



California Council of Community Mental Health Agencies

Representing Non-Profit Community Mental Health Agencies Throughout California

FROM FAIL-FIRST TO HELP-FIRST - PROPOSITION 63 TRANSFORMS CALIFORNIA'S MENTAL HEALTH SYSTEM

Implementation guide prepared for California Council of Community Mental Health Agencies by Rusty Selix, Executive Director, California Council of Community Mental Health Agencies and official co-proponent and co-author of Proposition 63- together with Assemblymember Darrell Steinberg.

Sixth Edition February 3, 2005 – This guide is not a CCMHA policy document nor is it intended as the definitive answer to any question. It has been prepared and updated as questions have been presented. It is intended to guide discussion and will continually be updated. Member agencies are encouraged to share this with others and CCMHA staff welcomes suggestions for changes as well as comments and disagreements not just from members but also from other stakeholders. Send comments to rselix@cccmha.org.

PURPOSE AND OVERVIEW

In making the quantum leap from campaigning for passage to implementing this amazing new law, the first and foremost thing that everyone needs to recognize is that it is not increased funding for the old mental health system that we have known for the past decades. Instead, it is a complete transformation to a new system. The old law since realignment in 1991 has had a defined target population of only children with serious emotional disturbances and adults with severe mental illnesses. We are now creating a new approach that brings into action for the first time prevention and early intervention dimension to keep mental illnesses from becoming so severe in the first place.

It also will provide enough funding to eventually enable us to serve everyone who is facing a disabling mental illness.

Now we have a fail first system of waiting for people to hit rock bottom. Hospitalizations, incarcerations, out of home placements, special education and other failures, are the norm before getting the services needed. Usually such tragedies are suffered for several years. Even then we are only able to meet the needs of about half of the population we encounter in this manner.

Now we must move from fail first to help first. Give everyone the right care at the right time in the right place. No child should age out of the child welfare system and be dumped on the streets. No one should be discharged from psychiatric hospitalization without follow up care or discharged from a jail or juvenile justice system without being enrolled in a program appropriate to their level of need. This won't happen overnight, but in a few years it should be an expectation.

A BIG INCREASE IN FUNDING

The Legislative Analyst and the Department of Finance have estimated that the funding increase will average \$800 million over the first five years. That is based upon incomes received through tax year 2002. For 2004-05, 2005-06 and 2006-07, these estimates reflect the actual dollars that will be received. Each fiscal year thereafter the funding will be adjusted based upon the extent to which the actual income tax receipts are above or below what had been estimated. Accordingly the 2007-08 funds will be revised to reflect what is actually collected for tax year 2005 and future years will be adjusted in the same manner.

Overall the funds were projected to grow at a 7% annual rate which exceeds population and inflation and means that we should eventually have sufficient funds to meet all needs – if we maintain the same level of efficiency and effectiveness. With the prevention and early intervention programs we should be able to improve on cost effectiveness, but this may be offset by program cost increases. As we expand programs the current shortages in facilities and qualified staff will be heightened leading to increased costs in attracting and retaining staff and facilities.

Measured against current **total** state and federal funding for public mental health services and **not counting federal funds that this funding will attract**, this represents about a 15% increase in revenues. However, it will not be spread evenly but is concentrated in three areas:

- Comprehensive Community Mental Health Services to Adults (Including Transition Age Youth 18-25) with severe mental illnesses in accordance with the standards of the Adults System of Care (also known as the AB 34 program) It will probably increase funding for such services by at least 100% - doubling the # that can be served
- Comprehensive Community Mental Health Services to Children and Adolescents with serious emotional disturbances in accordance with the standards of the Children's System of Care – for those youth who do not qualify for services under one of the existing entitlement programs such as MediCal (mostly funded through EPSDT (Early and Periodic Screening Diagnosis and Treatment) Foster Care (which creates MediCal eligibility) and Special Education (Mental Health Services are funded through the so called AB 3632 program) It will significantly increase the # of such children who are served but only represent about a 10% increase in available funding because the most expensive children have entitlements to care through other funds such as Child Welfare and EPSDT or AB 3632.

(Funds will also be available where existing funding/entitlements/private insurance is not sufficient to keep a child at home.)

- Prevention and Early Intervention Programs to offer help early in the onset of a potentially severe mental illness to prevent mental illnesses from becoming disabling and life threatening (they are currently the leading causes of disability representing 35% of people who get SSI (social security) benefits due to disability. Suicide, which is nearly always due to a mental illness, is the 3rd leading cause of death among

teenagers.) This is almost all new money as there are virtually no funds for these purposes.

