

## **POLICY AND SYSTEM DEVELOPMENT END-OF-YEAR SUMMARY 2008 -2009**

As a part of the Planning Council Vital Signs review of the status of the mental health system this year, the Policy and System Development Committee (PSDC) focused on two major areas: status reports from counties and housing. Staff requested presentations from county mental health departments to address the impacts, both positive and negative, that Mental Health Services Act (MHSA) funding - along with simultaneous budget cuts - have had on community mental health. Housing, an important community indicator of recovery and wellness principles at work, has had several development opportunities through Proposition 1C and Proposition 46, plus funding through the MHSA Housing Initiative. There was some initial housing funding allowed through MHSA Community Services and Supports (CSS) funding when counties had start-up funding, but this is no longer allowed. In 2009, the committee looked for signs of progress and patterns of impediments faced by counties as they worked to incorporate funding modifications and housing into their communities.

This report summarizes the yearlong examination of these two issues from the perspective of the counties. There were many common threads, and some unexpected outcomes, but the most frequently cited outcome of the MHSA and budget impacts was the systems change from hierarchical clinical settings to a more community-based, lateral system that emphasized partnership and teamwork. MHSA funding created several efficient and effective programs, but, in focusing on that, the committee gave other important areas, such as IMDs<sup>1</sup>, dual-diagnosis services, and other, non-MHSA related programs less attention. Also, given the systemic direction of reaching outward rather than upward, it is disappointing that the perspectives of consumer and family members were not also captured in our process.

### **Part I - Hearing from Counties**

#### **Process**

In order to get a broad view of the mental health system in California, the PSDC invited county mental health departments that could represent services in both rural and urban areas, representing Southern, Central, and Northern California. Between October 2008 and June 2009, six counties presented on their mental health systems: Colusa, Kern, Los Angeles, Sacramento, San Benito, and San Bernardino. Presenters ranged from mental health department directors to MHSA coordinators and program specialists. In order to focus the discussions and identify trends, all presenters were asked to address the following questions:

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<sup>1</sup> Title 42, Code of Federal Regulations, Section 435.1009(b)(2), defines an IMD as "a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. IMDs in California generally include facilities in the following licensing categories, if the facility has 17 beds or more: acute psychiatric hospitals, psychiatric health facilities (PHFs), skilled nursing facilities (SNFs) with a certified special treatment program for the mentally disordered (STP), and mental health rehabilitation centers (MHRCs). (DMH Letter no. 02-06)

- What programs have been added through the MHSA and how many more people are being served as a result?
- What core programs/services have been reduced and how many fewer people are being served as a result?
- What has been the net result of these additions and reductions in programs and services?
- How have these changes impacted racial and ethnic disparities in access to services?
- What services or other activities are critical to transformation and how have those activities and services been impacted by the current budget situation?

## Summary of the results of the inquiry

**Additions:** *Counties reported adding programs and reconfiguring existing programs to create services consistent with MHSA values and goals.*

Counties had unique ways of making these changes. MHSA funding in smaller counties seemed to effect more additions and specialized services that were more age and population specific, while larger counties appeared to adapt and expand through reconfiguration. For example, Colusa was able to add a Children’s System of Care, Direct Schools Program, Wrap Around program, and Tribal Collaboration program. Between the fiscal years 2006-07 and 2007-08, their staff increased from 12 to 41 and the caseload increased from 206 to 838. San Benito reported similar additions to its system, having added a Transition Age Youth (TAY), Esperanza TAY and Adult, Adult, and Older Adults program, resulting in a client-base increase of 690 over three years.

