



California Network of Mental Health Clients

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California Network of Mental Health Clients (CNMHC) Comments on the State Department of Mental Health (DMH) Draft Proposed Mental Health Services Act (MHSA) Capital Facilities Guidelines

The CNMHC welcomes the opportunity to comment on the DMH's April 30 *Draft Proposed Guidelines for the Initial Capital Facilities Component of the County's Three-Year Program and Expenditure Plan*. The opportunities this component offers for land and buildings to be acquired and built upon for client-driven, recovery-based services and supports in community settings, including client-operated mutual support programs, are very promising to mental health clients. We strongly support the use of these funds to make existing buildings used for MHSA service delivery more accessible for people with disabilities. And we hope to be involved much more as the planning process for this component unfolds.

However, we have a number of serious concerns with the current Draft Proposed Capital Facilities Guidelines that we feel must be addressed.

Restrictive settings

Among the various types of buildings for which the Draft Guidelines say MHSA funds may be used are what are termed "restrictive settings". On the recent Statewide Conference Call on Capital Facilities, DMH Special Projects Chief Jane Laciste defined a restrictive setting as "a facility in which an individual is there involuntarily; a locked facility."¹

The Draft Proposed Guidelines outline a set of criteria that must be met in order for a county to use MHSA funds to pay for these settings:

Restrictive Settings. In general, Capital Facilities funds shall be used for buildings that serve clients in less restrictive settings. However, if a county submits a proposal for a Capital Facilities project that is a restrictive setting, in accordance with Welfare and Institutions Code Section 5847(a) (5), the County must demonstrate the need for a building with a restrictive setting by submitting specific facts and justifications for the Department's review and approval as follows:

- There is an unmet need within the county for a restrictive facility in order to adequately serve individuals with severe mental illness and/or serious emotional disorder.

¹ California Department of Mental Health (DMH) Statewide Conference Call on Draft Proposed Capital Facilities Guidelines, May 14, 2007.

- These needs cannot be adequately served in a less-restrictive setting. The County shall include specific reasons to substantiate the inability to meet the needs in a less-restrictive setting.
- It is not feasible to build the required facility using non-MHSA funds. The County shall include specific reasons for non-feasibility.
- The County has pursued, and been unable to obtain, other sources of funding.
- The proposal for a restrictive facility was developed through a Community Program Planning Process in accordance with California Code of Regulations 3300, 3310, and 3315.²

The CNMHC acknowledges that the above criteria reflect similar language on restrictive settings in the Mental Health Services Act (emphasis ours):

§ 5847. Integrated Plans for Prevention, Innovation and System of Care Services.

(a) Each county mental health program shall prepare and submit a three year plan which shall be updated at least annually and approved by the department after review and comment by the Oversight and Accountability Commission. The plan and update shall include all of the following:

...

(5) A program for technological needs and capital facilities needed to provide services pursuant to Parts 3, 3.6 and 4. *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.*³

It is the position of the CNMHC that the wording of the Section 5847(a)(5) above is an anomaly within the MHSA and inconsistent with the words, intent and purpose of the Act itself. One of the goals of the MHSA, according to the DMH, is to reduce hospitalization and involuntary treatment.⁴ Moreover, the use of MHSA funds for restrictive settings is inconsistent with the Recovery Vision outlined in the Act and its intent of systemic transformation.⁵ Notwithstanding this inconsistency within the MHSA itself, the CNMHC recommends additional criteria in the DMH Capital Facilities Guidelines governing the use of Restrictive Settings within Counties, as we have outlined on p. 4 below.

The MHSA's promise and mandate is to develop alternative ways of helping people in emotional distress, not to fall back on the same old, unsuccessful answers. MHSA funds

² DMH, *Draft Proposed Guidelines for the Initial Capital Facilities Component of the County's Three-Year Program and Expenditure Plan*, April 30, 2007.

³ Mental Health Services Act (MHSA), California Welfare and Institutions Code (WIC) Section 5847(a)(5).

⁴ DMH, *MHSA CSS Program and Expenditure Plan Requirements*, August 1, 2005, P. 1.

⁵ MHSA, WIC Section 5813.5(d).

are required to provide incentives for alternative answers, not support for the failed conventional ones.