The 100% increase in funding for extensive community care for adults is several hundred million dollars and will enable us to serve at least 50,000 people currently “in harm’s way” (homeless, hospitalized or incarcerated - or at high risk of one of these) due to lack of treatment for a severe mental illness. We estimate that there are currently 50,000 such people homeless on the streets and another 50,000 in other settings. 50,000 seems a reasonable estimate of how many more we need to serve as not all will come in at once and many will be eligible for services through other funding – particularly veterans who have a federal entitlement to funds through Veterans Affairs Healthcare.

END THE DELAYS IN GETTING SERVICES

Programs that see people earlier in the onset of a mental illness can reduce disabilities. The early mental health initiative successfully treats moderate conditions in schools. State Mental Health Director Steve Mayberg has said “we never see those kids again”. This shows the cost-effectiveness of prevention and early intervention strategies.

Similarly, many nations led by Australia and Norway have invested in programs known as early psychosis to educate our society to recognize the symptoms of schizophrenia within the first few months of onset. They get people into treatment with the result being that most are living fully productive lives within one year no longer needing extensive mental health treatment, other than maintenance, medications and support.

Teen screen is a program to recognize and prevent suicide that is being implemented in many states. New efforts connect primary care and mental health services to recognize and treat mental illness at primary care settings to reduce the stigma that keeps people from utilizing mental health services.

Proposition 10 (First Five) Commissions have funded a number of programs successful in helping pre school children which could move from pilot projects to system models under Proposition 63.

All of these represent our opportunities to transform the system, but as with so many great ideas, lofty goals are easy to articulate but the devil is in the details.

STRUCTURE OF PROPOSITION 63 PROGRAMS

We are overwhelmed if we try to look at implementation across all of its components. Instead, it must be broken down into each of its many separate programs that are funded with an analysis as to how each part of it can and should be implemented.

STATE ADMINISTRATION

The legislation creates nine categories of expenditures with subcategories within some of them. Two categories are kept at the state level - 1) state administration and oversight and 2) human resources.

5% of the funds are for state administration which will be divided among the responsibilities of the Department of Mental Health, the Mental Health Planning Council and the newly created Oversight and Accountability Commission

HUMAN RESOURCES

The human resources program, officially known as the Education and Training Program, commencing with Section 5820 of the Welfare and Institutions Code, actually consists of six programs, each of which must be developed in accordance with three primary policies:

- Promotion of the employment of mental health consumers and family members.
- Promotion of the meaningful inclusion of mental health consumers and family members and incorporating their viewpoint experiences in all the training and education programs.
- Promotion of the inclusion of cultural competency in training and education programs.

The six programs are:

1. Expansion plans for the capacity of post-secondary education to meet the needs of identified mental health occupational shortages such as expansion of graduate school programs for psychiatry, psychology, social work, marriage and family therapy, nurses, psychiatric technicians and other programs.
2. Plans for forgiveness and scholarship programs in return for a commitment to employment in California's public mental health system and for current employees who seek to obtain advanced degrees beyond their current level of education and commit to returning to employment in publicly funded mental health services.
3. A stipend program allowing people to be employed while working part-time in academic institutions modeled after the federal 4E program for child welfare system - people to be, or already, enrolled in academic institutions and employed in publicly funded mental health services.
4. Partnerships between local mental health systems and education systems on a regional basis to expand outreach to multi-cultural communities, increase the diversity of the mental health work force, reduce stigma associated with mental illness and promote the use of web-based technologies.
5. Strategies to recruit high school students for mental health occupations-increasing the prevalence of mental health occupations in high school career development programs, such as health science academies, adult schools and regional occupation centers and increasing the number of human service academies.
6. Curriculum to train and re-train existing staff to provide services that meet the requirements and principles of the children's system of care, the adult system of care, the prevention and early intervention programs and the innovative programs created through the act.

The human resources program has been allocated approximately \$300 million over the first three years. County plans are required to identify the needs for particular professions. It is essential that the needs of CCCMHA members be fully considered in this analysis, including stipends to attract professionals to agencies, which have not been able to offer salary comparable to counties or other organizations. These county plans are submitted to the state, which will develop a five-year plan and provide allocations of funding to each of these programs that are intended to assist counties and their providers to expand their staff to implement the act.