In response to ongoing reductions of state general funding, two of the larger counties, Kern and Los Angeles, adopted a collapse and reconfiguration model. Kern eliminated 14 discrete programs representing different segments of its mental health treatment program, such as Benefits Acquisition Team, Homeless Outreach, Crisis Stabilization, AB 2034<sup>2</sup> and others, and reconfigured them into a Self-Empowerment Team, Homeless Adult Team, and Recovery and Wellness Centers. Overall, Kern reported an increase of service to 1,182 unduplicated clients. Los Angeles transformed 6 Adult System of Care programs into a single, 4-tiered system, ranging from high-intensity Full Service Partnership (FSP) services to less intensive client-run centers. Sacramento’s MHSA dollars were split evenly between general systems development endeavors such as *Transitional Community Opportunities for Recovery*, Wellness and Recovery Centers, and FSPs for elderly, formerly homeless, and the *Trans-cultural Wellness Center*. San Bernardino County expanded several of their original adult programs and was also able to add Early Wraparound, Children’s Crisis Response

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<sup>2</sup> Established under Assembly Bill 34, and expanded under Assembly Bill 2034 (Steinberg, Chapter 617 and 518, Statutes of 1999 and 2000), the programs provided for a comprehensive array of services including outreach, housing assistance, employment, substance abuse, and mental and physical healthcare. The programs were very successful in reducing the number of homeless days, jail days and psychiatric hospital days experienced by individuals enrolled in them and helped inform the framework for Proposition 63, the MHSA. Although extremely successful and cost-effective, the Governor, citing budget concerns, defunded the program in 2007.

Team, 4 One-Stop Centers for TAY, Regional Crisis Walk in clinics, a Psychiatric Triage Diversion Team and an older adult Mobile Outreach and Case Management program.

**Effectiveness:** *Counties reported a positive impact on the way they do business due to increased family, consumer and staff participation.*

As part of their reconfiguration efforts, Kern, Los Angeles, and San Bernardino counties adhered to a consolidated, democratic model that relied heavily on input from clients, family members and staff. San Bernardino County developed, recruited, and placed 19 Peer and Family Advocates into county-operated program positions and 17 for contracted providers.

Los Angeles' redesign required appointing its staff as the change agents that would address all facets of the organization: internal culture, external messages and outreach, the form of the program design, and the functional capacity of program services and supports. Their MHSA program has been using the Milestones of Recovery (MORS) scale to track consumers' progress and outcomes. Additionally, Los Angeles strives to create and maintain an accepting, inclusive atmosphere for clients and family members in the workplace by promoting recovery, resilience, and wellness principles and by adding anti-stigma content into new employee orientation packets.

Kern County has also solidly endorsed hiring clients and family members and actively seeks the means to do so. At present, 10% of the Mental Health staff are self-disclosed consumers or family members, and the department anticipates contracting with Recovery Innovations, a Peer Empowerment and Employment organization, due to the flexibility it provides to both the consumer and the mental health team. Upcoming projects include establishing a 100% consumer-run program in a crisis residential setting through MHSA Innovation funding. The MHSA Oversight and Accountability Commission approved their application for the *The Freise HOPE House* on August 12, 2009.

**Capacity:** *All counties reported an increase in clients served*

Most counties were able to quantify the increase in their client base with a number: Colusa – 632; Kern – 1182; Sacramento – 1881, San Benito – 690 (over three years). San Bernardino reported their services utilization count at 46,347 between July 2006 and September 2008. Los Angeles reported an increase in enrollment at the higher level FSPs due to the greater flexibility in “stepping down” to less intensive, more appropriate service levels. Kern reported a decrease in Medicare patients who were transitioned out to other services.

**Racial and Ethnic Disparities and Client Diversity:** *Counties reported success in designing programs that can serve diverse populations, but some had difficulties in increasing racial and ethnic penetration rates and reducing disparities in access to services.*

Colusa County had a 40.3% increase in first-time Latino clients. San Benito accomplished an exceptional penetration rate that proportionately represents its population through creative programs and outreach, hiring bilingual Latino staff at all levels, and creating a welcoming atmosphere at its sites. Much of its success may have to do with the fact that it is a small, close-knit community, and people are familiar and comfortable with each other.

