Mental Health Services
Oversight & Accountability Commission

Report to the Governor and Legislature

Report prepared by the Mental Health Services Oversight and Accountability Commission

■■■ December 2013 ■■■

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The Mental Health Services Oversight and Accountability Commission is comprised of sixteen Commissioners that include: the Attorney General or his or her designee, the Superintendent of Public Instruction or his or her designee, the Chairperson of the Senate Health and Human Services Committee or another member of the Senate selected by the President pro Tempore of the Senate, the Chairperson of the Assembly Health Committee or another member of the Assembly selected by the Speaker of the Assembly and twelve Governor's appointees that represent specific statutory statewide interests.

VISION

Right care, right time, right place for all individuals, children and families at risk for or living with mental illness

OUR MISSION

Provide vision and leadership, in collaboration with government and community partners, clients and their family members to ensure Californians understand mental health is essential to overall health. The MHSOAC holds public mental health systems accountable and provides oversight for eliminating disparities, promoting mental wellness, recovery and resiliency, and ensuring positive outcomes for individuals living with serious mental illness and their families.

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MESSAGE FROM THE CHAIR AND VICE CHAIR

Governor Brown and Members of the Legislature:

On behalf of the Mental Health Oversight and Accountability Commission (MHSOAC), we are pleased to present this report to the Governor and Members of the Legislature. Proposition 63 (Prop 63), the Mental Health Services Act (MHSA), funded through a one percent tax on personal income in excess of $1 million, established the MHSOAC to provide oversight and accountability for the MHSA and the larger public community mental health system.

The last report highlighted the MHSOAC's task to provide meaningful and effective oversight and accountability for Prop 63 in a changing mental health environment which included the elimination of the Department of Mental Health. This report addresses how that oversight continues, including evaluation, new Prevention and Early Intervention (PEI) and Innovation (INN) regulations and the addition of triage/crisis intervention personnel throughout California.

In its ongoing commitment to tell the statewide story, the MHSOAC launched a five-year comprehensive approach to evaluation to effectively demonstrate the outcomes of public investments. Initial evaluations of the use of Prop 63 money are showing results; in a 2012 study on Full Service Partnerships, for every Prop 63 dollar spent in the "whatever it takes" Full Service Partnerships to treat the most severely mentally ill, there was a cost savings of $1.27. Youth saw the greatest savings from avoiding the criminal justice system while adults and seniors saw the greatest savings from avoiding psychiatric hospitalization. The five year evaluation plan will build and expand on what we know to complete a comprehensive, cohesive look at the public mental health system.

In addition, new regulations for PEI and INN will give counties clear direction for implementing and evaluating programs that are the hallmark of Prop 63.

This report also documents how much funding is supporting the public mental health system, with a focus on Prop 63 revenues.

The MHSOAC looks forward to ensuring that the values and intended outcomes established by Prop 63 continue to be realized.

Sincerely,

Richard Van Horn
Chair

David Pating, M.D.
Vice-Chair

INTRODUCTION

The Mental Health Services Oversight and Accountability Commission (MHSOAC) is providing this report to inform the Governor and Members of the Legislature about the impact that Proposition 63 (Prop 63), the Mental Health Services Act (MHSA), has had on mental health services in the state of California since it went into effect in 2005.

BACKGROUND

California voters approved Prop 63 in November 2004 to expand and fund a new generation of recovery-driven mental health programs across the state. Prop 63 is funded through a one percent tax on incomes in excess of one million dollars. Prop 63 established the MHSOAC to provide oversight and accountability for Prop 63, Adult and Older Adult System of Care Act and Children's Mental Health Services Act, which is generally described as the public mental health system. The MHSOAC is the only state entity that has as its sole responsibility the oversight of the public mental health system.

Prop 63 has undergone various changes since its inception. One of the most significant was in 2011 with the passage of Assembly Bill (AB) 100 (Chapter 5, Statutes of 2011) in which the MHSOAC was no longer responsible for reviewing or approving local MHSA funding requests. With AB 1467 (Chapter 23, Statutes 2012), the MHSOAC received county MHSA plans again, checked them for compliance with the law, and approved Innovation expenditures. Then AB 82 (Chapter 32, Statutes of 2013) gave the MHSOAC responsibility for adopting regulations for Prevention and Early Intervention and Innovation programs. Throughout, the MHSOAC expanded its focus of providing oversight through evaluation.

Stigma and discrimination against persons with mental illness and their family members is a significant factor in persons choosing not to seek mental health services

MHSA Components

The money generated by Prop 63 funds five components: Community Services and Supports (CSS), Prevention and Early Intervention (PEI), Innovation (INN), Workforce Education and Training (WET), and Capital Facilities and Technology (CFTN).

