AGENDA
ASSEMBLY BUDGET SUBCOMMITTEE NO. 1 ON HEALTH AND HUMAN SERVICES

Assemblymember Judy Chu, Chair

WEDNESDAY, APRIL 23, 2002
STATE CAPITOL, ROOM 444
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ITEM # 4200 DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS

ISSUE 1: DRUG COURT PARTNERSHIP ACT

The Subcommittee will hear the findings from the report and the preliminary findings on the Drug Court Partnership (DCP) felony only program.

BACKGROUND:

The DCP program was established by the Legislature in 1998 as a four-year demonstration project in 33 counties funded on two separate funding cycles through a grant process. The report released in April 2002, from a statutorily mandated evaluation of the program, found that the program is diverting a significant number of offenders to treatment who would otherwise be incarcerated. This data estimates that per every $1 spent in felony Drug Courts, the state saves $3 from prison days diverted. Additionally, data showed that the treatment provided to drug- and alcohol-addicted offenders was reducing the rates at which they committed new offenses.

In the Budget Act of 2002, the Legislature consolidated the DCP from a two-cycle process into a single cycle. The annualized cost of the program in 2001-02 was $7.6 million. The Legislature also statutorily changed the DCP to a felony only caseload. Currently, the funding is distributed to counties based on the funding levels established under the grant process. There is also preliminary data from the October - December quarter of the program on the savings from prison days avoided under this consolidated program. This data has not been released.

Generally, the goals of drug court programs are to reduce drug usage and recidivism, provide court supervised treatment, offer the capability to integrate drug treatment with other rehabilitation services to promote long-term recovery and reduce social costs, and access federal and state support for local drug courts. The DADP has two models of drug court that it funds: the Drug Court Partnership (DCP) and the Comprehensive Drug Court Implementation (CDCI). The drug courts are diverse and serve various populations such as adults, juveniles, repeat drug offenders, multiple offenders, and probation violators. Generally, drug court participants have abused alcohol or other drugs for ten or more years and received little of no substance abuse treatment.

The CDCI program was enacted in 1999 and has annually granted General Fund to 47 counties beginning in December 2000. These funds are based on population and in support of adult, juvenile, and dependency drug courts. The DCP program is discussed above.

ITEM # 4200 DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS

ISSUE 2: SUBSTANCE ABUSE RECOVERY MANAGEMENT SYSTEM (SARMS)

The Subcommittee will hear the status of a report on the SARMS Drug Court model from the Department of Social Services who is conducting the study.

BACKGROUND:

As part of the Budget Act of 2002, AB 444 (Committee on Budget) was signed into law containing the components for the social services trailer bill. In it, Section 6.5 outlined the intent of the Legislature to be informed about the San Diego SARMS model drug court.

Specifically, the Legislature provided for an independent and objective evaluation of the San Diego model program known as SARMS. The Department of Social Services was directed to conduct the evaluation and provide an oral report to the Legislature at the budget hearings in 2003 on the status of the evaluation.

The focus of the evaluation was to determine the relative costs and fiscal benefits to the state and to the county of reducing foster care costs through the provision of substance abuse treatment to parents with a need for that treatment who are involved in dependency court cases.

The evaluation was to examine the availability of funding or other resources from:
- Local government agencies
- Private foundations
- Universities
- Federal grants

COMMENTS:

The Subcommittee would benefit from understanding:
- Sources of funding for the SARMS program;
- Funds saved from foster care days avoided;
- Variables considered in studying the system;
- Number of parents involved in the program, including the gender breakdown;
- Number of children involved in the program.

ITEM # 4200 DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS

ISSUE 3: LITTLE HOOVER COMMISSION REPORT ON SUBSTANCE ABUSE TREATMENT SERVICES IN CALIFORNIA

The Subcommittee will hear testimony on the report from the Little Hoover Commission.

BACKGROUND:

The Little Hoover Commission published on March 11, 2003 their report titled For Our Health and Safety: Joining Hands to Defeat Addiction. In it, the Commission makes several findings and recommendations.

Finding: The State has not structured substance abuse treatment programs to provide a statewide basic level of quality or encourage continuous quality improvement. The Department of Alcohol and Drug Programs (ADP) oversees substance abuse treatment and prevention programs in California. The Health and Safety Code charges the director with developing minimal statewide levels of quality provided by alcohol and other drug programs. This requirement involves setting standards for personnel, programs, and facilities providing services.

The Commission cites a significant number of limitations of the director to achieve these goals. The director must submit regulations to county program directors before adopting them. And the director does not have authority over treatment programs within the Department of Corrections (CDC). Moreover, the Commission notes that there is no agreed upon protocol for measuring quality. Three areas in which to improve quality are: 1) ensuring a competent workforce; 2) safe and supportive facilities; 3) the best available methodologies.

Finding: To be effective, substance abuse treatment must be coordinated and integrated with other social services to effectively reduce the social and financial costs of alcohol and drug abuse. According to DADP, 77 percent of public clients are unemployed and 39 percent do not have a high school education. Some 21 percent are homeless and 8 percent also have a mental illness. Looking more broadly, UCLA researchers estimate that 75 percent of California's 360,000 homeless have substance abuse problems. And, 50 percent of the mentally ill suffer from substance abuse.

The Commission states that recovering from addiction may require help with housing, education, job training, physical and mental health services, family counseling and legal assistance. As with treatment, eligibility rules for these programs are restrictive. And ultimately, clients may get some, but not all, of what they need to become self-reliant and healthy.