Los Angeles has reached out to its extremely large, diverse population, but reported that it has been unable to match targeted populations with culturally competent staff in FSPs. Kern reports that it is a Latino majority county, but it has a slightly lower penetration rate, and cost per person is slightly lower for the Latino population. These numbers will likely increase slightly as mental health aligns itself more closely with primary care, particularly at local federally qualified health centers (FQHCs) where many Latino clients seek services. Sacramento County mental health had to defund its Asian/Pacific Islander outreach effort, but has somewhat offset the loss by establishing the Trans-Cultural Wellness Center.

**Transformation Catalysts:** *Counties reported activities that were critical to transformation.*

Counties split between workplace (cultural) and programmatic (practical) activities when citing the most important catalysts for change. Colusa integrated primary care and mental health services and worked with external agencies, such as Adult Protective Services to seek referrals, along with establishing a 4-bedroom supportive housing program to help decrease Psychiatric Hospital Facility usage. Kern cited 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. Los Angeles County relied on its staff as systems change agents and reinforced its collaborations with community-based organizations in order to help integrate clients into the community. Both Sacramento and San Bernardino counties reported that they transformed existing programs into FSPs or other MHSAs-based programs. San Bernardino County's recognition of consumers and family members as the true experts in the recovery process resulted in stronger collaborations with community partners to identify mental health needs and successfully transform its mental health delivery system. San Benito shifted from a clinical, one-on-one counseling emphasis to community-based services by offering more group sessions, especially at their Esperanza Center, an important community asset and meeting place.

**Fiscal Impacts:** *Financial difficulties continue to plague counties and impede their success*

Despite all of the positives that MHSAs funds have brought to counties, they all still struggle with what the state "takes away" each year as fallout from the annual budget negotiations and the ever-burgeoning fiscal crises. All of them have had to reduce or eliminate programs or hours of operation or shift staff and services to MHSAs-funded programs in order to preserve them. Two counties reported increased operating costs due to Psychiatric Health Facilities (PHF – acute inpatient facilities) usage. Sacramento's PHF costs are not reimbursed because the 100-bed program exceeds the census reimbursed by Medi-Cal. Colusa has seen an increase in PHF days from 65 to 260, and also an increase in out-of-county placement costs. Additionally, the Department of Mental Health (DMH) significantly delayed non-MHSA disbursements for FY08-09, creating more stress on a budget that was already in the red. As early implementers, Kern found itself facing the prudent reserve requirement sooner than other counties, just as it was accommodating an influx of early retirements instigated by the county fiscal crisis. Los Angeles responded to budget impacts by transforming some core services to MHSAs-funded programs in order to preserve them, while San Bernardino changed staff assignments to MHSAs programs for the same reason.

In addition to the uncompensated PHF days, Sacramento had absorbed a \$6.2 million cut to the mental health budget (as of October 2008) and lost supportive housing units due to AB 2034 funding elimination. Sacramento used the one-time CSS funding, disbursed by DMH

after AB 2034 was eliminated, to create a step-down service for its clients rather than shoring up FSP programs. This strategy essentially mirrored Los Angeles' approach of smoothing the transitions between levels-of-care and creating more space at the more intensive service end of the spectrum.

San Benito's entire Children's System of Care funding was eliminated, but not the need for the services, which resurfaced as TAY and children's services at the Esperanza Center and integrated with the PEI programs *El Joven Noble* and *Cara Y Corazon*. Colusa eliminated its free services, San Bernardino scaled back clinic hours, and Kern significantly reduced its Behavioral Medicine Clinic, mini-clinic for the uninsured, and the integrated system-of-care for co-occurring disorders.

The ongoing budget cuts are eroding long-standing safety net programs provided through county mental health funding and diluting MHSA funded programs' effectiveness and reach.

**Net Result:** *The net result of changes over the years was described as follows:*

All of the counties expressed a high level of satisfaction with the quality of the services they offered in the face of the constant fiscal fluctuations. While services may not have always reached the "whatever it takes" intensity envisioned by the MHSA, all of the counties reported a closer connection to their communities, an appreciation and respect for what clients and family members brought to the system, and a true belief in the power of recovery and wellness as a motivation to keep trying.

