MENTAL HEALTH SERVICES ACT LONG RANGE PLAN

A ROAD MAP FROM FAIL FIRST TO HELP FIRST

Background and Context

In the transformation of mental health services in California from our current fail-first system to our desired help-first system, the first long range plan must present a vision of what that help-first system could look like in the future and then delineate steps that can be taken to gradually make the transformation.

A vision of what that care looks like and a set of realistic steps that shows how we can make that transformation is necessary to guide current and future decisions so that they are all heading in the right direction. It is equally important to show that this is a realistic vision even with the skepticism that we can transform our attitude because of limited funds. The future vision requires an attitude that we will have sufficient resources to meet everyone's needs if we invest in the right strategies.

Proposition 63 was written primarily for the specific purpose of making two transformation from fail-first to help-first and from inefficiently serving a few to efficiently serving everyone.

1. Fail First to Help First – Developing Prevention & Early Intervention Programs

The fundamental purpose of including prevention and early intervention programs in a ballot proposition that primarily focuses on severe mental illness, is to prevent people from having to hit rock bottom or "fail first" before those with severe mental illnesses (which includes serious emotional disturbances of children as defined in Proposition 63) can get the help that they need.

a) Current Programs That We Know Work

The children's and adults' systems of care which form the basis for what has become community services and supports are existing programs adopted by legislation and tested through pilot programs that have become statewide. The prevention and early intervention component of the Mental Health Services Act requires the establishment of a new program for which there is no existing legislative framework. The MHSA does reference two types of programs that have proven to be successful in small programs outside of California's public mental health system. These approaches are required to be included in the

program being developed. One of these approaches is an early intervention program which has been successful in reducing the duration of untreated severe mental illness and succeeded in achieving much more complete and rapid recovery. The other approach addresses mental illness before it becomes severe and reduces the likelihood that the conditions will become severe and disabling.

b) Early Psychosis Programs- Reducing Duration of Untreated Severe Mental Illness

The first of these types of programs referenced in the Act are those which are successful in reducing the duration of untreated severe mental illness. The model for these programs, the Early Psychosis Prevention and Intervention Center (EPPIC), was begun in Australia in the mid 90's. It was the so-called EPPIC program in Melbourne, Australia. It was the first program in an evolving field of very early identification and treatment of psychosis. Information about numerous programs can be obtained from the International Early Psychosis Association at www.iepa.org. The programs were began after research indicated that if people with early signs of psychosis got treatment within the first few months of onset of the primary active symptoms of psychosis, they did not experience anywhere near the levels of disability that are typically seen with the disease. In addition, they were able to quickly respond to treatment. The program reported that 80% of its enrollees were back to fulltime work or educational pursuit within a year without seemingly having lost much progress.

Another researched program is the Early Treatment and Identification of Psychosis (TIPS) program in Norway, which is led by a Yale University psychiatric researcher, Tom McGlashan. In Norway, the programs to detect psychosis/ early in its onset was conducted in one city while results were compared with another city of similar demographics and population where the program was not conducted. The early results showed that psychosis was detected within the first few months in the pilot community, and it took several years on average (similar to what happens in the United States) when those strategies were not conducted.

These programs, initially begun as academic pilots in many Western European nations, Australia and Canada, provide the best evidence on how to do a coordinated strategy to detect and treat early in their onset mental illnesses that are potentially severe and disabling.

c) Six Elements Needed for Success

These programs affirm that the key to success is to have six program elements all in place at the same time in the same community. The six elements are:

1. Have people in position (a) to recognize the symptoms of severe mental illness, (b) who have the knowledge to know what symptoms to look for and (c) who have the ability to recognize the symptoms. OR People with the knowledge to know what symptoms to look for and the ability to recognize them.

2. They need to know <u>who to communicate that information to</u> for action to take place.

3. They must have the <u>motivation</u> and desire to take action. Sometimes this means elimination of stigma or denial of a mental illness. Sometimes it may be an incentive for employees of health plans, schools or others to take action.

4. When action is sought, <u>the needed care must be available</u> - meaning that there <u>has to be adequate funding</u> (either public or private) and capacity in the programs.

5. The programs have to offer in a timely manner and welcoming place, care that is best suited to the specific target population.

1. Finally, that care must be readily accessible so it is easy for the people needing care to get the care and there are no geographic, attitudinal or bureaucratic barriers or other hoops they have to be jump through making it unlikely that people will actually get the care even if it is theoretically available.

If any one of those six pieces is missing nothing will happen.

<u>We must</u> determine the techniques needed to most successfully implement each program element - what has been tried and worked, what has been tried and hasn't worked and how to <u>determine</u> which strategies will be the most cost-effective for different populations within California. We must learn how to translate these findings not just to different populations based on age and culture, but also for other diseases where the symptoms are not as obvious as psychotic disorders.

One reason there has been little research on these issues, with the exception of a few very small academic programs, in the United States, is that when this type of research is completed, it can increase the demand for services and unless there is the potential to significantly increase funding and the capacity of care, there can be no assurance that the care will be available. Another reason is that public policy currently focuses on treating the disability resulting from untreated mental illness instead of on the prevention of the disabling conditions through early, effective treatment.

Only the passage of the Mental Health Services Act gives California the opportunity to create these programs. They must be created in the implementation period. If we wait too many years then even the added capacity of the Mental Health Services Act creates will get absorbed for other purposes and the current opportunities to create these programs will be lost.

It is critical that as we develop prevention and early intervention programs that the "non-service related" education and outreach (primary prevention) be integrated wit h early intervention (secondary prevention) efforts and the community services supports program to provide the needed range of services for people whose sever mental illness is detected early in its onset. Care for this population must be separate from the care provided to people who have failed first and are entering the system in a more disabled state and several years older.

By means of comparison, in 2001, the average age of people entering the AB 34 programs in California was 28, whereas the age of people entering EPPIC program in Australia was 22.

d) Care Designed for the Specific Population

Studies of the Australia EPPIC program pointed out that a critical component to its success is to isolate these young people in a program just for them in which most are able to regain full academic or employment productivity within a year. These programs are separate from the programs that treat people with schizophrenia or other mental illnesses who are older and more disabled and for whom the likelihood of "graduating from the program within a short period of time" is significantly less.