Additional funds are expected to be made available in future years whenever there are “one time funds” due to a “spike” in revenues that is not likely to continue or whenever a county can’t provide services (for which funding is available) due to the lack of available personnel. Funds will be provided for human resources out of the allocations that would otherwise go to increased services.

A broad and inclusive planning effort at both the state and county level needs to occur to determine how to develop the details for each of the six programs and how to allocate funds among numerous competing priorities.

Clearly a high early priority must be to ensure that all key personnel receive appropriate training in the values goals and requirements for these new programs and for the transformation of our entire mental health system.

Equally important is to use the leverage of this funding to restructure the curriculum of mental health professional education to better match the needs of the public mental health system.

The human resources program creates new relationships between public mental health systems and educational systems – primarily higher education and high schools. The students in these settings are the highest priority age group for our prevention and early intervention efforts. We need to use these relationships and the leverage of the funding also to ensure that these institutions are doing everything that can and should be doing to provide education and timely help for their own students who may be showing the early signs of a severe mental illness.

COUNTY PROGRAMS

All other funds are allocated to counties for the following seven program elements:

1. Integrated plans for prevention innovation and system of care services.
2. Prevention and early intervention programs.
3. Services to adults with severe mental illnesses in accordance with the adult system of care (the AB 34 program).
4. Services to seriously emotionally disturbed children to the extent such services are not paid for through other funds. These are part of the children’s system of care statute and

subject to values, outcomes, treatment plan requirements, and evaluation set forth in that law.

5. Capital facilities and technology improvements necessary to enable a county to adequately implement all of the other programs.
6. Innovative services.
7. Prudent reserves.

COUNTY PLANS

Integrated plans - pursuant to Section 5847 of the Welfare and Institutions Code are the heart of the transformation of our publicly funded mental health system.

No funds may be provided from the state to the counties for any of the other purposes unless such spending is in accordance with a plan developed in accordance with numerous requirements. These include stakeholder input, public hearings and meaningful response to comments and approved by the state. In addition, prevention, early intervention and innovative services programs must be approved by the Oversight and Accountability Commission as opposed to the Department of Mental Health. The full plan including the provisions for the programs must be approved by the State Department of Mental Health after review and comment by the Oversight and Accountability Commission.

Before the plan is submitted, counties, as well as their major providers, will have to plan to assess their capacity and needs in order to transform their services and expand their care in accordance with other provisions.

Each plan is a three-year plan that must be updated annually and each update must also be submitted to the state for review. Up to 5% of the revenues received each year may be allocated to counties for this purpose.

Even before the state rules for county plans are developed, counties and their providers and other stakeholders need to begin the needs assessment. The best way to do this is to look at their safety net. Where are the holes? Who are we missing? Counties can determine the numbers of people who are released from jail or juvenile justice with severe mental illnesses, the number of hospitalizations, the number of SED children who age out of the foster care system and work with police and housing agencies to estimate the number of homeless and assume that 1/3 have a severe mental illness.

The funding for Adults and Children's System of Care services will not be allocated by a formula. Rather they will be allocated annually based upon each county's demonstration of unmet need and capacity to expand SUCCESSFUL programs.

The state has determined that funding for these programs will be made available before the funding for Prevention and Early Intervention so the first steps in county planning and the first plan elements will focus on these programs. County planning accordingly should initially focus on determining the needs- the # of SMI/SED in "Harm's Way" – due to lack of care, and the capacity of current and potential providers to establish and expand programs that will

demonstrate successful results in accordance with the standards of the Children and Adults Systems of Care.

County planning will also identify people with SMI/SED who are currently being served who need extensive services over several months but don't get what they need and would need additional services to increase and expedite recovery in accordance with children's and adults systems of care. However, the state, counties and key stakeholders will need to work to determine how to identify such individuals when they are not "in harm's way" and how much additional services they should be made eligible for.

These efforts will have to be repeated on an annual basis as annual updates of county plans will be the primary analysis of where each county stands and how much progress is being made. That will determine future funding which will continue to be based upon unmet need and demonstrated capacity to provide successful services.

While the plans are mainly to guide the funding for Proposition 63, it will be necessary to look at all current services – both private and public, from all funding sources.

The prevention and early intervention program will often be a vehicle to refer people to privately funded services as well as EPSDT, Healthy Families, Medicare and other public funded services.

Accordingly from the outset county plans must include detailed information about all services – using estimates for those aspects of privately funded care that cannot be ascertained from public reports (generally submitted to the State Department of Managed Health Care).