By county, the exercise in adaption resulted in:

- Colusa: Increased outreach and teamwork/collaboration – Tribal Collaboration, Schools, Adult Protective Services, and Primary Care providers; but, also an increase in PHF days due to increased community awareness.
- Kern: Increased participation of clients and family members; establishment of client-driven and client-run teams and wellness centers. Consolidated and centralized some services to allow other, more intensive services to be located in more sites.
- Los Angeles: More fluidity between levels of care has meant more people can enter into an FSP. Services levels are more seamless and scaled to need.
- Sacramento: Increased PHF use due to lack of options such as Crisis Residential Treatment centers and community-based organizations. PEI funding may be able to help address the reliance on PHFs.
- San Benito: Increased outpatient client base, added monolingual telemedicine access, expanded community collaboration through the Esperanza Center; increased group sessions, which doubled available psychiatric hours.

San Bernardino: Emphasis on expanding prevention programs in order to avoid costlier services later, such as Forensic and Community ACT programs, Forensic mental health court, Hospital Diversion Team.

### **Review of DMH MHSa Implementation Study – Year Three Report**

At the end of the process of hearing from counties, the PSDC reviewed the DMH MHSa Implementation Study, Year Three Report. The purpose of the study was to gather information about the early implementation of the CSS component of the MHSa in selected counties (El Dorado, Los Angeles, Madera, Monterey, Riverside, San Mateo, and Stanislaus) and determine what worked well and what was challenging. Some findings from the report are as follows:

- The current financial situation is creating significant problems for counties
- From a staff survey it is reported that workload demands impede progress
- The CSS program implementation in the Study Counties was proceeding well although space for programs and culturally diverse human resources were still problems
- Counties were making significant efforts to improve access to services, particularly to FSPs
- A disparity in funding exists between MHSa and non-MHSa programs
- MHSa CSS has allowed for increased engagement of the TAY population and continued development of infrastructure for older adult services
- Counties have implemented programs to reduce disparities and increase services to diverse populations but this still remains a significant challenge
- Study Counties were still optimistic about the MHSa as a catalyst for transformation of the system and were working hard on implementing the core elements of CSS: wellness/recovery and resiliency focus, consumer and family driven systems, cultural competence, community collaboration and integrated service experiences for clients and families

The findings of the Study confirm and augment the information gathered from counties through the year of the PSDC inquiry.

### **Summary Statement:**

All of the counties who presented to the committee gave valuable information on how the mental health departments transformed their budget challenges into opportunities for comprehensive systems of care. The MHSa Study confirmed and augmented this information. From this inquiry the PSDC has concluded the following:

- The MHSa brought great optimism about creating an exemplary system of mental health services in California
- The MHSa has been successful in transforming some services and infusing the core elements – wellness recovery and resiliency focus, consumer and family driven systems, cultural competence, community collaboration and integrated service experiences for clients – in many services

- However, the exemplary programs and services created by the MHSA are not sufficient to cope with the undermining of county mental health infrastructure and core services due to the fiscal crises in California and its impact on the mental health funding. Examples include: reduction in Medi-Cal Managed Care funds, delays in Medi-Cal and AB3632 payments, erosion of sales tax funding due to “first draw” of Child Welfare Services and In-Home Support Services on these funds and other problems.
- With anticipated reductions in the MHSA funding source due to the current economic recession, counties may have difficulty holding on to the gains made through CSS.
- Without the MHSA funds, county mental health would have been horribly impacted, so the Proposition 63 funding source has been the lifeboat in an otherwise disastrous situation. This confirmation of the importance of a dedicated funding source for mental health services has implications for future advocacy.
- The MHSA spoke to the importance of non-supplantation; in the current fiscal crises with counties cutting programs, eliminating programs, transforming programs, and creating new programs, it is not possible for advocates to track the import of the non-supplantation clause and its impact.

