

**MENTAL ILLNESS F.A.C.T.S.
FAMILY AND CONSUMER TRUE STORIES**

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Brown Administration Reorganization Creates Opportunity and Challenge:

Comply with Mental Health Services Act—Remedy Waste—Maximize Benefits of Integration/Parity

by Rose King

PURPOSE: This is to recommend that discussions about policy change take place in a context in which all participants are informed of current conditions, as well as options and limits on future operations already determined by the state. The purpose of the following is to briefly summarize issues that warrant recognition in reorganization of public health. Criticism is restrained in the interests of progress, and recommendations are a product of recent years of analyses, formal complaints, action proposals, and experiences of many consumers, family members, advocates throughout the state—individuals who seek compliance with Prop 63/Mental Health Services Act, integration and parity in public mental health, and elimination of discriminatory provisions of law. Many report that past appeals are not resolved by the Department of Mental Health and the MHSA Oversight and Accountability Commission, or by local and state officials and advocate organizations. See Recommendations of Rose King and Teresa Pasquini, partners in advocacy and [facebook.com/mentalillnessfacts](https://www.facebook.com/mentalillnessfacts). We believe Governor Brown’s objective of targeting more revenue for direct services can be met by complying with the intent and integrity of state and federal law. We suggest that **reorganization recognize these principles:**

1. **Realignment, Reorganization, Integration are key elements of progress in the quality of public health—but not license to abandon state responsibility for use of taxpayer dollars.** Stakeholders believe the state cannot walk away from a history of neglect and complex problems of its own making, though the making occurred under earlier administrations. State and federal laws mandate standards and articulate minimum treatment options for serious mental illness; decades of research affirm benefits of collaborative, integrated service systems. The state cannot “realign” its obligation to comply with the law and maximize return on public spending; cannot send money and human service programs to counties without clarity of purpose and process.
2. **State Cannot Transfer Dysfunctional, Inefficient System to counties, expecting local officials to correct mistakes/failures of DMH and OAC.** In the last decade alone, Department of Finance audits document widespread mismanagement, waste, and noncompliance with laws governing state and local mental health facilities, 1991 Realignment expectations, and the 2004 MHSA/Prop 63. State codes specify responsibilities of the state Planning Council and county Mental Health Boards and Commissions, but they are denied the capacity and training to fulfill duties, and Prop 63’s OAC is unable to deliver a product of its creation. The state cannot compound inefficiency and waste by transferring problematic programs, but FIRST must fix its own messy department functions and the confounding department regulations.
3. **MHSA Cannot Fund Noncompliant Programs, and is not open to varying state and local interpretations.** MHSA is not an open-ended funding source for programs favored by influential advocates or political interests. Informed stakeholders are expected to recommend priorities within known guidelines of “*Systems of Care*.” Noncompliant DMH regulations corrupt the purpose of MHSA and compliance cannot be left to varying local interventions—but must be standardized to reduce waste of time and money. In the treatment of serious mental illness, Prop 63 revenue is for county “*Systems of Care*,” explained in California law, and developed, tested, vetted over a period of 20 years— never adequately funded to serve unmet need, but intended for expansion with 75% of MHSA revenue. New prevention programs within Systems of Care are to reduce severity or disability of serious mental illnesses and funded with 20% of MHSA revenue.

The State DMH did not implement provisions of MHSA or equip local governments and community stakeholders to meet informed objectives. State reorganization policies must strengthen local **capacity to deliver cost-efficient and client-effective** mental health services. This resource-starved public service cannot support a process where every county is reinventing the wheel and operating from a “blank-slate” agenda, without benefit of standardized procedures and knowledge of proven service models. A San Diego stakeholder/consumer activist pinpointed the fundamental problem of Prop 63 implementation: ***“The state launched a massive, expensive new program with no Operating Manual.”***

I. PROBLEMS REQUIRE STATE AGENCY/DEPT LEADERSHIP.

The state has no established method of assessing and reporting on the quality of county mental health services—knowledge is anecdotal and episodic. The Little Hoover Commission of 2000-01 told state officials that the magnitude of need or neglect could not even be described because there is no central source of information. And the California HealthCare Foundation likewise found that *“Information for Policymaking is absent.”* State leadership is essential to change the conditions leading to the incompetent implementation of the MHSA, the object of sharp criticism in a 2008 Department of Finance audit, a 2009 Whistleblower Complaint which I filed with the California State Auditor, a continuous flow of stakeholder grievances, and a growing number of press reports. DMH/OAC were unresponsive to requests for productive organization and management practices.