<u>Community Services and Support (CSS)</u>

CSS, the largest component, is 80% of county MHSA funding. CSS provides funds for direct services to individuals with severe mental illness. These services are focused on recovery and resilience while integrating the service experience for clients and families. Full Service Partnerships (FSP) are in this category. FSPs provide wrap-around or "whatever it takes" services to clients. Housing is also included in this component.

<u>Prevention & Early Intervention (PEI)</u>

PEI, the second largest component, is 20% of county MHSA funding. PEI programs are created to prevent mental illness from becoming severe and disabling by recognizing the early signs of mental illness and improve early access to services and programs, including the reduction of stigma and discrimination.

Background

Oversee the Adult and Older Adult Mental Health System of Care Act, Human Resources, Education, and Training Programs, Innovative Programs, Prevention and Early Intervention Programs and the Children's Mental Health Services Act. (W&I Code §5845(a))

Innovation (INN)

INN is the smallest component. It is funded by utilizing 5% of CSS and 5% of PEI MHSA dollars. INN funds and evaluates untested, out-of-the-box, time-limited approaches to find new ways to engage mental health clients, increase the quality of services, or improve the service delivery system.

Workforce Education and Training (WET)

WET is a time-limited source of funding that is available over ten years to build the capacity of the mental health workforce, as well as improve the cultural and language competency of that workforce.

Capital Facilities and Technological Needs (CFTN)

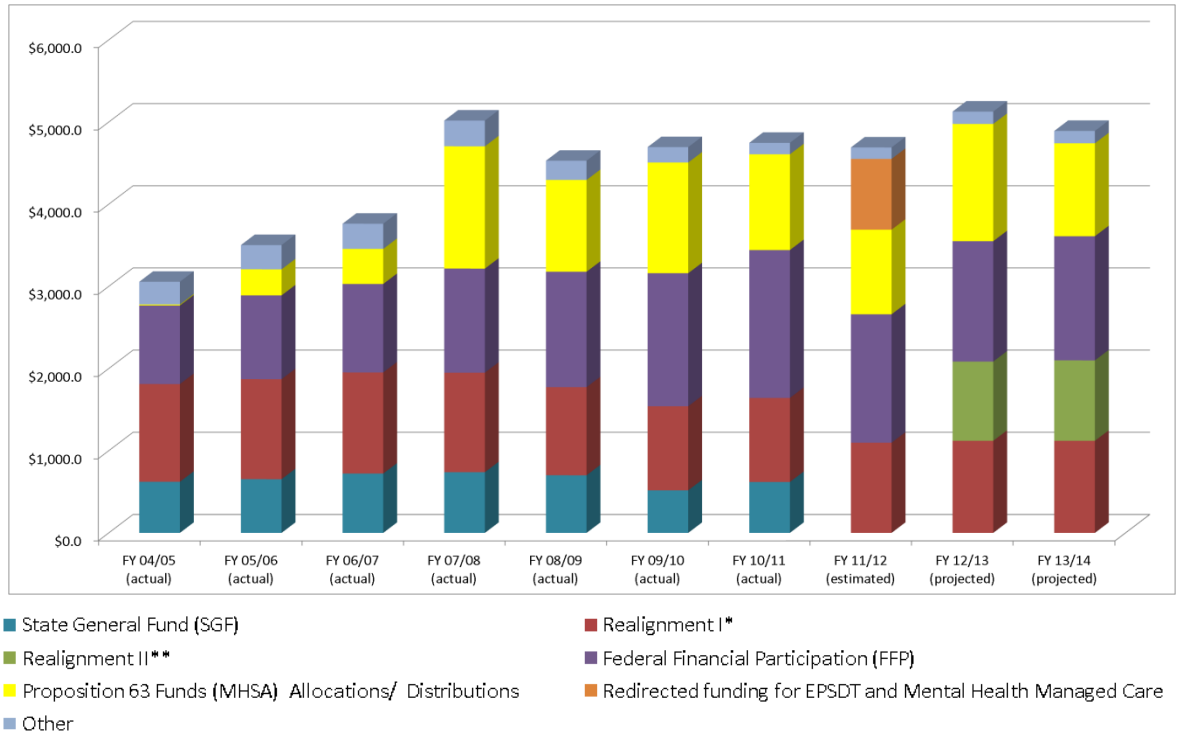
CFTN is a time-limited source of funding that is available over ten years for building projects and to increase technological capacity to improve the mental health service delivery system.

