Full Service Partnerships: $2.5 billion unaccounted for

In 2004, California passed Proposition 63, the Mental Health Services Act (MHSA) to provide services to people with the most serious mental illnesses. In 2013, the State Auditor reported that the Oversight Commissioners—most of whom are employed by organizations that receive MHSA funds, failed to provide oversight and therefore the state could not know if the funds were spent effectively or not. Simultaneously, Mental Illness Policy Org. issued a report called "MHSA: California's 10-year, $10 billion Bait and Switch" found that a feeding frenzy erupted as worthy and unworthy social service programs masqueraded as mental health programs to make themselves eligible for funding. The full report is available at http://mentalillnesspolicy.org/states/california/mhsa/mhsa_prop63_bait&switchsummary.html. Following is the section on **Full Service Partnerships (FSP).**

FSPs Background: MHSA was intended to expand successful existing programs [1]

Full Service Partnerships (FSP) were not an existing program and do not appear in California law or MHSA legislation. After Proposition 63 passed, the California Department of Mental Health created a broad definition of them:

> *"the collaborative relationship between the County and the client, and when appropriate the client's family, through which the County plans for and provides the full spectrum of community services so that the client can achieve the identified goals."*[2]

FSPs are colloquially described as "doing whatever it takes", albeit only for voluntary patients. As a result of direction to spend money on FSPs,[3] $2.5 billion went to FSPs instead of existing programs that had already proven their effectiveness.[4] FSPs are serving some people with serious mental illness and doing a good job. FSPs are only voluntary, and therefore exclude many of the most seriously ill, like those who are psychotic. No information is collected or reported on the diagnosis of those being served. It is unclear how many of the individuals in FSPs have serious mental illnesses like schizophrenia or bipolar disorder or if FSPs are better than the existing programs that failed to receive funding as a result of the prioritization of FSPs.

Problems

1. Zero oversight to ensure people enrolled in FSPs have schizophrenia, bipolar disorder or other serious mental illness.

The Oversight Commission collects extensive information on age, ethnicity, sexual orientation of FSP enrollees, but not diagnosis.[5] Thus, there is no way to know whether the $2.5 billion FSP initiative is serving people with serious mental illness as required by the legislation.

Partially in response to growing public concerns, MHSOAC did contract with UCLA, a large recipient of MHSA funds for a report on FSPs.[6]

- Before releasing the report, at the request of the commission and others, the UCLA authors amended the supposedly independent report to "focus on positive outcomes".[7]
- The report intentionally and knowingly overstated cost savings from incarceration by allocating fixed costs (which do not change due to number of people served) to each patient and calculating it as savings.[8]
- In order to "prove" FSPs save money, the UCLA authors added 'physical health' savings--a welcome, secondary, but not primary goal of MHSA, and a goal that can be readily achieved by serving people with physical illnesses rather than serious mental illnesses.
- The report recommended more studies be conducted the result of which would send more money to programs associated with the commissioners.
- The UCLA report did not include any information of diagnosis of participants.
- The UCLA report did not reveal the multiple regulations that make many of the most seriously mentally ill ineligible for FSP services or that FSPs were only serving those well enough to volunteer.

Oversight Commissioners used the UCLA report to declare their stewardship of FSP programs a success.

2. FSPs exclude many of the most seriously ill. They only serve those well enough to recognize they are ill.

Regulations were issued that required MHSA funded programs to be designed for voluntary patients only.[9] This made the most seriously ill ineligible for FSPs. Up to 40% of those with bipolar disorder and 50% of those with schizophrenia are so ill, they don't know they are ill (anosognosia).[10] For example, a homeless person yelling they are the Messiah, or screaming the FBI planted a transmitter in their head would not likely be well enough to volunteer for services. These individuals are excluded from FSPs. Doing 'whatever it takes', should extend to helping people who lack awareness of their illness.[11] See Appendix D flow charts show the steps programs are skipping when determining if someone qualifies for MHSA-funded support.[12]

4. To fund FSPs, programs that that help people with serious mental illness who are homeless were left unfunded.

Proponents of Full Service Partnerships claim FSPs *are* referred to in MHSA because the Finding and Declarations reference AB 34 programs.[13] The population served by AB 34 Existing Systems of Care programs are "**severely mentally ill** adults who are **homeless, recently released from a county jail or state prison**, or otherwise at risk of homelessness or incarceration."[14] There is no indication FSPs are serving the same population as AB-34 programs. In fact, since 2007, "the proportion of prison inmates with mental illnesses has grown from 19 percent in 2007 to 26 percent now".[15]

AB 34 programs reduced the number of consumers hospitalized, 42.3%; number of hospital admissions, 28.4%; number of hospital days, 55.8%; number of consumers incarcerated, 58.3%; number of incarcerations, 45.9%; number of incarceration days, 72.1%; number of consumers who were homeless, 73%; and many other barometers of success.[16] They deserve equal or better funding than FSPs.