### **Recommendations:**

- The Planning Council should meet with the Mental Health Services Oversight and Accountability Commission (MHSOAC) and review the above concerns in light of the pending evaluation of the Mental Health Services Act
- The Planning Council should meet with the advocates who created Proposition 63 and discuss impact, strategy and advocacy, particularly in regard to
  - Tracking transformation of the mental health system in spite of budget problems
  - Preventing the use of MHSA funding as “gap” funding for General Fund programs, and
  - Replacing funds for non-MHSA services and programs when the state budget improves.
- The Planning Council should continue to monitor counties’ progress on MHSA implementation in the context of the budget crisis.

## **Part II: Housing**

Housing is a key indicator of successful recovery planning and ranks as one of the highest priorities in community mental health systems. Several funding streams intended for housing have emerged through the legislation and the budget process. Voters approved Proposition 46 in 2002, and Proposition 1C in November 2006. Both were intended for low income, affordable housing and shelters, but neither one isolated or committed funding to supportive housing for mentally ill as a discrete program. The MHSA passed in November 2004, and DMH released the first planning estimate for counties in May 2007, allocating the first \$400 million of CSS funds for supportive housing units for mentally ill populations. This program is now the MHSA Housing Program. The PSDC has followed the program’s progress and tried to identify the successes and challenges experienced by counties as they implement the program.

## **Program Models:**

Allowable MHSA housing models are either shared – a single unit shared by two or more unrelated adults with locking bedrooms but shared kitchen and bath facilities shared by two or more unrelated adults; or rental housing, which are apartments, either for singles, related couples or families. Under the MHSA Housing program, a family could be eligible based on the qualifying status of the adult member, or as an innovation, it could be based on the status of the child in the family unit. (A family can qualify based on having a child who qualifies for services under the Mental Health Services Act.) All MHSA Housing units are restricted by the income of the tenants. Initially, the MHSA Housing program prohibited mixing of rental housing with shared housing, but CalHFA recently changed their program rules to allow mixing of the two models. All developments must have a minimum of 10% of housing units, with a minimum of five units in a larger development reserved for MHSA residents in order to qualify for development funds. Subsidies were carved out of the initial planning estimates for rental subsidies to close the gap between marketplace rental rates and the residents' contribution. Subsidies cannot be requested until the applicant has demonstrated that all other sources of funding have been exhausted. Both models require the developer to enter into a Memorandum of Understanding with the service provider and the property manager so the boundaries and responsibilities of each are clearly defined.

### **Experts:** *Who weighed in?*

The committee received periodic updates from the Housing and Community Development (HCD) staff to gain perspective on the HCD Programs under Prop 1C and Prop 46 to see how the interface with the MHSA Housing Program was working. The Committee had periodic updates on the MHSA Housing funding through CalHFA and DMH. The Committee also solicited input from county mental health program administrators. In June, 2009, a roundtable of housing experts from DMH, CalHFA, California Mental Health Directors Association Housing subcommittee, and the Corporation for Supportive Housing was held to address questions the committee had about shared housing, alternative housing models, and observable trends in financing options and challenges.

### **Background:**

Across the board, the general feedback from counties was that the program was rolled out with no input from the county mental health directors, and that the funding formulas and disbursements were too rigid and incompatible with real estate market trends. Larger counties had the advantage of proximity to housing consultants and developers and access to their local housing authority with whom they could partner. Smaller counties felt that the shared housing model was the most realistic option for them, given the size of their housing planning estimate; however, they were unable to approach the housing market because funds would not be disbursed without an application, and an application could not be made until a property was identified. If the housing dollars had been distributed in advance like the other CSS dollars, this would not have been an issue.