Of California's 26.9 million adults, 2.2 million (8.37%) have a mental health need. Just over half (50.6%) of the 2.2 million adults in California who have a mental health need reported not receiving any treatment from a primary care physician nor from a mental health professional

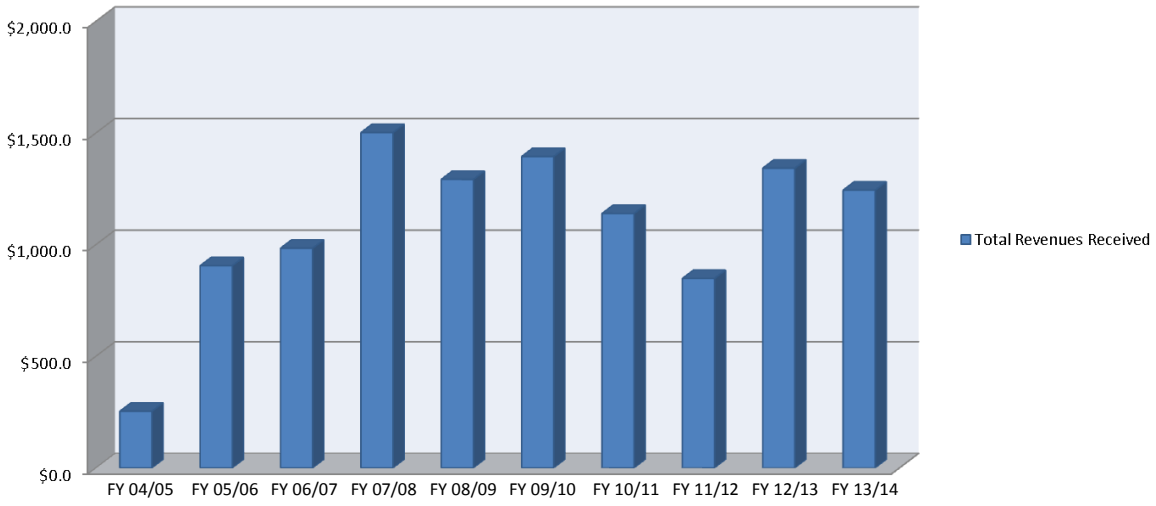
Financial Report

FINANCIAL REPORT

Mental Health System Funding Trends



MHSA Funding



Financial Report contd.

Mental Health System Funding Details

	FY 04/05 (actual)	FY 05/06 (actual)	FY 06/07 (actual)	FY 07/08 (actual)	FY 08/09 (actual)	FY 09/10 (actual)	FY 10/11 (actual)	SFY 11/12 (estimated)	SFY 12/13 (projected)	SFY 13/14 (projected)
State General Fund (SGF)	$621.6	$653.5	$721.8	$738.5	$701.0	$518.0	$619.4	$0.1	$0.0	$0.0
Realignment I*	$1,189.9	$1,217.1	$1,230.9	$1,211.5	$1,072.4	$1,023.0	$1,023.0	$1,097.6	$1,120.5	$1,120.5
Realignment II**	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$964.5	$979.0
Federal Financial Participation (FFP)	$955.5	$1,019.9	$1,076.8	$1,266.4	$1,404.6	$1,619.2	$1,799.9	$1,562.5	$1,465.0	$1,511.0
Proposition 63 Funds (MHSA) Allocations/ Distributions	$12.7	$316.9	$426.3	$1,488.2	$1,117.0	$1,347.0	$1,165.1	$1,029.9	$1,427.0	$1,131.0
Redirected funding for EPSDT and Mental Health Managed Care	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$861.2	$0.0	$0.0
Other	$276.2	$295.4	$306.8	$313.3	$233.9	$187.6	$139.4	$139.4	$150.0	$150.0
TOTAL	$3,055.9	$3,502.8	$3,762.6	$5,017.9	$4,528.9	$4,694.8	$4,746.8	$4,690.7	$5,127.0	$4,891.5

*Includes $14 million in Vehicle License Fee Collections. Fiscal Year (FY) 11/12 and FY 12/13 and amounts from Governor's proposed FY 13/14.
**Managed Care and EPSDT share of 2011 Behavioral Health Subaccount only. FY 12/13 and13/14 growth estimated on percentage of growth in Behavioral Health Subaccount from Governor's proposed FY 13/14 budget.