The outreach programs were developed using focus groups of teenagers, families, and primary care physicians to find out what information had to be communicated and what forms and what ways would produce the desired response. Just as in writing Proposition 63, we sought focus groups of people outside of the mental health system to get a sense of how they would view the issue. The same thing must be done in the prevention and early intervention program. What we in the mental health community think will work may not be what should be funded, it's what the evidence-based research proves will work that needs to be funded.

e) Cost-Effective Strategies – Leveraging Private Insurers and Education Funding and   Supports

Equally important, is to make sure that we use cost-effective strategies. The early psychosis programs focus primarily on individuals who appear to be developing early signs of schizophrenia because worldwide it accounts for the majority of all public mental health system expenditures both in those countries

and in the United States. Schizophrenia is the cause of most hospitalizations and the most consistent cause of long term disability. The cost of the early intervention strategies in Norway (not counting treatment) was approximately $1 per capita per year. For these programs to be successful, the treatment costs must be borne by existing insurance programs, particularly private health insurance in the U.S. With mental health parity, treatment for major mental illnesses is a covered benefit in health plans. It is critical in developing these programs that we work with private health plans to make sure that they will have the appropriate care in place when the need is identified among their enrollees.

In addition both health plans and schools have many support services for enrollees and students through primary care offices, school health centers and other student supports. MHSA funds can be used as leverage to incentivize comprehensive supportive care from health plans and schools utilizing existing funding and services which can be restructured to support our MHSA prevention and early intervention objectives.

We must educate the stakeholders about these types of programs, bringing in experts who can show us the models for success. Building on that, the program development process must include significant participation from the necessary partners for success: education, primary care, various forms of media, teenagers and people in their early 20's.

f) Early Mental Health Initiative

The other program that reported success was the Early Mental Health Initiative (EMHI) or Primary Intervention Program (PIP) which is provided in California elementary schools for children between the ages of 5 and 8 – kindergarten through third grade. It was reported that the cost for each case in providing services in this program was about $600. It was also reported that the public mental health system rarely sees these children again so that they do not become disabled and do not wind up in special education or child welfare or the juvenile justice system, which are the normal entry points into the community service and supports public mental health system.

We need to study these programs to determine the methodologies utilized by schools to identify the children needing this care, what is the type of care provided that works and how do we monitor these children after the care to make sure that they continue to succeed and to not have relapses.

A key component is the accessibility of on campus care. Numerous studies have pointed out that the majority of children who receive mental health care receive it at school. In designing prevention and early intervention programs for school-age children, we either need to make sure that these programs (many of which will involve services funded through private health insurance) are available on campus or need to develop ways of overcoming the barriers that prevent children

from accessing mental health care when it is not available on their school campuses.

In both of these programs the key to success is ensuring that people not in the mental health system, who are in a position to take the initial action have the knowledge, motivation and access to needed care. The mental health community's responsibility is to make sure that the care that is offered is the right care for early onset.

As with the early psychosis programs MHSA funds must be used to incentivize school districts and health plans to combine MHSA funds with other funded programs or plan benefits to broaden participation, reduce access barriers and put in place comprehensive systems to consistently detect and treat conditions early in their onset.

g) Proposition 10 – Programs for Ages 0- 5

While not spelled out in the act other programs that appear successful include efforts to identify and treat mental disorders for infants and preschool children. One example has been the grant provided from the state, Proposition 10 or First Five Commission, to the Department of Mental Health with pilot programs in Los Angeles, Sacramento and other counties to identify mental health problems of very young children (0-3) early in their onset and provide appropriate treatment.

An unpublished study looking at 600 children in California's public mental health system, showed that on average these children began getting help in the public mental health system at age 11. Interviews with their parents showed that at age 3 they first sensed that something was wrong and at age 6 they first began seeking help but did not seek mental health care because they did not know that was the problem or stigma and denial caused them to hope it was something else. A Prop. 10 program involving several providers in a few counties led by the State Department of Mental shows success in identifying mental illnesses for children between the ages of 0 and 3 and getting them treatment. These programs can be expanded in partnership between Proposition 10 funding and Mental Health Services Act funding combining with public and private insurance.

Research published by Webster-Stratton has demonstrated through evidence-based models such as The Incredible Years, that conduct disorders can be identified early on in preschoolers, and successfully treated. The work of Offord et al. on oppositional defiant disorders (ODD) and conduct disorders in very young children reflect that 7-25% of very young children meet diagnostic criteria for ODD, exhibiting early behavioral problems which place them at risk for future school failure and/or involvement in the juvenile justice system.

The Lerner et al journal article titled Pr*eschool Behaviors Can Predict Future Psychiatric Disorders* determined that those children who scored highest for behavioral problems proved to have the highest need for future psychiatric evaluation or treatment and that aggressive children, withdrawn children, hyperactive-distractible children, and those with speech and language problems are at risk for developing future psychiatric disorders.

Several California community mental health service providers are implementing programs to serve these children in evidence based models including River Oak Center for Children, Los Angles Child Guidance Clinic and Foothill Family Service.

Children when parents are being seen in the mental health system of care and very young children in the foster care system should be top priorities for early intervention screening. Thirty-three percent of California's foster care population is 5 or younger. Linked to this initiative should be mental health professionals trained via the State Department of Mental Health's ICARE project. ICARE has produced a cadre of mental health professionals in community-based agencies with considerable expertise in the "0-3" population. Local departments of mental health and child welfare should work in concert to link these trained professionals to IDEA Part C agencies to serve the very vulnerable population of maltreated children.

Efforts to re-unify removed children should take place within supportive models which help parents manage their children's emotional/behavioral problems or remediate developmental delay(s). Relational, home-based services are especially critical to successful reunification, in essence, a wraparound-style program for very young children and their families.

SAMSHA's System of Care document on *Promising Practices in Early Childhood Mental Health* (2002 Series) includes of model programs along with principles which guide the development of early childhood mental health programs. There are other studies and compendiums which address the importance and effectiveness of early interventions directed toward children 5 and younger which should be considered.

h) Reducing the Incidence of Mental Illnesses

Reports show that the incidence of depression in the United States is double or triple that of most other nations. Clearly this cannot be explained by demographics but can only be due to environmental factors such as violence, substance abuse, competitive pressures and other stressful or disheartening aspects of our society that are not as prevalent in other nations.

