State Administration of Community Mental Health

California Mental Health Directors Association (CMHDA) Recommendations

September 7, 2011

Introduction

The administration of community mental health programs in California is undergoing significant change. The 2011-12 state budget and associated trailer bills authorized the transfer of all Medi-Cal functions to the California Department of Health Care Services, realigned Medi-Cal Specialty Mental Health from the state to counties, and significantly changed the state's responsibilities for administering the Mental Health Services Act (MHSA). Additionally, the Governor has proposed to eliminate the California Department of Mental Health (DMH) and Department of Alcohol and Drug Programs (DADP), and create a new Department of State Hospitals. In light of these momentous shifts in the state's role in community mental health, DMH is soliciting input from community mental health stakeholders about the future of state administration for non-Medi-Cal programs and services.

This paper provides recommendations about the state administration of non-Medi-Cal community mental health from the perspective of county mental health departments, as represented by the California Mental Health Directors Association (CMHDA). The paper provides CMHDA's recommendations in two central ways: 1) Identifies the state entities that might be best positioned to perform specific DMH functions, should DMH be eliminated as the Governor proposed, and 2) Identifies opportunities for improvement in the future administration of each function.

Oversight of County Mental Health

State Entity Roles

CMHDA agrees with the sentiment in Governor Brown's January 2011-12 state budget, indicating that his Administration wants to allow "governments at all levels to focus on becoming more efficient and effective, facilitating services to be delivered to the public for less money." Additionally, we agree that duplication and overhead costs should be reduced and minimized. To that end, we believe the appropriate state-level administrative body for non-Medi-Cal community mental health services would be the **Department of Health Care Services (DHCS)**, which is already taking on the administration of Medi-Cal Specialty Mental Health. We

believe it would be most efficient for one state department to provide oversight and technical assistance to county mental health agencies, as well as focus on policy leadership and performance outcomes across various community mental health programs. Additionally, given the major shifts in our nation's health care policies, we believe an integrated focus on mental health, substance use, and physical health is more feasible if the various government healthcare programs are administered by one state entity.

We are pleased that DHCS has already made clear a commitment to creating high-level leadership positions for community mental health and substance use disorder programs in the area of Medi-Cal administration. However, within the large, health and Medi-Cal focused structure of DHCS, it will be vital to ensure an ongoing commitment to California's community mental health system. Adequate, high-level leadership within DHCS would be charged with promoting mental health, wellness, resiliency and recovery in California's diverse communities.

Opportunities for Improvement

- Streamline Compliance and Auditing: The compliance and auditing activities the state and counties conduct for community mental health should not be duplicative and needlessly time-intensive across programs. Compliance and reporting requirements should be no more burdensome than existing federal and state laws, and should provide valuable information to decision-makers and the public about the community mental health system's performance in assisting consumers with recovery and wellness. Reducing counties' required administrative activities would help counties maximize available resources to provide direct consumer services.

- Focus on Performance Outcomes: A vital function seriously lacking in the current state-level administration of community mental health is performance outcomes monitoring. We would strongly support a state-level administrative body that:

    - Develops the annual state-county performance contract, which outlines the statutory and regulatory responsibilities of counties in their role as contractors for the state;
    - Establishes, collects, analyzes and publishes performance measures and quality indicators for all community mental health programs and funding streams. This can be done directly or with research entities by contract;
    - Supports counties in their efforts to collect and analyze data by providing support to those that might need assistance in conducting more rigorous data collection and evaluation;
    - Facilitates county quality improvement efforts and ensures that the technology at the state level is able to accept and meaningfully use the information it receives from counties;

- Develops necessary state regulations for community mental health (including MHSA) services, while promoting the integration of overlapping federal, state and local requirements; and
- Provides support to each county to promote its success in implementing a recovery-focused community mental health system, and achieving positive outcomes for consumers.

- Focus on the Existing Performance Contract: While program administration and delivery of services is the responsibility of counties, it remains the responsibility of the state to ensure that counties administer the programs and delivery of services in accordance with applicable state and federal laws. An annual performance contract is required by statute. Through execution of this contract, the state authorizes county expenditure of funds. As stated later in this document, we believe language should be incorporated into the county performance contract that requires compliance with the existing statute for county submission of the MHSA Three-Year Plan and annual update.

  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.

- Better Utilize Existing Oversight Bodies: Existing policy and oversight bodies need not be re-invented. There are already existing policy and oversight bodies specified in statute -- the California Mental Health Planning Council and MHSOAC -- that include stakeholders and advocates who play a role in informing the state on their perspectives regarding the important policy issues impacting the community mental health system.
  These two bodies help ensure adequate, high-level leadership within state government that help promote mental health, wellness, resiliency and recovery in California's diverse communities.