### **Finance Challenges:** *Closing the gaps*

For MHSA projects, the original operating subsidy formula was estimated too low at 30% and was increased to 33%. CalHFA reported that, to date, the operating subsidies requested have run at about 44% of the estimate, and the subsidy funding will be

exhausted before the development funds. This has been a major issue as, unless the allocation between housing subsidy funds (for capitalized rent subsidies) and MHSA Housing funds for development is changed, some counties will be unable to proceed with use of their MHSA Housing funds due to lack of funds for the rent subsidies.

External financing has been hit hard by the current economic climate. Bond markets for tax exempt funding has disappeared, and most of the funding comes from Fannie Mae and Freddie Mac. HR 3221 established a new Housing and Urban Development (HUD) Housing Trust Fund (HTF), program, which requires Freddie Mac and Fannie Mae, to contribute a portion of the value of their new loan purchases to fund it. However, the contributions were suspended in December 2008 and not expected to resume until 2010 when it is hoped that the agencies restore their solvency.

The State HCD has had difficulty issuing general obligation bonds under Proposition 1C, and tax credits shelter programs are becoming obsolete because there are not enough profits that need sheltering. The Pooled Money Investment Board (PMIB) funding was frozen and HCD has been unable to meet their current obligations for projects that have already been awarded funding under HCD Multifamily Housing Program (MHP) programs. This has created extreme challenges for projects that have matched MHSA funding with HCD MHP funds. California will receive \$1 billion in federal American Recovery and Reinvestment Act funding, but that will only cover current pending projects, not accommodate new ones. The State Treasurer has announced that general obligation bond sales will resume in the fall of 2009. Some of the proceeds will be distributed to HCD, which will relieve some of the pressure. At present, \$400 million is needed to cover the current award obligations. Low Income Housing Tax Credits legislation sponsored by Lowenthal will also strengthen tax credit allocations if SB 450<sup>3</sup> is passed, as expected, in January 2010.

#### **Application Process:**

Recognizing that the current application process is cumbersome and not reflective of the needs of its constituents, CalHFA is considering a modification of the application. Plans are to divide it in two parts so that the stakeholder process and service plan can be approved without identifying a building site. This is crucial for small counties who need rapid access to funding in order to avoid missing out on market opportunities.

#### **Committee Recommendations:**

Based on the information received from small counties and housing consultants, the PSDC feels that the MHSA Housing Program application process needs to be re-evaluated to allow more flexibility for counties. All counties, but particularly small counties, need more technical assistance, and identification of developers who are willing to develop and operate the housing. Technical assistance is available through the Corporation for Supportive Housing, but small counties typically do not have staff dedicated to housing to which it can be provided. CalHFA has already modified rules to allow a mix of shared housing and rental housing models. Following through on the preceding observations, the PSDC recommends the following program modifications:

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<sup>3</sup> SB 450 assigns HTF administration to HCD, diverts 10% for Cal Housing, and includes language for tax credit modifications originally sponsored in SB 16.

- Solicit input from county representatives regarding future housing program or application modifications.
- Advance the funding for small projects to counties.
- Simplify the application process by identifying and allocating funds that can be used for development planning and/or consultant fees.
- CalHFA should publish a list of all the exceptions granted, and consider modifying their program rules to avoid the need for many of these exceptions.
- The CalHFA/MHSA Housing Program work group formed to look at guidelines and assistance for shared housing models should begin meeting and communicating their progress to stakeholders.
- The structure and distribution ratio of MHSA Housing funds between operating subsidies and capital should be re-examined, and allocating more funds to capitalized operating subsidies should be considered.
- If travel restrictions and budget constraints impede technical assistance to counties, alternative methods of dissemination should be explored and implemented.
- The role of the DMH review process and timeline should be examined. Presently, the application requires proof of community stakeholder input prior to submittal. Upon receipt of the application, both DMH and MHSOAC call for client and family member review and input for the supportive services section. This appears to add an unnecessary and repetitive step to the review process.
- The role of CalHFA should be re-evaluated to determine if there is an alternative method of administration of the MHSA program.