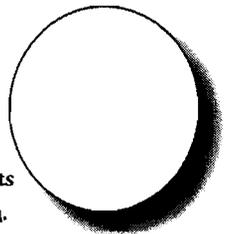


California's Mental Health System

Aligning California's physical and mental health services to strengthen the state's capacity for federal coverage expansion

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Insure the Uninsured Project
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Abstract:

This report will analyze the delivery of mental health services in California and will investigate the potential impacts of federal health reform legislation on the State and counties. California has operated successful mental health pilots where physical health has become more integrated with mental health. Results from these pilot programs will also be discussed, in addition to policy challenges and recommendations.

Introduction

The World Health Organization defines mental health as a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community. Determinants of mental health include multiple social, psychological, and biological factors that influence the level of mental health of a person throughout his or her life.¹

The California Department of Mental Health reports approximately 2 million people in California suffer from severe mental illness or a severe emotional disorder, which comprises almost 7 percent of the population.² The need for mental health care is very common in California, where 1 in 5 people report the need for such services.³ This means that more than four million Californians may be at risk for distress, pain, disability, and death associated with mental disorders.⁴ The unmet need for mental and behavioral⁵ health services is greatest among underserved groups, including elderly persons, racial/ethnic minorities, those with low incomes, those without health insurance, and residents of rural areas.⁶ As a result the health and wellness of the individual is jeopardized and the effects to society spread across communities, schools, businesses, prisons and jails, and healthcare delivery systems.

In the United States, and specifically in California, policy formation has been guided by the community's perception and acceptance of those who suffer from mental illness. Expanding and improving mental health care and coverage is largely decided through public support and recognition that mental illness can be treatable and preventable. Studies continue to show that early identification and treatment can help prevent the onset of disease, decrease rates of chronic disease, and help people lead longer, healthier lives.⁷

Policy provisions in the 2010 Patient Protection and Affordable Care Act (ACA) will require that health insurance plans offer equal physical and behavioral health coverage, including mental health and substance abuse services, starting 2014.⁸ Upon full implementation of healthcare reform, approximately 235,000 Californians with mental illness or addiction disorders will have new coverage through Medi-Cal or the Exchange.⁹ Building on ongoing State efforts to reform health care, the ACA and §1115 Waiver will provide California with new tools, flexibility, and resources to provide better mental health care coverage.

¹ World Health Organization. June 2011. *Mental Health*. Information available at <http://www.who.int/features/qa/62/en/index.html>

² Dept. Mental Health. 2002. Prevalence data retrieved at http://www.dmh.ca.gov/Statistics_and_Data_Analysis/Prevalence_Rates_Mental_Disorders.asp, 2.2 percent suffer from a severe mental illness or serious emotional disturbance.

³ UCLA Center for Health Policy Research. July 28, 2010. Nearly 1 in 5 Californians report need for mental health services, study finds: Stigma, lack of insurance, a barrier to treatment. Article available at <http://www.healthpolicy.ucla.edu/newsreleasedetails.aspx?id=58>

⁴ Department of Health Care: *Mental Health Care in California Counties - Perceived Need and Barriers to Access*. <http://www.cdph.ca.gov/pubsforms/Pubs/OHIRmentalhealthCareCA2001.pdf>

⁵ This paper focuses primarily on mental health services, with limited discussion of substance abuse. "Behavioral health" is the umbrella term for both mental health and substance abuse concerns.

⁶ US Department of Health and Human Services. 2011. National Strategy 2011. Mental Wellness Priorities available at http://www.healthcare.gov/center/councils/nphpphc/strategy/mental_emotional_well_being.pdf

⁷ National Research Council and Institute of Medicine. 2009. *Preventing Mental Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities. Committee on the Prevention of Mental Disorders and Substance Abuse Among Children*. Accessed June 2011 from http://books.nap.edu/openbook.php?record_id=12480

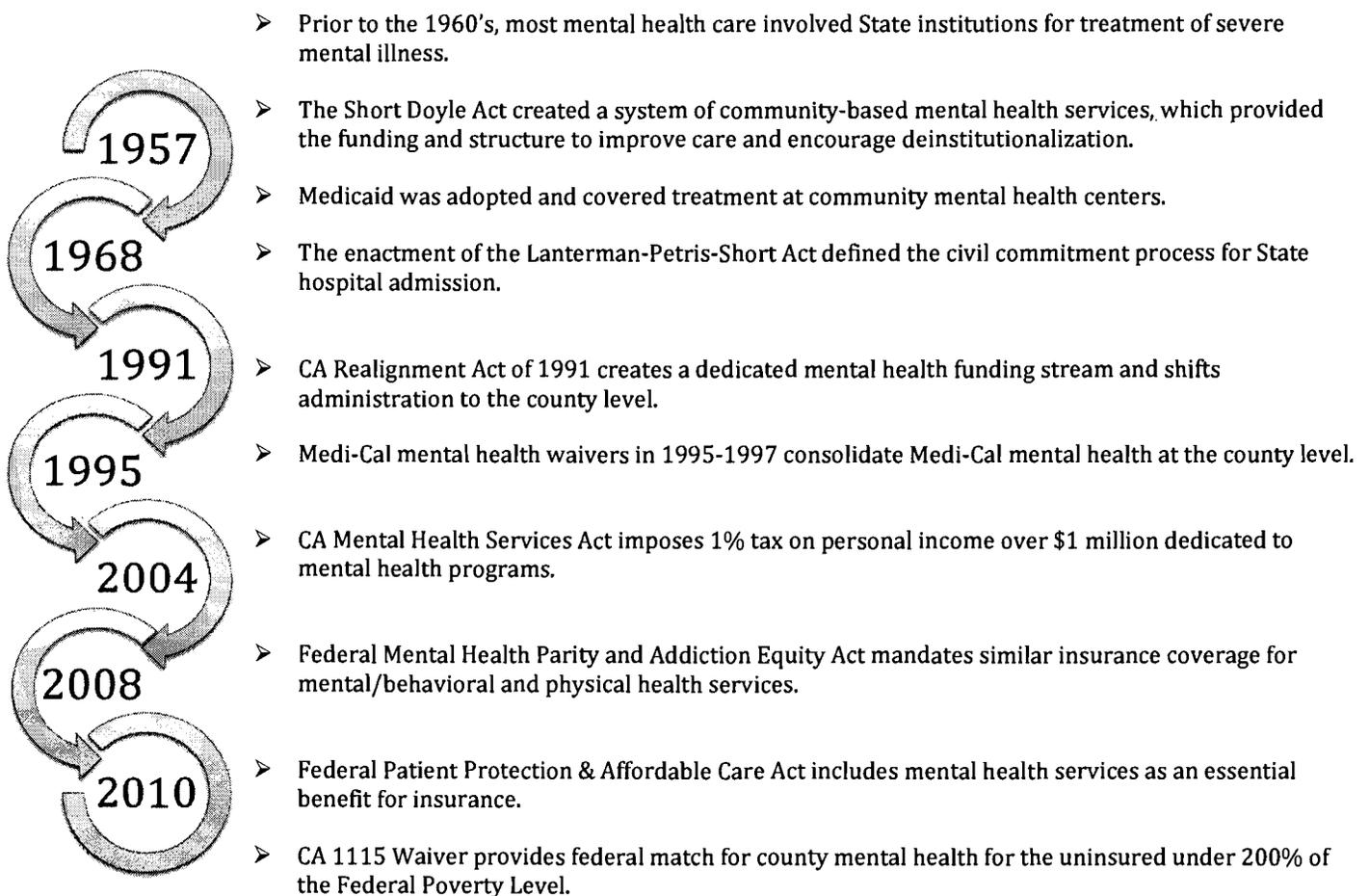
⁸ Patient Protection and Accountable Care Act. March 21, 2010. Accessible at: www.cms.gov/LegislativeUpdate/downloads/PPACA.pdf.

⁹ California Institute for Mental Health and California Mental Health Directors Association, *Implications/Impact of Healthcare Reform and Parity for Behavioral Health*, DHCS 1115 Waiver Behavioral Health Technical Work Group, April 28, 2010. Powerpoint Presentation, accessed from <http://www.dhcs.ca.gov/provgovpart/>

History

To better understand California's current mental health system, the following section describes its history, placing emphasis on the course of financing as community mental health care and managed care emerged. In the past half century, California experienced significant changes in the care and treatment of people with mental illness, particularly a transition from state institutionalized care to care delivered at the community level under county governance. This transition was and continues to be a difficult one, with often inadequate funding and without a clear vision of how to create desired robust, comprehensive, community-based care systems. The structural shift from a system built around control and confinement of people with mental illness to an open system based on consent and support presented challenges that remain unresolved.

The timeline below provides a summary of historical events in the development of mental health care in California.



Appendix 1 has an additional timeline of legislative milestones.

Deinstitutionalization of Mental Health Services in California

Prior to the 1960s, most individuals requiring public mental health services were treated for lengthy periods of time in State Hospitals. Beginning the transition to a system of community-based mental health services, the Short Doyle Act was implemented in 1957 and provided the funding and structure to improve care and encourage deinstitutionalization. The Short Doyle Act provided financial assistance (50% match) to local governments to establish and develop locally administered and controlled community mental health programs.