In moving from fail first to help first the key measurement should be how many people are failing and how many are getting timely help. County plans should all be required to measure the current status (January 2005) and track annual progress in getting more people into timely help and measuring how successful that is in reducing the # of people who wind up in jail, out of home placement, special education, or other measures of failure.

Similarly as these changes take place we should see more people and the duration of cost per person should go down so that we track the cost per person across all services – not just those funded by Proposition 63.

PREVENTION AND EARLY INTERVENTION

Prevention and early intervention programs are a completely new part of California's mental health system. It is easy to state the goals – Prevent mental illnesses from becoming disabling or life threatening and to do this by intervening early in the onset of a potentially severe mental illness. However, it is much more difficult to settle on the best strategies to do this as it has not been done systematically ever in California and on a very limited basis in other states.

The State Department of Mental Health will establish the terms and conditions of this program, which must be developed before counties can develop their plans. It will probably

take longer to develop than the services for existing programs for people with severe mental illnesses.

The law requires the program to include elements that have been successful in preventing mental illnesses from becoming severe as well as those successful in reducing the duration of untreated severe mental illnesses and assisting people in quickly regaining productive lives.

Below are some examples that will be studied for inclusion.

A program effective in preventing mental illnesses in becoming severe could be similar to the early mental health initiative which treats moderate conditions in schools for kindergarten to third grade students and is funded with only modest grants totaling \$5 million each year for three-year grants to a limited number of school districts. Teachers observe children exhibiting problems that may warrant treatment. That knowledge needs to get to parents and providers so that children receive treatment while they are still relatively healthy and the cost and duration of what is required is much less and the success in preventing disability is much greater.

Another successful program “teen screen” is successful in reducing suicide. It helps those at high risk to evaluate themselves and be connected to assistance.

Programs for early intervention with young children are established under Proposition 10 and could be expanded.

Other successful models for prevention include efforts to reduce the stigma which keeps people from seeking mental health treatment. They could be educational in nature and provide better linkages to primary care settings where people are more likely to seek help than by going directly to mental health programs.

The best known model for programs, which reduce the duration of untreated severe mental illness, are programs such as the TIPS program pioneered in Norway and EPPIC in Melbourne, Australia, which have become models for most European and other western nations. These programs work to educate people in the age group of 15 to 25, as well as their family, friends and primary care physicians to recognize the early signs of schizophrenia or other disabling mental illnesses early in their onset. CCCMHA has done extensive research in these programs and some of that material is available on our website: www.cccmha.org. For more details call Stephanie Welch or Rusty Selix at 916-557-1166 or swelch@cccmha.org or rselix@cccmha.org.

20% of total funding is allocated by formula for prevention and early intervention. Additional amounts are allowed, to a county which demonstrates that the additional investment will reduce other expenditures by a comparable amount.

This program represents the biggest change in our current mental health system. We are not aware of any state which has extensive prevention and early intervention services, so this program may represent a new area in which California will lead the nation. It is also the program which has the greatest potential to reduce other costs by reducing the necessary intensity and duration of treatment. With people seen more quickly and levels of disability

reduced the array of private insurance services will more often be adequate and that will also reduce the burden on the public mental health system. Similarly, as people recover more quickly, they will return to the workforce and be less dependent on mental health and other public services generating even more savings.

Community mental health agencies report that in our current “fail first” system nearly every child or adult they see has been sick for years before one or more crises finally got them to the right care. That has to be the key objective of this system which is to reduce the average duration of untreated mental illness (DUMI).

While the programs will need to address all ages and settings, in terms of potential saving of dollars and lives, a most important target age group will be 15-25 which is the age at which people usually first present with Schizophrenia or Bipolar disorder as well as the group at highest risk for suicide. Recent statistics indicate that 8% of people in this age group make a suicide attempt serious enough to result in a 911 call. More than 2% make an attempt every year. While less than 1 in 10 such attempts results in death the number of young people at that level of despair is a measure of our failure to provide timely assistance and programs to reduce that rate of suicide attempts must also be a key component of our prevention and early intervention programs.

It will require extensive training to prepare our systems for implementing this new program. The human resources program provides such funding.

These will all be new programs. It is important to take time to develop a program that is the highest possible with lots of input and strong requirements, but also recognizing that since it is new there needs to be some variation of how the elements are carried out. Each local prevention and early intervention program will probably need to have the following components.