We do not see significant improvements or cost-savings because local governments and community interests were uninformed and misinformed by state DMH regulations. A Brown Administration amendment eliminated a costly, superficial state pre-approval process for MHSA plans, and unfolding health policies promise to integrate treatment of physical and mental illness and substance use disorders. Stakeholders are grateful for important first steps but anxious about uncertain alternatives.

Independent County Administration. The record of county control and County Boards of Supervisors is not reassuring to stakeholders. Sacramento County purged its mental health clinics of 4,500 consumers in 2009, cutting people off from medications and doctors. MHSA allocations exceeding \$180 million in Sacramento have not relieved the crisis of denied services. A UC Davis psychiatrist confronting system failures said in a Sacramento Bee commentary ***“there is not enough space in this newspaper to describe the many ways in which people with mental illness are treated as second-class citizens.”***

Last week, reading the same morning paper, the front page headline is *“Death of man shot by cop haunts friends.”* The 32-year old man had *“disrupted thinking”* and was without medication for bipolar disorder and schizophrenia. He told friends he *“needed medication and counseling but was frustrated by waits at county facilities.”* He appeared threatening and was armed with a child’s baseball bat when killed by the police officer. In the same paper on the same day, the front page of the regional section reported another *“suspicious man on a bike,”* killed by a sheriff’s deputy in the early afternoon. He was riding his bike and had a machete strapped to his back. People familiar with the young man said he *“was paranoid,”* and *“his behavior is often strange...kind of odd.”* People like me, on alert for danger to a family member with mental illness, know immediately how this story will play out. The three to four deaths by suicide last week in Sacramento county didn’t make any headlines—nor did the dark despair or tortured delusions of other men and women waiting for help, asking for help, and denied help by a cruel system of designed neglect. People who die by their own hand, or because their care is assigned to law enforcement, are most often clients in the dysfunctional system, dependent upon inadequate and inappropriate treatment.

State Regulations Must Ensure Compliance with Intent of Law. State policies should be informed by independent, integrated, comprehensive data on current conditions, and by the institutional knowledge and experience of stakeholders. Regulations should be informed by the language of the law.

It would be irresponsible and improbable to expect individual counties to correct the state's willful violation of MHSA law and creation of flawed and fabricated regulations.

In Brief, the Following Problems Require State Intervention:

- **State Approves Money for New Programs with No Data on Old Programs.** DMH/OAC approve billions for new county programs with no knowledge of existing county programs. State and local managers and stakeholders cannot report service gaps, overall system resources, or basic service capacity and access in any given county. The state must take responsibility for developing county baselines—no credible measure of progress toward a successful end point is possible without baseline knowledge of each county's starting point.
- **Noncompliant Regulations—Two-Tier System.** Noncompliant DMH regulations deceived stakeholders and resulted in two-tier county systems, with MHSA operating independent of existing systems and their clients. New programs are layered over existing programs, and each provision of MHSA is designed independent of the other. The state is responsible for creating massive public and private county bureaucracies, and the state must facilitate collapse of two-tier system, reduction in county bureaucracies, and integration of programs and funding streams.
- **Distortion of MHSA Supplantation Clause.** DMH misinformed state and county officials and stakeholders regarding the MHSA "*supplantation*" clause. The intent of this provision is to prohibit counties from substituting MHSA revenue for county realignment/general fund revenue to support a current level of service—it is NOT to prohibit improvement of existing programs or an increase in treatment options, such as funding new employment counseling services for existing clients or reducing existing clinic caseloads of psychiatrists and case workers to increase consumer access to timely appointments. The state promoted MHSA "*new programs for newly recruited clients,*" a costly, extravagant waste which will continue without state intervention.
- **Noncompliant Prevention/Early Intervention Guidelines.** The "principles and priorities" issued by the OAC do not serve MHSA target populations, and, instead, allow counties to divert mental health prevention monies to many social programs unrelated to serious mental illness. Some programs are frivolous and some meet legitimate civic needs— none should be funded by MHSA prevention monies unless they are intended to reduce the severity and/or disability of serious mental illnesses. The state must correct misuse of funds by issuing appropriate guidelines.
- **Discriminatory Provisions of California Codes Obstruct Parity.** The federal health care reform soon to be implemented in California mandates parity in treatment of physical and mental illnesses and substance use disorders. California codes have blocked parity even among MediCal insured, and indigent residents likewise have no entitlement to appropriate mental health services. Administrative reorganization should rely upon cost-efficiency and consumer-effectiveness in devising new management of mental health services—do not delay the benefits of integration and parity to satisfy political anxieties.
- **No Implementation Strategy.** Absent a plan, MHSA policies are open to arbitrary decisions, corruption of purpose by special interests, and ad-hoc governance. Stakeholder grievances are thwarted because they have little standing to challenge arbitrary policies. There is no measure of success or failure, no shared understanding of purpose, and no context to restrict political influences. DMH must develop a state plan to ensure widespread agreement of intent, consistent implementation across counties, and efficient means of tracking system progress. Pricey contract "evaluations" by DMH and OAC are generally irrelevant because they continue to report on a five percent segment of the population in treatment.

