



California Network of Mental Health Clients

1722 "J" Street, Suite 324, Sacramento, California 95814

(916) 443-3232 • 1-800-626-7447 • Fax: (916) 443-4089

E-mail: main@californiaclients.org Web: www.californiaclients.org

CNMHC Response to the California Department of Mental Health (CDMH) Stakeholder Inquiry Regarding Potential Use of MHSA Funds for Short-Term Hospitalization -August, 2005

On its MHSA website, the CDMH recently announced it "is seeking input on the question of including the provision of short term acute inpatient care for individuals under [MHSA] Full Service Partnerships...."¹ As Carol Hood stated the question on the August 12 stakeholder conference call: Should MHSA funds be used for short-term hospitalization for indigent people who are involuntarily committed from a MHSA funded Community Services and Supports (CSS) program?²

The California Network strongly opposes any amendment or addendum to the CDMH's recently finalized *MHSA CSS Three Year Program and Expenditure Plan Requirements* that would allow MHSA funds to follow people into short-term hospitalization. Such use of these funds would violate the spirit and intent of the MHSA and the CDMH's *Requirements*, undermine county accountability, and fly in the face of common sense and practicality. Our reasons follow:

1. Flawed Rationale

The CDMH has stated that the impetus prompting them to consider the use of MHSA funds for indigent people in CSS programs who are involuntarily committed is the hypothesis that with the increase of people served by the MHSA, the counties would have an increased burden for short-term hospitalization.³ Basically, the underlying rationale is that the addition of people who are served by the mental health system because of the MHSA will produce more involuntary commitments.

At a minimum, the Department's assumption is that people in CSS programs will need involuntary hospitalization in enough numbers to cause the hospitals financial hardship.

This reasoning is flawed. It is contrary to the expected outcomes for MHSA programs and the actual outcomes of AB 34/2034 programs, the model for MHSA services.

A stated outcome for the CSS component in the CDMH's *Requirements* is "Reduction in involuntary services, reduction in institutionalization, and reduction in out-of-home

¹ <http://www.dmh.ca.gov/MHSA/docs/ReqforInput.pdf>

² CDMH Systems of Care Deputy Director Carol Hood, August 12 MHSA Stakeholder Conference Call outlining revisions in the final *CSS Requirements*.

³ Carol Hood, August 12 MHSA Stakeholder Conference Call.

placements”.⁴ The emphasis throughout the *CSS Requirements* is on the importance of providing an array of 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. Indeed, 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.

Experience supports this presumption. AB 34/2034 services have produced a 55.8% reduction of number of days hospitalized for persons enrolled in the services.⁵ Therefore, if MHSA services lead to a pattern of increased county expenditures for involuntary services, something is terribly wrong. Such a pattern would indicate a county’s failure to transform the delivery of services as required for MHSA funding.

2. Accountability of Programs

If CSS programs not only fail to deliver the outcomes detailed in the *Requirements*, but in fact produce the opposite result, the failed programs should be held accountable. More involuntary short-term hospitalization – or, for that matter, *any* involuntary hospitalization – would be a bad result, based on the very goals stated in the *Requirements*. This bad result would be a program failure, not a person failure. Programs should not be rewarded with more funds for failing the goals of the MHSA. Allowing funds for short-term hospitalization would not hold counties accountable for bad results.

In addition, allowing funds for short-term hospitalization would provide incentives for involuntary treatment. If funds are allowed for involuntary treatment, people will be involuntarily treated; treatment will follow the funds. The CDMH’s allowance of MHSA funds for short-term hospitalization would promote short-term hospitalization as an acceptable result. To allow counties to use MHSA monies to involuntarily hospitalize medically indigent MHSA clients would only encourage many more failures of this nature, and would set the stage for the complete undoing of much of the transformation promised in the Act and prescribed in the *Requirements*. Thus the initial failure of individual counties would usher in an unwanted and unprecedented resurgence of “fail-first” public policy.

3. High End Costs of Hospitalization

Short-term in-patient care is exorbitant compared to outpatient community services. Involuntary in-patient care is cost ineffective, and would divert too much of a county’s MHSA funds away from voluntary outpatient community services. As a provider participant in the August 12 CDMH-sponsored stakeholder teleconference exclaimed, “There goes the money!”

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

⁵ CDMH Director Stephen W. Mayberg, *Effectiveness of Integrated Services for Homeless Adults with Serious Mental Illness*, May 2003, P. 5.

