MHSOAC Services Committee
Transforming the Mental Health System through Integration
November 9, 2011

Introduction

The Mental Health Services Oversight and Accountability Commission (MHSOAC) Services Committee is reasserting and updating the recommendations of its previous Co-Occurring Disorders Report and responding to the 2011 Charter to prepare a draft report highlighting examples of "Transforming the Mental Health System through Integration".

This paper also provides a guide for the integration of all services under the Mental Health Services Act forward.

The committee has provided the MHSOAC four (4) enclosed recommendations to reassert its commitment to improve the care for individuals with co-occurring disorders by continuing to endorse strategies that 'Transform' our Mental Health System through Systems and Services Integration. These recommendations, including an additional recommendation that the health needs of individuals with co-occurring disorders become a statewide priority focus in California's implementation of health care reform can also be incorporated in the MHSOAC 2012 Work Plan.

Background

In November 2008 the Mental Health Services and Oversight and Accountability Commission (MHSOAC) adopted the comprehensive "Mental Health Services Oversight and Accountability Commission Report on Co-Occurring Disorder Services", authorized by its 19-member Workgroup on Co-occurring Disorders (COD). This report summarized recommendations to improve the care for individuals with co-occurring mental health and substance use disorders.

Central to the MHOSAC Co-occurring Disorders Report was the finding that "if we want people with co-occurring disorders to recover, we must promote systemic recovery. From the ground up, our mental health system must be transformed to instill hope, create and support partnerships, build on strengths and celebrate small changes for individuals and families living with mental illness and substance abuse." As noted by the President's New Freedom Commission on Mental Health, "to achieve the promise of community living for everyone, new service delivery patterns and incentives must ensure that every American has easy and continuous access to the most current treatments and best support services."[1]

To advance the promise of a transformed health system, the Co-occurring Disorders Report emphasized two key tenets of the Mental Health Services Act: 1) effective services for people living with serious mental illnesses must include "whatever it takes"

[1] New Freedom Commission on Mental Health, 2002

for recovery, and 2) those services must be integrated. "Whatever it takes" refers, in part, to flexible funding for a wide array of clinical and supportive services beyond traditional mental health care, often including housing, employment and treatment for co-occurring disorders (COD). "Integrated" refers to services that are concurrently delivered by a coordinated team of caregivers, often sharing a single site.

Based on this, the MHSOAC moved and endorsed that: Co-occurring Disorders Competency be a core value in implementation of the MHSA; and directed its staff to incorporate 10 transformative goals into the commission's annual strategic plan. These transformative goals for the Mental Health Services Act include:

Goal 1: Create a Comprehensive Culturally Competent Integrated System
Goal 2: Establish Systemic Partnerships
Goal 3: Encourage DMH and ADP Collaboration
Goal 4: Provide Ample Training and Technical Assistance
Goal 5: Close Gaps in the Continuum of Care
Goal 6: Expand Peer-based Wellness and Recovery Services
Goal 7: Support Families to Enhance Recovery
Goal 8: Effectively Recognize and Treat Trauma
Goal 9: Use Outcomes to Measure Progress
Goal 10: Provide Incentives to Promote Transformation

While improvements have been made in these domains through MHSA Community Supports and Services and Prevention and Early Intervention programs[i], the current mental health, addiction treatment and medical service delivery systems continue to inadequately address the needs of individuals with co-occurring disorders[ii]. Individuals impaired by co-occurring mental health, substance use and medical disorders are pervasive and their health conditions are disabling. For those enrolled in our publicly funded health system, co-morbidities should be the expectation, not the exception. Unfortunately, individuals with co-occurring disorders are still among California's most underserved and disproportionately represented among arrestees, incarcerated youth and adults, foster care placements, veterans, hospitalizations and the homeless. Touching every part of California's systems the co-occurring population is more expensive to treat, has more medical problems, poorer treatment outcomes, more negative social consequences, more unemployment and a lower quality of life.[2] In an era of health care reform, these are unacceptable outcomes.

Expanded focus on Behavioral Health Integration

Recent trends support expansion of the scope of co-occurring disorders to include medical co-morbidities along side behavioral health (mental health and substance use) conditions. This expanded focus is partially driven by efforts to promote the systemic change mandated by the Health Care Reform. Implicit in implementation of the Affordable Care Act (2010) are service delivery reforms to our health care system that will be driven by "pay for performance" funding. Equally important are new federal

[2] Cite reference

requirements mandating essential health insurance benefits that include mental health and substance abuse services offered at comparable levels (parity) with benefits for medical disorders.