California has failed to inform, enforce, and fund any uniform standards, including those specified by federal MediCal regulations and those specified by Prop 63 and code sections of “Systems of Care.” Prop 63/MHSA followed a decade of public and private reports, including the report of the 2001 Joint Legislative Committee on Mental Health Reform. The results were in, studies complete, service models proven but unfunded. Teresa Pasquini of Contra Costa County has been a family member representative in the local MHSA planning process since 2006. She said she *“advocates for the promise of Prop 63 to restore the hope held as I walked my neighborhood gathering signatures of support—and neighborhoods where the ambulances pull up before homes and wait for law enforcement to walk handcuffed adult children to their ride to a locked crisis facility. People have seen psychosis enter their neighborhood and their neighbor’s lives. My community believed in the promise of this law as written and supported by the voters. I believe that consumers, families and front line workers must work in partnership to protect and maintain the integrity of Proposition 63.”*

The individuals who went to friends and neighbors and strangers to solicit contributions and collect signatures to qualify Prop 63 believed passage of the MHSA would pay for those programs desired by consumers and communities. A glaring example of failure is the **\$2 Billion idling in a state MHSA Trust Fund, while people with diagnosed serious mental illnesses are denied treatment in their communities.** Current public officials exploited the incompetence of previous management by raiding MHSA revenue to backfill budget deficits—but no administration or legislative leaders, or capitol advocates, asked why the money intended for mental health systems was unspent.

II. STATE’S FRAGMENTED SYSTEM IS SOURCE OF STAKEHOLDER GRIEVANCES

California’s leaderless, ill-defined, fluid mental health system fosters anxiety and uncertainty—compounded by the growth of new bureaucracy paid for by Prop 63. Consumers, families, providers have no reliable guarantee of any given service or treatment option at any given time...people move from one county to another in search of a particular treatment environment...the menu of services changes from one county to the next, and can change from one month to the next within counties... a diagnosis of serious mental illness in the public mental health system does not come with an orientation of any kind, definitely does not come with a serious evaluation of needs for adults and older adults, and sometimes not for children either. “Treatment Plans” are generally designed for MediCal reimbursements and other accounting purposes, and may reflect interests of the consumer, but supports to pursue goals are not funded. **Failure to achieve any stated objectives in treatment plan are found to be the fault of the consumer.** These are the conditions I have been informed of, observed, and experienced.

MediCal Insurance is fragmented, discriminatory. MediCal Insured consumers have no guarantee that the minimum range of mental health services covered by MediCal is available in the county where they live. Most people in the system for any length of time abandon expectations. MediCal health coverage for physical illness or injury is a separate insurance plan than MediCal for mental illness—a legal, codified discrimination in California law. *“The experience of my son, Michael King, illustrates the common consequences of this discrimination. MediCal entitled Michael to services of a top specialist for successful treatment of the potentially deadly medical condition of Hepatitis B and C, while he was consistently denied decent services for his serious mental illness, treated in humiliating environments, deceived and denied access to needed medications, doctors, hospitalization, rehabilitation. He was completely free of Hepatitis virus when he died by suicide, leaving our devastated family and friends to remember his courage, convictions, and love.”*

Fear of Retaliation. A condition well known in the mental health community, many consumers and families are reluctant to speak out publicly because of fear of retaliation within the public mental health system. The state should consider this factor in seeking feedback now, and in design of an ongoing process for advocacy and resolution of grievances.