  There are also statutorily-required local public input structures and processes in existence today, such as the Local Mental Health Boards and Commissions and the MHSA local planning process, which assure the participation of community members in the design and implementation of the community mental health system in each county. These statutorily required structures act in an advisory capacity to county government and the county Boards of Supervisors. In the future, we believe an assessment of the functions of the Mental Health Planning Council and MHSOAC could be conducted to identify areas of potential consolidation.

Multicultural Programs and Cultural Competency

State Entity Roles

CMHDA strongly supports the state's ongoing commitment to ensuring cultural competence and reducing disparities remain a strong focus in the new organizational structure of state administration of health care and community mental health. We believe **DHCS** could play this role and is committed to these goals, as evidenced by the contents of its draft transition plan for Medi-Cal Specialty Mental Health. For example, the transition plan already identifies that one of DHCS' planned activities is to identify DMH's current requirements and processes and develop policies and a plan to assure Mental Health Plan (MHP) accountability for cultural competence. We would suggest that DHCS work with counties and other appropriate stakeholders, including the MHSOAC, in this process.

Support for Mental Health Consumers and Their Families

State Entity Roles

CMHDA strongly supports the state's ongoing commitment to ensuring that support for mental health consumers and their families remains a strong focus in the new organizational structure of state administration of community mental health. We believe **DHCS** could play this role and is committed to this, as evidenced by the contents of its draft transition plan for Medi-Cal Specialty Mental Health. For example, the transition plan identifies a commitment to providing opportunities for meaningful input from consumers and family members, and identifies a number of new efficiencies/improvements that includes expanding peer support, reducing discrimination and stigma, and ensuring equal access to services.

Mental Health Services Act (MHSA) Administration

State Entity Roles

- Allocation of MHSA Funds: CMHDA supports the state maintaining the approach codified by AB 100 (Committee on Budget, Statutes of 2011), which requires the State Controller to distribute MHSA funds to counties on a monthly basis, based on a formula determined by "the state" in consultation with CMHDA. CMHDA recommends that "the state," for these purposes, should be the **Department of Finance** and the **State Controllers Office**. CMHDA has consistently supported the continuous distribution of MHSA funds to communities where they can be quickly utilized for direct consumer services. Additionally, this makes the distribution of MHSA funds comparable to the distribution of existing sales tax and vehicle license fees under 1991 Realignment.

- Mental Health Program Evaluation: We believe that the current "siloed" approach to community mental health evaluation has not served the legislature or the public well. It has provided little information regarding the results of expenditures for services and has created

a vacuum to be filled by opinion and anecdote. To be effective the evaluation efforts currently conducted by the Planning Council, the MHSOAC and the department need to be integrated and the results reported from a consumer, system and community perspective. While DMH may currently play a role in receiving data from counties, the department has historically been unable to conduct evaluation of counties' programs. The MHSOAC in collaboration with the Planning Council and DHCS are all uniquely positioned to focus their efforts on conducting adequate research and evaluation of community mental health programs in California.

- Statewide Prevention & Early Intervention (PEI) Projects: We believe the **California Mental Health Services Authority (CalMHSA)** is best positioned to administer the MHSA-PEI statewide projects (i.e., Reducing Disparities, Suicide Prevention, Student Mental Health, Stigma & Discrimination Reduction). This organization is already successfully administering nearly $130 million in counties' pooled MHSA funds in this area. We would recommend that CalMHSA ensure that it allows for administrative flexibility to small counties with unique needs and approaches to PEI statewide projects.

- Statewide and Regional Workforce, Education, & Training (WET) Projects: We believe **CalMHSA** is best positioned to administer WET statewide and regional projects. However, we would recommend that CalMHSA ensure that it allows for administrative flexibility to small counties with unique needs and approaches to WET. CalMHSA in conjunction with the Mental Health Planning Council would also need to begin development of a new 5-year statewide WET plan. Appropriate stakeholders should be reconvened to evaluate the first WET plan, and begin development of the new plan.

Opportunities for Improvement

In order to promote the efficient and cost-effective implementation of the voter-approved initiative, CMHDA recommends the state follow the clear language of the statute to maintain the intent of the voters and to reduce unnecessary regulatory and administrative burdens. Specific opportunities for improvement and efficiency in the administration of MHSA include:

- Maintain Prudent Reserve and PEI Policies: The existing MHSA prudent reserve policy should be maintained, which requires counties to deposit and withdraw MHSA funds from their prudent reserves [consistent with WIC 5847(a)7 and WIC 5892(b)]; additional state guidance is unnecessary. Similarly, existing PEI program requirements should be maintained based on WIC 5840; additional state guidance is unnecessary.

- Streamline Innovation Component: Consistent with WIC 5830, we recommend that counties expend 5% of their CSS System of Care (80%) and PEI (20%) funds on Innovation, rather than treat Innovation as a separate state MHSA set aside and allocation. Counties will develop Innovation programs as a part of the 3-year plan and update process and will expend the

Innovation funds consistent with the provisions of the MHSA; additional state guidance in unnecessary.