By 1962-63, only 20 jurisdictions had implemented the Short Doyle Act. To encourage more programs, 1963 legislation increased the state share to 75% and enlarged the reimbursable scope of services.¹⁰ The federal Community Mental Health Centers Act of 1963 provided additional funding to establish local mental health services.¹¹

With the passage and adoption of Medicaid in 1965, financing and coverage for mental illness treatment shifted quite dramatically from mental hospitals to community care. Medicaid excluded coverage of State Mental Hospitals for adults aged 21-65 and extended coverage to community mental health centers, which were funded by both Medicaid and the federal Community Mental Health Center Program. This led to a sustained period of deinstitutionalization. Beginning in 1967, many geriatric state hospital patients were moved from state hospitals to nursing homes, where the federal government covered half the cost - in lieu of the state paying 100 percent of the state hospital cost.

The move from institutional to community-based care was further propelled by laws limiting involuntary commitment. The Lanterman-Petris-Short Act (LPS) of 1968 was intended to end inappropriate, indefinite, and involuntary commitment of people with mental disorders, developmentally disabled people and people impaired by chronic alcoholism. As a result of LPS, a patient cannot be involuntarily hospitalized for a mental illness without timely psychiatric evaluation and a judicial hearing.¹² In addition, the patient must be felt to be a danger to his or herself or to others, or gravely disabled (unable to provide food, clothing or shelter).¹³ LPS also increased state funding for community mental health programs to 90 percent of costs.

In the early seventies, because of the declining hospital population, several State hospitals closed and treatment of people with mental illness increasingly became the responsibility of the counties' community mental health programs. At that time, counties' local funding and any opportunity for increased State support was tied directly to a permanent reduction in State hospital beds.¹⁴ The adequacy and equity of State funding to the counties for community mental health care continued to be a contentious issue through the 1970s and 1980s.¹⁵

Realignment Impact

In 1991, California shifted authority and funding for many health and mental health programs from the State to the counties through a process known as "realignment". The Bronzan-McCorquodale Act created a dedicated funding base for community mental health services and provided county governments with greater autonomy and flexibility in managing their local mental health programs. At the same time, realignment funding for mental health did not take into account prior inadequacy of mental health funding; it has not kept pace with population or cost of treatment growth, and is vulnerable to economic recessions.¹⁶

The revenues identified as part of the Realignment were a portion of the state's sales tax and vehicle license fees. These funds are collected by the state and then allocated to separate health, social services, and mental health funding accounts in the Local Revenue Fund. The Mental Health Subaccount is the principal fund that contains revenues for the provision of local mental health services. These funds are distributed to the counties on a formula basis.¹⁷

¹⁰ Legislative Analyst's Office. March 2, 2000. Major Milestones: 43 Years of Care and Treatment Of the Mentally Ill. Read more at: http://www.lao.ca.gov/2000/030200_mental_illness/030200_mental_illness.html

¹¹ David Rochefort. *Origins of the "Third Psychiatric Revolution": The Community Mental Health Centers Act of 1963*. Journal of Health Politics, Policy and Law 1984 9(1):1-30.

¹² Legislative Analyst's Office. March 2, 2000. Major Milestones: 43 Years of Care and Treatment Of the Mentally Ill. Read more at: http://www.lao.ca.gov/2000/030200_mental_illness/030200_mental_illness.html

¹³ Los Angeles Superior Court. 2011. *Facility Based Hearings*. Information available at: <http://www.lasuperiorcourt.org/mentalhealth/FacilityBasedHearings.htm>

¹⁴ Kears, Dave. 2011. Personal Communication with Insure the Uninsured Project.

¹⁵ Legislative Analyst's Office. March 2, 2000. Major Milestones: 43 Years of Care and Treatment Of the Mentally Ill. Read more at: http://www.lao.ca.gov/2000/030200_mental_illness/030200_mental_illness.html

¹⁶ California Mental Health Directors Association. March 2006. *History and Funding Sources of California's Public Mental Health System*.

¹⁷ Deborah Kelch. March 2011. *The Crucial Role of Counties in the Health of Californians: An Overview*. California HealthCare Foundation.

Medi-Cal Mental Health Waivers to Establish County Mental Health Plans

From 1995 to 1997, the federal Freedom of Choice Waiver allowed the state to merge state and county, inpatient and outpatient Medi-Cal mental health service into a single, county-level managed care program. This consolidated the two existing Medi-Cal mental health programs (county Short-Doyle and state Fee-For-Service) into one managed care delivery system administered at the county level.¹⁸ The waiver consolidated Medi-Cal psychiatric inpatient hospital services at the county level in January 1995, and consolidated Medi-Cal outpatient mental health services from November 1997 through June 1998.¹⁹ It continued the shift in financial responsibility from the state to the county level.

Under this delivery system, psychiatric inpatient hospital services and outpatient specialty mental health services (such as clinic outpatient providers, psychiatrists, psychologists, and some nursing services) became the responsibility of a single entity, the Mental Health Plan (MHP) in each county. Counties were required to match federal Medicaid funding with local funds. Counties could refuse to participate in the MHP, but would then have to give some county funds to the state to help another entity become the MHP. Medi-Cal recipients must obtain the covered mental health services through the MHP.

Expansion of Medication in Treatment of Mental Illness

Since the 1970's, mental health professionals began to utilize increasingly effective medication in the outpatient treatment of people with mental illness.²⁰ From 1998 through 2002, county mental health spending on pharmaceutical treatment for mental illnesses increased significantly, corresponding to national trends of increased use of behavioral pharmaceuticals.²¹ This is also notable because these pharmaceuticals were not included in the Medi-Cal specialty mental health carve out, meaning that the cost of mental health prescriptions for Medi-Cal patients are paid by the state Department of Health Care Services through Fee For Service or by Managed Care Medi-Cal plans, not by county MHPs.²²

Increased Funding from Mental Health Services Act

Despite new revenues from realignment and Medi-Cal, the mental health care delivery system continued to be plagued by an increased need for treatment and an underfunded system. In 2004, Californian voters approved Proposition 63, The Mental Health Services Act, which imposed a 1% income tax surcharge on personal income in excess of \$1 million.²³ This revenue provides increased funding, personnel and other resources to support county mental health programs. The state Mental Health Department monitors local progress toward statewide goals for children, transition age youth, adults, older adults and families. The Act addresses a broad continuum of prevention, early intervention and service needs, as well as the necessary infrastructure, technology and training elements to effectively support this system. Proposition 63 was designed to build on rather than supplant existing state and local mental health program funding.

Although the MHSA provides a dedicated source of funds, the funding is derived from the income tax surcharge on millionaires, a volatile revenue stream that was severely impacted by the economic recession when stock and real estate values began a steep decline.

¹⁸ Ryan, P. Feb 2009. California Mental Health Funding, Evolution and Policy Implications: Pre- and Post- MHSA. *California Mental Health Directors Association*. Presentation available at

http://cmhda.org/go/Portals/0/CMHDA%20Files/Breaking%20News/0902_News/0902_CMHDA%20History%20of%20Mental%20Health%20Financing.pdf

¹⁹ Buck, J. July 2003. Medicaid, Health Care Financing Trends, and the Future of State-Based Public Mental Health Services. *American Psychiatric Association*. *Pub Med*. 54:969-975

²⁰ Caitlin and Et Al. 2008. National Expenditure Accounts Team. National Health Spending in 2006: A Year of Change for Prescription Drugs. *Health Affairs*. 27(1):14-29.

²¹ Coffey and Et. Al. Feb 2011. Changes In US Spending On Mental Health And Substance Abuse Treatment, 1986-2005, And Implications For Policy: *Health Affairs*. 30:2284-292; doi:10.1377/hlthaff.2010.0765

²² Ryan, P. Feb 2009. California Mental Health Funding, Evolution and Policy Implications: Pre- and Post- MHSA. *California Mental Health Directors Association*. Presentation available at

http://cmhda.org/go/Portals/0/CMHDA%20Files/Breaking%20News/0902_News/0902_CMHDA%20History%20of%20Mental%20Health%20Financing.pdf

²³ Section 1302. Patient Protection and Affordable Care Act. 2010. Essential health benefits requirements: Accessible at:

www.cms.gov/LegislativeUpdate/downloads/PPACA.pdf.

Parity between Physical and Mental Health

The 2008 federal Mental Health Parity and Addiction Equity Act (MHPAEA) was enacted to end health insurers' common practice of setting far higher limits, co-payments and deductibles for mental health and substance abuse services than for any other medical illness service. Under the law, insurers cannot set higher co-payments and deductibles or stricter limits on mental health benefits.²⁴ The MHPAEA does not require any employer to offer mental health or substance abuse benefits.

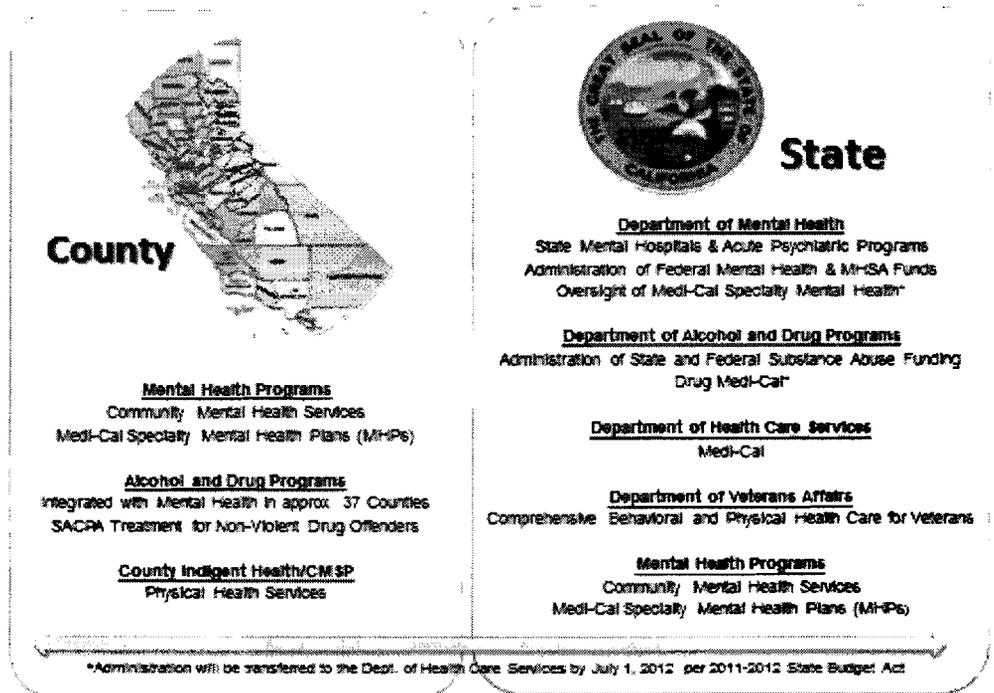
Debate has ensued among various stakeholders over rules issued to enforce the MHPAEA,²⁵ with plans and providers disputing whether restrictions on "non-quantitative treatment limits" such as "treatment plans", reimbursement and prior authorization may pose a threat to successful cost containment methods. While all sides to this dispute support the Act for its promise to remove discriminatory practices, the disputes over "parity" now extend beyond the traditional dispute over numbers of covered days and visits. New disputes are likely to center on the definition of medical necessity.

