Date of Hearing: May 18, 2020

ASSEMBLY COMMITTEE ON HEALTH
Jim Wood, Chair
AB 2265 (Quirk-Silva) – As Amended May 4, 2020

SUBJECT: Mental Health Services Act: use of funds for substance use disorder treatment.

SUMMARY. Authorizes expenditure of funds under the Mental Health Services Act (MHSA) to be used to treat a person with co-occurring mental health and substance use disorders (SUD) when the person would be eligible for treatment of a mental health disorder under MHSA. Specifically, **this bill:**

1) Authorizes expenditure of funds under the MHSA to be used to treat a person with co-occurring mental health and SUD when the person would be eligible for treatment of the mental health disorder under MHSA.

2) Requires that treatment of co-occurring mental health and SUD be identified in a county's three-year MHSA program and expenditure plan or annual update, as required.

3) Requires that when a person being treated for co-occurring mental health under 1) above is determined to not need the mental health services that are eligible for funding under MHSA, the county to, as quickly as possible, refer the person receiving treatment to SUD treatment services.

4) Authorizes funding under MHSA to be used to assess whether a person has co-occurring mental health and SUD and to treat a person who is preliminarily assessed to have co-occurring mental health and SUD, even when the person is later determined not to be eligible for MHSA services.

5) Requires that counties that elect to use funding as specified in this bill to report to the Department of Health Care Services (DHCS) on their policies and practices and the outcomes achieved, in a form and manner determined by the DHCS.

6) Requires the county reporting to include, but not be limited to all of the following:

    a) The number of people assessed for co-occurring mental health and substance use disorders;
    b) The number of people assessed for co-occurring mental health and substance use disorders who have a mental health diagnosis, the number of those who were eligible for services using MHSA funds, and the number who received recommended services;
    c) The number of people assessed for co-occurring mental health and substance use disorders who have a substance use disorder, the number of those who were eligible for services using MHSA funds during the assessment period, and the number who received recommended services during the assessment period; and,
    d) The number of people assessed for co-occurring mental health and substance use disorders who have both a mental health diagnosis and a substance use disorder, the number of those who were eligible for services using MHSA funds, and the number who received recommended services.

7) Authorizes a county, with approval from DHCS, to submit individually identifiable data, in a manner determined by the department that is consistent with state and federal data sharing requirements, if necessary to enable the department to produce an annual report on the outcomes associated with this section.

8) Requires DHCS by January 1, 2022 and each January 1, thereafter to publish on its website a report summarizing county activities during the prior fiscal year pursuant to this section. Requires the data to be reported statewide and by county or groupings of counties as necessary to protect the private health information of persons assessed, served or referred for services.

EXISTING LAW:

1) Establishes the MHSA, enacted by voters in 2004 as Proposition 63, to provide funds to counties to expand services, develop innovative programs, and integrated service plans for mentally ill children, adults, and seniors through a 1% income tax on personal income above $1 million.

2) Establishes the Mental Health Services Oversight and Accountability Commission (MHSOAC) to oversee the implementation of MHSA, made up of 16 members appointed by the Governor, and the Legislature, as specified.

3) Specifies that the MHSA can only be amended by a two-thirds vote of both houses of the Legislature and only as long as the amendment is consistent with and furthers the intent of the MHSA. Permits provisions clarifying the procedures and terms of the MHSA to be amended by majority vote.

4) Requires MHSOAC to ensure that the perspective and participation of diverse community members is reflective of California's populations and others suffering from severe mental illness (SMI) and their family members is a significant factor in all of its decisions and recommendations.

5) Requires counties to implement a broadly inclusive Community Program Planning (CPP) process to identify local-level needs, define MHSA funding priorities, and guide the creation, implementation, oversight, and evaluation of MHSA funded programs.

6) Requires all expenditures for county mental health programs to be consistent with currently approved mental health plan or update.