- A. An early detection of schizophrenia or other severe mental illness program similar to those established in other nations that are targeted to high school, college students and others in those age groups.
- B. Aimed at the same age groups, a program for suicide prevention such as the teen screen program with an assistance line.
- C. Programs designed to identify and access services for preschools, elementary schools, secondary schools and higher education.
- D. Coordination with primary care and increasing the detection of mental illnesses and primary care services.
- E. Special outreach to Latino and Asian communities.
- F. Linkages to those where there is a high likelihood of co-occurring needs for mental illness such as substance abuse, developmental disabilities, child welfare and criminal justice populations.
- G. Seniors.

H. Infants and Toddlers and preschool age children 0-5, where traditional mental health diagnoses are less common.

AB 34 – ADULT SYSTEM OF CARE

The original motivation for Proposition 63 was to “fully fund (Assemblymember Darrell Steinberg’s) AB 34 program.” In addition the campaign literature including ballot arguments stated that all funds would go to this “proven model.”

Section 5891 explicitly states that Proposition 63 funds may only be used for the programs specified in Section 5892. That section lists only the adult system of care (the AB 34 program) as an eligible program for the portion of Proposition 63 funds to serve adults with severe mental illnesses. Accordingly, all Prop 63 funded services to adults with severe mental illness must be in accordance with the AB 34 adult system of care and must follow the rigorous requirements of that program. This means integrated services or a so-called whatever it takes approach with an individual treatment plan that includes not only mental health services but all other support services.

Such programs are now established in nearly 40 counties, but in most counties they represent only a small fraction of services and do not reflect a general philosophy of utilizing that model. While the model is broadly supported as policy, lack of funds has prevented counties in the past from transforming existing services to that model. Proposition 63 broadens the eligible population for AB 34 programs to all adults with a severe mental illness (not just those who are homeless or at risk of homelessness). (However, existing provisions of AB 34 (the adult system of care) still apply which lists those homeless or at risk of homelessness as the highest priority.)

The expanded eligible population includes adults currently receiving services which do not meet system of care standards (generally set forth in Welfare and Institutions Code Section 5806), whose services could be supplemented by the care offered in section 5806 – unless they don’t need that level of care. Proposition 63 adds a planning requirement to provide AB 34 services to everyone with a severe mental illness for everyone who needs that level of care. For such transformations, the funding under Proposition 63 would provide for the costs of making the change, as well as any gap between the amounts currently being expended and the amount per person that would be required.

However, not everyone needs the full AB 34 level of care. This includes not only those already receiving lesser levels of service but also those who are already being served under AB 34 type programs and whose recovery has progressed to a level where they don’t need the extensive services generally required in the first year, but still needing some services beyond maintenance and peer support. This will require the development of new standards and procedures and outcome measurements to determine who needs higher or lower levels of care. Until these new criteria are developed it is likely that Proposition 63 funds will be targeted to people who currently are not receiving any care. This also is consistent with the expectations of voters who see “street people” as those most needing to be helped.

Funding for the higher level of full AB 34 type services is provided in a case-rate based on the number of individuals that a county serves with flexibility to allocate resources. Contracts with individual private providers are directed to retain the same case-rate flexibility. The terms and conditions for the lower levels of care must still be developed.

All of these programs are subject to rigorous outcome measures to demonstrate and compare their effectiveness in reducing hospitalizations, incarcerations, increasing housing independence and employment.

With the new level of funding counties will be able to offer AB 34 services not only to those who have been homeless or recently released from jail but also to those who have been hospitalized and those who have been in the child welfare system and are “aging out” of that system but still have a severe mental illness.

Accordingly, the outreach component of these program must include not only the homeless outreach but also discharge planning and coordination with these other services.

Funding levels for this program and services to children with serious emotional disturbances are not set by formula. Each county will have to reapply each year for this funding and demonstrate that there is still a significant unmet need and that it has cost-effectively utilized funds provided in previous years and provided services in accordance with the standards of the adult system of care. In applying each year counties will only receive funding for that portion of care that can't be met with other existing funds. That requires counties to continue to utilize realignment and other funds that serve these needs and if a county withdraws any such funds for other purposes that funding still counts towards the other available funds and reduces eligibility for new state funds.

With the permanent dedicated funding of Proposition 63, counties and providers can look at permanent housing to acquire or construct instead of having to rent housing based upon the limited uncertain funding of AB34 in past years. There are a variety of local state and federal programs to assist in meeting these housing needs and counties and providers will need to partner with the organizations that receive and allocate those funds in order to maximize access to those funds and most cost effectively meet the housing component –which is often the most expensive and difficult component of AB 34 services.