The 2010 ACA makes mental health and substance abuse services a part of the essential benefits for health insurance plans for every American citizen and legal permanent resident.²⁶ Inadequate capacity in the mental health delivery system when faced with this influx of new patients will be a major concern.

Behavioral Health Infrastructure and Financing

Although counties are responsible for many behavioral health services, California's behavioral health system is composed of multiple agencies serving overlapping populations with major gaps in coverage. Mental health and substance abuse care are often uncoordinated, as well as separated from physical health services.

At the state level, the Department of Mental Health and Department of Alcohol and Drug Programs are responsible for administering and overseeing funding provided for direct or contracted services at the county level, with DMH also providing direct inpatient mental health services. At the county level, safety net physical and behavioral health are paid for and overseen by separate agencies, with Medi-Cal and CMSP/County Indigent Health programs responsible for physical health and care for mild mental illness and county behavioral health departments responsible for specialty mental health and for substance abuse care.



²⁴ California Department of Mental Health. *ACA & Mental Health Services Act*. Information available at http://www.dmh.ca.gov/Prop_63/MHSA/default.asp

²⁵ Pear, Robert. May 9, 2010. *Fight Erupts Over Rules Issued for 'Mental Health Parity' Insurance Law*. *The New York Times*. Article available at <http://www.nytimes.com/2010/05/10/health/policy/10health.html>

²⁶ Section 1302. Patient Protection and Affordable Care Act. 2010. Essential health benefits requirements: Accessible at: www.cms.gov/LegislativeUpdate/downloads/PPACA.pdf

The above diagram outlines the various entities that provide, finance, or oversee care for those with mental illnesses at the state and county level, discussed below:

California Department of Mental Health (DMH)

California's public mental health system offers an array of community and hospital-based services that are available to adults who have a serious mental illness and children with a severe emotional disorder.²⁷ The California Department of Mental Health (DMH) delivers institutional care in the five state-operated mental hospitals and oversees community mental health through county mental health departments. It also administers and oversees several federal SAMHSA grants and MHSA funds for mental health.

The DMH licenses both Mental Health Rehabilitation Centers, which provide round-the clock intensive support for adults with mental illness who would otherwise be placed in state hospitals, and Psychiatric Health Facilities, which provide inpatient treatment for acute mental disorders as an alternative to acute psychiatric hospitals. DMH also certifies Social Rehabilitation Facilities, Community Treatment Facilities, Special Treatment Programs in Skilled Nursing Facilities, and other mental health treatment programs that are licensed by the California Department of Social Services and Department of Public Health.²⁸

DMH: State Hospitals

The DMH directly provides state mental hospital services to persons committed to treatment by the courts or the Board of Prison Terms. The DMH directly operates five state hospitals throughout California, bulleted below, and each provides inpatient treatment services for serious mental illnesses.²⁹

- Atascadero State Hospital (San Luis Obispo County)
- Coalinga State Hospital (Fresno County)
- Metropolitan State Hospital (Los Angeles County)
- Napa State Hospital (Napa County)
- Patton State Hospital (San Bernardino County)

The number and percent of state mental hospital patients entering through civil procedures has declined significantly over the past few decades. In 2010, only 7.6% of the state's nearly 6,000 mental hospital patients had entered civilly through Lanterman-Petris-Short procedures, with the remaining 92.4% referred through the criminal justice system.³⁰

The DMH also provides mental health services to the California Department of Corrections and Rehabilitation. It operates two psychiatric programs at correctional facilities, Salinas Valley Psychiatric Program and Vacaville Psychiatric Program. The Forensic Conditional Release Program provides outpatient treatment and conducts evaluations of "Mentally Disordered Offenders" (MDO) who are required to undergo mental health treatment as a condition of parole. A Sex Offender Commitment Program (SOCP) is offered for persons who are found, upon release from prison, to be sexually violent predators.³¹ Since "Jessica's law" of 2006 expanded criteria for "potentially violent sex offenders," many more sex offenders have been referred to DMH for evaluation. However, a recent state audit found that less than 1% were actually enrolled in the SOCP and recommended that the referral process be revised.³²

²⁷ California Department of Mental Health. 2011. Services and Programs. Information available at http://www.dmh.ca.gov/Services_and_Programs/

²⁸ CA Senate Office of Research. July 2009. Policy Brief: Finding Answers, A Resource Guide on the Licensing and Certification of Health and Community Care Facilities in California.

²⁹ California Department of Mental Health. 2011. State Hospital information available at http://www.dmh.ca.gov/services_and_programs/State_Hospitals/Default.asp

³⁰ California Health and Human Services Agency, Department of Mental Health. "State Hospital In-Hospital Population 2008-2012." Available online at: <http://www.ebudget.ca.gov/StateAgencyBudgets/4000/4440/department.html>. State Hospitals for the Mentally Disabled In-Hospital Population Plus Short-Term Leave, Diagnostic Category and Legal Class Group by Funding Source, June 30, 2001. Statistics and Data Analysis, November 2001.

³¹ California Department of Mental Health. 2011. Forensic Services information available at: http://www.dmh.ca.gov/services_and_programs/Forensic_Services/default.asp

³² California State Auditor Program. July 2011. *Sex Offender Commitment Program*. Available at <http://www.bsa.ca.gov/pdfs/reports/2010-116.pdf>.

DMH: Community Services Division

Through its Community Services Division (CSD), the DMH oversees California counties who provide community-based, public mental health services.³³ CSD has responsibility for oversight of the Mental Health Services Act, Specialty Mental Health Medi-Cal, and specialized programs to support county mental health departments. Each year, CSD administers over \$3 billion for local mental health services, including approximately \$1 billion in MHSA funds to counties.³⁴

Information about county mental health care is accessible through a Service Directory³⁵ that details behavioral health and supportive services provided by schools, clinics, hospitals, research foundations, and other community-based organizations. The following types of services are directly provided or arranged for by local (county) mental health departments under the oversight of CSD:

- Rehabilitation and support
- Evaluation and assessment
- Vocational rehabilitation
- Individual service planning
- Residential treatment
- Medication education and management
- Case management Groups
- Wrap-around services

DMH: SAMHSA Grants

The Substance Abuse and Mental Health Services Administration (SAMHSA) helps reduce the impact of substance abuse and mental illness through federal grants. The DMH administers the SAMHSA grants for Projects for Assistance in Transition for Homelessness (PATH, \$9.07 million in FY 2010-2011) and Community Mental Health Services Block Grant (\$53.67 million in FY 2010-2011).³⁶ In 2010, SAMHSA awarded over \$50 million in grants³⁷ to be used to promote the colocation of primary and specialty care in community-based mental health settings. Recipients in California include Alameda County Behavioral Health Care Services, Asian Community Mental Health Board, County of San Mateo, Glenn County Health Services Agency, and Tarzana Treatment Centers, Inc. The 2011 and 2012 grant opportunities will also incorporate Health Information Technology (HIT) and primary care integration into mental health services, in addition to various substance abuse prevention and early intervention programs.³⁸

California currently applies for and administers SAMHSA mental health and substance abuse grants separately, with the Department of Alcohol and Drug Programs (ADP) handling the Substance Abuse Prevention and Treatment block grant (see below). Beginning in FY 2012, SAMHSA will implement a new unified application and reporting process that will necessitate coordination between DMH and ADP.³⁹

DMH: Programs for Children and Youth

The DMH oversees those counties who administer a number of programs for children and youth.⁴⁰ The program services are directly provided at the local level by counties and their contract providers. These programs include the following:

³³ California Department of Mental Health. May 2011. County Information. Document available at <http://www.dmh.ca.gov/docs/CMHDA.pdf>

³⁴ California Department of Mental Health. April 2011. *Community Services Division*. Available online at www.dmh.ca.gov/services_and_programs/docs/CSD_Brochure.pdf.

³⁵ Network of Care originally was sponsored by an innovation grant from the State of California in partnership with county governments and Trilogy Integrated Resources Inc. Information available at <http://networkofcare.org/index2.cfm?productid=2&stateid=6>

³⁶ U.S. Department of Health & Human Services: Substance Abuse and Mental Health Services Administration. 2011. California Grant Information available at <http://www.samhsa.gov/Statesummaries/StateSummaries.aspx>

³⁷ Substance Abuse and Mental Health Services Administration, 2011. Background information available at <http://www.samhsa.gov>. Information on Sec. 5604 grants available at http://www.samhsa.gov/healthreform/docs/Co-locating_Primary_Care_Community_MH_508.pdf

³⁸ Substance Abuse and Mental Health Services Administration. 2011. Grant application information available at <http://www.samhsa.gov/Grants>.