Key Grievances brought to my attention by stakeholders are related to fragmented, arbitrary, chaotic county mental health systems; collaboration and integration are not funded, information is illusive and sometimes inaccurate, access to preferred services is mysterious process.

- **Access to doctor appointments, urgent care contacts, and service workers has declined.** Consumers are waiting longer for shorter doctor appointments, and there is no guarantee of a walk-in appointment at clinics when there are medication problems or onset of crisis symptoms. Typical of the trend, Stanislaus County mental health officials told the Modesto Bee in 2011 that their service capacity has declined from 12,000 in 2005 to 9,000 today. Unequipped Emergency Rooms are now drop-in centers for urgent care—where consumers and families and physicians complain of hours and days waiting for inappropriate or inadequate care from untrained personnel. The state should ensure that counties provide minimum standards in Systems of Care codes as first priority for MHSA funds.
- **County MHSA programs are product of misinterpretation, misinformation, and arbitrary policymaking. Stakeholders deceived about use of MHSA revenue.** There is no shared understanding of MHSA guidelines, no awareness of SYSTEMS OF CARE services, no known parameters for funding decisions. Every county is “reinventing the wheel” in setting priorities, spending decisions are arbitrary, and stakeholders do not have tools for effective participation—particularly accurate information about purpose and objectives of MHSA revenue. DMH issued continuing regulations instead of guidelines on Systems of Care, and the state must now ensure consistent, broad-based understanding of basic provisions of the law.
- **Lack of transparency at state and county levels.** Past DMH reports do not include detail of annual administrative/contract expenditures, the OAC has never released an expenditure report. County websites do not provide accessible data on annual MHSA/Realignment expenditures, county programs, private contracts. Consumers and families, county mental health boards and commissions, and news reporters cannot find public information from state, county, advocate sources. Professionals with abundant resources and disabled consumers alike say they are denied access directly and indirectly through impenetrable “information” systems, while millions in MHSA funds are spent on endless IT meetings. County employees also lack access. The state must require a standard format for informative reports from counties and state agencies.
- **OAC is not responsive to grievances and has taken no action on oversight or accountability. Stakeholders are frustrated by competing state and local entities;** there is no single source or known process to address individual grievances. Different agencies offer differing answers, and OAC Commissioners and staff members are among those misinformed about MHSA provisions and intent. Stakeholders anticipated that OAC would ensure DMH compliance with MHSA law, but grievances were referred back to DMH. The OAC cannot answer questions about misuse of funds and failure to improve Systems of Care, and there is no functioning, informed, or trained agency to resolve grievances—the Mental Health Planning Council, OAC and DMH proliferation of commissions, councils, committees adds to stress, confusion, passing the buck; no agency is ultimately in charge of MHSA compliance, as far as consumers and families can determine. County board/commissions are not empowered or likewise attempt to satisfy complaints through more committees and evaluations. State should designate an efficient, functional oversight and advocacy organization, consolidate competing stakeholder groups, and eliminate the fragmented accountability process which costs more and produces less.
- **Waste, waste, waste.** Stakeholders, including mental health directors and providers, complained of wasted time and money at the outset because of DMH failure to issue requirements for integrated plans for all MHSA components. Ongoing complaints relate to excessive expenses of meetings, conferences, reports, and disjointed fiscal, performance, and audit requirements. County boards and commissions, consumers and families report excessive and unnecessary expenses for focus groups, consultants, facilitators—far too much money diverted for process and far too little available for direct services. A highly critical DOF May 2008 audit did little to

change practices; many joined me in calling for a full public audit of DMH in 2010. Counties continue to waste money today hiring consultants and facilitators for an ongoing stakeholder process for each of six separate MHSAs. DMH must expedite integration of MHSAs and all mental health services as the first step to full integration of public health services.

