost 500,000 individuals served in 1997-98, over 300,000 of these individuals were enrolled in Medi-Cal. Data regarding this population show the following:

- 61 percent are adults, 3 percent are older adults (over 65 years), and 36 percent are children/youth (under 21 years). The adults used 63 percent of the funding resources, older adults used 2 percent and children/youth used 35 percent.
- For adults, services are principally provided in outpatient (55 percent) and day treatment (13 percent) settings.
- Inpatient costs for adults accounted for 26 percent of treatment expenditures, and crisis services accounted for 6 percent. Over the past several years, expenditures have been shifting from inpatient services to outpatient and day treatment services.
- About 5 percent of the adult Medi-Cal population received mental health services in 1997-98. (Based on the above survey data, the service penetration level should be higher.)
- With respect to children/youth services, services are principally provided in outpatient (66 percent) and day treatment (17 percent) settings.
- Inpatient costs for children accounted for 15 percent of treatment expenditures and crisis services accounted for 3 percent. As with adults, expenditures have been shifting from inpatient services to outpatient and day treatment services.
- With respect to ethnicity, the data show the following:
 - 30 percent of the total Medi-Cal population is Caucasian, while 43 percent of those receiving mental health services are Caucasian.
 - 43 percent of the total Medi-Cal population is Hispanic/Latino, while 13 percent of those receiving mental health services are Hispanic/Latino.
 - 13 percent of the total Medi-Cal population is African American, while 14 percent of those receiving mental health services are African American.
 - 7 percent of the total Medi-Cal population is Asian, while 8 percent of those receiving mental health services are Asian.

Considerably more data analysis, particularly regarding prevalence rates, the use of mental health services, and whom our public mental health system serves, clearly needs to be conducted. With the implementation of performance and outcome measures, as discussed below, more data will be available to measure the strengths and weakness of the system.

B. Summary of California's Public Mental Health System Prior to Realignment: California has a decentralized mental health service delivery system with most direct services provided through the County mental health system. This system of community-based mental health services was initiated

through the Short-Doyle Act of 1957 that created a funding structure for the development of community-based mental health services. The purpose of the Short-Doyle Act was to develop a community-based system of services to improve care and encourage deinstitutionalization. Prior to 1957, most individuals requiring public mental health services were treated for lengthy periods in the State Hospitals (about 37,000 residents in 1957), which at the time had questionable efficacy.

To assist in funding this new system of community-based care, the state initially covered 50 percent of the costs for those counties that chose to establish a mental health system. There was no federal participation in this program until 1971 when the Short-Doyle/Medi-Cal pilot project began. This new federal funding mechanism enabled counties to obtain a 50 percent federal match.

In 1968, the Lanterman-Petris-Short (LPS) Act established standards for the involuntary treatment of individuals and further facilitated the use of community-based services rather than State Hospital services. This statute strengthened commitment laws by eliminating lengthy, open-ended commitments and afforded individuals with certain due process rights.

Specifically, the LPS Act sets forth the conditions under which an individual may be involuntarily hospitalized and the rights afforded to individuals for whom this commitment is being sought (See Attachment). The legal criterion for an individual to be involuntarily detained and treated is: *A probable cause to believe the individual is, due to a mental disorder, a danger to himself, a danger to others, or gravely disabled (i.e., cannot provide for basic needs such as food, clothing or shelter)*. The Attachment outlines the statutorily defined periods of involuntary detention and treatment. It should be noted that an individual with a grave disability can be placed under a conservatorship for up to one year, or longer with court approval.

With respect to state funding, the state did slightly increase its funding commitment for community-based services from 1969 to 1973. However, the state failed to distribute to community programs much of the savings achieved through the State Hospital closures and client population shifts (i.e., from the State Hospitals to community-based programs.). According to a 1990 report by the California Mental Health Directors Association, between 1975 and 1990 the mental health system experienced an erosion of about \$320 million due to unfunded client population growth and increases in the cost of providing services. In addition, with the passage of Proposition 13 (1978), the counties' ability to provide funds also deteriorated.