If we could change some of these factors we would reduce the incidence of depression and also anxiety and other mental illnesses that are not as likely to involve a hereditary biological condition that must be treated and cannot be prevented. While not as consistently severe, these forms of mental illness still have the potential to become life threatening or disabling and so preventing them from occurring in the first place does achieve the objectives of the Prevention and Early Intervention Program.

Reducing the incidence of mental illness goes even a step beyond early intervention and prevention of disability and is not included directly within the proposed Prevention and Early Intervention Program requirements of the MHSA. However, to the extent that they represent cost effective approaches to reduce the burden of life threatening and disabling mental illnesses they are eligible for consideration.

As with any other strategy each proposed program must be evaluated to determine its impact in terms of saving lives and reducing community services and supports caseloads and costs. These strategies are going to have additional social benefits so even more than for other program elements MHSA funds should be used to leverage actions by others. However, unlike the other type of prevention and early intervention approaches these strategies will not result in the need for mental health services so they will not require the simultaneous development of the six steps listed under the early psychosis programs (but equally applicable to the Early Mental Health Initiative and every other program to get mental illnesses recognized and treated early in their onset.)

i) Prevention & Early Intervention - The Fundamental Vision for the Future

If we look for enough into the future where we are not concerned with providing care to anyone who is currently in the public mental health system receiving care for a current severe mental illnesses, we can envision a system in which nearly all mental illnesses, including less obvious late onset mental illnesses in older adults, are detected early in their onset and appropriate care is usually provided at that time in the appropriate setting. That is the key objective of the prevention and early intervention program.

In this context, the long range planning for prevention and early intervention should not be limited to what can be accomplished within the 20% of Mental Health Services Act funds which are reserved for that program. It must be anticipated that through the success of prevention and early intervention programs, the availability of better community care for people who already have mental illnesses and the improvement of the effectiveness and efficiency of that care, that there will be substantial savings from both pre-existing funds and Mental Health Services Act funds expended on community services and supports. It is envisioned that eventually a far greater percentage of Mental Health Services Act funds will be expended on prevention and early intervention.

2. Adequacy of Resources

The Mental Health Services Act increases funding for the public mental health system from approximately $5 Billion to approximately $6 Billion, or about a 20% increase. On the surface, that would not seem adequate given the general perception that it is meeting the needs of about half of those whom it should be providing care for in the community services and supports program.

However, the current funding and new funding must be viewed in the context of how much of the current funding is actually providing direct community care that assists in recovery or stabilization. The amount of current funding for that type of care is probably somewhere between $1 Billion and $2 Billion. That means that the expansion from the Mental Health Services Act is between 50-100%. Moreover, when you factor in improvements in efficiency and federal matching funds for Medi-Cal recipients, the value of future dollars could be double or triple what we now have. This does not even count the expected savings that will be realized through the prevention and early intervention program, which is certain to slow growth in caseload demands as people get in and out of higher levels of care more quickly. Finally, MHSA revenues are expected to grow at a rate that exceeds growth in population and cost of living.

Appendix B includes charts show how MHSA $$ will grow relative to other funds and how this becomes a doubling or tripling of funds for community services and supports.

These charts one based upon very rough estimates of current and future revenues. They show how MHSA funds increase not just in total $$ but as a percentage of total funds and how the funds to offer community services and supports and prevention and early intervention will grow. The dollar figures are very rough numbers that are intended only to give a possible scenario and not as carefully constructed current revenue totals or future projections. However, they are sufficiently realistic to enable us to see how much more capable we will be of meeting all needs as this funding grows over the next decade.

3. Future Vision – Community Services and Supports

A major strength of the current public mental health system is the existence of programs which successfully treat serious emotional disturbances and severe mental illnesses in community programs that provide for recovery and resilience and enable children, adults and older adults to lead productive lives.

While the most commonly voiced concern has been the lack of adequate funding what we also lack at this time is a set of standardized care so that we can be sure everyone is using the most consistently effective and efficient ways of delivering that care to each population being served.

Presently, each county and each private provider in training its own staff relies on its own protocols and its own evaluation of effectiveness and efficiency. There appear to be wide variations without any meaningful comparisons of quality in resource usage.

If we can agree on a set of ways of evaluating care we should also be able to agree on more standardized approaches for each population and eventually more standardized care. As was remarked by Proposition 10 Commissioner and state legislative staff, Dr. Luis Vismara, a Cardiologist, "When I began practicing, we cardiologists did a hundred different things." "When I stopped practicing, we were only doing 5." What had happened in cardiology is what needs to happen in mental health. We should be able to determine the best models and structures of care and then only use those models and structures.

b) Community Services and Supports – Building Capacity

The community service and supports system that we currently have and the one envisioned for the future reflect such a significant shift that it is difficult to see how we get from here to there. What is needed is a way to measure gradual transformation and progress in community mental health systems. These questions apply to county systems (not individual outcomes) to identify markers that reassure access and quality of services. The questions would be annually answered to measure progress and to determine the extent to which more people are receiving more appropriate services. These questions and measures should be continually refined in consultation with consumers, family members, community advocacy groups, and community providers.

Following is a set of questions. Some of these are already included in the Community Services and Supports Planning Requirements and may be refined to enable easier comparisons among counties and over time).

SYSTEM CAPACITY

For each of the following services, please answer the following questions.

Does your county currently have...

Acute inpatient (or psychiatric health facility) beds for short-term voluntary hospitalizations?

If yes:

What is the total voluntary acute bed capacity currently available?

During the most recent complete fiscal year, what is the average daily census (% of beds occupied)?

During the most recent complete fiscal year, what is that average waiting period (days) before a voluntary bed is available?

Acute inpatient (or psychiatric health facility) beds for short –term involuntary hospitalization?

If yes:

What is the total involuntary acute bed capacity currently available?

During the most recent complete fiscal year, what is the average daily census (% of beds occupied)?

During the most recent complete fiscal year, what is the average waiting period (days) before an involuntary bed is available?

24-Hour Crisis Residential beds?

If yes:

What is the total crisis residential bed capacity currently available?

During the most recent complete fiscal year, what is the average daily census (% of beds occupied)?

During the most recent complete fiscal year, what is the average waiting period (days) before a crisis residential bed is available?