- **Conflicts of interest are a continuing problem in county MHSAs policies.** There are no known standards or ethics for stakeholder participation and county funding decisions. Many county stakeholders have appealed to their own Boards of Supervisors, the OAC, the state Planning Council, and DMH and report no satisfactory results. In Sacramento County, city and county employees, and organizations funded by county grants, cast decisive votes on which MHSAs programs would be funded, raising objections from the community. The state should provide standard ethical guidelines for stakeholder participation and funding policies.

I know of no stakeholder objections to consolidation of management, compliance, and standards of service in the Department of Health Care Services, with the understanding that this reorganization will maximize entitlement to integrated quality health care. **State officials must lead integration and collaboration**, changing the fragmented, silo models of management, and providing county models for reorganization. Under separate management, with known standards, state mental hospital costs and populations can be reduced when the state supports a fully functioning, integrated public health system that provides timely, appropriate, and integrated mental health services. No provision of MHSAs discriminates against consumers who are involuntarily committed. Contrary to DMH declarations, consumers under conservatorship or confined in a locked facility can also benefit from improved services funded by MHSAs.

III. HEALTHY SYSTEM OF TREATMENT FOR MENTAL ILLNESS

State Agency and Department Administrators have a short time frame to analyze reports and investigate performance, correct a widely criticized record, and launch a reorganization to ensure a healthy system of treatment for serious mental illnesses. The state must: **(1.)** comply with intent of MHSAs law; **(2.)** ensure stakeholder confidence in new structure/procedures; and **(3.)** establish a workable measure of county compliance with MHSAs law.

The state's challenge is illustrated by reports that defy reconciliation.

A September 2011 Los Angeles Times headline tells us ***“ERs Are Becoming Costly Destinations for Mentally Disturbed Patients,”*** and a week later, Los Angeles County Mental Health Director Marv Southard reports the great success of MHSAs and the county system in a Capitol Weekly opinion article. The Mental Health Director claims ***“those in crisis are more likely to find the help they need in cost-effective community services rather than costly settings like jails and institutions.”*** But the Los Angeles Hospital Emergency Room Director says ***“We are inundated...The system is broken”*** How does the state DMH reconcile these contradictory reports in the absence of comprehensive, integrated information? AND, the larger question for the state and counties: ***“What is Los Angeles County doing with \$2 BILLION in MHSAs money allocated to date?”*** Southard reports that 6,256 LA consumers are now fully served with those billions. Stakeholders look to Governor Brown, his Department of Finance, agency and department heads to deliver more ***“bang for the buck”*** than this typical result.

ACTION: Comply With Language and Intent of Law.

1. **Develop Implementation plan.** Take advice of 2008 DOF audit. The DMH still needs to develop and promulgate a state MHSAs implementation plan—essential to compliance, cost-efficiency, and effective stakeholder participation. Absent a plan, policies are open to arbitrary decisions, corruption of purpose by special interests, and lack accountability. The DMH-devised fable requiring MHSAs expenditures on ***“new programs for new clients”*** could have been prevented if a plan were in place. **Describe the final product.** What does an effective mental health system

look like? What range of services are available and how does the service delivery system function? **Make all policy decisions within this context.** Stop ad-hoc policymaking and demand that every policy meet the test of ensuring progress toward effective Systems of Care objectives. **Utilize major findings of respected research/investigative sources.** Programs should spring from the body of knowledge that developed Systems of Care and the California Mental Health Master Plan, and utilize research at California public foundations, institutions, and state and federal health agencies. **Collaboration models should include proposals to address federal and state regulations that inhibit and/or facilitate integration of services.** Collaboration is at a very primitive stage of development at most levels of government. State leadership is necessary to forge intergovernmental and interagency cooperation, and the costs of same should be recognized. The MHPA **Implementation Plan should anticipate federal health care reforms, integration, and parity** – and not delay or impede the most effective model for public health.