This policy expansion is supported by evidence that the majority of individuals with mental health or substance abuse disorders also suffer debilitating medical co-morbidities. Most alarming, individuals with chronic mental health or substance use disorders have a life expectancy that is 25 years less than average, mostly due to preventable medical conditions (diabetes, obesity, chronic obstructive pulmonary disorder and cardiovascular disease). This movement has been paralleled by commitments from federal and state health systems to integrate behavioral health (mental health and substance abuse treatment) into primary care services, both as part of the national standards for Federally Qualified Health Centers, and for non-qualifying medical clinics under the anticipated expansion of Medicaid under the Affordable Care Act.

Currently, public services for behavioral health (mental health and substance use) disorders in California and throughout the United States continue to be typically separate from those services provided for medical disorders. Like most other states, California lacks a system owner to provide collaborative leadership in improving and expanding the integrated care for co-occurring behavioral and medical service delivery. The deficiencies of mental health and substance abuse treatment integration were outlined in the 2008 MHSOAC Co-occurring Disorders Report. A comparable comprehensive survey of integrated medical and behavioral services is not available at this time.[iii] Several statewide efforts to promote statewide integration of behavioral health and medical care, under the umbrella concept of "Primary Care Medical Home." have been developed in collaborative grants by such agencies as the California Institute of Mental Health and the Integrated Behavioral Health Project. These collaborative efforts have been implementation oriented projects to develop service delivery models, standards, toolkits and trainings, which are designed to bridge the cultural gap between behavioral health and medical services, to advance the integration of behavioral health into primary care settings.

Recommendations

In light of the national and statewide trends expanding the urgent need to improve the care of individuals with co-occurring behavioral health and medical disorders, the MHSOAC reasserts and updates the recommendations of its previous COD Report to emphasize those strategies that will be most productive in our currently changing environment.

The MHSOAC reasserts its commitment to improve the care for individuals with co-occurring disorders by endorsing strategies that: Transform our Mental Health System through Systemic and Services Integration and recommends the following:

1. The MHSOAC recommends that during the current period of government realignment and restructuring, an integrated, high level permanent restructured state entity be established to work with SAMHSA to promote statewide integration of mental health, substance abuse treatment and medical services. Moreover, integrated services for co-occurring mental health, substance abuse and medical disorders should remain a priority for the Departments of Mental Health, Alcohol and Drug Programs and Public Health.

2. The MHSOAC recommends that community and statewide MHSA stakeholders involved in implementing Mental Health Services Act programs seek opportunities to align MHSA services with program reforms mandated by the Mental Health Parity and Addiction Equity Act (2009) and Affordable Care Act (2010).
Public and private health plans which have programs that are funded by the Mental Health Services Act should ensure that integrated mental health, substance abuse treatment and medical services are available for all clients who need them. Medical necessity criteria for treatments for co-occurring disorders must be both explicit and designed to address the needs of individuals with co-occurring disorders. Moreover, individuals with co-occurring disorders must not be improperly denied treatment based on their co-morbidities.
MHSA stakeholders should specifically consider using MHSA funds to facilitate Medicaid enrollment for underserved individuals; fill mental health service continuum gaps for uninsured individuals who are ineligible for Medicaid (Safety Net); or blend services to provide behavioral health treatment concurrently with primary medical care.

3. The MHSOAC recommends continued support of systemic integration activities by the Co-occurring Joint Action Council, [iv] the California Institute of Mental Health and the Integrated Behavioral Health Project to promote integrated behavioral health and medical services. The MHSOAC also recommends its Services Committee explore and support opportunities to promote Training or Technical Assistance to promote integrated behavioral health and medical services.

4. The MHSOAC recommends that state entities, along with its Funding and Evaluation Committees, strive to develop a unified mental health care delivery framework, which includes integrated funding and data systems to promote optimally integrated service delivery for co-occurring behavioral health and medical disorders. "Integrated funding" means state and county leadership should seek all feasible means to overcome service fragmentation that results from misaligned federal block grant requirements. Similarly, leadership should seek to integrate or reconcile federally mandated data systems for Mental Health (DCR) and Alcohol and Drug Programs (CalOMS) with SAMHSA's National Outcome Measures (NOMS) to provide an accurate picture of substance abuse and mental health services outcomes for co-occurring disorders.