In 1988, the Wright, McCorquodale, Bronzan Act (AB 3777) established reforms regarding services to adults with serious mental illness. It set forth a "systems of care" service delivery model whose core elements include consumer and family focused services, a personal service plan, coordinated services delivery system, intensive case management assistance, and the delivery of services that are measurable and accountable.

Three pilot projects were established through this legislation--one in Ventura County, one in Los Angeles County, and one in Stanislaus County. As noted by an independent evaluator and by reviews conducted by the DMH, these projects have proven to be highly successful. Though this integrated services approach was cost-effective and commendable, funding was not provided to expand to other counties.

As noted by the California Mental Health Planning Council, the mental health system was disadvantaged financially, as well as by a lack of clear governance structure. The state controlled funding authority, while the counties were responsible for the provision of services and program operation. As such, no entity was fully accountable.

Commencing in 1989, the state began to reduce its General Fund commitment to mental health services. Since mental health services were never established as an "entitlement", it made it difficult for these services to compete for state General Fund moneys during a time of economic recession and diminishing state revenues. By 1990-91, the state projected a \$14 billion General Fund shortfall and numerous

services, including those pertaining to mental health, were on the chopping block. According to the California Coalition on Mental Health, more and more individuals with serious mental illness were not receiving assistance due to a lack of funding, which in turn, led to increased homelessness and incarceration for these individuals.

Due to these various concerns, mental health advocates began discussions on a variety of system reform proposals. AB 904 (Farr), Statutes of 1990, mandated that the California Planning Council create a Mental Health Master Plan to guide reform efforts. This work paid off when the restructuring/realignment discussions commenced.

C. Realignment-Significantly Changes Governance Structure and Funding: AB 1288 (Bronzan and McCorquodale), Statutes of 1991, realigned the fiscal and administrative responsibility under county authority. The intent of mental health realignment was generally to:

- Provide a more stable funding source for community-based services;
- Shift program accountability to the local level (counties and two cities);
- Establish local advisory boards in each county to provide advice to local mental health directors;
- Make services more client centered and family focused;
- Develop performance measures and outcome data;
- Redefine the role of the state in providing services through the State Hospital system and its responsibilities in program oversight and evaluation.

In 1992, Realignment funding replaced about \$700 million in state General Fund support for community mental health services. Realignment revenues, funded by an increase in the Sales Tax and in vehicle license fees, are collected by the state and allocated to various accounts and subaccounts in the Local Revenue Fund. The Mental Health Subaccount is the principal fund that contains revenues for the provision of local mental health services. These funds are distributed to the counties on a formula basis as contained in statute. Funds used for the allocation of state hospital beds and a portion of funds allocated for Institutions for Mental Disease (IMDs) were also converted for use by the counties.

The statute also defined appropriate use of these funds and established definitions for priority target populations to help focus how resources are spent. Specifically, counties are required to provide services to individuals who have a severe mental illness or serious emotional disturbance, *to the extent that resources are available*. The criteria include diagnoses with psychotic features, serious functional impairment, risk of hospitalization, and risk of removal from home (mainly for children). There are no income eligibility provisions; therefore, individuals with assets are charged fees according to an established schedule.

Among other things, changes initiated in realignment have led to a significant reduction in the number of State Hospital beds that counties use. For example, in 1989-90 counties purchased about 2,489 beds and for 2000-01 it is estimated that they will only purchase 850 beds, for a reduction of almost 66 percent. Counties have shifted their resources towards designing programs at the local level, including multi-agency coordinated systems of care for adults and children, capitated full-service systems for costly patients, and new long-term care services in the community.