4. Financial Burden to Hospitals vs. Unmet Needs of Service Seekers

Hospitals argue that they already absorb the cost of inpatient hospitalization for indigent people, and that with the expected influx of new clients in MHSA-funded Full Service Partnerships, hospitals will have to absorb the cost of more inpatient hospital days. However, the MHSA was not designed to ease the financial burden to hospitals; it was designed to help meet the unmet needs of people seeking mental health services. Moreover, a prominent attorney who represents low-income people with psychiatric disabilities contends that “[c]ounties are already required to provide medically necessary inpatient hospitalization for individuals who are eligible for county mental health services.”⁶

5. Erosion of Trust

The existence of MHSA funds for involuntary in-patient treatment for people in CSS programs will erode consumer trust that is requisite for a successful relationship between helper and helped and an effective recovery process. The success of CSS programs will depend on the level of trust between a consumer and his or her helping environment. The knowledge that forced treatment hovers in the background will undermine that trust. This is especially true of unserved and underserved people. It may cause homeless people who are wary of the mental health system, and people from communities of color and cultures who distrust state-funded services, to avoid any and all contact with MHSA services. Indeed, for many survivors of forced psychiatric hospitalization, the fear of being again committed against their will has caused them to avoid mental health services altogether. The threat of forced treatment has the potential of scaring away many of the very same unserved people whom the MHSA is targeting.

6. Hospitalization Is Conventional, not Transformational

The use of MHSA funds for short-term involuntary treatment, for any reason or for any group of people, defies the spirit and intent of the MHSA. The Act promises a transformation of the mental health system, with services that transcend entrenched and stigmatizing reactions to people with mental disabilities. Involuntary treatment reinforces such stigma and discrimination, both in the mental health system and in society as a whole, looking backwards, not forwards. Whereas the conventional system has used coercion and force in its attempt to deal with emotional crises, a transformed system would create alternative options that maximize client self-determination and autonomy. Some people do experience times of great emotional distress; however there are alternative ways of assisting a person in such distress – for example, voluntary crisis drop-in respite centers, peer-run supportive housing, voluntary crisis residential houses, or support in the home. The MHSA promise is to develop alternative ways of helping people in severe emotional distress, not look back to the same old, unsuccessful answers. MHSA funds should provide incentives for alternative answers, and not support for the failed conventional ones.

⁶ Letter dated August 26, 2005, to Carol S. Hood, from PAIMI Attorney Daniel Brzovic of Protection & Advocacy, Inc.

7. Use of MHSA Funds for Inpatient Hospitalization Is Prohibited in the Act

In a recent letter to Deputy Director Hood, PAIMI Attorney Daniel Brzovic of Protection & Advocacy, Inc., pointed out that “the MHSA does not allow for the use of funds for inpatient hospitalization, involuntary services, or services that the counties are already obligated to provide.

“Furthermore, any use of MHSA funds for involuntary hospitalization would violate the requirements that MHSA funds be used only for voluntary services, as well as the prohibition in the MHSA on the use of funds for inpatient hospitalization.

“The use of MHSA funds for inpatient hospitalization would also violate the non-supplantation provisions of the MHSA. ... If the MHSA is bringing new people into the county mental health system such that the counties are now being faced with providing services that they would have been obligated to provide in the absence of the MHSA, the counties should provide those services in accordance with their preexisting obligations.”⁷

For these reasons, the CNMHC strongly urges the CDMH not to adopt any addition to the *MHSA CSS Requirements* that would allow MHSA funds to be used for short-term hospitalization. To use MHSA funds for this purpose based on a flawed presumption would reward counties for bad results, provide incentives for forced treatment, divert vast sums of money from voluntary services, ease hospitals’ financial woes at the expense of clients’ unmet mental health needs, greatly erode client trust, break the promise of transformation, and flout the letter and spirit of both the Act and the *Requirements*.

The CDMH and the architects of the MHSA have often advised stakeholders that CSS Full Service Partnerships must provide “whatever it takes”. In implementing the Act, it is important to keep in mind that this description is based on the law governing Adult System of Care, Welfare and Institutions Code Section 5806, which mandates as part of its service standards, “an individual service plan in which each client participates.”⁸ Hence, “whatever it takes” must be grounded in client self-direction and choice.

With the planning stages drawing to a close and implementation of this historic Act soon to unfold, the road to a brighter, transformed future for California’s public mental health system now stretches out before us. Let’s not forget how much work so many have done over the past two years – at CDMH, in the counties, among clients, family members, service providers, and so many others – to bring us to this point. The eyes of the nation are upon us. Let’s prove that we can do the job right, with foresight, accountability, economy, and sensitivity, keeping the promise and staying true to word and intent of the Act and the *Requirements*. This is a once-in-a-lifetime opportunity; let’s make the most of it.

⁷ Letter dated August 26, 2005, to Carol S. Hood from Daniel Brzovic; see also letters dated December 23, 2004 and March 31, 2005, to Carol S. Hood, from Daniel Brzovic; and letter dated June 6, 2005, to Stephen W. Mayberg, from Daniel Brzovic.

⁸ Welfare and Institutions Code, Section 5806, 11 b.

Update, September 2006: Permission to use MHSA funds for short term hospitalization is being considered for emergency regulations by the California Department of Mental Health