³⁹ Substance Abuse and Mental Health Services Administration. 2011. Grant application information available at <http://www.samhsa.gov/grants/blockgrant/>.

⁴⁰ California Department of Mental Health. June 2011. *Programs for Children and Youth*. Information available at http://www.dmh.ca.gov/Services_and_Programs/Children_and_Youth/default.asp

- Children’s System of Care/Interage Enrollee-Based Program (IEBP)
- Early Mental Health Initiative (EMHI)
- Early and Periodic Screening, Treatment, & Diagnosis for Mental Health Services (EPSDT)
- Mental Health Services for Special Education Pupils (AB 3632)
- Out of County Placements program (SB 785)⁴¹

Under the oversight of DMH, many counties also operate mental health programs focused specifically on Transitional Age Youth that provide mental health and supportive services for youth age 16 to 25 with severe and persistent mental illness. These programs can be critical for youth who are homeless and/or aging out of children’s mental health, child welfare, or juvenile justice systems, and for those experiencing their first episode of major mental illness.⁴²

DMH: Programs for Adults

The California Department of Mental Health oversees counties who administer a number of mental health programs for adults.⁴³ These programs, listed below, are provided directly at the local level through counties and their contract providers.

- California Mental Health Cooperative Programs Employment with Support
- Caregiver Resource Centers, Mental Health Services Act (Prop. 63)
- Olmstead Decision - New Freedom Initiative
- Project for Assistance in Transition from Homelessness (PATH)
- Substance Abuse and Mental Health Services Administration (SAMHSA) projects
- Traumatic Brain Injury

Under the oversight of DMH, many counties also operate programs and services for older adults (age 60 and over) with mental illness. Services in these agencies typically involve screening and assessment, case management services, individual and family treatment and crisis intervention services.⁴⁴ These services can be particularly critical for patients age 60 to 64, who may experience discontinuity in care because they do not yet qualify for Medicare coverage.

California Department of Alcohol and Drug Programs (ADP)

The California Department of Alcohol and Drug Programs (ADP) coordinates the state’s alcohol and drug abuse prevention, treatment, and recovery services. ADP administers the federal SAMHSA Substance Abuse Prevention and Treatment (SAPT) Block Grant (\$251.66 million in FY 2010-2011).⁴⁵

ADP administers funds to county alcohol and drug programs that directly provide or contract for substance abuse services.⁴⁶ Some of these funds come from the Drug Medi-Cal Program, which provides “medically necessary substance abuse services” to Medi-Cal beneficiaries, mostly on an outpatient basis. ADP manages Drug Medi-Cal and contracts with counties or directly with service providers to provide substance abuse services.⁴⁷

ADP licenses residential, non-medical alcohol and other drug-treatment facilities and outpatient narcotic treatment programs. Other Outpatient Drug Free Facilities, such as Sober Living Homes, are not licensed, but may apply to ADP for voluntary certification.⁴⁸

⁴¹ Out of County Placement information available at http://www.dmh.ca.gov/services_and_programs/children_and_youth/SB785.asp

⁴² Department of Mental Health: Transition Age Youth Programs. Information available at http://dmh.lacounty.gov/wps/portal/dmh/our_services/tay.

⁴³ Programs for Adults. CA Dept. of Mental Health 2011. Information available at http://www.dmh.ca.gov/Services_and_Programs/Adults/Default.asp

⁴⁴ California Department of Mental Health. 2011. Older Adult information available at http://www.dmh.lacounty.gov/DMHServices/older_adults.html

⁴⁵ U.S. Department of Health & Human Services: Substance Abuse and Mental Health Services Administration. 2011. California Grant Information available at <http://www.samhsa.gov/Statesummaries/StateSummaries.aspx>

⁴⁶ California Department of Alcohol and Drug Programs. 2011. Information available at <http://www.adp.cahwnet.gov/about/index.shtml>

⁴⁷ Deborah Kelch. March 2011. *The Crucial Role of Counties in the Health of Californians: An Overview*. California HealthCare Foundation.

⁴⁸ CA Senate Office of Research. July 2009. Policy Brief: Finding Answers, A Resource Guide on the Licensing and Certification of Health and Community Care Facilities in California

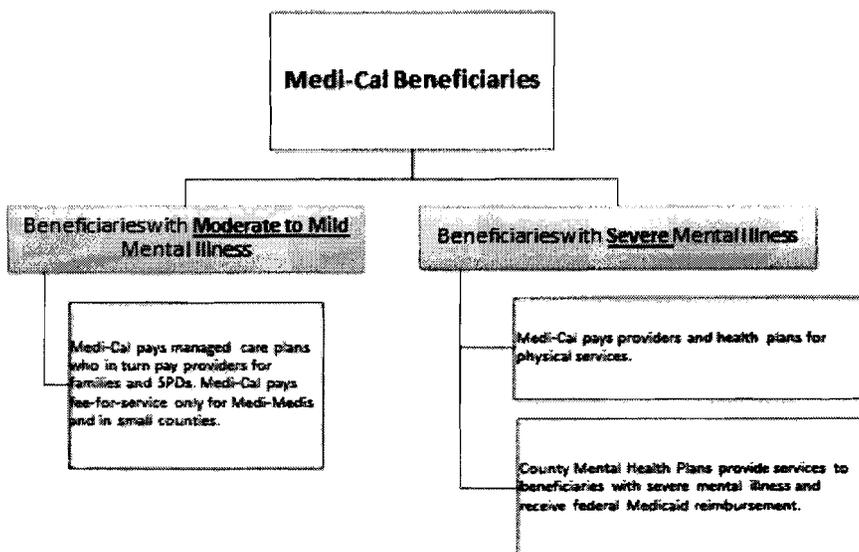
California Department of Veteran Affairs

For adults who have served the United States Military, The California Department of Veteran Affairs provides mental health services within the State of California.⁴⁹ The Department of Defense offers mental health services for recently deployed military, through its Military Health System.⁵⁰ Additional mental health services are offered through the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury.⁵¹

County Service Delivery

At the county level, both payment and service delivery for patients with mental illness are fragmented, with different systems for medically indigent adults and for Medi-Cal beneficiaries. In both systems, the majority of patients with severe mental illness receive mental health care from one agency and physical health services from another. Substance abuse services may or may not be delivered by the mental health provider and may or may not be overseen by the same county agency responsible for mental health. In fact, there is tremendous variation between counties in how mental health programs, alcohol and drug programs, physical health programs, and public health programs are organized.⁵² Thirty-seven counties have integrated behavioral health departments responsible for both mental health and substance abuse, while the rest have separate departments or combine behavioral health with public health.⁵³

The county agency responsible for treatment of patients with mental illness is determined by the degree and nature of illness, which some counties distinguish by 3 tiers of severity of mental illness.⁵⁴ Level 1 comprises patients with chronic and severe mental diseases such as schizophrenia, where debilitation from the progression of the disease may pose harm to the individual and or society. Mental health services for these patients are carved out of both Medi-Cal and county indigent health programs and instead fall within the purview of county mental health programs. While all county MHPs must provide this care to Medi-Cal beneficiaries, eligibility criteria and service availability for medically indigent adults can vary significantly between counties.



Level 3 encompasses the majority of people who experience moderate to mild mental illness such as mild depression or anxiety disorders; these patients are able to improve through medication, management, counseling, and other outpatient treatments. This level of service can be managed by a primary care physician

⁴⁹ California Department of Veteran Affairs. 2011. Information available at <http://www.cdva.ca.gov>.

⁵⁰ Military Health Services. 2009. In Transition: Department of Defense. Information available at <http://www.health.mil/InTransition/default.aspx>.

⁵¹ Military Health Services. 2011. Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury. Information available at <http://www.dcoe.health.mil/>

⁵² Nicholas C. Petris Center on Health Care Markets and Consumer Welfare. January 2005. Measuring Mental Health in California's Counties: What Can We Learn? Report available at <http://www.petriss.org/Docs/MentalHealth.pdf>

⁵³ Sarkin, Cliff. April 1, 2011. Insure the Uninsured Project. County LIHP Proposals: Summary and Analysis. Report available at <http://itup.org/wp-content/plugins/download-monitor/download.php?id=5>

⁵⁴ Presentation: Behavioral Health Care Administration in California. 2011. Insure the Uninsured Project in attendance. Report available at

and is usually provided by a patient's physical health provider and paid for by the county indigent health program or by Medi-Cal.

The middle ground of serious but non-recurring mental illness such as a temporary but severe depression after divorce or death of a loved one, defines Level 2 treatment. This is an area of unclear responsibility, falling in between the county MHP and Medi-Cal/indigent health agencies. Many counties have gaps in services for patients who experience serious but non-recurring mental illness.