Generally, the realignment of mental health services has been viewed as a moderate success (California Mental Health Planning Council, "Effects of Realignment on the Delivery of Mental Health Services", 1995), though not an answer in itself. Among other things, realignment has:

- Offered some fiscal stability, though sales tax revenues can fluctuate with the economy. Without realignment it is likely that additional General Fund reductions would have occurred during the early to mid-1990s.
- Enabled counties to claim increased federal funds, such as for the Medicaid Rehabilitation Option (1993) and the EPSDT Program (1995). It is unlikely that these programs would have been expanded if state General Fund moneys were the sole source of the required match.
- Helped to reshape service delivery by implementing a client-centered system of care approach.
- Increased availability of self-help groups by individuals with serious mental illness.
- Eliminated categorical program requirements and funding which has enabled counties to design more innovative programs.
- Increased services to the target population-- adults and children with the most serious mental illnesses. (California Policy Research Center, UC Berkeley, November 1999.)
- Established performance outcome measures and the use of consumer-tested instruments with proven reliability.

D. *Medi-Cal Mental Health Managed Care-Consolidation and Capitation:* Implementation of Medi-Cal Mental Health Managed Care has included the consolidation of Medi-Cal psychiatric inpatient hospital services ("Phase I"), which occurred in January 1995 and the consolidation of Medi-Cal specialty mental health services ("Phase II"), which occurred from November 1997 through June 1998. These two phases of implementation consolidated the two existing Medi-Cal mental health programs (Short-Doyle and Fee-For-Service) into one service delivery system.

Under this delivery system, psychiatric inpatient hospital services and outpatient specialty mental health services, such as clinic outpatient providers, psychiatrists, psychologists, and some nursing services, became the responsibility of a single entity, the Mental Health Plan (MHP) in each county. Medi-Cal recipients must obtain services through the MHP. The DMH is responsible for monitoring and oversight activities of the MHPs to ensure quality of care and to comply with federal and state requirements.

The DMH notes that design of policies for all phases on implementation has been accomplished through an ongoing public planning process that has included individuals receiving services, family members, the California Mental Health Directors Association, the California Mental Health Planning Council, providers, advocates, other state agencies, and other interested parties.

Under this capitation model, MHPs are at risk for the state matching funds for services provided to Medi-Cal recipients and claim federal matching funds on a cost or negotiated rate basis. An annual state General Fund allocation is provided for this purpose. This allocation is adjusted each fiscal year to reflect adjustments as required by Chapter 633, Statutes of 1994 (AB 757, Polanco). These adjustments typically include changes in the number of eligibles served, factors pertaining to prepaid health plans, changes to the consumer price index for medical services, and other relevant factors.

Based on 1997-98 expenditures, California's total dollars rank as second highest of all states. However, on a per capita basis, California expends only \$58.10 per person, which is 24th among the states.

California currently is operating under a waiver extension. The second waiver renewal, submitted to the Health Care Financing Administration in November 1999, is presently under federal review. As such, HCFA has temporarily extended the existing waiver through March 2000.

Implementation of the waiver, particularly the newly developed State Quality Improvement Committee, the results of the Independent Assessment (federally required assessment for waiver renewal), and the recently opened DMH Ombudsman Office, will be further discussed during Subcommittee hearings.

II. PUBLIC MENTAL HEALTH FUNDING

Funding for the public mental health system is somewhat complex. It consists of a blending of funding sources, including state General Fund, County Realignment funds, federal Medicaid funds (Title XIX), federal Substance Abuse and Mental Health Services Administration block grant funds, federal S-CHIP (Title XXI) funds, and even some Proposition 98 General Fund moneys.

The Governor's budget proposes expenditures of \$1.664 billion (\$739.7 million General Fund) for the Department of Mental Health (DMH), not including capital outlay expenditures. In addition, Realignment funding is estimated to be \$1.081 billion (includes all mental health-related subaccounts). Therefore, total resources of \$2.745 billion (total funds) are available for mental health services. (These funds do not include resources appropriated for the provision of mental health services via the criminal justice or juvenile justice systems.)

With respect to the State Hospitals, about \$559 million is budgeted for 2000-01, including state administration. Generally, Medi-Cal reimbursement is *not* available in the State Hospital system per federal statute. The DMH estimates a population of 4,421 patients at the four State Hospitals. Of this population, only 19 percent or 850 beds are to be purchased by the counties with the remaining 3,571 beds, or 81 percent, designated for penal code-related patients. (This is discussed further in the Subcommittee No. 3 section of this report.)