4. The FSP model may help higher functioning get housing but is least successful at helping people with schizophrenia and bipolar disorder get housing—the two most serious mental illnesses.[17]

Conclusion:
$2.5 billion is spent on FSPs without any oversight of whether they are serving eligible individuals. FSPs exclude many of the most seriously ill.

Prepared by Mental Illness Policy Org (http://mentalillnesspolicy.org) 8/13

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[1] "The legislature found "By expanding programs that have demonstrated their effectiveness, California can save lives and money" (Findings and Declarations (f)). The Purpose and Intent of the law was "To expand the kinds of successful, innovative service programs for children, adults and seniors begun in California"

[2] Emergency regulation in Cal. Admin. Code tit. 9, § 3200.130

[3] Because FSPs were an unproven new program it might have been appropriate to spend Innovative Funds on them. 5% of MHSA funds are set aside for Innovative New Programs. Instead, massive general funding was mandated to be used. See direction at http://www.dmh.ca.gov/DMHDocs/docs/letters05/05-05CSS.pdf

[4] MHSOAC allocated 51% of all CSS funds which are 50% of all MHSA funds to them, making FSPs the largest MHSA expenditure. If MHSA raised $10 billion since inception, $2.5 billion were spent on FSPs.

[5] Diagnosis information would be available via MediCal or anonymized questionnaires.

[6] "Full Service Partnerships: California's Commitment to Support Children and Transition-Age Youth with Serious Emotional Disturbance and Adults and Older Adults with Serious Mental Illness" prepared by UCLA Center for Healthier Children, Youth and Families (10/31/12). Available at http://mhsoac.ca.gov/Meetings/docs/Meetings/2012/Nov/OAC_111512_Tab4_MHSA_CostOffset_Report_FSP.pdf

[7] See page 4 of UCLA Report.

[8] See discussion by Commissioner Brown (who represents law enforcement on the commission) starting on page 16 of November 2012 Oversight Commission Board meeting minutes. Among other comments, Commissioner Brown noted the use of fixed versus variable costs and correctly stated, "(T)hat that is not an accurate measure of cost savings and may taint the rest of the report in terms of what savings are achieved. This report will be open to criticism regarding the types of cost savings indicated. Additionally, there is a disparity where Los Angeles used a figure of over $1,000 a day when every other county used a figure substantially lower."
"Available at http://mhsoac.ca.gov/Meetings/docs/Meetings/2013/OAC_012413_Tab1_Minutes111512.pdf

[9] CCR Title 9 Regulation 3400(b)
(b) Programs and/or services provided with MHSA funds shall…(2) be designed for voluntary participation" While the regulation went on to state, "No person shall be denied access based solely on his/her voluntary or involuntary status" the use of MHSA funds to prevent implementation of Laura's Law has obviated that option.

[10] See anosognosia at http://mentalillnesspolicy.org/medical/anosognosia-studies.html

[11] One way around this conundrum would be for counties to implement Laura's Law.

[12] Flow charts: Impact of the Full Service Partnership Programs on Independent Living. Nicholas C. Petris Center on Health Care Markets and Consumer Welfare School of Public Health University of California, Berkeley May 2010

[13] Findings and Declarations (b): A recent innovative approach, begun under Assembly Bill 34 in 1999, was recognized in 2003 as a model program by the President's Commission on Mental Health[13]. This program combines prevention services with a full range of integrated services to treat the whole person, with the goal of self sufficiency for those who may have otherwise faced homelessness or dependence on the state for years to come.

[14] Legislative analysis at http://www.leginfo.ca.gov/pub/99-00/bill/asm/ab_0001-0050/ab_34_cfa_19990816_185010_sen_comm.html

[15] Associated Press. California Mental Health Dollars Bypass Mentally Ill , July 28, 2012 as published in Sacramento Bee.

[16] http://www.homebaseccc.org/PDFs/CATenYearPlan/CAHighlightOutreach.pdf

[17] Schizophrenia and bipolar disorder are two of the most serious mental illnesses. The housing initiatives funded by MHSA help people with those disorders the least. *"The Impact of the Full Service Partnership Programs on Independent Living* found *"not having schizophrenia or bipolar disorder*" led to increased likelihood of independent living." *Nicholas C. Petris Center on Health Care Markets and Consumer Welfare School of Public Health University of California, Berkeley . "The Impact of the Full Service Partnership Programs on Independent Living: A Markov Analysis of Residential Transitions" Petris Report # 2010-3. Available at http://www.dmh.ca.gov/Prop_63/MHSA/Publications/docs/3_Petris_Residential_Report_Final.pdf*