



California Association of Mental Health Peer-Run Organizations
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Victor Carrion, MD
Chair
Mental Health Services Oversight and Accountability Commission
1325 J Street, 17th Floor
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RE: CAMHPRO Comments on Little Hoover Commission's *Promises to Keep: A Decade of the Mental Health Services Act* Recommendation

Subject

Little Hoover Commission's *Promises to Keep: A Decade of the Mental Health Services Act* recommendation to:

Require the MHSOAC to review and approve county Prevention and Early Intervention (PEI) plans annually, as it currently does for Innovation plans and empower the Commission to impose sanctions, if and when it identifies deficiencies in a county's spending plan.

General Comments about the Little Hoover Commission's Report

1. The Mental Health Services Act (MHSA) is changing the way behavioral health services deliver services and the services they deliver. It is moving the mental health system from a disease model to a wellness model, and expectations for people with mental health problems from chronicity to recovery. It is a long term process that is incremental. The LHC Report doesn't focus on the larger goal, and instead immerses itself in the (real) problems of managing and administering the process. It misses the big picture. Also, instead of commending the successful outcomes that have been reported and are easily accessible, it focuses on what has not been or is in the process of being studied and reported. If the MHSA survives the naysayers and the defenders of the status quo, history will describe it as transforming behavioral health in California.
2. Accountability for consumers and recipients of services means something different from what the LHC or State entities describe as accountability. For example, "using MHSA funds to supplant other program funds or directing all funds to programs for the severely mentally ill without finding PEI programs as required by law" are examples of actual instances of county non compliance. Although these are important, they are not what consumers mean when they talk about the lack of accountability. Consumers are not as concerned about technical compliance to the law as the quality of the services. Consumers are concerned about how services are provided and the kind of services provided. They are angered when a program isn't doing what the program plan said it would do or what it reports it is doing. Although there are local complaint processes in place, they are not independent of the services provider or funder, and there is no place to hear and then address concerns if the local process has reached a dead end.



The community forums are the closest to a vehicle for people to express their experiences with the MHSA, but these are not independent venues to voice complaints and get resolution.

Discussion

The specific question of whether OAC should expand its authority to review and approve PEI plans and have power to impose sanctions requires an in depth discussion involving stakeholders, both the government entities that the decision would affect, and the community. There are ramifications, foreseen and unforeseen, that should be explored. We see the opportunity to present today as just the beginning of an in depth discussion. We would like to suggest **guidelines for the discussion**.

1. Maintaining a balance of power. The best governance is when there is a balance of power, checks and balances, in this case between local and state/central control. With the legislative changes in the MHSA and the loss of an independent Department of Mental Health, the shift now is toward local control without any meaningful state oversight. There is no review of County's plans before funding (except for Innovations.) and the authority to sanction does not appear to be used. On the other hand, too much state /central control can slow down the implementation of services.
2. Consistency. The inconsistency of the different and interrelated roles of the government administrative bodies that manage the MHSA is a challenge. Consistency would mean that if a government function is to review and approve plans, than all components' plans should be reviewed and approved before funding. Or if one agency has authority to sanction, then it should sanction all components. Although expanding the OAC's authority to review and approve funding for PEI plans might be helpful in solving a specific problem, the public's misperception of the value of prevention and early intervention, it would only add to the inconsistency in governance that currently exists.
3. Erecting firewalls between funders/service providers and the role of oversight. It is very hard on a local level to express concerns about oversight to the funder of your programs and provider of your services.
4. Involvement of consumers, family members, caregivers, and members of cultural and ethnic communities. Consumers, family members, caregivers, and members of cultural and ethnic communities should be active members of accountability and evaluative bodies. "Counties shall demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement in mental health policy, program planning, and implementation, monitoring, *quality improvement, evaluation, and budget allocations.*" (Italics added.)

Conclusion

There is a great need for public education about the new recovery and wellness model as different from the prevalent disease model of mental illness. In addition to transforming the mental health system from an illness to a wellness model, public belief systems about mental illness and its treatment have to transform. Prevention and Early Intervention programs make sense for a recovery and wellness oriented



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culture, not a disease oriented culture. For the MHSA to be perceived as transformative, the prevalent belief system about mental illness has to change.

In addition, stigma and discrimination reduction activities are increasingly important in today's environment of profiling people with mental disabilities for the ills of society. Educational efforts need to address the myth of the violent mental patient and the multiple causes of homelessness. Based on negative stereotypes of people with mental disabilities, the public expects the MHSA/mental health services to make changes in society that are not sourced or sole sourced in mental health. For example, if mental health services were available for everyone who needed them, we would still have 96 % of violent crimes against other people. And, although because of the MHSA there is affordable housing for some people with mental disabilities, affordable and accessible housing – not mental health services - will end homelessness. There is an exaggerated and unrealistic expectation of the MHSA because there is an exaggerated and unrealistic negative perception of people with mental disabilities.

Prepared by Sally Zinman

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