The following chart depicts the major sources of funds and the general criteria for eligibility and reimbursement.

MAJOR SOURCES OF PUBLIC MENTAL HEALTH FUNDING

	Realignment	Medi-Cal	CalWORKS	EPSDT	Children's System of Care	Healthy Families
Purpose	Provides mental health services to <i>target population, to the extent resources are available.</i>	Provides medically necessary psychiatric inpatient hospital, rehabilitative services and case management.	Reduces mental health barriers to employment.	Provides medically necessary specialty mental health services, such as behavior management modeling, medication monitoring, family therapy, and crisis intervention	Provides mental health services to children who are seriously emotionally disturbed.	Provides supplemental mental health services to children who are seriously emotionally disturbed.
Eligibility	Services provided on a sliding fee basis.	Enrolled in Medi-Cal.	Temporary Assistance for Needy Families (TANF) recipient.	Enrolled in Medi-Cal.	Enrolled by county	Enrolled in Healthy Families Program and referred to that county.
Age Limits	None.	None.	16 (if not in school) through 59 years. Voluntary after age 59.	Under age 21 years	Under age 21 years	Birth to 19 years
Severity of Disability	Focuses mainly on people with serious and/or persistent mental illness or serious emotional disturbance.	Requires a diagnosis of severe impairment in life functioning and not responsive to physical health care based treatment. Includes episodic users as well as people with serious disabilities.	Based on whether mental health is barrier to employment rather than severity of mental illness. Expect broad range of disability.	Requires determination of being "medically necessary" to correct or ameliorate a mental illness or condition. Includes episodic users as well as people with serious disabilities.	Serious emotional disturbance.	Serious emotional disturbance.
Type of Funding	County Realignment Funds—Mental Health Subaccount—which consists of state sales tax and vehicle licensing fees.	Depending upon the service being provided, either Realignment funds or state General Fund moneys are used to draw a federal match.	For Medi-Cal eligible services, state General Fund moneys from an annual allocation amount are used to draw a federal match.	Realignment funds are used up to a baseline amount established for each county and then state General Fund moneys are used beyond the baseline. These funds are used to draw a federal match.	State General Fund.	Realignment Funds are used to draw a federal match.
Federal Funds	None.	About 50% match.	About 50% match.	About 50% match.	None.	About 65% match.

Most of the General Fund increases over the past several years have been to (1) fund certain Medi-Cal entitlements, such as for the Early Periodic Screening Diagnosis and Treatment (EPSDT) Program, and (2) maintain services at the State Hospitals for penal-code related patients (100 percent state responsibility) and provide for state administrative overhead costs.

Some General Fund increases have been provided for community-based services, most notably for (1) the gradual expansion of the Children's System of Care Program, (2) AB 34 (Steinberg), Statutes of 1999, pilot projects to expand services to adult populations at risk of homelessness, and (3) implementation of the supplemental mental health benefit provided under the Healthy Families Program. However, these increases have been modest and other legislative increases, such as for housing assistance or mental health screens for foster care children, have been vetoed.

III. OPTIONS FOR EXPANSION

Additional funding considerations should be deliberated, in the context of the state's budget, in order to provide more comprehensive services to mitigate disability, family disintegration, unemployment, and homelessness and to facilitate optimum health and quality of life. Senate Pro Tempore Burton has identified expansion of mental health services as a budget priority. The following suggestions are posed to serve as a *framework* for discussion during the Subcommittee process.

A. *General Lack of Baseline Funding:* First, as noted by the DMH in recent public testimony, limited funding of the existing public mental health system is the foremost limiting factor in providing adequate services. Adequate funding has never been provided and reductions implemented during the recession years exacerbated the situation.