State General Fund (SGF): The SGF is funded through personal income tax, sales and use tax, corporation tax, and other revenue and transfers. Prior to the Governor's FY 2011/12 Budget Proposal, the primary obligations of the SGF provided to counties for mental health are to fund specialty mental health benefits of entitlement programs including Medi-Cal Managed Care, Early and Periodic Screening Diagnosis Treatment (EPSDT) and Mental Health Services to Special Education Pupils (AB 3632).

Realignment: Realignment is the shift of funding and responsibility from the State to the counties to provide mental health services, social services and public health. There are two sources of revenue that fund realignment: 1/2 cent of State sales taxes and a portion of State vehicle license fees. The primary mental health obligation of realignment is to provide services to individuals who are a danger to self/others or unable to provide for immediate needs. It is also a primary funding source for community-based mental health services, State hospital services for civil commitments and Institutions for Mental Disease (IMDs) which provide long-term care services. 2011 Realignment gives counties the funding responsibility for EPSDT and Mental Health Managed Care.

Federal Financial Participation (FFP): FFP is the federal reimbursement counties receive for providing specialty mental health treatment to Medi-Cal and Healthy Families Program beneficiaries. The amount of federal reimbursement received by counties is based on a percentage established for California called the Federal Medical Assistance Percentage (FMAP).

Proposition 63 Funds (MHSA): The MHSA is funded by a 1% tax on personal income in excess of $1 million. The primary obligations of the MHSA is for counties to expand recovery based mental health services, to provide prevention and early intervention services, innovative programs, to educate, train and retain mental health professionals, etc.

Other: Other revenue comes from a variety of sources--county funds are from local property taxes, patient fees and insurance, grants, etc. The primary obligation of the county funds is the maintenance of effort (the amount of services required to be provided by counties in order to receive realignment funds).

Source: FY 2012/13 Governor's Budget, DOF, DMH (DHCS after June 30, 2012) MHSA Summary Comparison (posted 07/21/2011), MHSOAC Fiscal Consultant Projections , and California Department of Health Care Services, May 2013, Updated Semi-Annually.

Evaluation

STATEWIDE

Community Services and Supports

In 2012, a UCLA study of FY 08/09 and FY 09/10 expenditures found that FSPs showed significant cost savings:

- A cost savings of $1.27 for every Prop 63 dollar spent
  - Total Prop 63 dollars spent for new enrollees: $142,000,000
  - Total cost offset savings: $162,000,00
- As more people are being served by FSPs, overall costs continue to be offset by savings in other areas: incarceration, psychiatric hospitalization and homelessness
- It costs, on average, about $20,000 a year or $55 a day to treat a seriously mentally ill person in a FSP

This UCLA study also showed significant results for FSP participants when compared with their experiences in the 12 months prior to enrolling in a FSP:

- 3,513 fewer arrests, resulting in 80,377 fewer days spent in jail
- 977 fewer psychiatric hospitalizations, resulting in 39,313 fewer days spent in psychiatric hospital care
- 672 fewer prisoners, resulting in 88,268 fewer days in state prisons
- 452 fewer detained youth, resulting in 42,105 fewer days of juvenile sentences
- 321 fewer people admitted to long term care facilities, resulting in 71,877 fewer days spent in long term care

LOCAL SPOTLIGHT: BONITA HOUSE IN ALAMEDA COUNTY

- 117% increase in the number of clients employed
- 94% decrease in the number of new homeless episodes
- 83% decrease in the number of psychiatric hospitalization admissions
- 67% decrease in the number of new incarcerations
- 457% increase in the number of clients in school or taking classes

Evaluation contd.

Prevention and Early Intervention

In 2013, enough counties implemented PEI services and programs that statewide evaluation trends began to emerge, which show:

- Decreased behavior problems and improved social competence and skills among children and youth
- Programs for transition-aged-youth have a positive impact on employment, homelessness, and legal involvement
- Parent-focused programs result in improved parenting knowledge and skills, improved family functioning, and decreased parenting depression, stress and anxiety
- Promoting a reduction in disparities in access to care by improving access for certain racial/ethnic groups (e.g. Latinos, Pacific Islanders, Vietnamese)

Half of all lifetime cases of mental health disorders start by age 14 and ¾ start by age 24

These results are currently being researched in more detail, including:

- Identify the total amounts spent on PEI programs
- Identify how much was spent on prevention and how much was spent on early intervention
- Identify the kinds of programs and activities that were implemented
- Evaluate the impact of early intervention clusters, like first break psychosis and trauma-focused programs for children who show signs of mental illness

Innovation

In 2013, counties were in the early stages of implementing INN programs and evaluating initial results. A few counties are seeing early, promising outcomes, like Los Angeles. Los Angeles County received Prop 63 INN funds to pilot two new services: the Integrated Clinic Model (ICM) and the Integrated Mobile Health Team Model (IMHT). ICM was designed to improve culturally competent services for individuals with physical health, mental health, and co-occurring substance use diagnoses by integrating care within both mental health and primary care provider sites. IMHT is a client-centered housing-first approach that uses harm reduction strategies across all modalities of mental health, physical health, and substance abuse treatment. Preliminary findings from these two INN projects include the following.