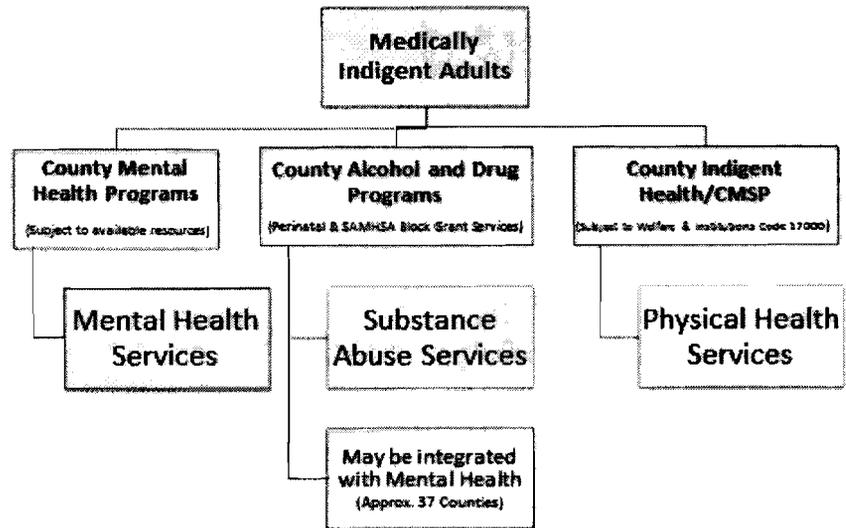
County: Medi-Cal and County Mental Health Plans

The State Department of Health Care Services' (DHCS) finances and administers the California Medical Assistance Program (Medi-Cal).⁵⁵ Medi-Cal pays for health care for the mentally ill who are eligible for the program – primarily low-income families, the disabled and seniors. In 2014, Medi-Cal coverage will expand to all legal permanent residents under 133% of the federal poverty line, and will therefore cover many more people with mental illness.

Medi-Cal subcontracts with health plans, with the state and county mental health departments to pay for and provide mental health services to its beneficiaries. Patients with mild to moderate (Level 3) mental illness

receive mental health care through their physical health provider, often managed by their Medi-Cal Managed Care Plan (MMP). Medi-Cal beneficiaries with more severe mental illness must receive their specialty mental health services (Level 1) through the County Mental Health Plan (MHP) as stipulated in the 1995 Freedom of Choice waiver. These services include: inpatient hospital, psychiatric health facility, adult residential treatment, crisis residential treatment, crisis stabilization, intensive day treatment, day rehabilitation, case management, mental health services, medication support, and crisis intervention. County MHPs also provide mental health services associated with the federal Early Prevention, Screening, Diagnosis, and Treatment (EPSDT) program to Medi-Cal beneficiaries under age 21. Every California County has its own MHP, operates its MHP through its County Organized Health System (San Mateo and Solano), or operates an MHP with in conjunction with a fellow county (Sutter and Yuba counties, Placer and Sierra counties).⁵⁶

Coordination of Mental Health Programs and Services is facilitated through, CalMEND, a “Quality Improvement Collaborative Partnership” between the DHCS and the Department of Mental Health to improve care for Medi-Cal beneficiaries with serious mental illness or serious emotional disturbance.⁵⁷ At the individual patient level, however, communication, information-sharing, and coordination for physical and mental health providers or plans sharing responsibility for the same patient can be very difficult. Parallel, disconnected systems also make it difficult to ensure accountability for managed care patients because MHPs do not report back to Medi-Cal



⁵⁵ California Department of Mental Health. July 2011. *Clarification and Updates*. Information available at http://www.dmh.ca.gov/Prop_63/MHSA/Community_Services_and_Supports/docs/FSP_FAQs_04-17-09.pdf

⁵⁶ Deborah Kelch. March 2011. *The Crucial Role of Counties in the Health of Californians: An Overview*. California HealthCare Foundation.

⁵⁷ California Department of Health Care Services. 2011. *Mental Health*. Information available at <http://www.dhcs.ca.gov/services/Pages/MentalHealth.aspx>

managed care plans. Many pilot programs, discussed later, aim to address this issue by co-locating physical and mental health services.

County: Indigent Health Programs/County Medical Services Program (CMSP) and Community Mental Health Services

California counties provide health care for their low-income uninsured adults through Indigent Health Programs or CMSP. In the 24 larger counties, each county designs and operates its own program to pay for or provide physical health services to the indigent uninsured, including those patients with mental illness. CMSP operates in 34 rural counties, providing health care services for adults residing in California who are indigent but not eligible for Medi-Cal. Both county Indigent Health Programs and CMSP pay for physical health services for eligible uninsured persons with mental illnesses, although eligibility rules, delivery networks, access to care and covered benefits vary across counties. Several of the larger counties and CMSP operate small pilot programs to provide integrated behavioral health in community and/or county clinics.

Realignment and W and I Section 17000 legally require counties to provide mental health care for seriously mentally ill adults, seriously emotional disturbed children, and those experiencing acute psychiatric crisis through a community mental health services program. However, this requirement is circumscribed by the extent that funding resources are available, meaning that counties can and do limit eligibility and access to mental health services for medically indigent adults.⁵⁸ This causes significant variation in mental health access and treatment for the uninsured across counties. The federal matching opportunities for Medi-Cal patients incentivize local maximization of mental health services for Medi-Cal patients, who receive a federal match, instead of the uninsured MIA population. The separation of physical and mental health care for indigent adults also leads to difficulties in coordination of care for MIAs similar to those seen for Medi-Cal patients. For example, a bi-polar patient with a substance abuse problem (also known as dual diagnosis) may well need to navigate the delivery systems and eligibility rules of three separate county agencies,

Under AB 3632, counties are also responsible for providing mental health services to children who are eligible for special education services. Due to a lack of state funding, this mandate was suspended in FY 2010-2011, and will continue to change in this year's budget (see Challenges below).⁵⁹

County: Alcohol and Drug Programs

Unlike mental health services, counties have no statutory obligation to provide most substance abuse services. Even so, every county (but one, Plumas) contracts with the state Department of Alcohol and Drug Programs to administer local programs through direct services, contracting, or a mix of both. Thirty-nine counties contract with ADP to operate a Drug Medi-Cal program, with ADP directly operating the program in the other 19.⁶⁰ These programs may be integrated with mental health programs through a single county department of behavioral health (37 counties), may be operated through a separate department, or may be integrated with a different department, such as public health.

Counties are legally required to provide drug treatment for eligible nonviolent offenders under the Substance Abuse and Crime Prevention Act (Prop. 36). Because state funding for these services was eliminated in FY 2009-2010, many counties have long waiting lists for the Offender Treatment Program.⁶¹

CURRENT CHALLENGES

The transition from state hospitals to community-based mental health care allowed many mentally ill Californians to live outside of institutional settings, but had unintended consequences and challenges, such as an increase in homeless mentally ill and an increase in mentally ill in state prisons and county jails some of which are discussed below. Funding has also been a source of ongoing concern.

⁵⁸ Deborah Kelch, March 2011. *The Crucial Role of Counties in the Health of Californians: An Overview*. California HealthCare Foundation.

⁵⁹ Deborah Kelch, March 2011. *The Crucial Role of Counties in the Health of Californians: An Overview*. California HealthCare Foundation.

⁶⁰ Deborah Kelch, March 2011. *The Crucial Role of Counties in the Health of Californians: An Overview*. California HealthCare Foundation.

⁶¹ Deborah Kelch, March 2011. *The Crucial Role of Counties in the Health of Californians: An Overview*. California HealthCare Foundation.

Safety in State Mental Hospitals

A Select Committee on State Hospital Safety, chaired by Assemblyman Michael Allen (D-Santa Rosa), published a report revealing that there were roughly 6,700 aggressive incidents and approximately 5,100 injuries at the state's mental health facilities; of those injuries, about 1,000 were suffered by staff members.⁶²

In 2005, the United States Department of Justice (USDOJ) conducted an investigation pursuant to the Civil Rights of Institutionalized Persons Act of 1980 (CRIPA).⁶³ CRIPA authorizes the U. S. Attorney General to conduct investigations and initiate litigation relating to conditions of confinement in state or locally operated institutions, including Intermediate Care Facilities for Persons with Mental Retardation.⁶⁴ The statute allows the federal government to identify and root out systemic irregularities such as those identified in California's case, rather than focus on individual civil rights violations. On May 2, 2006, the USDOJ and the State of California reached a settlement concerning civil rights violations at four California State Hospitals: Metropolitan State Hospital, Napa State Hospital, Patton State Hospital, and Atascadero State Hospital. The extensive reforms required by the five-year Consent Judgment ensure that individuals in the hospitals are adequately protected from harm and are provided adequate services to support their recovery and mental health.⁶⁵ The State is now addressing and correcting the agreed upon violations as identified by the USDOJ.

In response to the deaths that occurred in California's state mental health facilities, Health and Human Services Secretary Diana Dooley ordered installation of an alarm system at Napa State Hospital, lifted a hiring freeze, and added more jobs to hospital police officer teams and psychiatric technicians at state mental health hospitals within the next fiscal year.⁶⁶

Mental Health Care – Incarceration Overlap

Mental health care is a huge concern in the state's general prison population. Recent studies indicated that more mentally ill persons are in jails and prisons than hospitals, estimating at least 16 percent of all inmates incarcerated in California jails and prisons had a serious mental illness. In comparison to the number of patients in state, private and psychiatric units with mental illness, jails and prisons house nearly 4 times as many mentally ill.⁶⁷ Due to overcrowding and underfunding, management of prisoners with mental illness has become increasingly difficult and dangerous for the mentally ill prisoners, the guards, fellow inmates and those trying to provide care

To further complicate matters, on May 23, 2011, the U.S. Supreme Court ordered California to reduce its prison population by more than 33,000 inmates.⁶⁸ The 2011-12 budget realignment of these inmates, low level non-violent offenders, from state prisons to county jails will shift the burden of mental health services from state institutions to the counties.