Second, because counties are obligated to provide services to Medi-Cal recipients based on an entitlement and to the extent resources are available, indigent individuals not enrolled in Medi-Cal may not obtain the level of service treatment they need until an emergency arises. Therefore, access to increased non-categorical is needed to enable counties to better serve their baseline patient caseload.

Third, due to fiscal pressures in the Social Services Subaccount related to caseload-driven growth, it is likely that minimal, if any, growth funds will be available for local mental health services. A discussion regarding the allocation of growth funds may be warranted.

B. *Expansion of Treatment and Support Services:* Mental health issues are best treated upon detection. Without attention, illness may become more debilitating and chronic.

Individuals with severe mental illness require access to quality treatment services, as well as need support from a variety of agencies, such as housing, job-training, employment, and rehabilitation after incarceration. The DMH notes that for adults, integration of services is rare, leaving mental health services able to address hardly more than symptoms; thus, lasting gains in recovery cannot occur. With respect to children, at a minimum, additional funding is needed for children in foster care and to meet growing caseload needs.

Suggestions for expanded services could include the following:

- Comprehensive funding of the Adult Systems of Care model as established in 1989 and modified by AB 34. Though the Governor's budget provides \$20 million for this purpose (\$10 million to continue the three projects and \$10 million for expansion to three to six more sites), additional funds are needed for more comprehensive statewide efforts. In addition, an ongoing commitment from the state is needed, not one-time only appropriations.
- Expansion of the Dual Diagnosis (mental illness with alcohol and/or drug abuse) Demonstration Projects initiated in the Budget Act of 1995. A total of \$1 million (federal funds) is currently provided to four counties selected through a request for proposal process. A total of 28 additional counties applied, but funding was not available.

- Consider special rate adjustments for certain service providers which serve individuals with mental illness.
- Development of options for expanding medication management review in community settings.
- Comprehensive development of a discharge planning process.
- Further develop the provision of culturally competent services to ensure quality services and to improve access to services to ethnic minorities.
- Increased funding for the Mentally Ill Offender Crime Reduction Grant Program under the Board of Corrections.
- Increased use of Advanced Directive Plans to enable individuals to plan for the care of themselves, their home and their belongings during times of hospitalization and crisis.
- Funding of the Supportive Housing Assistance Program, established through trailer bill legislation for the Budget Act of 1999. The Legislature has twice proposed increases to this program which have been vetoed by the Governor. Only \$1 million is currently appropriated, and that is targeted to CalWORKS recipients.
- Comprehensive funding of the Children's System of Care Program.
- Development of transition age services (18 to 24 years) to provide continuity between the Children's System of Care Program and adult services.
- Development of services to older adults. Recent data show there is a scarcity of services to this growing population.
- Expansion of provider capacity, particularly in rural areas and in underserved areas. Funding assurance is needed to attract and maintain quality providers of services.
- Provide training assistance to mental health service providers, as well as other health and human services providers, to facilitate integration of services and improve service quality.

C. *Other Recommendations Are Likely Forthcoming:* Two significant efforts which will likely result in system reform recommendations are currently underway.

First, the statewide Lanterman-Petris-Short Act (LPS) Dialogue Project will soon be publishing a summary report. This project, sponsored by the DMH, California Association of Local Mental Health Boards and Commissions, California Mental Health Planning Council, California Institute for Mental Health and California Mental Health Directors Association, was initiated to examine the existing LPS system. For this purpose, three strategies were derived: (1) to conduct local forums throughout the state that would enable any individual to express their interests regarding the LPS system, (2) to examine research from other states who have studied involuntary care, and (3) to develop consensus recommendations for potential reforms and change. The local forums were conducted by facilitators and significant public participation was obtained (about 35 percent self-identified as a consumer of services and 31 percent were family members). Recommendations should be forthcoming around February.

Second, the DMH is in the process of analyzing an "independent assessment" of the Medi-Cal Mental Health Waiver. Considerable data have been tabulated and the contractor will be providing recommendations for system improvements. The Budget Act of 1999 required the DMH to provide this information to the Legislature upon completion.

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