Conclusion

The Mental Health Services Act envisions a transformed mental health system. Our charge is to ensure that 1) individuals receive comprehensive treatment delivered in a culturally competent integrated system of care; 2) mental health services are delivered in

collaboration with non-mental health partners; and 3) peers and families foster “client-centered” and “family-centered” wellness and recovery. Achieving these goals will require the use of multiple tools to promote system development in counties, including ample technical assistance, appropriate identification of outcomes to measure progress, and incentives to encourage competency and transformation. It is our intention that the recommendations for developing an integrated system of care for co-occurring disorders provide the template for integrated services under the Mental Health Services Act.

The MHSOAC reasserts that services for co-occurring disorder at all levels must continue to be culturally competent, gender responsive and trauma informed, as well as, focus of special populations including older adult, transition age youth, and individuals either currently in or recently released from the criminal justice system. For individuals with co-occurring disorders, there can be “no wrong door” to receive mental health, substance abuse treatment or medical services. In short, there can be no healthcare without behavioral healthcare if we are to promote individual, as well as, systemic wellness and recovery.

Attachment 1

The remaining nine (9) long-term recommendations from the MHSOAC Report on Co-Occurring Disorders listed below require review and reprioritization for action by the MHSOAC and its partners, in light of current state and local mental health and alcohol and drug realignment.

1. 1.2: The MHSOAC should work with the Department of Mental Health (DMH) and Alcohol and Drug Programs (ADP) to ensure that MHSA guidelines support flexible funding to allow development of integrated programs. Reporting requirements should not be a barrier to flexible funding for "whatever it takes" services.

2. 2.1: The MHSOAC should commission a work group on the Integrated Treatment of Youth.

3. 2.6: The MHSOAC should work with DMH's Office of Multicultural Services, ADP, CMHDA's Ethnic Services Manager and community-based organizations (CBOs) that primarily serve racial, ethnic and culturally diverse communities to identify culturally competent approaches and programs that show promise for individuals with COD.

4. 7.3: The MHSOAC should promote the use of MHSA Workforce Education and Training funds to train mental health and substance abuse providers to engage, collaborate, and support families as an essential resource. Training should include instruction to assess and refer families to collateral services when needed.

5. 7.4: The MHSOAC should include family members of individuals with COD as a priority population for PEI programs. In addition, mental health and ADP programs should provide referrals for family members to recovery services, including co-dependency and trauma services specifically for families.

6. 8.1**:** The MHSOAC should create a panel to educate the MHSOAC and the public about current public policy issues regarding trauma, including its impact on people with mental health and substance use disorders.

7. 8.2: The MHSOAC should establish a workgroup to inform and guide policy on the needs and perspectives of individuals who have experienced trauma, and create a plan to facilitate the implementation of core competency to recognize and address trauma.

8. 8.3: The MHSOAC should promote the use of MHSA Workforce Education and Training funds to educate and train mental health and substance abuse treatment providers in the identification, assessment and treatment of individuals suffering from trauma and a substance-use and/or mental disorder.

9. 9.4: The MHSOAC should promote the use of MHSA Workforce Education and Training o train and educate mental health and alcohol and drug treatment staff to

improve accuracy of screening, assessment, and diagnostic coding for COD and other serious mental illnesses.

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[i] [i] [appendix or footnote only] At this time, 46, or 83.6 percent of the 55 recommendations are complete and marked as done or ongoing with long-term objectives. The MHSOAC Prevention and Early Intervention (PEI) program trends report shows that 86% percent of counties included co-occurring mental health and substance abuse issues as an element of at least one PEI program. The MHSOAC Services Committee believes it is important to maintain and continually improve upon these efforts as on-going system enhancements. The remaining nine (9) long term recommendations (see Attachment #1) require review and reprioritization for action by the MHSOAC and its partners in light of current state and local mental health and alcohol and drug realignment.

[ii] [ii] *[(omit)A recent federal Substance Abuse and Mental Health Services Administration (SAMSHA) Survey reviewed data on "Past Year Mental Health Care and Treatment for Substance Use Problems among Adults with Both Serious Mental Illness and a Substance Use Disorder" and found that contrary to effective evidence-based practices only 13.5 percent of this population received both mental health care and treatment for substance use problems; while 37.6 percent of this population received no treatment at all. Only 1.6 percent of this population received treatment for their substance use problems and 47.3 percent of this population received only mental health care.* [ii] *]*

[iii] Perahps cite CIMH or IBHI effort. Speak with Sandra Naylor Goodwin or Richard Rawson.

[iv] [iv] Funding for the Co-Occurring Joint Action Council (COJAC) initiated by California State Budget Language adopted in 1996 was eliminated this year, however their work is continuing as alternate funding is being sought.