



California Network of Mental Health Clients

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NEWS ALERT MARCH 2007

Important Upcoming MHSA Meetings: Let Your Voice Be Heard

Both the Department of Mental Health and the MHSA Oversight and Accountability Commission are holding important meetings in the next month. For transformation to occur and the mental health system to become client driven, it is essential for clients' voices to be heard at these meetings, and throughout every step of the MHSA implementation. Real transformation means client leadership

April 4, 2007 Statewide Conference Call, 3:30 – 5:00 PM.

Topic: Orientation to Prevention and Early Intervention Call In Number: 1-866-296-6505

Verbal pass code: MHSA

April 13, 2007 MHSA Workshop – Southern California

Topic: Prevention and Early Intervention

9:30 – 4:00 PM

Mission Inn

3649 Mission Inn Avenue

Riverside California

951-784-0300

April 26, 2007 MHSA Workshop – Northern California

Topic: Prevention and Early Intervention

9:30 – 4:00 PM

Hilton Garden Inn – San Francisco/Oakland Bay Brudge

1800 Powell Street

Emeryville, CA

510-658-9300

Oversight and Accountability Commission

Public Hearing on Stigma and Discrimination

April 12, 2007 – Southern California

3:00 – 6:00 PM

Mission Inn

3649 Mission Inn Avenue

Riverside California

951-784-0300

Oversight and Accountability Commission

Public Hearing on Stigma and Discrimination

April 26, 2007 – Northern California

6:00 – 9:00 PM

Hilton Garden Inn – San Francisco/Oakland Bay Brudge

1800 Powell Street

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510-658-9300

Public Comment and Hearing on the Use of MHSA Funds for Hospitalization

Background

The DMH recently adopted Mental Health Services Act (MHSA) emergency regulations. These Regulations govern the implementation of the MHSA. Section 3620 (k) of these Regulations allow counties to use MHSA funds to pay for up to 30 days of acute inpatient hospitalization for uninsured clients in Full Services Partnerships. Public comments on these Regulations are accepted until April 16. Also, a Public Hearing for the purpose of hearing testimony on the Regulations will be held on April 16 at 1:30 PM at 744 P Street in Sacramento.

Action

- The DMH is sponsoring a Statewide Conference Call for clients/survivors to learn more about Section 3620(k), as well as the mechanisms to get our voices heard through public comments and testimony.
Tuesday, April 10, 9 – 11 AM
Toll-free call in: 1-866-296-6505
Passcode: MHSA
- The California Network of Mental Health Clients (CNMHC) is holding a **Day at the Hearing** on Monday, April 16. Join us at the Educational Gathering at 11:30 AM (preceding the 1:30 Hearing) at 744 P Street.
- Submit your public comment through mail, fax, or e-mail on this Regulation. Public comment must be received by 5:00 PM on April 16. You can mail, fax, or e-mail your comments to Steve Appel, Chief, Office of Regulations, California Department of Mental health, 1600 Ninth Street, Room 153, Sacramento, CA 95814. Fax: 916-651-9919 E-mail: Steve.Appel@dmh.ca.gov

For more information on any of these activities, contact the CNMHC office at 800-626-7447 or go to www.californiaclients.org

The CNMHC Strongly Opposes Emergency Regulation Section 3620 (k)

The use of MHSA funds for inpatient hospitalization violates the letter and spirit of the Act and the DMH *Community Services and Supports Three-Year Program and Expenditure Plan Requirements* of August 2005. It undermines county accountability, and flies in the face of common sense and practicality. It is discriminatory and stigmatizing to all mental health clients. As such, it threatens to erode clients' trust in the MHSA and its possibilities for real transformation.