2. **Issue Requirements for Integrated County MHPA plans.** Requirements for county three-year integrated plans are required by Section 5848 (c). This is necessary to comply with law, integrate the six separate plans in each 58 counties, and eliminate expense of six separate and ongoing stakeholder conferences, committees, reports, et al in each 58 counties. Enforcement of this provision is necessary to end the fragmented, costly process also noted by DOF auditors, in which each MHPA component operates independent of the other and independent of existing system. This is an essential first step toward full integration of county mental health and expansion of Systems of Care—END the two-tier system.
3. **Eliminate/Revise Existing MHPA Regulations,** including invention of “CSS” in place of known Systems of Care, categories of Full Service Partnerships, Outreach, and System Development, and target populations for such categories. Target populations are clearly identified in existing law. This is an example of a redundant, unnecessary requirement of counties—and an example of how the state can reduce unnecessary bureaucratic overhead, reporting, and accounting. DMH renamed Systems of Care and invented categories for private objectives, and never rationalized purpose. New regulations must be essential and supported by provision of the law. New regulations should facilitate reduction of county paperwork and administration workforce to succeed in targeting more funds for direct services. Streamlined regulations should govern the expansion of existing Systems of Care and new prevention programs, as well as Innovation programs within these MHPA programs. Innovation is misunderstood and funds are misused by counties and stakeholders because of faulty regulations. Modify regulations necessary to support CMHPA recommendation re: Innovation programs, workforce development (WET), information technology, and capital outlays.
4. **Develop New Prevention Guidelines.** Misuse of MHPA Prevention Program funds is the most egregious fiscal violation of language and intent of the law. We oppose recommendations to leave state and local Prevention Programs and guidelines intact. Prevention program spending is not legal, OAC “Principles and Priorities” are outside of the law, and a product of mismanagement, incompetence, and potential conflicts of interest (outlined in the 2009 Whistleblower Complaint.) State and county MHPA Prevention revenues are funding programs and contracts which are not related to reducing the severity and/or disability of a serious mental illness. Special interests, political interests, favored community service organizations may all benefit from MHPA prevention revenue because there are no understood parameters. (In a private staff meeting I attended in 2006, senior MHPA managers as well as the contract facilitator hired to manage the OAC Prevention process, described the guidelines as “wide enough to drive a truck through.”) The process was flawed and so is the product. Back to the drawing board with these guidelines.
5. **Review State Contracts and Use of MHPA Housing Funds.** I question the state contracts for Suicide Prevention, Disparities Project, Education Initiative, and Anti-Stigma campaigns—there is no evidence that programs deliver results, and proposals lack documentation that services actually fulfill the vital need. My objections are documented in 2009 Whistleblower Complaint to

the California State Auditor. It appears that contracts were handed out as party favors to all invited guests. Audit and review by professionals would support my objections. For example, the anti-stigma campaign objectives were developed by a large committee which did not include a communications, marketing, or media expert, did not draw upon the extensive SAMHSA and AdCouncil expertise, or consult anyone in the business of opinion-making. The Housing Program is likewise questionable in its invention. Under MHSA provisions, does the state have legal authority to transfer funds to Governor's Homeless Initiative, do county MHSA expenditures have to be for supportive housing only, do counties have authority to expend MHSA revenue on new housing developments, what are parameters for county expenditures on housing? AG public opinions issued in 2006 address limits for use of MHSA revenue for mental health services. The state should ensure state contracts comply with the law.

ACTION: Ensure Informed Stakeholder Community & Confidence in Process.

1. **Provide Tools for Effective Stakeholder Participation.** End "Dog and Pony" shows that waste money and frustrate stakeholders. The public cannot be effective when they are not informed of context, guidelines, budgets, and reasonable objectives. The state must issue a standardized MHSA Stakeholder Guide. The state must ensure that all counties operate with knowledge of the capacity and quality of services. All stakeholders must know service gaps, understand which services are actually in demand by consumers, and have background knowledge such as available resources, research, and reports on existing conditions. Today, stakeholders operate in an information vacuum when reviewing documents, and similar problems exist whether the document is a Statewide Prevention Plan or an individual county CSS plan, whether the evaluator is a private individual seeking to make a contribution or a Planning Council Member or County Commissioner fulfilling an official duty. Council members, Commissioners, stakeholders, et.al cannot be effective in a traditional silo environment, reinforcing ad-hoc, fragmented operations. Stakeholder process is too often expensive theatre of public participation.
2. **Develop Efficient Grievance Process, Managed by Single Agent.** The MHSA grievance process is frustrated by lack of uniform standards and guidelines for spending and program priorities, and the absence of a known plan with known end objectives. The state must resolve this problem first. Frustration has generated an ever-growing number of advisory bodies for a countless number of consumer, family, provider advocates—and the state funds both public and private entities. The function and productivity of stakeholder entities, and outcome of expenditures, must be thoroughly reviewed. The state must bring some order to the fragmented and often fruitless process of eliciting stakeholder input, and should consider consolidating government entities, and funding and clarifying existing duties. OAC Commissioners are already designated members of the Planning Council, their duties were considerably reduced by the amended MHSA law, but an added responsibility requires OAC to provide technical assistance to counties. These bodies should meet and act as one, improve capacity to fulfill responsibilities, and anticipate overlapping and conflicting issues of "Technical Assistance" and "Grievance Resolution." The resources and responsibilities of these two stakeholder entities should be combined because both bodies need to build capacity to fulfill duties. The state can fund efficient stakeholder input without legislative amendments.
3. **Conduct Public Relations Campaign.** Conduct education/public relations campaign to ensure widespread understanding of law, its purpose and implementation process. Management and community must have the knowledge to determine whether/how any program moves county system toward goals of fully functioning Systems of Care. **This essential campaign is a logical component of "Technical Assistance."** The OAC/P.C. should be considered to carry out these duties after regulations are in compliance with MHSA law. In addition to employing communication professionals, OAC and Council can engage stakeholders to conduct a field operation, increase awareness among nontraditional stakeholders and office holders, and ensure