Eventually counties will be able to find that all of these needs are being met. That will then enable a county to utilize savings it is realizing in its realignment or other funds to make other system improvements or changes. However, until a county demonstrates that everyone with a severe mental illness who is seeking care, is receiving AB 34/system of care services, not only can't a county spend proposition 63 funds for any other purpose but it can't withdraw any current funds from services which complement AB 34. This not only prohibits transferring funds out of mental health to other purposes as explicitly prohibited by Section 5891, but also means that a county can't shift its utilization of realignment or other funds to purposes which reduce the resources which support achievement of the goal of serving everyone.

This is the first and foremost goal of Proposition 63 - get everyone into AB 34 services. As the funding under Proposition 63 expands and the prevention and early intervention programs reduce the cost and duration of treatment, this goal will be achieved – probably over 5 to 10 years.

CHILDREN'S SYSTEM OF CARE SERVICES

Services to children with serious emotional disturbances fill in the gaps between the many existing entitlements that are covered with other funds. The EPSDT program generally provides comprehensive services to children enrolled in Medi-Cal. The AB 3632 program provides services to those in special education. The Healthy Families program includes a special supplement for children with serious emotional disturbances. The mental health parity law requires comprehensive mental health services for all children with serious emotional disturbances. Nonetheless, some children do not get all of the services they need in spite of these entitlements. Some children have no insurance including many who have been in the juvenile justice system and may have lost benefits that were previously available to them.

A new program that is part of the children's system of care statute, serves these children. The services must meet the Children's System of Care standards for services set forth in Section 5868 of the Welfare and Institutions Code which includes a treatment plan, family involvement and a case manager who will also be responsible for ensuring that these services are coordinated with other services the child may be receiving from other agencies. The funds can only be utilized for the services. The children's services portion of Proposition 63 does not fund all elements of the Children's System of Care. Those funds cannot be used for the interagency policy coordination, planning or other non service elements that had been funded through grants to counties as parts of the children's system of care statute. However, counties may be able to use the administrative and planning funds (5% of total funds) for many of those purposes and others might qualify under innovative services (5% of what a county receives for other programs or about 4% of total funds)

State funds for the Children's System of Care were deleted in the 2004-05 budget. Other provisions in the mental health service act require that all funds be maintained at the 2003-04 levels thereby requiring the state to restore that \$20 million in funding that had been lost.

The services under this program are similar to those services provided in the Healthy Families Program and with reimbursement in a similar manner, which means utilizing the same rates and criteria for reimbursement as under the Medi-Cal program. However, there may be a need to expand the services to include outreach and engagement services similar to the adults system of care.

Where a child has limited private insurance, these funds can be utilized to cover the gap between what the insurance would pay for and what would have been provided if more comprehensive insurance were available.

These services must meet medical necessity criteria. Other services which may be non-traditional in nature, such as respite care, may be available where a finding can be made that these services are helping for a family to keep a child at home – for children who do not meet the criteria for "Wrap Around Programs" which are funded through child welfare funds.

In addition, before accessing these dollars for that purpose, each county is required to establish a wrap-around program whereby those children who meet criteria for out of home placement but could be served instead while in their home through a comprehensive wrap-around program will get that care instead of out of home placement. Accordingly these non

traditional funds are limited to situations in which a child does not meet criteria for wrap around programs, but a child with a serious emotional disturbance is still at risk of out of home placement due to lack of these services. These will most likely be children for whom there has been a visit by child protective services but no placement was made. However, that is still to be developed as this is a new program and the rules need to be settled before such services can be provided.

Funds are also provided for the State Department of Social Services to provide technical assistance to counties to establish such programs if they haven't previously. All counties must establish such programs unless they can make a finding that it is not feasible (With the possible exception of very small counties, it seems unlikely that any county would be able to make such a finding, but even small counties would need to get the training and work toward establishing such programs before they could legitimately find that it is not feasible).

State funding for the EPSDT entitlement program and the AB 3632 program must be retained and the state must pay for those services with state funds. Prop 63 funds cannot be utilized to pay for those services for children enrolled in those programs.

CAPITAL FACILITIES & TECHNOLOGY

For capital facilities and technology there are funds set aside in the first three years recognizing that the system lacks the physical and technological infrastructure capacity to meet the expanded service levels that will be available with the additional funding provided by Proposition 63. These funds may be used for virtually any capital facility or technological need that is documented in a county's plan as requiring additional facilities in order to meet the needs.