- Clients had been homeless for significantly fewer days at the six-month assessment
- There was a significant increase in the percent of clients who were insured from baseline to six months
- Clients experienced fewer emergency room visits, hospitalizations, and incarcerations at the six month mark
- Decreases were seen in substance use
- Improvements were seen in progress of client recovery and management of health conditions

Future INN evaluation efforts include assessing the quality of current evaluations of local programs and taking steps to ensure that counties are receiving enough support to independently conduct rigorous evaluations.

Evaluation contd.

Populations Helped by Prop 63

Focus on: **Veterans**

Many counties decided to direct Prop 63 funds to serve their local veterans. Some of these programs include:

- Amador County: Sierra Wind Wellness Center
- Los Angeles County: Veterans Systems Navigators
- Nevada County: Veterans Family Wellness
- San Bernardino County: Military Service and Family Support Program
- San Francisco County: Veterans Common Housing
- Sonoma County: Mobile Intervention Team

Focus on: **Youth**

In its 2012 evaluation examining CSS, UCLA found participation in a FSP was associated with measurable cost offsets related to other public health, mental health and criminal justice system involvement. For youth aged 16 to 24, 147% of FSP program costs for new enrollees in FY 09-10 were offset by savings to the public mental health, health and justice system. These youth consistently report better well-being, function and social connectedness as a result of participation in mental health services. As part of a 2011 evaluation, UCLA found these youth in FSPs experienced:

Frequently students do not seek help for mental health issues due to stigma and discrimination.

- reduced homelessness
- reduced psychiatric hospitalizations
- decreased arrests
- fewer incarcerations

Focus on: **Homeless**

Prop 63 came about because of the need to serve chronically homeless, severely mentally ill individuals. Some local programs created to serve the homeless include:

- Butte County: Housing Development Program
- Los Angeles County: Integrated Mobile Health Team
- Marin County: Odyssey Program
- Mendocino County: Community Action for Recovery and Empowerment (CARE)
- Sacramento County: Pathways to Success After Homelessness
- Tulare County: Supportive Housing

Looking to the future

MHSOAC 2014 ACTIVITES

Evaluation

In 2014, the MHSOAC expects to produce the following evaluation deliverables:

- February 2014: A report on the use of PEI funds
- April 2014: An in-depth analysis of the impact of the MHSA on reducing disparities in access to care
- July 2014: Establish trends in initial priority indicators of individuals who have been served from FY 04/05 through 11/12
- July 2014: Assess consumer and family member perspectives regarding the MHSA's impact on reducing disparities in access to care
- August 2014: Report on the results of the impact of clusters of PEI programs
- August 2014: Summarize the results of evaluations of local programs conducted by counties
- November 2014: Report on promising local community planning practices
- December 2014: Assess the quality of INN evaluations currently being conducted by counties

Triage and Crisis Intervention Services

Currently not all counties have an array of crisis services specifically intended to divert persons to less restrictive, recovery-focused, levels of care. This leaves individuals with little choice but to access an emergency room for assistance which may result in an unnecessary hospitalization. Additionally, this often results in law enforcement personnel needing to stay with persons in an emergency room waiting area until a less intensive and less restrictive level of care can be found. Senate Bill (SB) 82, known as the Investment in Mental Health Wellness Act of 2013, utilizes Prop 63 to expand crisis services statewide. Adding triage personnel at various points of access, such as at designated community-based service points, homeless shelters, and clinics is expected to lead to improved life outcomes for the persons served and improved system outcomes for mental health and its community partners.

The MHSOAC will award grants to counties with the goal of hiring 600 triage personnel. The MHSOAC will meet in January 2014 to begin awarding grants.

Regulations

On June 26, 2013, Governor Brown signed into law AB 82 mandating that the MHSOAC adopt regulations for PEI and INN programs and expenditures.

In 2013, the MHSOAC approved the Draft Proposed PEI and INN regulations. The anticipated filing with the Office of Administrative Law (OAL) is January 2014, which then begins a 45-day public comment period. The MHSOAC's goal is to submit the Rulemaking Record to the OAL in late spring of 2014.