high visibility for goals. Counties must provide stakeholders with accurate information regarding consumer demands, unmet needs, system gaps, target populations, etc. Communities must determine which services are actually in demand by its unique consumers and cultures, which services are unfunded, and understand what type of services may be funded by MHSA. DHCS/DMH should actively promote benefits of integrated services, and a streamlined system of coordinated health benefits for physical and mental illnesses and substance use disorders. Rapidly approaching federal health care reforms and expansion is decisive factor. Consumers and families have little disagreement with this objective, but need evidence of an infrastructure, resources, and responsive leadership to maintain importance and visibility for treatment of serious mental illnesses

4. **Identify and Eliminate Waste of Resources—Open the Books on Expenditures.** Build stakeholder confidence with commitment to fund direct services before studies, conferences, committees, and their attendant consultants, organizers, facilitators, et al. The state and counties must make public declaration of such commitments. FOR EXAMPLE, Government and private providers know what actions to take to improve cultural competency and provide treatment of co-occurring disorders. **Declare a spending moratorium on studies, reports, and committees devoted to cultural competency and co-occurring disorders** until all known remedies and productive services are fully funded. Transparent and public reporting of all mental health expenditures is essential to identify and eliminate waste of resources. Counties should provide accounting wherever consumers and families may gain ready access to spending and budget information. Instead of “Vision” conferences and needless “Expert” gatherings, counties would have high participation rate at briefings where managers **Open the Books on mental health spending.** Review the decades of **consumer surveys conducted by DMH** and on shelves at academic institutions. The stated priorities differ considerably from the claims of their self-identified representatives in government forums. Conduct brief, relevant, uniform surveys of outpatient clients in the existing system, ensure confidentiality of respondents, and review results at public hearings.

ACTION: Measure County Compliance With MHSA Law

1. **Develop County Baseline of Service Stipulated by Systems of Care.** The state must take responsibility for obtaining this baseline data. In response to DMH requirements, counties using DMH definitions already reported that 100 percent of their clients are inappropriately served. But counties were not asked what improvements were needed to fully serve their clients. This is now the critical question for counties and the state to answer in order to define compliance with MHSA. The state and counties, and stakeholder communities, must know how the county mental health system measures up to the standards in Systems of Care. What are service gaps, inadequacies, critical needs of unique regions and populations?
2. **Revise County Performance Contracts and Reporting Requirements.** Performance Contracts should include obligations for proper expenditures of MHSA revenue, including integrated service systems, and recognition of state MHSA plan. Contract may be proper vehicle to acknowledge gap analysis. The state MHSA Implementation Plan will specify steps to comply with law, integrate program and funding streams, measure progress toward fully-functioning Systems of Care, and ensure inclusive, transparent stakeholder contributions. This measure of performance must report current capacity to meet standards and advances achieved through MHSA funding.
3. **Define Terms of Compliance as Progress toward Comprehensive System.** Each county utilizing MHSA revenue must have integrated plan to meet end objectives of comprehensive Systems of Care for children, adults, older adults. Terms of compliance are SYSTEM PROGRESS reports toward these stated objectives. Progress can be measured only when

elements of current system are determined and reported. Range of treatment options, program models, and principles of cultural competency, recovery model, family and client-driven concepts are all covered in SOC code sections. Informed stakeholders, with an understanding of available resources as well as unmet needs, can then make useful contributions to establish priorities.