24-Hour mobile Crisis Unit?

If yes:

During the most recent complete fiscal year, how many calls did your 24-mobile crisis response unit make?

During the most recent complete fiscal year, what is the average response time (days/hours/minutes from the moment a call is received to the moment face-to-face contact is made with the consumer/caller?

During the most recent complete fiscal year, what is the average daily response rate (% of visits made out of all calls received)?

Children's Wraparound Services?

If yes:

What is the total current wraparound slot capacity?

During the most recent complete fiscal year, what is the average daily census (% of wraparound slots occupied)?

During the most recent complete fiscal year, what is the average waiting period (years) before a wraparound slot is available?

During the most recent complete fiscal year, what is the average daily number on your waiting list for a wraparound slot?

Transition Age Youth Programs?

If yes:

What is the total current specialized TAY slot capacity?

During the most recent complete fiscal year, what is the average daily census (% of TAY slots occupied)?

During the most recent complete fiscal year, what is the average waiting period (days) before a TAY slot is available?

During the most recent complete fiscal year, what is the average daily number on your waiting list for a TAY slot?

Older Adult Program?

If yes:

What is the total current specialized older adult slot openings?

What is the average % of slots occupied?

What is the average waiting period (day) before a slot is available?

Linkage services from IMDs to community-based services (e.g., peer bridger programs)?

If yes:

During the most recent complete fiscal year, what is the total number of consumers that entered your community-based services who came from an IMD?>

During the most recent complete fiscal year, what is the percentage of the above consumers that received linkage services?

Linkage services from jails and prisons to community-based services (e.g., jail outreach programs)?

If yes:

During the most recent complete fiscal year, what is the total number of consumers that entered your community-based services who came from a jail/prison?

During the most recent complete fiscal year, what is the percentage of the above consumers that received linkage services?

Community Care Facilities (Licensed Board and Care Facilities)?

If yes:

During the most recent fiscal year, what is the total number of consumers living in Board and Care facilities?

During the most recent complete fiscal year, what is the number of consumers who moved from a Board and Care facility to a more independent living situation?

During the most recent complete fiscal year, what is the number of consumers who moved from a Board and Care facility to a more restrictive living situation?

Institutions for Mental Disease/Skilled Nursing Facilities?

If yes:

During the most recent fiscal year, what is the total number of consumer living in IMD and Skilled Nursing facilities?

During the most recent complete fiscal year, what is the number of consumers who moved from an IMD or SNF to a more independent living situation?

During the most recent complete fiscal year, what is the number of consumers who moved from an IMD or SNF to a more restrictive living situation (State Hospital)?

Integrated Dual Diagnosis Treatment Programs?

If yes:

During the most recent fiscal year, what is the total number of consumers diagnosed with a co-occurring substance abuse disorder?

During the most recent complete fiscal year, what is the number of the above consumers who were served in an integrated dual diagnosis treatment program?

System Access

> <u>System features and access to appropriate services, such as:</u>

- Number of days a consumer is in institutional care prior to linkage with outpatient services
- Number of days between the time a person requests mental health services through county "access' and receives services of any nature;
- Average wait and length of list for child/youth to see psychiatrist for assessment/services;
- Average caseloads of Service Coordinators/Case Mangers in adult and children systems for largest percentage of consumers (consumers not in any type of intensive case management or integrated system), and those likely to have been identified by county in their estimate of "underserved/inappropriately served?" What are county practices/procedures for reviewing caseloads?—vary a great deal, e.g. some close a case if Service Coordinator gets a disconnected phone or no response over a three month period.
- Percentage and numbers of consumers being served in programs based on Recovery Model, and staffed by service team trained in Wellness, Recovery, Resilience approach;
- Accessible services within Recovery Model programs and percentage of consumers utilizing services;

b) Community Services and Supports – Integration of Funding Sources and Transitioning all services into the Systems of Care Models

In the future, the Mental Health Services Act will represent an ever increasing percentage of funds since it is a revenue source that is expected to grow faster than other revenue sources. A key early challenge is the integration of the funding provided by the Mental Health Services Act and the rest of the county public mental health system.

County three year plans will identify the steps being taken and those still needed to <u>transform all services into the system of care model for those who require that</u>

level of care (as is required by the MHSA). Specifically for adults, the MHSA states that county plans should plan for systems in which everyone will be receiving services in accordance with the adult system of care/AB 34 except for those people who don't need that level of care. Evidence based practices, potentially modeled after AB 34 programs must be developed for older adults. Counties must be planning for a future system in which this happens and planning with the expectation that eventually the resources will be adequate. They must also be looking at everyone currently being served and determine if each person is receiving the right level of care.

c) How Many People Need CSS Services That Are Not Currently Funded?

Each county plan should identify how many people require services within each level of a full service partnership (as set forth below) and how many are not receiving that needed level of service.

Those requiring full service partnership are generally those "in harm's way" and others identified through outreach that are at risk of those results unless they receive "whatever it takes" service partnerships. Two larger categories of people will be (1.) those unserved by county systems, whose only access to service has been in institutional settings, and (2.) those chronically underserved who could make significant gains in a recovery model of integrated, comprehensive services, and who could achieve social and financial independence, along with services through private or public, primary care health systems. These statistics can be identified by adding to those who are already receiving "whatever it takes" services, the number of people who are likely to need those services, who can be found among the following:

1. Other people in the system who are unstable require frequent hospitalizations or have had recent suicide attempts, arrests or other problems.

2. People with severe mental illnesses not in the system who have experienced a 5150, a suicide attempt, or an incarceration.

3. Children with serious emotional disturbances aging out of the foster care system.

4. Indigent children whose families do not qualify for Medi-Cal or AB 3632, or any other entitlement, but still have a mental health problem severe enough to require extensive community mental health services and meet the statutory "serious emotional disturbed" definition even though they have not qualified and would not qualify for the entitlements under child welfare or AB 3632.

