

**Joint Senate and Assembly Health Policy and Budget Subcommittees  
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**Testimony of Rusty Selix  
Executive Director  
California Council of Community Mental Health Agencies and  
Mental Health Association of California  
(also known as Mental Health America of California) and  
Co-Author (with Senate President Pro Tem Darrell Steinberg)  
Of Proposition 63 of 2004 (the Mental Health Services Act)**

**CONTEXT**

When we developed, campaigned for and enacted Proposition 63 we said that our primary goal was to end the fail first system of the revolving door of hospital jail and homelessness and to invest in programs to identify mental illnesses early in their onset to keep them from becoming disabling. The goals for implementation we called the 3 “E”s – Serve **Everyone** who has a mental illness. Give them **everything** they need to recover and live a fully productive life, and start **early** by identifying and get services started as soon as possible after the first signs of illness. We recognized that we needed to make sure that our limited resources were only allocated to programs that met two other “E”s of **effective and efficient**.

Proposition 63s - Mental Health Service Act (MHSA) full service partnerships implementing the children’s and adults and older adults systems of care have succeeded in transforming care into recovery oriented client centered flexible service models that do offer **everything needed** for those that these programs serve.

While Proposition 63’s MHSA revenues have not grown to the levels that seemed possible in the first few years after passage and we thus have not made much progress toward serving everyone, the expanded entitlements, funding and insurance coverage from the Affordable Care Act will provide an obligation and a supplement starting in 2014 that requires and allows us to plan to **serve everyone**.

Proposition 63’s Prevention and Early Intervention Programs have provided essential funding and linkages to start the programs needed to **identify and serve people early in the onset** of their mental illness. However, it is clear that the state must exercise leadership to require public and private health plans to add early identification and co-located evaluation and initial treatment in primary care so that referrals come from there rather than the current situation of referrals coming from child welfare, special education, hospitals and the criminal justice system. The reorganization and merger of mental health, alcohol and drug, and physical health into a single department provides a structure that makes such leadership possible, but it will take more than simply putting the same old people into a new structure to make it happen. It will require creative, proactive outside the box strategic planning, leadership and partnerships to make it happen.

Similarly, a great failure of the Department of Mental Health in its implementation of Proposition 63 has been the lack of comparative outcome and expenditure reports so that we have no idea where we have the most **effective or efficient programs** or why. These actually existed before the act as the reporting was set forth and were being generated before the act for the programs funded by the children's and adults and older adults systems of care. The new structure gives us a new chance to get this right. We need to provide adequate resources and clear responsibilities for the Department of Health Care Services, the Mental Health Services Oversight and Accountability Commission and counties and this legislation and budget process is the perfect time to get it right.

If we get it right it will enable us to accomplish the "**3 Es**". It will also help balance the budget by reducing the caseloads of prisons, hospitals, child welfare, and special education which are all significantly inflated due to our failure over decades to provide timely and appropriate mental health and alcohol and drug services.

Put together this restates the vision that we had when we wrote the act. The mental health community met together with Senate Pro Tem and co-author Darrell Steinberg last fall and re-affirmed this vision. Now what is needed is for the legislature and the administration to work together with stakeholders over the next few months to put together the budget and statutory framework within which to accomplish it.

### *Questions for Counties, Providers and Consumers*

#### *Current and Budget Year*

*(26) What are your primary concerns with the Administration's proposals to reorganize mental health and substance use disorder programs?*

#### **Three key issues:**

1. **Oversight and accountability** – Spring 2011 AB 100 report from Mental Health Services Oversight and Accountability Commission (OAC) and stakeholders workgroup identified key actions required that have not been addressed:
  - a. **Accountability and Quality Improvement** -Develop system to collect and report comparative results among providers and counties to identify best practices – both in MediCal and in Prop 63 (mental health services act) – nothing has been presented but OAC Evaluation Committee is working on it
  - b. **Oversight and Enforcement** – The AB 100 work group recommended using the county performance contract to ensure that all proposed expenditures and activities were consistent with state laws. The restructuring proposal does not acknowledge that and says it is unenforceable - Enforcement can be accomplished by clarifying oversight and accountability commission findings on plan consistency create a rebuttable presumption similar to housing plan law. Moreover, a series of actions that DHCS could take when funds are misspent could be established in statute similar to the state authority over MediCal funds.

- c. **OAC Statewide Funds and PEI Guidance Authority** -The proposal to have county plans go to the OAC for review is a good first step. What is also needed is clear authority for the OAC to require counties to ensure that Prevention and Early Intervention Funds are spent in accordance with state rules and to be able to require that counties dedicate funds for statewide prevention and early intervention projects.
  - d. **Reporting on systems of care-** The administration's proposal to have funds for Children's and Adults and Older Adults system of care funds (so called Community Services and Supports) be allocated without additional guidance from the state seems reasonable given the detailed requirements of those statutes so long as there is a means to enforce the requirements for outcomes reporting that has not been implemented by DMH up until now.
2. **Make mental health and alcohol and drug true "equity" partners with physical health** – The integration has many promising concepts but none have been put in place except as they relate to the proposed Dual eligible integration plans – which were largely developed by outside consultants. Several actions seem necessary:
- a. **High level leadership** is intended but does not yet exist. The hiring challenge seems significant since the position has been open for many months. Raising the status to chief deputy would help.
  - b. **Put mental health and alcohol and drug in the title of the department. It is not right to have no state department with mental health or alcohol and drug in the title.** While the leadership of DHCS makes statements about term "health" including mental health and alcohol and drug they have always been viewed as lesser element of healthcare rather than equal voices in decisions.
  - c. Amend statutes to specifically **require that all departmental policies include equal consideration of the needs to address mental health and alcohol and drug needs.** The administration seems open to this but it may require considerable work to identify all of the relevant sections of law.
  - d. **Require full coverage and appropriate bi-directional integration – Numerous studies have shown that efforts to screen, identify, evaluate and provide initial treatment for mental health and substance use disorders co-located in primary care and maternity and perinatal care pay for themselves in reduced physical health hospitalizations.** This should become the policy of the state and efforts to implement this should be built into all MediCal managed care strategies. This may also require statutory action and should also be **extended to commercial plans** which allow people with potentially severe mental illnesses to be ignored until they reach a crisis. Similarly co-located physical health care is needed for people with severe mental illnesses will similar cost savings projections. The Section 1115 Waiver requirements to shift people with disabilities into MediCal Managed Care speaks to medical homes but much more work needs to be done.
3. **Licensing and Certification** – The administration's proposal to consolidate licensing and certification of psychiatric rehabilitation centers in the department of social services provides an opportunity to re-examine all of the problems of licensing in that department that have affected social rehabilitation centers for adults and residential placement in high level group homes for children with serious emotional disorders. **Positive discussions with administration officials** offer hope that this can be resolved along the following lines:

- a. The licensing and certification of substance abuse and mental health treatment facilities need to be under the **same authority** and should not be split between separate state departments.
- b. A **distinct unit** should be established to perform these licensing and certification functions.
- c. This unit should be comprised of staff who previously conducted these functions at the Departments of Alcohol and Drug Programs and Mental Health and/or who have **experience working in community substance abuse and mental health treatment**.
- d. Staff should adhere to wellness and recovery principles and be **allowed to modify or waive rules** when appropriate to support the people being served.
- e. The unit should have an **advisory committee** comprised of clients, family members, providers and county officials.
- f. Nationally **accredited facilities should be exempt from most licensing requirements** that duplicate the national standards.
- g. For facilities funded by counties there should be **an option for counties** to incorporate the necessary findings into their contract oversight and not require additional state reviews.

*(27) What, if any, information about the proposed reorganization have you been waiting for from the Administration in order to evaluate its effects on the group(s) that you represent?*

1. An **overall plan** to show that we will meet all needs and move the system from fail first to help first through prevention and early intervention is needed. The 1115 Waiver requires a plan to meet these needs to be completed by November. In addition counties will have to prepare **new integrated mental Health services Act plans in 2013 and will need guidance from the state**. Completion of these plans and having appropriate statutory clarification of the roles of DHCS, the oversight commission counties and stakeholders is needed during 2012.
2. Besides the key concerns listed above we also need clarifications on **how to provide funds to counties under the Mental health Services Act**. Either there will be a state agency with authority to set the formulas or the formulas need to be in statute. Either way there has to be a way to account for all funds including **funds that have been set aside for specific purposes such as the statewide programs for underserved communities that has not yet been started**.

*(28) What have you learned from the ongoing efforts to transfer Medi-Cal related mental health and Drug Medi-Cal functions that can inform what the Administration is proposing to do to further change how mental health and substance use disorder services are administered?*

It makes sense to have everything in one place. If MediCal mental health is going to be at DHCS then the rest should be there too but so far what we have mostly seen is just the efforts to move staff and functions and do not yet see any **meaningful attention to the major policy issues**. That is a concern that will affect the rest of the transfer unless DHCS quickly gets several knowledgeable high level new hires or get outside help. In either case we need a **policy oriented plan**.

Moving the office of **Multicultural services** to the Department of Public Health could also be problematic without clear connectivity and requirements that the impact on persons of underserved communities be considered in all policy decisions of DHCS. Moreover, mental illnesses are not recognized as medical problems in most Hispanic and Asian cultures so there is a need to keep the specific mental health multicultural unit intact. There needs to be a plan and detailed statutory clarification to make that happen.

*(29) What are your main questions or concerns for the July 1, 2012 transfer that the Legislature and Administration should be made aware of at this time?*

The biggest issue is the realignment of EPSDT and MediCal managed care and the funding formulas for initial funding and growth. Mental Health needs to have its own dedicated funds and assured fair share of growth that cannot be transferred to other purposes in order to properly integrate planning and funding with Proposition 63 funds.

*(30) Do you think the proposed reorganization will make it easier for you to work with the state?*

If all of the concerns we have stated can be addressed we see the potential for this to improve our ability to work with the state but at the moment there are too many issues for which there is no clear responsibility or clarity and that for the time being has made things much worse.

*(31) What program regulations, practices and policies would you like to see changed if DMH and DADP are merged with DHCS?*

Most important is to focus on **prevention and early intervention** opportunities through primary care to **end the fail first system** we have always had.

*(32) What state-level organization of these programs and services would be best for consumers?*

One of the things that the old department of mental health did well was to involve consumers and family members in its decision making. That is still important and requires that:

1. Consumers **views are factored into all decisions**; including those of **underserved communities**
2. there are clear **reports** that enable consumers to see what and where the best performing programs are to enable them to advocate for that elsewhere and
3. to ensure that there are effective **means of redress** for any concerns about counties not following the law or providing medically necessary services.

*If this involves a transfer, what transfer process and timeline would you recommend*

The **AB 100 workgroup** from last spring provided a template for most of the issues. We are frustrated that there has been so little that the administration has been able to implement and we see **the need to increase resources and clarify roles** so that all of this can be completed in 2012 and counties can have all off 2013 to plan for the major changes of federal healthcare reform that will begin on January 1 2014.