While Realignment may fund Systems of Care to the extent resources are available, MHSA revenue must be expended to improve quality and capacity.

CONCLUSION:

The Promise of Community Mental Health Services—Unfulfilled and Violated. This Summary of Comments and Recommendations is not a comprehensive inventory of violations of law and deceptions. Department of Mental Health and Oversight and Accountability documents include statements that are not true, and most are not discussed here inasmuch as new, compliant regulations are the straightforward objective. Current requirements and guidelines mislead and deceive all Californians who relied upon the voting material provided by the California Attorney General and independent Legislative Analyst. The electorate and the law did not discriminate against consumers who may be involuntarily committed, who may appear to have resources or minimal services, or who may reject the quality of treatment offered. The law did not give preference to those with no services and deny recovery to those with useless, inappropriate, or harmful services. Implementation of the Act was flawed at best, and I believe most advocates agree that the management of programs is in need of repair. This Summary is intended to promote understanding and lead to action and agreement about reorganization, integration, and parity.

There is no disagreement in the mental health community about the magnitude of unmet need in California's mental health system. There is no revenue to spare for other social needs—**the needs of Californians with serious mental illness have never been met.** generations of people have been denied recovery, and the wait must be over! Expressions of debate and complaint reflect differing perspectives on achieving similar goals. California voters and most officeholders know that the promise to shift funding from state mental health hospitals to community services remains unfulfilled since Governor Ronald Reagan started closing the institutions in the 1960's. In 2004, voters intended to finally make good on that promise after California governors and legislatures failed to act for more than 40 years. The electorate enacted Prop 63, the Mental Health Services Act, to fund proven service models known as "Systems of Care" for all ages in every community, and to create new prevention programs to help reduce the severity and disability of mental illnesses. It is time the state fulfilled the promise.

THIS IS DEFINITION OF UNDERSERVED/INAPPROPRIATELY SERVED PROVIDED BY DEPARTMENT OF MENTAL HEALTH TO COUNTIES IN AUGUST 2005 CSS REQUIREMENTS FOR COUNTY PLANS

FOLLOWING ARE POPULATION WHO ARE NOT TO BE GIVEN PRIORITY.....

August 2005 DMH Requirements for CSS Three Year Plans were distributed to OAC Commissioners because **the following consumers defined by DMH were NOT to be given priority by counties:**

Underserved/inappropriately served – *individuals who have been diagnosed with serious mental illness and children who have been diagnosed with serious emotional disorders, and their families, who are getting some service, but whose services do not provide the necessary opportunities to participate and move forward and pursue their wellness/recovery goals. This category would also include individuals who are so poorly served that they are at risk of situational characteristics such as homelessness, institutionalization, incarceration, out-of home placement or other serious consequence.*

Examples of people who are underserved or inappropriately served include older adults who are in institutions because they are not receiving services that would allow them to remain in their own homes, adults who are in Institutions of Mental Disease (IMDs) and Board and Care facilities but not receiving services that would allow them to move to more independent and permanent housing, transition-age youth who are not getting the vocational services they need to become successfully employed, and/or children and youth who may be receiving mental health services in out-of county placements, but do not have the in-home supports needed to allow them to return home with their families. Frequently, underserved individuals/families are a part of racial ethnic populations that have not had access to mental health programs due to barriers such as poor identification of their needs, provider barriers lacking ethno-culturally competent services, poor engagement and outreach, limited language access, limited access in rural areas and American Indian rancherias or reservations and lack of culturally competent services and programs within existing mental health programs.

Billions in MHSA revenue is distributed to county programs which exclude the above individuals.

Thank you for considering this issue and I hope this sheds some light on the widespread dissatisfaction among consumers and family members. I am grateful for future opportunities to get this right, and develop a shared agreement about the purpose and function of MHSA.

MEMORANDUM AND ROADMAP FOR COMPLIANCE WITH MHSA PROVISIONS AND VOTER INTENT