5. Gaps in the care provided to children with entitlements (EPSDT or AB 3632 which will cover most of the care and in many cases all of the care required

for a full service partnership) where there are additional services not covered by those entitlements that are necessary in order to ensure that the children get whatever it takes services.

d) Different Levels of Full Service Partnerships and Follow Up Care

The analysis should categorize people according to levels of needed service within systems of care. In general everyone should meet one of the following categories:

- Hospital/IMD population - Severely disabled and unlikely to be responsive to any form of rehabilitative care and needing to be in a hospital or other 24 hour care facility.
- Full Service Partnership high need population – People who have become disabled as a result of a mental illness and need a significant array of "whatever it takes" services for at least a few months to achieve or regain full productivity or whatever level is possible given their condition and responsiveness to whatever has already been offered. A portion of this group is a population who can be served with a "Help First" approach once counties have established programs for that younger and less disabled population that must be treated separately from older more disabled adults. (See section on early identification of schizophrenia/bipolar disorder).
- Full Service Partnership medium need population-People who are at the initial stages of service and need an array of "whatever it takes" service to achieve or regain full productivity, but for whom the array of services needed may be less extensive.
- Full Service Partnership low need population – People who have been in full service partnership services for a considerable period of time and appear unlikely to make additional significant gains or to risk significant deterioration from continued high level care but who still need some level of significant services.
- Maintenance SED/SMI - people who have had full service partnerships and have achieved stability and independence in living skills and needs and also have achieved a level of productivity in school or work that is not likely to be improved by additional intensive services. They require regular support and monitoring that may include medication management and other support. Full service partnership case managers would continue to be responsible for ensuring the success of this population. They must remain eligible for reinstatement of higher services if there is a relapse as will undoubtedly happen with many.
- Not SMI/SED – This includes people who are receiving preventive or early intervention services and graduates from full service partnerships who are not presently needing any significant services

or frequent monitoring. Relapses are still possible with this population. If they had been in higher levels of care there must be continued contact to ensure there is no deterioration that might require more care.

This framework enables each county to develop an unmet needs analysis of both the numbers of people with needs and estimated costs of providing those services.

The estimated costs must reflect the time that people will remain in each of the higher levels of care. Performance evaluations will establish how long people should remain at the higher full service level, while maximum recovery oriented services are being provided; at what point people would appear to have reached a plateau where that level of investment is not necessary; and when people are sufficiently stable and not significantly requiring or likely to benefit from the level of enhanced services that a lower level of care is appropriate.

An even lower level of care will be provided for people who need only medication monitoring and peer support and graduates from the system living productively and independently, needing only an occasional check to make sure nothing has changed.

e) Documenting Progress through Each Three-Year Plan and Update

The initial planning and program development will be completed soon, but transformation to a time when everyone receives system of care services will depend upon available resources and the number of additional years will vary from county to county.

Progress can be measured against the number of additional slots in each type of program a county estimates it will need and the estimated average cost per person in each category or special population

In addition to identifying the unmet needs, each county plan will look at all of its services that need to be changed and how it will accomplish the restructuring of existing services that are not aligned with these models. In making this change, plans must be consistent with the fact that the MHSA only allows funding for children's and adults system of care services. No matter how valuable or necessary another service might seem by itself, it cannot be funded through the MHSA unless it is restructured to become part of the full service partnership system of care. Both the children's and adults' systems of care are built around full service partnerships which mean a partnership between the individual/family being served and the provider/county to give someone "whatever it takes". While there are many forms and levels of full service partnerships anything short of that will not be part of our future community services and supports and cannot be funded through MHSA funds.

For children currently receiving services under entitlements such as EPSDT or AB 3632 the plans should look at what those programs cover and what more is needed to approach the "whatever it takes" level. Planning should look at different populations of both those children and those not currently being served at all to identify priority populations.

For those not receiving any current services and not eligible for an entitlement to services from other funds the programs should look at the number of children to be served and a case rate for serving them in addition to identifying who are the priority populations and how they will be selected.

For all other age groups the plans must evaluate those currently receiving limited services that are not full service partnerships. Anyone not receiving any services will directly be enrolled in a full service partnership and is selected by being in a priority group based upon county planning priorities.

Each program should have an identified case rate as in the original AB 34 program funding so that it is clear that providers are responsible for a "whatever it takes" approach. The funds that currently provide limited services must be added to MHSA funds to develop the appropriate case rate and facilitate full service partnerships for those already in the system and to restructure current service programs so that they are provided in accordance with the system of care.

Plans should make it clear how "System Development" services complete the spectrum of offering full service partnerships (of many different levels in different settings including "bringing the care to where people are" for those being supported by families or with their own limited support). This requires a case rate cost analysis and how MHSA funds are combined with existing funds for a program. It also requires identifying populations that do not need that level of care, and how people can move to higher and lower levels of care as appropriate.

As we make this transition it would not be consistent with the long term vision of the MHSA for counties to use MHSA funds (or other funds) to close gaps of care under other models. The planning and spending plans each year should be directed to how many people can we move into a full service partnership. As required by the MHSA, funds must be dedicated to that purpose. During the transition period county plans will identify how other funds and programs are utilized.   It is expected that realignment and other funds will have savings through prevention and early intervention and more and better community care through growth of FSPs both which will reduce the need for hospitalizations. Given the recent reductions in realignment funding and its virtually non existent growth projections it may be several years before counties begin to realize such savings. However as they occur counties would be expected to direct such funds

to additional FSPs or FSP related services and the multi year plans would document how any such funds are being expended.

f) Varying Rates of Progress Among Counties

The MHSA indicates that after allocating the funds set aside for Prevention and Early Intervention, Innovations and State Administration all of the remaining funds are for expansion of Community Services and Supports. (This will be 70% starting in 2008-09, however, the Act does have provisions for transferring or utilizing Community Services and Supports funds for Local Planning, Prevention and Early Intervention, Capital Facilities and Technology, Education and Training and Reserves.)

The MHSA indicates that the allocation to counties is to be determined annually reflecting each county's need and capacity to provide services in accordance with the requirements of the Children's and Adults and Older Adults Systems of Care.

In the first few years it is expected that capacity will be the most limiting factor as it will take several years to develop the human resources changes through the education and training programs as well as the efficiency improvements expected through Capital Facilities and Technology and Prevention and Early Intervention.

Capacity will largely be determined by evaluating how a county had been able to utilize previous allocations. During these first few years there will be wide variance in how effectively counties are able to put new funds to appropriate use and the outcomes reports will reflect many different levels of costs and effectiveness of services.