With the transfer of thousands of inmates around California, and budget cuts threatening to dismantle mental health services, California faces immense challenges in bolstering its management of the criminal mentally ill. On April 4, 2011, Governor Edmund G. Brown Jr. signed Assembly Bill 109, historic legislation that will enable

⁶² California Association of Psychiatric Technicians. 2011. Select Committee on State Hospital Safety. 2010. Available at www.psychtechs.net

⁶³ Department of Aging and Disability Services. April 5, 2007. Civil Rights of Institutionalized Persons Act: Briefing available at http://www.dads.state.tx.us/news_info/presentations/archive/cripa_4-5-07.pdf

⁶⁴ United States Department of Justice. Civil Rights of Institutionalized Persons Act. Information available at <http://www.justice.gov/crt/about/spl/cripa.php>

⁶⁵ State Department of Mental Health. May 2, 2006. United States Department of Justice Agree on Enhancement Plan for State Hospitals. Press Release available at http://www.dmh.ca.gov/News/Press_Releases/2006/PressRelease_06May2.asp

⁶⁶ Romney. May 16, 2011. Plans target state hospital safety: Bills would separate violent patients and increase surveillance at mental facilities. *Los Angeles Times*. Article available at <http://articles.latimes.com/2011/may/16/local/la-me-hospital-violence-20110516/2>

⁶⁷ Torrey EF, Kennard AD, Eslinger D, Lamb R, Payle K. May 2010. *More Mentally Ill Persons in Jails and Prisons Than Hospitals: A Survey of the States*. Treatment Advocacy Center.

⁶⁸ California Supreme Court. 2011. Information available at <http://www.supremecourt.gov/opinions/10pdf/09-1233.pdf>

California to close the revolving door of low-level inmates cycling in and out of prison. ⁶⁹AB 109 ensures that the state will continue to incarcerate serious criminals and will support counties in the supervision, rehabilitation and management of less serious offenders.

California 2011-12 Budget - Funding Allocation

Budget: Realigning Services to Local Governments

The enacted budget contains funding changes, which will impact the DMH's oversight of community mental health programs and direct services in state mental hospitals, and counties will be affected by a new distribution of realignment funds. DMH's oversight of community mental health is eliminated and shifted to DHCS. DMH's operation of state mental hospitals is shifted to a new Department of State Hospitals. A series of mental health programs are combined in a new mental health realignment from the state to the counties.⁷⁰ Public safety programs are realigned to the counties, as are social services programs and Drug Medi-Cal. This may provide the opportunity to reorganize and improve the efficiency of mental health care services in California. The Budget allocates \$4.5 billion (\$1.3 billion-General Fund) to the State DMH in 2011-12.⁷¹ The total for the state to county program realignment in the 2011-12 Budget is \$5.1 billion.

2011- 12 Budget: Mental Health Services and Youth

An important fiscal solution in the budget is to fund existing Community Mental Health Programs from Prop 63 the Mental Health Services Fund (MHSF). Legislation authorizes the one-time use of the MHSF as match for mental health services delivered through the Early and Periodic Screening, Diagnosis and Treatment program, the Mental Health Managed Care program, and mental health services to special education students.

In efforts to contain costs and ensure quality of mental health care and education for children with mental illness, the Budget shifts the responsibility for providing mental health services to the schools, which includes out-of-home residential services. From the MHSF, \$98.6 million will be allocated to county mental health agencies on a one-time basis for mental health services to special education students, and the ongoing responsibility for these services is realigned to school districts.⁷² The Budget recalculates the Proposition 98 guarantee of school funding and provides an increase of \$221.8 million - General Fund to shift responsibility for providing mental health services for children from county mental health departments and county welfare departments to school districts. Schools districts may contract with county mental health to provide these services using the designated Proposition 63 funds, but schools would be responsible for any costs exceeding that amount.

California Initiatives

Bridging the Gap between Physical and Mental Health Coverage:

The §1115 Medicaid Waiver

The State's §1115 Medicaid Waiver will provide funding and support for major improvements in California's mental health care delivery system. The previous §1115 Waiver originated as 10 pilot "Coverage Initiatives" designed to expand coverage to low-income populations in California and limited to \$180 million annually in new federal funds. The waiver renewal in 2010 includes all 58 counties, lifts the federal budget cap for care of

⁶⁹ http://www.leginfo.ca.gov/pub/11-12/bill/asm/ab_0101-0150/ab_109_bill_20110329_enrolled.html

⁷⁰ Realignment funding from the January Budget provided \$104 million to operate services associated with AB 3632.

⁷¹ California Department of Finance. June 30, 2011. *2011-2012 Enacted Budget: Summary Veto Message*. Information available at http://www.dof.ca.gov/budget/historical/2011-12/documents/2011-12_Enacted_California_Budget_Summary-Veto_Message_Package.pdf

⁷² Department of Finance. 2011. California Budget Summary available at <http://www.ebudget.ca.gov/pdf/Enacted/BudgetSummary/HealthandHumanServices.pdf>

indigent adults with incomes of less than 133% of the Federal Poverty Level and includes match funding for mental health services.⁷³

The waiver also requires the SPDs (Seniors and Persons with Disabilities) to enroll in Medi-Cal managed care plans. Only those with joint Medicare and Medicaid coverage (Medi-Medis) are exempt from mandatory enrollment although they may enroll voluntarily. Nearly a quarter of California's SPDs have a need for mental health care services, making up 22% of the population.⁷⁴

The waiver provisions may help facilitate the integration of physical and behavioral health. In the new §1115 Waiver, the Low Income Health Program (LIHP) presents California counties the opportunity to receive millions of dollars in federal matching funds to provide improved coverage for their medically indigent adult (MIA) populations.⁷⁵ If they participate in the LIHP, counties will identify MIAs, have additional resources to pay for expanded health and mental health services, update and expand their delivery systems, increase access to care, and transition the MIA population into managed care programs through either the Medi-Cal program or California's new Health Benefit Exchange starting on January 1, 2014.

Under the Low Income Health Program (LIHP), limited mental health coverage is mandatory for the population under 133% of FPL and optional if a county chooses to offer coverage to higher income populations. Counties are required to cover minimum mental health services that meet a defined medical severity threshold (significant impairment in life functioning or probability of significant deterioration in important life functioning). Programs must provide at least ten days of inpatient mental health care, all psychiatric pharmaceuticals, and at least twelve outpatient mental health visits annually. Resources permitting, counties can provide additional mental health services, and can provide substance abuse services.

Counties had the option to propose a system for mental health services that would either be separate (i.e. carved out, subcontracted to mental healthcare providers) or included in their network or delivery system. Counties such as Contra Costa, Kern, Monterey, Pasadena, San Diego, Santa Barbara, and Ventura will include mental health services in their networks, but in 16 other counties (Alameda, Fresno, Los Angeles, Merced, Orange, Placer, Riverside, Sacramento, San Francisco, San Bernardino, San Joaquin, San Luis Obispo, Santa Clara, Santa Cruz, Tulare, and Yolo), mental health services will be separated (carved out) from their physical health networks.⁷⁶

Under the Waiver, counties can receive a federal match for their local mental health services spending to the MIA population. Matching is also available for county substance abuse services. Counties may choose to expand their care threshold and networks of mental health care with the new funding. The Waiver facilitates but does not require a connection among county health departments, mental health departments, hospitals and community clinics to work together to best serve the needs of their patients.

Waiver Integration Initiatives

Under the Waiver, public hospital systems are eligible to participate in a Delivery System Reform Incentive Program (DSRIP), which will provide federal reimbursement subject to the achievement of multiple milestones related to delivery system transformation. Counties across the state are experimenting with models in which the delivery of behavioral and mental health are more closely aligned and integrated. Ten public hospitals, listed

⁷³ California State Waiver initiatives and progress are described in a series of ITUP reports. Overview, Update and Summary of California's §1115 Waiver Coverage Expansion Initiatives accessible at www.itup.org

⁷⁴ National Alliance on Mental Illness. October 7, 2010. US State Data on Disability Income, Housing Costs and People with Mental Illness. Report available at <http://www.disabled-world.com/disability/statistics/state-data.ph>

⁷⁵ County LIHP Proposals: Summary and Analysis. 2011. Insure the Uninsured Project. Article available at http://www.itup.org/Reports/Health%20Reform/County_LIHP_Proposals_03312011.pdf

⁷⁶ Department of Health Care. California's county information available at <http://www.dhcs.ca.gov/provgovpart/Documents/LIHP/Applications/ProgramRequirementsandApplicationProcessREV01-25-11.pdf>

in the following chart, included projects to integrate physical and behavioral health as part of their DSRIP plans.⁷⁷

County	Innovative Integration Models
Los Angeles	Operating three initial pilot programs (with the intention of expanding to eight sites) in which a mental health practice is co-located in a physical health center; LA Dept. of Mental Health is funding an integrated clinic model, mobile health team, and a consumer self-help service. LA Dept. of Mental Health is funding Level 2 services in clinic and county sites.
San Mateo	Implementing primary care provider “curbside” consultations; co-location of nurse practitioners providing the physical health needs for mental health patients in behavioral health clinics; allowing mental health clinics to serve as the medical home for a patient with a predominance of mental health issues.
Santa Clara	Considering the placement of psychiatrists and other mental health specialists in primary care clinics.
Contra Costa	Combining mental health treatment, substance abuse treatment, and homeless assistance into one entity, so patients can utilize the same assessment tools and case managers; Building a new health center in which multi-disciplinary team members work on the same floor and in close proximity.
San Francisco	Integrating behaviorists into community health centers available for both curbside advice and/or warm hand-offs for 20-minute interventions. Behaviorist assistants are also available to link patients with community resources. Maxine Hall, the most successful behaviorist integration clinic, has provided 485 visits to 442 patients with an average patient satisfaction rating of 8.5.
Ventura	Ventura County Medical Center will be co-locating primary and behavioral health care for adults and pediatrics, as well as utilizing the evidence-based Improving Mood Promoting Access to Collaborative Care Treatment (IMPACT) Model for prevention and early intervention of behavioral health conditions within the primary care setting.