Our reasons follow:

1. Flawed Rationale

The DMH has stated that the impetus prompting them to consider the use of MHSA funds for inpatient hospitalization of adults participating in CSS Full-Service Partnership programs is the hypothesis that with the influx of new people into the mental health system through Full-Service Partnerships, the Counties would have an increased burden for inpatient hospitalization.¹ The underlying rationale appears to be that the addition of new clients to mental health services under the MHSA will produce more inpatient commitments. At a minimum, the Department's assumption is that people in CSS programs will need inpatient 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 DMH *Requirements* is “[r]eduction in involuntary services, reduction in institutionalization, and reduction in out-of-home placements”.² 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.³ 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 inpatient hospitalization of any length will be a bad result, based on the very goals stated in the *Requirements*. This bad result will be a program failure, not a failure on the part of clients. Programs should not be rewarded with more funds for failing the goals of the MHSA. Allowing funds for inpatient hospitalization will not hold Counties accountable for bad results.

In addition, allowing funds for hospitalization will provide incentives for involuntary treatment. The provision to allow MHSA funds for hospitalization will inevitably lead to involuntary treatment within hospital settings; the treatment will follow the funds. Furthermore, the DMH's allowance of MHSA funds for hospitalization

¹ DMH Deputy Director Carol Hood, August 12, 2005 MHSA Stakeholder Conference Call.

² DMH, *MHSA CSS Program and Expenditure Plan Requirements*, August 1, 2005, P. 1.

³ DMH Director Stephen W. Mayberg, *Effectiveness of Integrated Services for Homeless Adults with Serious Mental Illness*, May 2003, P. 5.

promotes hospitalization as an acceptable result. To allow Counties to use MHSA monies to involuntarily hospitalize MHSA clients will only encourage many more failures of this nature, and sets the stage for the complete undoing of much of the transformation promised in the Act and prescribed in the *Requirements*. Thus, any initial failure of an individual County that leads to the use of MHSA funds for hospitalization under this provision will usher in an unwanted and unprecedented resurgence of “fail-first” public policy.

3. High End Costs of Hospitalization

Inpatient care is exorbitant compared to outpatient community services. Inpatient 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 2005 MHSA Stakeholder Conference Call remarked, “There goes the money!”

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 “Counties are already required to provide medically necessary inpatient hospitalization for individuals who are eligible for County mental health services.”⁴

5. Erosion of Trust

The existence of an emergency regulation provision allowing the use of MHSA funds for inpatient hospitalization of adults in CSS programs will erode the consumer trust that is requisite for a successful relationship between helper and helped and for 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 (as it does even for those who commit themselves to inpatient units voluntarily) will undermine that trust.

This is especially true of unserved and underserved people. It may cause people from communities of color and cultures who distrust State-funded services, as well as homeless people who are wary of the mental health system, 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 inpatient hospitalization, 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 discriminatory and stigmatizing reactions to people with mental disabilities. Hospitalization reinforces such discrimination and stigma, both in the mental health system and in society as a whole; it looks backwards, not forwards.

Whereas the conventional system has used hospitalization, 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. Yes, people do experience times of great emotional distress; however there are alternative ways

⁴ Letter to Carol Hood from PAIMI attorney Daniel Brzovic of Protection & Advocacy, Inc., dated August 26, 2005,

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 MHSA’s promise is to develop alternative ways of helping people in emotional distress, not to fall back on the same old, unsuccessful answers. MHSA funds should provide incentives for alternative answers, not support for the failed conventional ones.

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

In a letter to the DMH in August 2005, a PAIMI attorney 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.”⁵

The DMH 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.”⁶ Hence, “whatever it takes”, rather than provider driven, must be client driven, grounded in client self-direction and choice.

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. This is a once-in-a-lifetime opportunity; let’s make the most of it.

(This is a draft paper. A final version will be submitted formally to the DMH as the CNMHC’s comments on Emergency Regulation 3620 (k).)

⁵ Letter to Carol Hood from PAIMI Attorney Daniel Brzovic of Protection & Advocacy, Inc., dated August 26, 2005. See also letters to C. Hood, from D. Brzovic dated December 23, 2004 and March 31, 2005; and a letter to Stephen Mayberg, from D. Brzovic, dated June 6, 2005.

⁶ Welfare and Institutions Code, Section 5806, 11 b.