Significant new funds should be withheld until a county program is demonstrating good cost effective results. This is necessary to ensure that funds only go toward the overall MHSA goals and that funds are spent effectively and efficiently. However, this will also be most seen as penalizing some who have the greatest needs including those with long term underserved populations which are listed as a special priority in making allocations. Accordingly the allocation process must reserve funds for those counties who do not currently have a record of success or capacity so that the funds will be there for them in future years meaning that their allocations will be delayed rather than denied. In addition some of the funds for such counties should be redirected to education and training to increase the knowledge and skill of the county and private contractor workforce to where it matches those of the counties which have demonstrated greater success as well as increasing the human resources capacity for all counties.

4. Innovative Services

It is far too early to determine how innovative service funds should be expended. However, the recommended design of this program should be to ensure that investments are all meaningful. Each program should be of sufficient duration and size (often requiring collaboration between counties and committing funds over several years) to provide meaningful evaluations of their value.

There should not be too many programs that are the same, but a variety of programs to test many different activities.

It is not envisioned that this will be an element of the program, where each county will develop an expenditure plan for its own activities on an annual basis. Each year a portion of the counties are likely to receive funds for multiyear programs with many of the programs requiring collaborative efforts – particularly among the smaller counties.

Far more than for any other portion of the Mental Health Services Act funding, it is best to reserve allocations for a county's innovative services funding until an appropriate project comes along to make sure that the funding is there when a need arises rather than to assume that all of the money should be spent each year.

5. Reduced Paperwork Burden

The greatest area of inefficiency lies not in the delivery of care, but in the amount of human resources that are required to be expended on things other than the direct provision of care to a client. Community mental health agencies, whose services must be regarded by the county and state as 100% spent on direct services, actually report that 40% out of every dollar they receive is spent on paperwork; meaning that only 60% is available for direct care. This does not even count the dollars that are expended in state and county administrative functions and other activities that are not direct care, making the overall administrative burden over 50% of the expenditures. Reducing this burden will be accomplished primarily through technology. Planning should develop agreements on what are the critical pieces of information that are required and bringing together the many disparate forms of recordkeeping.

There is no one source of these paperwork burdens. Rather, it is dozens of small requirements that individually make perfect sense when viewed by themselves, but collectively impose a cumulative burden that takes a disproportionate amount of funding away from direct care.

6. Capital Facilities and Technology

The capital facilities and technologies program must be developed in a way to develop an electronic health record program and an electronic recordkeeping system that minimizes staff time and duplicative form completions. As much as

possible there should be automated reports, whereby not only the preparation of reports but the review of those reports is completed electronically without the need for human intervention except where a review of the results indicates that there is a failure needing further investigation.

The future needs for capital facilities and technology will be met through the identification of such needs in county annual plans.

In each year, a county plan will identify its capital facilities and technology needs in order to accomplish its objectives in providing services under the children's system of care, the adult and older adults system of care and prevention and early intervention programs.

It is expected that there will be many years in which the amount of additional funds available to a county for community services and supports will exceed its ability to provide those services without an additional investment in capitol facilities and/or technology. In such years, it is expected that counties will seek to have a portion of their community services and supports funds earmarked for capitol facilities and technologies to stay current.

There may be times when it is more cost-effective to have a statewide upgrade to our information and technology system. In such years, the state may condition approval of county community services and supports expenditure plans on a commitment that a portion of funds to go into a statewide information and technology program.

7. Education and Training- A crisis in workforce capacity

The immediate challenge in education and training reflects the shortages of qualified staff in nearly every category, especially those trained to serve people of different cultures and ethnicities who may have special needs and for programs that need to be tailored for those cultures. Particularly for cultural competency, we will need pipeline programs that engage minority youth in the mental health and helping professions.

There is also the need to re-train current staff for the different type of system we are creating and for the involvement of non-professional staff, particularly individuals who have mental illnesses and have had successful care, as well as family members critical to their success.

The long term needs for education and training go far beyond the direct mental health community and include all of the types of professions that will have to be involved in making the prevention and early intervention program succeed. The detection of a mental illness will rarely occur within the mental health care delivery system. It is putting in place the mechanisms to make sure there is a referral to that system that is done in the right way at the right time. The mental

health system's job is to make sure the capacity is there to provide the right services and that they are readily accessible, but the recognition of that care requires significant education and training of other professions that probably starts with those working in primary care and education.

The initial challenge in developing the education and training programs is balancing the need to allocate funds to expanding the long term supply of mental health professionals by increasing the slots in academic programs versus the need for short term relief to attract people immediately into the public mental health system who already have the necessary academic work completed.

In the long run, only the expansion of the supply of mental health professionals can get us out from under the human resource crisis that we now have. The loan forgiveness and stipend programs must go hand-in-hand in order to make sure that California's investment in expanding the supply of mental health professionals will go to benefit the California public mental health system as opposed to systems of other states or private mental health services that do not assist in meeting the objectives of the Mental Health Services Act.

All of these programs must be structured to fit the types of services and employment that will be required in the transformed system.

The needs for human resources will not go away after 2007-08, when the earmarked funds collected during the first four years of the Mental Health Services Act terminate.

Annually, county integrated plans are required to identify continuing human resource needs. After 2007-08, the Act provides two methods for meeting those needs. A county may elect to meet the needs directly itself utilizing a portion of its funds for community services and supports if it has a program that addresses those needs. However, most of the types of needs – particularly the long term needs, cannot be met through county programs and must instead be met through the statewide programs established through the education and training fund. Particularly in years in which the revenues from the Mental Health Services Act grow faster than the expected levels funds should be allocated to increase human resources programs and ensure that programs established during the first four years can be continued in future years in order to make sure that the human resources needs continue to be met.

The State Mental Health Planning Council, the State Department of Mental Health and the Oversight and Accountability Commission will annually be evaluating the unmet needs identified by counties together with the progress made in meeting human resources challenges and may insist that county plans earmark a portion of funds for the continuation or expansion of particular education and training programs.