Local and County Pilot Projects:

Integrated Behavioral Health Project (IBHP)

Launched in 2006, the Integrated Behavioral Health Project (IBHP) is a four-year initiative to accelerate the integration of behavioral health services into primary care settings in California. Its goals are to enhance access to behavioral treatment services, improve treatment outcomes for underserved populations, and reduce the stigma associated with seeking such services. IBHP is funded by The California Endowment as a part of its strategic goal to promote the health of underserved individuals and families by expanding access to quality health and mental health services.⁷⁸ The IBHP published “Partners in Health: Primary Care/County Mental Health Tool Kit,”⁷⁹ which is designed to help primary care clinics and government mental health agencies forge collaborative relationships. The report provides practical operational advice, forms, strategies and prototypes for integrating mental and physical services.

The Integration Policy Initiative (IPI)

Funded by the California Endowment, IPI launched in 2008 and is led by the California Institute of Mental Health (CiMH), the California Primary Care Association (CPCA), and the Integrated Behavioral Health Project (IBHP). IPI recently produced a report as part of the California Primary Care, Mental Health and Substance Abuse Initiative⁸⁰, a product of several discussions between county and state mental health and health leaders to enhance collaborative care in California. Exploring models of integrated care throughout the State, the report makes recommendations for service delivery, finances, regulations and measurements.

⁷⁷ Insure the Uninsured Project. 2011. Safety Net Integration. Report available at www.itup.org

⁷⁸ California Endowment, Tides Project. Information available at <http://www.ibhp.org/>

⁷⁹ Integrated Behavioral Health Project. Partners in Health: Primary Care / County Mental Health Tool Kit, Report available at <http://www.ibhp.org>

⁸⁰ California Department of Health Care Services. Information available at http://www.dhcs.ca.gov/provgovpart/Documents/IPI_Vol_I_Report_9-14-09_lo.pdf

County Medical Services Program Behavioral Health Pilot Project (CMSP)

The CMSP Governing Board designed a behavioral health pilot project (CMSP BHPP) to test the quality and cost-effectiveness of covering short-term mental health and substance abuse treatment, integrated with primary care⁸¹. The pilot project operated for three years (March 2008-February 2011) and provided grantee sites with administrative support payments of up to 15% of direct service costs to help pay for oversight, administration, and data collection (a total of \$352,000 in administrative support payments across the sites). The chart below shows the participating counties in California.

CMSP BHPP - Funded Pilot Project Sites, by Region

Region	Lead Agency (Grantee)	Other Sites
Coastal North	Open Door Community Health Centers	Del Norte Community Health Center Eureka Community Health Center Humboldt Open Door North Country Clinic
	Redwoods Rural Health Center	
Bay Area	Community Health Clinic Ole	
	Petaluma Health Center	Southwest Community Health Ctr. West County Health Centers, Inc.
	Sonoma Valley Community Health Center	
Central Valley North	Del Norte Clinics, Inc.	Chico Family Health Center, Del Norte Family Health Center, Lindhurst Family Health Center, Oroville Family Health Center Richland Family Center
	Shasta Consortium of Community Health Centers	Hill Country Community Clinic, Shasta Community Health Center Shingletown Medical Center
	Tehama County Health Services Agency	Corning Medical Associates, Inc.
Mountain North	McCloud Healthcare Clinic, LLC	
	Chapa-De Indian Health Program, Inc.	
	Sierra Family Medical Clinic, Inc.	Western Sierra Medical Clinic, Inc. Miners Community Clinic, Inc.
Mountain South	El Dorado County Community Health Center	
	Southern Mono Healthcare District	Mammoth Hospital
	Sonora Regional Medical Center	

Four CMSP behavioral health pilot project sites concurrently participated in the IBHP: Chapa-De Indian Health; Open Door Community Health Centers; Petaluma Health Center; and Sierra Family Health Center.⁸²

Results from the evaluation are depicted in the graphs below, from The Lewin Group evaluation⁸³. The redistribution of costs and shift in percentage for each expenditure category suggests improved delivery of mental health services, where alignment with behavioral health has decreased inpatient costs. Strengthening integration of primary care and behavioral health care and providing additional coverage for behavioral health

⁸¹ County Medical Services Program Governing Board, CMSP Behavioral Health Pilot Project RFP. Retrieved December 20, 2010, from: http://www.cmsspcounties.org/pdf_files/BHRFP.pdf.

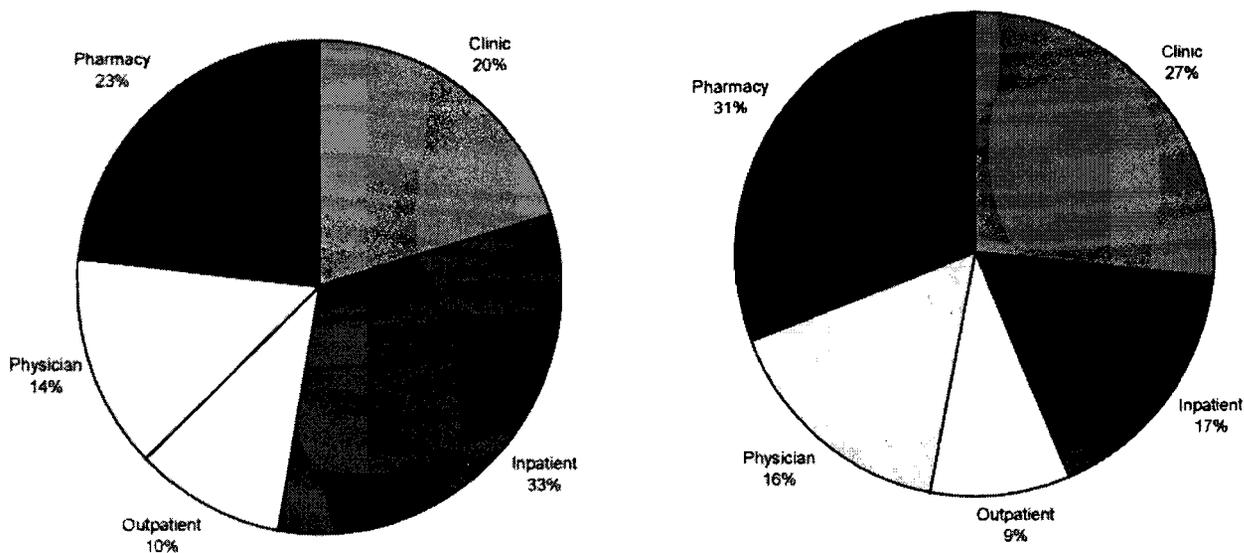
⁸² Integrated Behavioral Health Project. Recipient information available at: <http://www.ibhp.org/index.php?section=pages&cid=217>.

⁸³ CMSP Governing Board Strategic Planning Meeting Butte County Data. Retrieved January 31, 2011, from: http://www.cmsspcounties.org/pdf_files/data/BUTTE04.pdf.

services can lead to more appropriate service delivery, with potential for improved health and savings in the long term.

CMSP BHPP – Pilot Participant Expenditures:

Cost for Pilot Participants Before and After Enrollment



Pilot Conclusions

Analysis provided by Lewis Group shows the pilot proved successful in achieving benchmarks pertaining to appropriate service delivery and care coordination.⁸⁴ In terms of access to care, the pilot reported an increase in the number of prescribed psychiatric medications and in the number of mental health office visits in comparison to the control group. A significant decline in the rate of psychiatric hospitalizations and lower emergency room usage is indicative of the coordinated care improvements. Analysis suggests that physical and mental health integration will yield better health outcomes and savings.

Medical Education Improvements

A study conducted in part by the Institute of Medicine, indicates that the curriculum in most U.S. medical schools is limited in behavioral health education.⁸⁵ The Office of Behavioral and Social Sciences Research (OBSSR)⁸⁶, in association with the National Institute of Health (NIH), created several pilot programs to enhance Behavioral and Social Sciences in medical education. The David Geffen School of Medicine at the University of California, Los Angeles, was among the 2008 grant recipients.⁸⁷

⁸⁴ County Medical Services Program. Evaluation of Pilot Programs by Lewin Group. Report available at www.cmspcounties.org/pdf_files/CMSPBHPPFINALRPT021711.pdf

⁸⁵ National Institute of Health (NIH). (July 2004). Study available at <http://www.absame.org/pdf/10M%20Exec%20Sum.pdf>; copyrights obtained through National Academies Press at www.nap.edu

⁸⁶ Office of Behavioral and Social Sciences Research. (Nov 2008). Strengthening Behavioral and Social Science in Medical School :Progress Report. Accessible at: <http://obssr.od.nih.gov>.

