CALIFORNIA DEPARTMENT OF
Mental Health

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July 9, 2008

DMH INFORMATION NOTICE NO.: 08-17

TO: LOCAL MENTAL HEALTH DIRECTORS
LOCAL MENTAL HEALTH PROGRAM CHIEFS
LOCAL MENTAL HEALTH ADMINISTRATORS
COUNTY ADMINISTRATIVE OFFICERS
CHAIRPERSONS, LOCAL MENTAL HEALTH BOARDS

SUBJECT: INITIAL STEPS TOWARD INTEGRATED MENTAL HEALTH SYSTEM

REFERENCE WELFARE AND INSTITUTIONS CODE SECTIONS 5846-5848

The goal of the department is to promote an integrated public mental health system which includes the Mental Health Services Act (MHSA) as a primary agent of transformation. A quality improvement approach is essential to make progress toward this goal. During the summer of 2008, it is our intent to develop the guidelines that will integrate the components of the MHSA into a simplified, single annual report which includes the funding request for the following year for all components and a report on progress for the prior year. Our goal for this upcoming MHSA integration phase is to streamline current processes and to have accountability more focused on indicators. We also intend to develop the conceptual design of a three-year plan which integrates the MHSA into the larger public mental health system.

An interim step toward this overall goal of integration of the MHSA within the public mental health system is to provide additional guidance to counties on the flexibility that counties and their local communities have in making changes in their system with MHSA CSS funding. The overall intent of the CSS funds as stated in DMH Letter No.: 05-05 is as follows:

> *"The Vision Statement and Guiding Principles for DMH implementation of the MHSA envision full implementation of an approach to services and supports through which clients and their families, when appropriate, participate in the development of individualized services and supports plans, consistent with the five fundamental concepts in which they choose and direct the kind and intensity of services that will assist the current mental health system from one that focuses primarily on clinical services into one in which county mental health programs can enter into partnerships with clients, their families and their communities to provide, under client and family direction, whatever it takes to enable people to attain their goals." (Enclosure 1, page 7)*

"The requirements look beyond "business as usual" and are intended to start building a system where access will be easier, services will be more effective, out-of-home placements, institutional care, homelessness and incarcerations will be reduced, and stigma toward those who are diagnosed with serious mental illness or serious emotional disturbance will no longer exist." (Enclosure 1, page 3)

There are five fundamental concepts inherent in the MHSA that must be embedded and continuously addressed.

- *Community Collaboration*
- *Cultural Competence*
- *Client/Family driven mental health system for older adults, adults and transition age youth and family driven system of care for children and youth*
- *Wellness focus, which includes the concepts of recovery and resilience*
- *Integrated service experiences for clients and their families throughout their interactions with the mental health system.*

Consistent with statutory requirements, expenditures of MHSA funds must be consistent with the county's approved plan. The department's interpretation for the initial implementation phase is that MHSA funding can only be used for approved programs/projects and that each approved program/project should be implemented. Counties are not held to line item amounts or total budgets by program/project. The number of clients identified to be served in the plan is considered an estimate and is not considered a maximum. Counties can expand the number of clients served and the total cost of an approved program without a plan update or any additional approvals from the state. The target population, service description, and strategies need to be consistent with what was proposed and approved.

Counties need to submit a plan update when additional MHSA funding is requested. For new programs or significant changes in the target population, service description and strategies that change the nature of the approved program, counties must request approval through the plan update process. Counties may not use MHSA funds for services and supports prior to submission and approval of a new, or significantly changed, program/project. Counties may request funding from planning estimates provided in separate DMH Information Notices in a single update. The funding available to counties is shown on the MHSA Agreement.

The CSS General System Development expenditures are intended to support the transformation of the whole system to one that reflects the vision and essential elements of the MHSA. These expenditures are intended to be braided with other funding to move towards those values. Following are a few examples. Staff training funded through the MHSA can be for mental health staff in programs from other sources. Vehicles purchased with MHSA funds can be used to increase mental health service provision in the client/family's community regardless of funding source for those services. Funding for staff with various functions can be distributed to appropriate, multiple funding sources.

Supplantation, which is prohibited, is replacing the funding for a program that was in effect on November 2, 2004, with MHSA funding. Only service expansions from program baseline level of November 2, 2004, or new programs can be funded with MHSA funding. It is not considered supplantation if individual staff are moved from existing programs to MHSA funded programs or if clients who previously received non-MHSA funded services now receive MHSA funded services.

While Community Program Planning (CPP) Process is required as a basis of all Plans and updates, as long as the CPP Process that was held forms a basis for an update, it is not necessary to hold another one. It is possible to build on existing processes. However, if programs/projects include new activities or address new issues or populations that were not discussed in the CPP process, an additional CPP Process should be held so stakeholders have an opportunity to weigh in on what is new. If the CPP Process that was held can reasonable be considered a basis for the update, no new CPP Process is required. This would generally be the case for continuation of programs/projects. Plan updates require a 30-day posting for stakeholder input; a public hearing is not required.

Small counties can consolidate CSS programs/workplans into a single workplan. Other counties need to have a workplan for each program. Plan updates and reporting for CSS is organized by program. A program is made up of one or more services used in an organized manner to provide strategies for services and supports to an individual to achieve positive outcomes. Counties consolidate programs in their plan update by including a listing of the previously approved programs/workplans and the name of the newly consolidated program/workplan, when consistent with aforementioned definition.

Counties are encouraged to use the oldest funds first, following the accounting principle of first-in, first-out. This will provide maximum local flexibility regarding reversion.

The department is committed to maintaining the integrity of the MHSA while promoting integration of this new way of doing business and new funding through the public mental health system. The guidance in this letter is intended to help counties achieve that goal.

Sincerely,

Original signed by

STEPHEN W. MAYBERG, Ph.D.
Director