8. Integration

The children and adults systems of care successfully integrate the different funding streams of care for children with serious emotional disturbances and provide access to the wide array of services needed for adults within a single program. However, to fully succeed, there are many other forms of integration that must occur including:

- Publicly funded and privately funded mental health care
- Primary care and mental health care
- Mental health and substance abuse services
- Mental health and developmental disabilities
- Mental health care for elderly and other older adults services
- Mental health services to special communities where mental illnesses are recognized in other ways and other services and programs that are likely to be far more successful in engaging people than a mental health program

a) Public and Private Funded Mental Health Care

A division in mental health care is between care for people who need a little short term care and those who need a lot, for a long time. Short term care is for those who are experiencing early signs of a mental illness or have sufficiently recovered to where their needs are only at a modest or maintainable level.

Others need more intensive services usually requiring a full service partnership and the ability to access a wide array of care. This will generally be someone in the process of moving from significant disability or risk of disability due to mental illness to a stage of full recovery or maximum recovery.

Private insurance has usually been willing to pay for the care for anyone who needs "only a little" mental health services and would have these services within a network of providers. However, what is lacking is access to that network with the entry points from primary care, schools, employer EAP programs or direct referral from a consumer or family member needing to be made easier. Private plans also need to establish relationships with public sector providers and work with counties to ensure inclusion of some of the supportive services that cannot be considered part of healthcare.

Presently, a very small number of persons with serious and disabling mental illness are insured in the private sector because most adults have lost their employment and any insurance by the time they are seeking care and require full service partnership. Children are also likely to have failed in school or in society and be placed under a separate entitlement program under the special education program or child welfare or juvenile justice government or court ordered care that often separates a child from his/her family regardless and where the private

insurance that may have been available is not primarily responsible for that child's care. After the development of the Prevention and Early Intervention programs, after a greater % of clients will have private insurance to pay for their mental heath care.

b) Primary Care Mental Health Integration

Primary care is frequently criticized for under-recognizing the need for mental health treatment, lack of referrals to mental health professionals and inconsistent prescribing of medications that are sometimes the wrong medication or an unnecessary medication. These problems would be reduced if a mental health professional was involved in providing the diagnosis and assessment.

Whether co-location in a primary care office or a school health center is the key step, or whether simple questionnaires that trigger the direct referral to a mental health program is the best model, remains to be seen. Clearly, the lack of significant coordination between these two sectors of health care needs to be addressed.

In the planning process each primary care organization seeking funding should be required to identify its overall strategy and plan and the existing resources it will be contributing.

c) Mental Health and Substance Abuse

The relationship between these two conditions is well understood and acknowledged. Model programs exist for adults with both diagnoses. Prevention programs designed to prevent substance abuse are also well established, but these are completely separate from any mental health program. While substance abuse is cited as being present in 80 to 90% of the homes in which a child protective service worker makes a visit for a possible referral, the availability of substance abuse treatment for the adult or child is not well covered as a funded benefit and thus seldom occurs even though it could prevent the need for far more intensive care.

While the need for co-treatment of mental health and substance abuse is accepted in some programs, there are still many places that refuse to accept for housing or mental health treatment those who are not "clean and sober." Similarly, there are substance abuse treatment programs that have no ability to recognize and treat an underlying mental illness, when that maybe a significant contributing cause to the substance abuse disorder.

Detection of either mental health or substance abuse should lead to referral to a single coordinated system of care that could determine the severity of each condition and provide the most appropriate care at the earliest possible time.

Some of the funding needs for substance abuse go beyond what the Mental Health Services Act can provide for and may not be met without significant advocacy for improved funding. With numerous studies showing that the savings in the criminal justice system alone more than offset the cost of comprehensive substance abuse treatment, this is an achievable change in public policy.

d) Older Adults

Older adults, generally the Medicare over 65 population, are frequently accessing health care and other publicly funded services. However, there is virtually no integration between these services and mental health services.

The 50% co-pay requirement under Medicare is a substantial barrier as is the lack of awareness of the substantial potential for older adults to experience disabling mental illnesses, often directly related to life transitions in life that are occurring in those ages. Another significant barrier is the array of services either Medicare or a Medicare Advantage program will not reimburse; for example, it will not reimburse for travel time to an older adult's home, case management services, etc. This requires legislative advocacy, education, training, coordination, and stigma reduction.

e) Increasing Availability of Federal Funds and Contribution of Private Health Insurance

There are components of care such as substance abuse treatment and peer support that appear not to be billable under California's currently structured set of benefits. Other states are able to bill for these through utilization of home and community-based waivers and/or bundled services for an integrated service agency or a PACT type program. The newly created home and community-based services option further increases opportunities for California to increase care for which federal financial participation will be available.

There are also significant delays in accessing social security benefits for people disabled due to mental illness that can be changed through better staffing, training and coordination with the State Department of Social Services in making its eligibility determinations.

Similarly, delays in regaining access to both Medi-Cal and social security benefits for people released from jail or prison can be reduced by suspending rather than terminating these benefits and working while people are incarcerated to ensure that benefits are available immediately after release.

9. Putting it all together

The MHSA requires that each three year county plan and annual update address all of the program elements in a single plan that shows how all of the pieces fit

together and identifies all of the challenges that each county is facing in making the transformation of the system from fail first to help first and serving a few to serving everyone.

While not directly contemplated in the drafting of the MHSA there was an early consensus shortly after its approval that developing the initial rules and spending plans for each component was better done separately and sequentially in order to give each program the attention that it is necessary. However, this also means a somewhat disjointed set of proposals until we have all of the elements developed and the ability for counties to have comprehensive plans and for the state department of mental health, the OAC and all statewide stakeholders to develop priorities for spending new funds for each program within a context of overall transformation.

The limited portion of funds already allocated for community services and supports reserves sufficient future revenues to facilitate this coordination. Similar steps need to be taken with the initial funding of other program elements so that the revenues are available when we have comprehensive plans from each county and can develop state priorities looking at how all of the pieces fit together. This should be possible by 2008.

10. Key Next Steps

1. Develop prevention and early intervention programs, education and training programs, and capital facilities and technology programs. Develop innovative services program after all other programs have received initial funding.

2. Develop capital facilities and technology program in a manner to significantly reduce the amount of funds not available for direct services, while at the same time providing better ability to measure the effectiveness and efficiency of direct services.

3. Answer key questions listed under community services and support building capacity.

4. Establish a special committee of providers, and outcome evaluators to determine what is effective and efficient and move us towards a set of standardized model full service partnerships with consistent training approaches and results. The models most include variations on programs for special populations for which the basic models of care will not fit due to age ethnicity or co-occurring disorders.