⁸⁷ Institute of Medicine. (2011). Mental Health information available at <http://iom.edu/Activities/PublicHealth/PrimaryCarePublicHealth.aspx>

Examples of County MHSA Improvements (Prop 63) in 2009

Featured in the County Progress and Highlights Fact Sheet, the chart below lists the impacts of MHSA on counties in California in terms of mental health service improvements.⁸⁸

County	2009 MHSA Affiliated Improvements
Colusa	Integrated primary care and mental health services. Is working with external agencies, such as Adult Protective Services to increase referrals, and is establishing a four-bedroom supportive housing program to help decrease Psychiatric Hospital Facility usage
Kern	Changing the system outlook from disability to recovery and wellness, including more peer specialists on staff, and integrating co-occurring disorders into mental health services. Kern also created a Self-Empowerment Team, Homeless Adult Team and Recovery and Wellness Centers. Kern reported an increase in services to 1,182 unduplicated clients.
Los Angeles	Reinforcing collaboration with community-based organizations to better integrate clients into the community. More fluidity between levels of care has meant more individuals can enter into a Full Service Partnership Program.
San Bernardino	Recognition of consumers and family members as the true experts in the recovery process resulted in stronger collaboration with community partners to identify mental health needs and successfully transform its mental health delivery system. They expanded several of their programs and added an Early Wraparound, Children's Crisis Response Team, and One-Stop Centers for Transitional Youth, a Psychiatric Triage Diversion Team and older adult Mobile Outreach and Case Management Program.
San Benito	Shifted from a clinical, one-on-one counseling emphasis to community-based services by offering more group sessions at their Esperanza Center, an important community asset and meeting place. They also added a Transition Age Youth (TAY) Program and reported an increase of 632 individuals in their client base.

Observations, Opportunities and Recommendations:

Although decreased State funding restricts efforts to improve mental health care services in California, devolution of responsibility to the local level may help improve the delivery of mental health care, where there are successful examples for interested counties to build upon. Furthermore the consolidation of mental health and drug Medi-Cal into state DHCS may improve state oversight, streamline state administration and ultimately increase accountability.

The §1115 Waiver provides an important opportunity for counties to develop major innovative improvements to California's mental health care delivery in the interim period leading up to 2014. It will be up to counties to grasp these opportunities during this period. The state and federal governments must assure accountability in those communities who may seek to absorb the new funds without embracing the necessary fundamental changes.

ACA will cover many of the uninsured mentally ill through Medi-Cal. 100% federal funds will pay for the new eligibles – a financial 180 degree turn since this care is now financed with 100% state and local funds. ACA will require California to upgrade coverage of mental health for current Medi-Cal patients. In particular, level 2 mental health services must be covered; there is uncertainty as to the extent of this cost, and California's policy makers will need to decide who will bear these new costs – the state or county governments, Prop 63 or some combination. There will likely be negotiated financial trade-offs between the state and county governments in these decisions.

⁸⁸ California Mental Health Planning Council, Published Reports: Policy and System Development End-of-Year Summary 2008-2009, January 2010 Report by Policy and System Development Committee (PSDC) available at http://www.mhsoac.ca.gov/About_MHSAAC/docs/FactSheet3.pdf

Policy makers will need to decide whether level 2 mental health should be under the governance of the local Medi-Cal managed care plan (MMC) or the local county Mental Health Plan (MHP) and how better coordination and integration of physical and mental health should proceed with respect to both plans and providers at all three tiers of mental health services. One evolutionary option is to use county MHPs as a subcontractor to the local Medi-Cal managed care plan to manage all levels of mental health services; another option would be to use the MHP as a subcontractor only for level 1 mental health care.

The implementation of parity and the inclusion of mental health as an essential benefit in the Exchange, private insurance and Medi-Cal will increase incentives to integrate physical and mental health coverage and promote more effective and accountable mental health care and treatments. The mental health carve out is not likely to be sustainable over the long term under ACA and federal parity rules, unless it can be demonstrated to produce superior results more cost effectively than the alternatives. Data will need to be collected and outcomes assessed; policy makers will need to decide whether a carved out and exclusive system of county mental health services for the severely mentally ill with Medi-Cal coverage produces better health outcomes for patients at affordable costs. Should there be competition? Can California introduce quality, price and outcome transparency into county systems? Can California assure comparable treatment of the mentally ill in all 58 counties, which it must under federal law.

The Exchange is likely to contract with private and public plans for the full range of physical and mental health services; there is significantly less likelihood of a mental health carve-out. The Exchange is likely to give the contracting plans the option to subcontract for specialty mental health with those plans and providers that offer the best outcomes at lowest cost. County mental health plans will need data and be able to show their outcomes and efficiency in order to secure such contracts.

Appendix 1

Understanding the changes in California's Mental Health System is critical to analyzing the current structure and status of public mental health services in California. The chart below, directly adopted from the Legislative Analyst's Office, depicts a timeline to summarize the development of mental health care in California throughout the years.⁸⁹ Milestones illustrate the transition from institutionalized care towards community-based treatment of people with mental illness.

Timeline of Mental Health Care Development in California- History of Service & Delivery	
Date	Major Milestones
Early Delivery of Mental Health Services in California - Process of Deinstitutionalization	
Prior to 1957	State Hospital System Before the sixties, most health care involved State institutions for treatment of people with severe mental illness. The State-operated and funded fourteen hospitals in total; 8 serving the mentally ill, 4 caring for the developmentally disabled, and 2 serving both populations.
1957	Short-Doyle Act Provided financial assistance to local governments to establish and develop locally administered and controlled community mental health programs. Originally the State paid for 50 percent of cost. By 1962-63 only 20 jurisdictions had established Short-Doyle programs. In 1963, legislation increased state funding participation to 75 percent for community mental health programs and expanded the scope of services reimbursed by the state, thus encouraging additional Short-Doyle programs (41 by 1968).
1965	Adoption of Medicaid The enactment of the Medi-Cal Program in 1966 shifts coverage of mental illness from mental hospitals to community sites. Starting in 1967 many geriatric state hospital patients were moved from the hospitals to nursing homes, where the federal government paid one-half the cost in lieu of the state paying 100 percent of the state hospital cost.
1968	Lanterman-Petris-Short Act (LPS) Made major change in the legal commitment process for the mentally ill by requiring a judicial hearing procedure prior to any involuntary hospitalization. State funding participation for community mental health programs was increased to 90 percent and all counties were covered by LPS. (enacted July 1, 1969)
Movement to Community Based Care - Distribution of Services and Funding Allocation Changes	
1969-74	First Closure of State Hospitals As a result of declining hospital population, three hospitals (Modesto, DeWitt, and Mendocino) were closed. Budget shortfalls displaced state's institutional savings away from counties' community mental health services until augmentation in 1974 when legislation made a major local program augmentation of \$40 million, an increase of approximately 34 percent.
1976	Equity Distribution of Funding Legislature adopted an "equity distribution" formula for the allocation of new funds to the counties as a result of the underfunding of some counties since the inception of the program. The formula was in effect for three years. Los Angeles, San Diego, Riverside, and San Bernardino Counties received approximately 50 percent of the funds.
1984	Equity Distribution of Funding Revisited Department of Mental Hygiene developed a "poverty/population model" for allocating new funds to counties, in response to the contention of many counties that they were still underfunded. A total of \$79 million of new money was allocated to the counties over a three year period using the new formula.
1985	Chapter 1286, Statutes of 1985 (Bronzan-Mojonnier Act) Enacted significant provisions relating to 1) identifying the shortage of services which resulted in the criminalization of the mentally disordered, 2) community support for homeless mentally disordered persons, 3) vocational services, and 4) seriously emotionally disturbed children.
1987-88	AB 377 (C. Wright) Expanded Ventura County's pilot project, Children's System of Care (CSOC), designed to test the effectiveness of a coordinated and closely monitored community- and home-based service delivery system for severely emotionally disturbed children. Increased state and federal funds have enabled expansion to 42 counties. 1988 Demonstration projects were established to test the effectiveness of a community-based, integrated service system of care for adults with serious mental illness.

⁸⁹ Chart adopted from Legislative Analyst's Office, March 2, 2000. Major Milestones: 43 Years of Care and Treatment of the Mentally Ill. Original document available at: http://www.lao.ca.gov/2000/030200_mental_illness/030200_mental_illness.html

Realignment Impact	
1989-91	Funding Shortfalls As a result of the state's economic downturn, no new General Fund money was proposed for two years. Instead budget provided \$25 million from the Cigarette and Tobacco Products Surtax Fund (Proposition 99) in 1989-90 and an additional \$10 million from that fund in 1990-91.
1991	Realignment Major shift of authority from state to counties for mental health and other health programs. Funding changes were intended to be fiscally neutral and included: new sales and vehicle license fee taxes and changed state/county cost sharing ratios in health and social service programs. Revenues initially fell short of expectations due to the recession.
1995	Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Increased state matching funds provided to counties in order to comply with the T.L. v. Belshe lawsuit, which required that all federally mandated Medi-Cal programs be funded.
1995-97	Medi-Cal Mental Health Managed Care and the State Waiver The Freedom of Choice Waiver merged county and state inpatient and outpatient Medi-Cal mental health service into a single county level mental health managed care program. Inpatient and various specialty psychiatric services became the responsibility of a single entity, the Mental Health Plan (MHP) in each county. All Medi-Cal recipients are required to obtain these services through the MHP.
1999	Chapter 617 (AB 34, Steinberg) Authorizes grants totaling \$9.5 million for one-year pilot programs in up to three counties to provide services to severely mentally ill adults who are (1) homeless, (2) recently released from jail or prison, or (3) at risk of being homeless or incarcerated in the absence of services. ⁹⁰
2004	Mental Health Services Act Authorizes 1 percent income tax applied to people who have incomes greater than 1 million.
Health Reform - Mental and Physical Health Services Connect	
2008	Mental Health Parity and Addiction Equity Act (MHPAEA) Enacted to create equal insurance coverage of both physical and mental health treatments.
2010	Patient Protection and Affordable Care Act (ACA) Passage of the ACA makes mental health services a part of essential benefits for public and private health insurance plans.

⁹⁰ The program was expanded in 2000 to 34 cities and counties, helping 4,720 homeless individuals with mental illness. Information at <http://www.calpsych.prg/publications/access/homelessness.htm>