- Proposed Regulations: Consistent with AB 100, reevaluate and consider withdrawing currently proposed regulations for the following components of MHSA: Innovation; PEI; Capital Facilities; and IT.

- Performance Contracts and Plan Development: Incorporate language into the county performance contracts that requires compliance with the existing statute for county development of the MHSA Three-Year Plan and annual update.

- Remove Barriers to MHSA Housing: First, provide an option for counties to continue to utilize the current DMH/CalHFA program for their assigned Housing Program funding, or to withdraw their unused but assigned funds for use by the county for housing consistent with the MHSA. Additionally, consistent with the recommendations outlined in the recently released Senate Office of Oversight and Outcomes report on the CalHFA MHSA Housing program provide flexibility for small counties (population under 200,000). Second, remove the current state-imposed cap on housing operating subsidies and allow counties to determine the amount of their Housing Program funds dedicated to operating subsidies and capital costs. This recommendation may require amendments to current statutes.

Co-Occurring Disorders

State Entity Roles

As stated earlier in this document, we believe that having **DHCS** administer both mental health and substance use programs will provide an integrated focus on mental health, substance use, and physical health. Given the broad overlap among populations of individuals in need of mental health care, substance use disorder treatment, and primary health care, we think it makes sense that the variety of government programs in these arenas be administered by one state agency.

Licensing and Certification

State Entity Roles

We believe **DHCS** is the appropriate state entity to oversee and perform the function of licensing and certification of community based mental health treatment settings and specialty mental health providers.

Opportunities for Improvement

We recommend that DHCS license and certify or oversee the county mental health plans' certification of all types of facilities and specialty mental health providers serving individuals with mental health and substance use disorders -- including those currently licensed by

Department of Social Services (DSS) or Department of Public Health (DPH). We believe it would be beneficial to the care provided to consumers in these facilities if all of them were licensed, certified, reviewed, and inspected by one state department whose staff possesses behavioral health and recovery model expertise. Additionally, DHCS should also collect, maintain, and analyze data on the facilities, their programs, and consumer outcomes.

Currently, DMH or the county mental health plan licenses/certifies nearly all community treatment facilities serving mental health consumers. However, Adult Residential Facilities and Community Treatment Facilities are licensed by DSS-Community Care Licensing (CCL), and Skilled Nursing Facilities (SNFs) are licensed and monitored by the Department of Public Health (DPH). As currently structured, there is a direct conflict between the rehabilitation and recovery orientation of DMH licensing and certification, and the custodial or institutional focus of DSS-CCL. This serves as a barrier to the development of strong mental health residential resources, and jeopardizes our ability to meet Olmstead requirements.

SAMHSA & PATH Grant Administration

State Entity Roles

We believe **CalMHSA** could appropriately administer the SAMHSA and the PATH grant programs. CalMHSA might consider contracting with the **California Institute for Mental Health (CiMH)** to perform some of these administrative functions. Additionally, CalMHSA should aggressively pursue new federal funding opportunities that would benefit California's community mental health consumers.

Inter-governmental Activities

State Entity Roles

We believe **DHCS** could play the role that DMH currently plays in serving on (and making appointments to) various state and national boards and commissions where mental health representation is necessary or desired. This role could be played by either the new DHCS Deputy Director for Behavioral Health, or new DHCS Chief for Specialty Mental Health.

We also believe the new DHCS Deputy Director for Behavioral Health and/or new DHCS Chief for Specialty Mental Health should be active on SAMHSA task forces and committees and with the National Association of State Mental Health Program Directors.

Finally, the new DHCS Deputy Director for Behavioral Health and/or new DHCS Chief for Specialty Mental Health could play the role DMH currently plays in coordinating with other state agencies and departments on crossover issues that significantly affect mental health consumers (e.g., Department of Corrections and Rehabilitation, Department of Veterans Affairs, Department of Education-Special Education Division, Department of Social Services-CalWORKs and Child Welfare Administration).

Veterans Mental Health

State Entity Roles

As stated earlier in this document, we believe the new **DHCS** Deputy Director for Behavioral Health and/or new DHCS Chief for Specialty Mental Health can play the role DMH currently plays in coordinating with other state agencies and departments on crossover issues that significantly affect mental health consumers. An extremely important area for intergovernmental coordination would be on veterans' mental health. As you know, significant numbers of California's veterans have health and mental health care needs that may not be adequately addressed by federal programs. As a result, it is critical that the state administrative body for mental health possess knowledge about and a commitment to addressing the unmet mental health needs of California's veterans.

Lanterman-Petris-Short (LPS) Act Administration

State Entity Roles

We believe **DHCS** can play the role DMH currently plays in implementation of the Lanterman-Petris-Short (LPS) Act (WIC 5000-5587). Given the complexities of LPS, we encourage DHCS to work with counties and other appropriate stakeholders as it takes on this role.