7) Establishes the MHSA Fund to be disbursed as follows:

    a) Twenty percent of funds to counties to be used for prevention and early intervention programs;
    b) Five percent of the total funding for each county mental health program for innovative programs;
    c) The balance of funds to be distributed to county mental health programs for services to persons with SMI, for the children's system of care, and for the adult and older adult system of care;

d) Permits no more than 20% of the average amount of funds allocated to a county for the previous five years to be used for technological needs and capital facilities, human resource needs, and for counties to establish a prudent reserve to ensure services do not have to be significantly reduced in years in which revenues are below the average of previous years;
e) Up to 5% of funds to be used for planning costs including for county mental health programs to pay for the costs of consumers, family members, and other stakeholders to participate in the planning process and for the planning and implementation required for private provider contracts to be significantly expanded to provide additional services; and,
f) Prior to making the allocations in a) through d) above, up to 5%t of funds to be reserved for the costs for the Department of Health Care Services (DHCS), the California Mental Health Planning Council, the Office of Statewide Health Planning and Development, the MHSOAC, the State Department of Public Health, and any other state agency to implement all duties pursuant to the MHSA.

8) Requires DHCS, in coordination with counties, to establish a program designed to prevent mental illnesses from becoming severe and disabling and requires the program to emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness:

   a) Suicide;
   b) Incarcerations;
   c) School failure or dropout;
   d) Unemployment;
   e) Prolonged suffering;
   f) Homelessness; and,
   g) Removal of children from their homes.

9) Requires each county to prepare the Annual MHSA Revenue and Expenditure Report and to electronically submit the MHSA Report to DHCS and MHSOAC. Requires DHCS and MSHOAC to post each county's report in a text-searchable format on its internet website in a timely manner.

FISCAL EFFECT: This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, some people living with serious mental illness simultaneously experience alcohol and drug use disorders; complicating diagnosis and treatment. A third of adults who receive county mental health services for serious mental illnesses, have a co-occurring SUD. The stakes for these individuals is especially high. People with drug or alcohol use disorders are almost six times more likely to attempt suicide than those without.

2) **BACKGROUND.**

   a) MHSA. Proposition 63, the MHSA was passed by voters in November, 2004. The MHSA imposes a 1% income tax on personal income in excess of $1 million and creates

the 16 member MHSOAC charged with overseeing the implementation of MHSA. The MHSA addresses a broad continuum of prevention, early intervention and service needs as well as providing funding for infrastructure, technology, and training needs for the community mental health system.
The MHSA requires each county mental health department to prepare and submit a three-year plan to DHCS that must be updated each year and approved by DHCS after review and comment by the MHSOAC. In their three-year plans, counties are required to include a list of all programs for which MHSA funding is being requested and that identifies how the funds will be spent and which populations will be served.

i) **Community Services and Supports**: Provides direct mental health services to the severely and seriously mentally ill, such as mental health treatment, cost of health care treatment, and housing supports. Regulation requires counties to direct the majority of its Community Services and Supports funds to Full-Service Partnerships (FSPs). FSPs are county coordinated plans, in collaboration with the client and the family to provide the full spectrum of community services. These services consist of mental health services and supports, such as peer support and crisis intervention services; and non-mental health services and supports, such as food, clothing, housing, and the cost of medical treatment;

ii) **Prevention and Early Intervention**: Provides services to mental health clients in order to help prevent mental illness from becoming severe and disabling;

iii) **Innovation**: Provides services and approaches that are creative in an effort to address mental health clients' persistent issues, such as improving services for underserved or unserved populations within the community;

iv) **Capital Facilities and Technological Needs**: Creates additional county infrastructure such as additional clinics and facilities and/or development of a technological infrastructure for the mental health system, such as electronic health records for mental health services; and,

v) **Workforce Education and Training**: Provides training for existing county mental health employees, outreach and recruitment to increase employment in the mental health system, and financial incentives to recruit or retain employees within the public mental health system.

Counties must submit their plans for approval to the MHSOAC before the counties may spend certain categories of funding including Prevention and Early Intervention and Innovation funds.

b) **MHSA CPP Process.** The CPP process provides a structure that counties are to use in partnership with stakeholders in determining how best to utilize funds that become available from the MHSA. The CPP process is used to identify community priorities and to develop the county's three-year plan This bill requires that prior to providing services to individuals with co-occurring mental health and SUD, a county's three-year MHSA program and expenditure plan or annual update, must identify treatment of co-occurring mental health and SUD. The county MSHA CPP process must adhere to the following general standards.