They include medical facilities as well as other types of facilities for supportive services or for prevention and early intervention programs. Facilities include school facilities or housing. There is a requirement that all facilities be part of a program for such facilities set forth in the county's plan. All plans for proposed facilities with restrictive settings shall demonstrate that the needs of the people to be served cannot be met in a less restrictive or more integrated setting.

While the capital facilities money is provided to counties, it does not prohibit these facilities from being owned by private providers. There are rules well established in other programs such as the federal community development block grant program where public funds may be utilized for a private provider to acquire a facility with a commitment to continue providing the publicly funded services for a designated number of years similar to the way in which home mortgages are paid off. If the agency ceases to provide the services before the designated time period, the remaining value is transferred back to the county in accordance with the terms of acquisition.

After the allocation of the funds provided in the first three years (estimated \$300 million which would be allocated in accordance with a formula developed by the state in consultation with county representatives) funds for this program may be allocated in future years. This is likely when revenues have grown beyond levels likely to be sustained due to a spike in state revenues and whenever a county is unable to provide as many additional services that it

would otherwise be finder for due to a shortage of facilities and thus is not able to fully utilize some of the service dollars.

INNOVATIVE SERVICES

This section is intentionally very broad and open-ended. The county must utilize 5% of the total amounts that it receives from prevention and early intervention and adults and children's services for innovative programs. The only restriction on these programs is they must be approved by the mental health Oversight and Accountability Commission and they must achieve the following purposes:

1. Access to underserved groups.
2. Increasing the quality of services including better outcomes.
3. Promoting inter-agency collaboration.
4. Increasing access to services.

Counties won't even know exactly how much money they are receiving for this program until it is determined how much they get for the other programs. Moreover, it will be only through the planning process for other programs and the challenges in implementing these other programs that counties will best be able to determine what type of innovations reflect the highest priorities. It is expected that the Oversight and Accountability Commission itself will signal priorities but will not likely expect all counties to do the same thing as the very purpose of innovation is to try different things in different places in order to see if we can do better than we have done.

The innovative services component is especially important recognizing that both the children's and adults systems of care began with pilot programs approved by the Legislature that were innovative in nature. Given the substantial new funding that mental health services are receiving through Proposition 63, it is unlikely that the Legislature would allocate significant funds for new mental health programs when so many other state funded services are suffering. This set aside represents the best way to ensure that we continually invest in ways to do better.

PRUDENT RESERVES

As part of the planning process, each county must determine an amount for reserves in order to ensure that in years in which revenues decline (as is inevitable with the ups and downs of our economy) it will have sufficient funds to continue to be able to provide services to at least as many people that it had served in the previous year.

Efforts at establishing rigid formulas to determine the necessary level of prudent reserves have proven to be unworkable. Accordingly, the law does not provide a specification other than to indicate that in years in which revenues are above historic averages funds are to be added to the reserves and in years in which funds are below historic averages funds may be withdrawn as necessary to maintain the previous year's level of services.

In the first several years after passage of Proposition 63, there is expected to be funds available to place into reserves because of the lack of the capacity of the system regardless of whether or not the economy is performing well. Accordingly, every county should be expected to allocate some funds for reserves each year for the first several years until the reserves appear to be adequate to sustain a downturn in revenues.

Funds placed in a reserve may not be loaned or transferred to any other county purpose. However, they may be invested together with other county funds and the reserve account must be credited with income at the rate that other county investments receive interest or other income.

QUESTIONS REGARDING IMPLEMENTATION

How can we protect against counties diverting existing mental health funds based upon these available new revenues?

It has been reported that Santa Clara County's County Counsel has already opined verbally that consistent with the intent of Proposition 63 a county may not reduce any current funding from other sources for mental health programs. As a county applies to the state for funds for additional services to adults or children with serious emotional disturbances or severe mental illnesses, a county receives funds only to the extent existing funds can't meet the need. The diversion of existing funds to other purposes will restrict a county's ability to get additional funds.

What will be the outcome measures for children's services?

The adults system of care (AB 34 program) includes outcome measures that are broadly accepted and widely considered to be valid measures of success. The children's system of care statute of requires outcomes to reduce out of home placements, juvenile justice recidivism, juvenile justice placements and academic performance. It has not been utilized to apply to an extensive level of children's services. It is not established that these measures determine the relative success of each program. There is considerable work needing to be done to develop appropriate ways of measuring how successful each children's program is relative to the funds provided to it and the potential success with those being served. Community mental health agencies must develop recommendations, as well as participating in state and county committees to develop outcome measures.