5. Expand community service and supports full service partnerships with the different levels as set forth in this plan utilizing both Mental Health Services Act funds and pre-existing funding sources. Expand care as appropriate to

people currently underserved who are at high risk of failure without more intensive services, as well as those currently in harm's way and not getting any care.

6. Initially measure progress by reductions in the numbers of failures, such as involuntary hospitalizations, arrests and incarcerations, out of home placements, special education placements and other simple measurements that show the gap we still have in moving from fail-first to help-first.

7. Capture savings generated through providing more community care, which should result in lower numbers of hospitalizations.

8. Develop specialized community service and supports programs that rely upon early identification of mental illnesses that are still sufficiently severe and disabling – primarily schizophrenia and bi-polar disorder.

11. Conclusions

Progress toward transformation of the system will not appear to be substantial in the short run. Rather, we are investing now for long-term change and putting in place the type of programs we need. For example the investment in housing results in an up-front cost, but provides housing that will be available in the future to offset the potential of diminishing availability through rentals and through the ability to design and locate housing in the most appropriate manner.

Similarly, the investments being made now should be done looking to the future and putting in place the appropriate structures of care envisioning a system transformed through the significant expansion in funding and earlier intervention.

Appendix A

Process for Developing this Plan

A constant challenge for state government in doing any kind of long range planning is that whenever there is a change of leadership there is an assumption that any plan prepared by a previous administration needs to be re-evaluated and people start all over again.

The current state mental health leadership under Dr. Stephen Mayberg, who is now serving his third Governor, cannot continue forever. We must expect that in the long run there will be changes in leadership at least every four or eight years.

To provide more continuity for an advisory long range plan, it is recommended that it be drafted not by government officials, but by mental health constituency groups and adopted by the Mental Health Oversight and Accountability Commission and not by the Department of Mental Health. While the overall majority of these commissioners are appointed by the Governor, the rotating appointment process with only 1/3 being up for appointment in any given year, provides the potential for a level of continuity. However, it is not proposed to be adopted as a binding and regulatory document, but merely as a guide to direct officials at all levels in how best to make current decisions in the context of where we hope to go in the future.

Local Long Range Plans and Revisions

It is envisioned that a similar process would take place in each county with mental health constituency groups developing their views for long range county plans that would build on the state plan.

Updates to this Plan

The proposed schedule for development of the long range plan is for mental health organizations to present a draft of the plan to the Oversight and Accountability Commission at its September meeting of even numbered years. The Commission would hold hearings on the plan at its fall meetings and take action at its January meeting. The plan would be expected to include within it a series of recommended steps that should be taken in the next two years towards its implementation.

Updating of the plan every two years would begin one year after each plan is adopted with the Commission soliciting views both statewide and in each community, to examine revisions in Mental Health Services Act implementation and the extent to which recommended steps have been taken and if they are not being taken why not. This information will form the basis for the drafting of any

necessary revisions to the plan based on changed circumstances and new information as it becomes available.

Projected Funding Levels and Percentages

		2006		2012		2020	
		Amount	% of county	Amount	% of county	Amount	% of county
Realignment	State	1.2b	40	1.3b	31	1.4b	24
	Federal	600m		700m		800m	
EPSDT	State	500m	25	700m	22	1.0b	22
	Federal	500m		700m		1.0b	
MHSA	State	1.0b	20	1.7b	36	3.1b	46
	Federal	100m		600m		1.1b	
Other	Local	200m	15	200m	11	200m	8
	3632	200m		250m		250m	
	State	100m		120m		150m	
	Federal	100m		120m		150m	
Total County		4.5 Billion		6.4 Billion		9.1 Billion	
State Hospitals		1 Billion		1.1 Billion		1.2 Billion	
TOTALS		5.5 Billion		7.5 Billion		10.3 Billion	

Per Capita - Projected Funding Levels and Percentages Adjusted for Inflation

		2006		2012		2020	
		Amount	% county	Amount	% county	Amount	% county
Realignment	State	1.2b	40%	1.0b	31%	800m	25%
	Federal	600m		500m		500m	
EPSDT	State	500m	22%	500m	21%	500b	19%
	Federal	500m		500m		500b	
MHSA	State	1.0b	24%	1.3b	36%	1.7b	44%
	Federal	100m		400m		600m	
Other	Local	200m	13%	200m	12%	200m	12%
	3632	200m		200m		200m	
	State	100m		100m		100m	
	Federal	100m		100m		100m	
Total County		4.5 Billion		4.8 Billion		5.2 Billion	

State Hospitals	1 Billion	1 Billion	1 Billion

Children's Funding for Community Services & Supports (CSS) & Early Intervention (PEI)

		2006	2012	2020
		Amount	Amount	Amount
Realignment	State	200m	220m	260m
	Federal	100m	110m	130m
EPSDT	State	450m	600m	800m
	Federal	450m	600m	800m
MHSA	State	50m	300m	600m
	Federal	0	0	0
Other	Local	100m	110m	130m
	3632	180m	250m	250m
	Other	100m	110m	130m
Sub Total		1.6 Billion	2.35 Billion	3.25 Billion
Prevention & Early Intervention		0	300m	700m
Total		1.6 Billion	2.65 Billion	4.05 Billion
Adjusted for Inflation		1.6 Billion		
Total in Current Per Capita $$*		1.6 Billion	2.1 Billion	2.3 Billion
TOTALS		5.5 Billion	5.8 Billion	6.2 Billion

Adult and Older Adult Funding for Community Services & Supports (CSS) and Prevention & Early Intervention (PEI)

		2006	2012	2020
		Amount	Amount	Amount
Realignment - CSS	State	600m	650m	750m
	Federal	500m	550m	650m
MHSA - CSS	State	300m	800m	1.6b
	Federal	100m	500m	1b
Local - CSS		100m	110m	130m
Other - CSS		100m	110m	130m
CSS Total		**1.7 Billion**	**2.8 Billion**	**4.2 Billion**
Prevention and Early Intervention		0	100m	200m
Total		**1.7 Billion**	**2.9 Billion**	**4.1 Billion**
Total Per Capita Current $$*		**1.7 Billion**	**2.2 Billion**	**2.4 Billion**

*Adjusted for population and inflation