Reduction in force and hospitalizations

An intended outcome for the MHSA stated in the Department's *CSS Three-Year Program and Expenditure Plan Requirements* of August 2005 is "[r]eduction in involuntary services, reduction in institutionalization, and reduction in out-of-home placements".⁶ The emphasis throughout the *CSS Requirements* is on the importance of providing an array of voluntary, community-based, client-driven, culturally sensitive, self-directed services that address the real life needs of persons with mental disabilities while avoiding intrusive and unwanted interventions – a "help first" approach rather than a "fail first" approach. If MHSA services are doing what they are supposed to do, the outcome should be a reduction of involuntary commitment. MHSA services should *prevent* hospitalization, not increase it.

Hospitalization vs. the MHSA Recovery Vision

Moreover, the use of MHSA funds for restrictive settings is inconsistent with the Recovery Vision outlined in the Act and its intent of systemic transformation:

§ 5813.5 (d) Planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers:

- (1) To promote concepts key to the recovery for individuals who have mental illness: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.
- (2) To promote consumer-operated services as a way to support recovery.
- (3) To reflect the cultural, ethnic and racial diversity of mental health consumers.
- (4) To plan for each consumer's individual needs.⁷

Language in this Section strongly reflects input from clients who participated in the writing of the Act. Services consistent with the MHSA Recovery Vision would transcend entrenched discriminatory and stigmatizing reactions to people with mental disabilities. On the other hand, hospitalization reinforces such discrimination and stigma, both in the mental health system and in society as a whole; it looks backwards, not forwards.

Hospitalization and force are conventional, not transformational

Whereas the conventional system has used hospitalization, coercion and force in its attempt to deal with emotional crises, a transformed system would create recovery-based options that maximize client self-determination and autonomy. Yes, people do

⁶ DMH, *MHSA CSS Program and Expenditure Plan Requirements*, August 1, 2005, P. 1.

⁷ MHSA, WIC Section 5813.5(d).

experience times of great emotional distress; however there are transformative, recovery-based ways of assisting persons in such distress – for example, voluntary crisis drop-in respite centers, peer-run supportive housing, voluntary crisis residential houses, or self-directed support in the home.

The Recovery Vision of the MHSA is also reflected in SAMHSA’s *National Consensus Statement on Mental Health Recovery*. The following passage defines a person’s sense of well-being as *self-directed*:

Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals.⁸

Recommendations

The CNMHC strongly recommends that the Department add two new criteria to the Draft Proposed Capital Facilities Guidelines governing the use of MHSA funding for restrictive settings within counties.

In addition to the conditions listed in the current Draft Proposed Guidelines (reprinted on pp. 1 and 2 above), a County seeking MHSA funds for a restrictive setting should also demonstrate the need for a building with a restrictive setting by submitting the following specific facts and justifications for the Department's review and approval:

- An array of client-driven, voluntary, self-directed, recovery-based, culturally and linguistically competent alternative programs in community settings are already being implemented by that county, for the same age group and population for whom the restrictive setting is being proposed.
- Research has been conducted demonstrating conclusively that these existing alternatives do not meet the needs of the age group and population of that county for whom the restrictive setting is being proposed, while the same needs would be better met in a more restrictive setting, necessitating a building with a restrictive setting.

The above criteria further clarify the DMH proposed condition that “[t]hese needs cannot be adequately served in a less-restrictive setting. The County shall include specific reasons to substantiate the inability to meet the needs in a less-restrictive setting.”

Lack of transparency, client and family involvement

Finally, the CNMHC is concerned that the process in which these Draft Proposed Capital Facilities Guidelines were developed lacked transparency and involvement of clients and family members. To remedy this, we propose an extension of the timeline for finalizing

⁸ U.S. Dept. of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), *National Consensus Statement on Mental Health Recovery*, 2006.

these Guidelines and an effort to include the CNMHC and organizations representing family members and youth in the process.

Despite the clear mandate in the Act and in the DMH Community Services and Supports (CSS) Three-Year Program and Expenditure Plan Requirements for a client- and family-driven stakeholder process, the Department's planning process for the Capital Facilities component has by and large lacked transparency and neglected to include clients and family members, save for brief presentations and public comment periods at the November 2006 DMH Stakeholder Meetings.

No clients were involved in the process of developing the Draft Proposed MHSA Capital Facilities Guidelines, only agency staff.

The CNMHC recommends that the time line on these Guidelines be extended to allow what has been a very system-driven process to be expanded to one inclusive of clients and family members, as called for in the Act.

Thank you for considering our recommendations for the Capital Facilities component.

Members of the CNMHC MHSA Implementation Team are available to consult on Capital Facilities recommended strategies and projects such as the ones outlined above and more.

For more information, please contact MHSA Client Involvement Program Director Delphine Brody at delphinegrrl@gmail.com.