Will counties receive funding for children's services in a total amount without regard to the number of children served, a case rate for each person to be served, on a fee for service basis in accordance with rates for each type of service up to some total amount or some other methodology?

The AB 2034 program pays counties in a negotiated case rate for each individual to be served and it is set a rate to cover all services that are not covered with other funds. That model is expected to be continued in making payments to counties for services for adults under proposition 63.

However, children's services have not been financed in that manner and there is no guidance on appropriate case rates. Presumably such services would be paid in the same manner in

which Healthy Families payments or EPSDT payments are made. However, there are two critical differences. Both of those are entitlement programs and the amounts of funding are not determined by utilization levels. In addition the funding is set through the state budget and for Proposition 63 the funding is limited by the funds available. This creates uncertainty as to how counties will be paid for these services.

When will funds for services become available?

The mental health services act funds begin collecting taxes based on income earned in 2005. This begins in January with withholding by employers and with quarterly tax payments in April. The funds received during the 2004-05 fiscal year may only be used for capital facilities, technology, and human resources and for state and county planning and administrative activities. The service dollars begin with the 2005-06 fiscal year which commences on July 1st.

Since these funds do not go through the state budget process, they will begin to become available as they are received in accordance with revenues collected by the state regardless of when the state adopts its budget. Funds will go into the mental health services account at the State Department of Mental Health. They are allocated to specific programs or specific counties when requisite planning reviews and approvals have taken place.

When will the Oversight and Accountability Commission members be appointed?

There are 16 members of this commission - two are constitutional officers, the attorney general and the superintendent of public instruction - two are members of the Legislature - the other 12 are appointed by the Governor. The commission can't begin to meet and carry out its duties until these appointments have been made, which could occur soon, but also could be delayed as many appointments are often delayed, and as a practical matter there is not much for the Commission to do until counties complete portions of their plans and are ready to submit them for review. Application information is available on the website for Governor's appointments. www.governor.ca.gov.

Can involuntary services be funded through Proposition 63?

The funds for services for adults with severe mental illnesses are limited to programs in accordance with AB 34/AB 2034 – the adult system of care. That program requires that each individual **voluntarily** enroll in a program with a comprehensive treatment plan. However, once enrolled such programs are responsible for all services and that has often included hospitalizations – even involuntary ones.

How does AB 1421 – court assisted outpatient apply?

Once someone is enrolled in an AB 2034 program there is funding for their services and this could also include court assisted outpatient orders- if the individual is in a county which has elected to implement this program and such funding is part of that county's plan for implementation and meets all of the requirements for AB 1421.

Can these issues be addressed in a treatment plan/advance directive?

The issues of what should happen if someone becomes gravely disabled and meets the standards for involuntary hospitalization can be addressed in an advance directive that is part of the treatment plan. Similarly such plans could address how court assisted outpatient would apply if an individual met the criteria for such assistance.

Can these funds pay for jail services?

For the most part jail services are paid for with other funds and that funding must be maintained to comply with the prohibitions against reducing other funding for services. However, just like hospitalization, people enrolled in AB 2034 programs may become incarcerated while they are in the program and some portion of their care can be continued while in jail and AB 2034/Proposition 63 funds can be expended upon such individuals. In addition those about to be discharged from jail are a priority population for enrollment and outreach services can include outreach and enrollment assistance to them while they are still in jail.

EVERYONE IS WATCHING US – HOPE ON THE STREET

The passage of Proposition 63 has raised hopes and expectations throughout California. Families who have loved ones that have been unable to access care will now expect to get it. News media, interest groups and government officials across the nation are anxious to see what difference it makes. Already several news stories have indicated that getting Crisis Intervention Teams to assist law enforcement with specially trained mental health workers will become common through out the state. Equally important will be supporting those teams with rapidly expanding enrollment in AB 34 service programs so that there indeed will be hope on the street and people can see these programs growing.

Besides those on the street we should be able to quickly begin enrolling children who “age out of the child welfare system”, or are discharged from hospitals or jails – including children discharged from juvenile justice facilities who lack eligibility for other forms of public assistance.

The prevention and early intervention programs will take longer to develop but establishing relationships with schools, primary care, employers and others in a position to recognize early warning signs can begin to immediately increase the # of people who get help early in the onset of a mental illness.

While it will take years to fully realize its benefits and completely move from fail first to help first, these are some things we should be able to do quickly to enable everyone to see that it is making a difference and moving us towards our goals.