i) Community Collaboration is a process by which clients and/or families receiving services, other community members, agencies, organizations, and businesses work together to share information and resources in order to fulfill a shared vision and goals;

ii) Cultural Competence means that equal access is provided to equal quality of services to all racial/ethnic, cultural, and linguistic communities. Disparities are identified and strategies developed to eliminate disparities. Cultural competence means that program planning and service delivery takes into account diverse belief systems and the impact of historic forms of racism and discrimination on the mental health of community members. Services and supports utilize strengths and forms of healing that are unique to an individual's racial/ethnic, cultural, and linguistic community. Service providers are trained to understand and address the needs and values of the particular communities they serve, and strategies are developed and implemented to promote equal opportunities for those involved in service delivery who share the cultural characteristics of individuals with SMI and/ or severe emotional disturbances (SMI/SED) in the community;

iii) Integrated Services Experience means the client, and when appropriate the client's family, accesses a full range of services provided by multiple agencies, programs and funding sources in a comprehensive and coordinated manner;

iv) Client Driven means that the client has the primary decision-making role in identifying their needs, preferences and strengths and a shared decision-making role in determining the services and supports that are most effective and helpful for them. Client-driven programs/services use clients' input as the main factor for planning, policies, procedures, service delivery, evaluation, and the definition and determination of outcomes;

v) Family Driven means that families of children and youth with SED a primary decision-making role in the care of their own children, including the identification of needs, preferences, and strengths, and a shared decision-making role in determining the services and supports that would be most effective and helpful for their children. Family-driven programs/services use the input of families as the main factor for planning, policies, procedures, service delivery, evaluation, and the definition and determination of outcomes; and,

vi) Wellness, Recovery, and Resilience focused means that planning for services are consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers: "To promote concepts key to the recovery for individuals who have mental illness: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination. To promote consumer-operated services as a way to support recovery." The MHSA CPP processes, must include the following participants and processes:

(1) Clients and family members: Involvement of clients with SMI/SED and their family members in all aspects of the Community Program Planning Process;

(2) Broad-based constituents: Participation of stakeholders defined by Welfare and Institution Code Section 5848a as adults and seniors with SMI, families of children, adults, and seniors with SMI, providers of services, law enforcement agencies, education, social services agencies, veterans, representatives from veterans organizations, providers of alcohol and drug services, health care organizations, and other important interests;

(3) Underserved populations: Participation from representatives of unserved and/or underserved populations and family members of unserved/underserved populations; and,
(4) Diversity: Stakeholders that "reflect the diversity of the demographics of the County, including but not limited to, geographic location, age, gender, and race/ethnicity, and have the opportunity to participate in the CPP process.

The MHSA CPP processes must include: training; outreach to clients with SMI/SED, and their family members, to ensure the opportunity to participate; and a local review process prior to submitting the Three-Year Program and Expenditure Plans or Annual Updates that includes a 30-day public comment period;

Counties must submit documentation of Three-Year Program and Expenditure Plans and Annual Updates that includes:

i) A description of methods used to circulate copies of the draft Three-Year Program and Expenditure Plan or Annual Update to representatives of stakeholders' interests and any other interested parties who request the draft for the purpose of public comment;
ii) Documentation that a public hearing was held by the local mental health board/commission, including the date of the hearing;
iii) A summary and analysis of any substantive recommendations; and,
iv) A description of any substantive changes made to the proposed Three-Year Program and Expenditure Plan or annual update that was circulated.

c) MHSOAC Workgroup on Co-Occurring Disorders (COD). In November 2007, the MHSOAC authorized a 19-member Workgroup on COD. The COD Workgroup was charged with developing comprehensive recommendations to address the needs of individuals with co-occurring mental illness and substance abuse. The COD Workgroup, which met from November 2007 through June 2008, heard briefings by state leaders and experts on the status of the treatment of co-occurring disorders in California. The central finding of the COD Workgroup issued in a report entitled, "Transforming the Mental Health System Through Integration – 10/14/08) was that COD are pervasive and disabling, yet individuals with co-occurring mental illness and substance abuse are among California's most underserved. Key findings of the COD Workgroup were:

i) COD are pervasive. Approximately one half of the people who have one of these conditions - a mental illness or a substance abuse disorder - also have the other condition. The proportion of co-occurrence may be even higher in adolescent populations. The onset of a diagnosable mental disorder often precedes the onset of a substance-use disorder, substance-use disorders developing typically five to 10 years later in late adolescence or early adulthood. CODs are the norm, not the exception.
ii) COD are disabling. Individuals with COD have more medical problems, poorer treatment outcomes, greater social consequences and lower quality of life. They have more relapses, rehospitalization, depression and suicidality, interpersonal violence, housing instability and homelessness, incarceration, treatment non-compliance, HIV, family burden and service utilization. These problems arise from risks associated with biological vulnerability, alcohol and drug interactions, deferred or delayed treatment,

and lifestyle and environmental conditions, including discrimination, community violence and poverty.

iii) **Individuals with co-occurring mental illness and substance abuse are among California's most underserved**. The COD Workgroup found that numerous studies demonstrate that integrated care is necessary for successful treatment of COD. To meet the needs of individuals with COD, there can be "no wrong door" to access treatment. Availability of comprehensively integrated treatment for mental health and substance abuse problems is currently the exception rather than the rule. The unmet need for integrated mental health, alcohol and drug abuse treatment in underserved racial and ethnic communities is even greater.

iv) **MHSA Full Service Partnerships (FSP).** MHSA FSP programs are the only significant publicly funded programs that offer integrated mental health and substance abuse treatment. Virtually all other programs provide treatment for only mental health or substance abuse. Most private insurance coverage and other funding mechanisms for treating mental illness or substance abuse are similarly separated.

3) **SUPPORT.** The California Alliance for Child and Family Services (the Alliance), in support, states that individuals living with serious mental illness often simultaneously experience alcohol and drug use conditions; complicating diagnosis and treatment. One-third of adults who receive county mental health services for serious mental illnesses have a co-occurring substance use disorder. Removing programmatic barriers to serving these individuals with MHSA funded services is particularly important in California's effort to end homelessness and combat the crisis of suicide, particularly among our young people. The Alliance concludes by stating that this bill preserves the MHSA's focus on meeting the state's large unmet mental health needs with a more comprehensive approach

4) **RELATED LEGISLATION.**

a) AB 1938 (Eggman) clarifies that to the extent MHSA funds are otherwise available for use under the act, those funds may be used to provide inpatient treatment, including involuntary treatment of a patient who is a danger to self or others or gravely disabled, in specified settings, including an acute psychiatric hospital, an institution for mental disease, and a mental health rehabilitation center, as defined. AB 1938 is pending hearing in the Assembly Health Committee

b) SB 665 (Umberg) authorizes MHSA funds to be used to provide services to persons incarcerated in county jails or subject to mandatory supervision, except for those convicted of a felony, as specified. SB 665 is pending at the Assembly Desk.

5) **PREVIOUS LEGISLATION.** SB 389 (Hertzberg), Chapter 209, Statutes of 2019, authorized counties to use MHSA moneys to provide services to persons who are participating in a presentencing or post-sentencing diversion program or who are on parole, probation, post-release community supervision, or mandatory supervision.

6) **AMENDMENTS.** In an effort to further clarify existing law and the purpose of this bill, the author has agreed to the following amendments:

a) Clarify who may receive services under the MHSA for purposes of this bill by adding the following:

"5891.5. (a) (1) Funding established pursuant to the Mental Health Services Act (MHSA) may be used to treat a person with cooccurring mental health and substance use disorders when the person would be eligible for treatment of the mental health disorder pursuant to the MHSA. ***MHSA defines the persons eligible for MHSA services as including persons with a serious mental disorder and a diagnosis of substance abuse, pursuant to Sections 5878.2 and 5813.5."***

b) Simplify and clarify the county reporting requirements as follows:

"5891.5 (c) (1) A county shall report to the department in a form and manner determined by the department the following:
(A)The number of people assessed for cooccurring mental health and substance use disorders.
(B) The number of people assessed for cooccurring mental health and substance use disorders who ***were ultimately determined to have only a substance use disorder without another cooccurring mental health condition.***

REGISTERED SUPPORT / OPPOSITION:

Support

California Alliance of Child and Family Services
County Behavioral Health Directors Association
National Association of Social Workers, California Chapter
Racial and Ethnic Mental Health Disparities Coalition

Opposition

None on file.

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