Public agencies struggle to overcome the regulatory, fiscal, and cultural barriers that make it difficult to respond to a person's entanglement of needs. From the Commission's work on foster care, criminal justice, and mental health, it recognizes that integrating services is often held up as the Holy Grail of effectiveness. For more than 20 years, administrators and policy-makers have tried to weave together substance abuse, mental health, and social services.

The Commission believes that the benefits of service integration include: addresses of multiple needs to return clients to productive citizen status, reduces or eliminates barriers to obtaining all

needed services, particularly categorical funding, supports families, and improves outcomes and reduces social service expenditures. Moreover, the Commission states that at a time of growing demands on the public system and declining resources, integrating already available public services to increase performance should be of the highest priority. At the very least, the Commission argues that state agencies need to be responsive to valid suggestions from counties and providers on ways to reduce reporting and other paper based obstacles to integration. In turn, counties can demonstrate leadership—as some already have—by mustering public and private resources in their community to meet the most crucial needs.

COMMENTS:

The recommendations from the Commission regarding quality is that the state should implement outcome-based quality control standards for treatment personnel, programs, and facilities, and encourage providers to strive for continuous quality improvement by linking pay to performance.

Specifically:

- **Define and enhance the director's authority.** The director of ADP should be given clear authority to assess prevention and treatment efforts and advocate for high-quality treatment wherever it occurs, particularly in the Department of Corrections. Health and Safety Code Section 11835 should be revised to allow the director to establish regulations without approval from county administrators.
- **Develop management tools.** The State should accelerate the implementation of the California Outcomes Measurement System to track the effectiveness of individual programs.
- **Establish a strategy to develop a well-qualified workforce.** ADP should ensure completion of an occupational analysis and establish a method for determining which candidates meet requirements.
- **Develop, promulgate, and enforce treatment quality standards.** The State should require counties to provide evidence-based treatments. The State should disseminate evidence-based best practices for each treatment modality. ADP should have others validate the goals of treatment, performance standards and outcome measures developed. The director should be required to report publicly on ineffective treatment programs.
- **Tie provider reimbursement to outcomes.** After establishing performance benchmarks and implementing CalOMS, the department should reward high-quality treatment providers with higher rates of reimbursement. Providers continually failing to meet specified outcomes should have their funding terminated.
- **Ensure safe and suitable treatment facilities.** The State should expand facility licensing to include outpatient facilities. An accreditation process similar to that used by the Joint Council on Accreditation of Hospital Organizations or other accrediting organizations should be developed and implemented.

The Commission also makes recommendations on improving treatments in prisons. Based on a pilot project that reduced recidivism, the State has expanded the use of therapeutic communities within prisons, and aftercare to those inmates when they are released. The CDC now operates 8,500 in-prison beds at a cost of nearly $120 million a year.

But recent evaluations by UCLA show the CDC is not faithfully replicating the pilot project. CDC's low-bid contracting rules preclude quality and prison administrators are putting inappropriate inmates in the program. The evaluators also concluded that CDC does not

institutionally support the goals of treatment, frustrating the program in numerous ways. Steps can be taken:

- Restructure the contracting process to account for quality of treatment rather than lowest price.
- Specify in contacts the type of inmates who can participate in the program.
- Monitor and report return to custody rates resulting from continued addiction.
- Promote a drug-free prison system including drug testing of inmates and staff as suggested in previous Commission studies.

The Commission recommends that the state should facilitate integration of alcohol and drug treatment with other social services to effectively reduce abuse and related public costs.

Ways to promote integration include:

- **Replicate and reinforce success.** The Health and Human Services agency—or in its absence, the counties—needs to encourage the replication of successful integrated programs by documenting how they work, how they have navigated the system, and training other providers to do the same.
- **Develop leaders.** Given that most integration occurs at the hands of individual and inspired leaders, the State should work with counties, professional organizations, and foundation to provide formal leadership development for agency managers and services providers.
- **Create a process and a venue to facilitate change.** DADP should develop a forum allowing for state and local government, treatment providers, educators and job trainers, mental health providers, and social services personnel to systematically identify and remove barriers to integration. Specifically:
  - They should identify ways to share data to understand demands on the system and to document performance.
  - They should identify which measures would most easily increase flexibility in funding, such as a waiver process or a single reporting format, and align funding for all social services with outcomes.
  - They should detail and prioritize regulatory and legislative changes necessary to streamline and integrate services.

ITEM # 4200 DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS

ISSUE 4: STATE INCENTIVE GRANT

The Subcommittee will consider the receipt of federal funds for prevention programs.

BACKGROUND:

The Department has received a federal grant award of $4 million annually for three years to implement science-based prevention programs and practices targeting binge drinking among 12 to 25 year old youth and young adults. Of the total, $3.5 million will be in local assistance and $500,000 in state operations. These funds would be allocated to counties based on a competitive grant process to approximately 20-25 counties, with the size of the grant dependent on the scope of the proposed local initiative, but no larger than $250,000 each, with community coalitions as a key component. The Department is also requesting the authority for three limited term positions effective January 1, 2003 to evaluate, plan, and implement the federal State Incentive Grant (SIG).

In the 2002 budget process, the Assembly Subcommittee recommended the inclusion of budget bill language to direct the department to apply for this federal grant.

Prevention services are funded primarily through the federal Substance Abuse Prevention and Treatment (SAPT) Block Grant and the Governor's position of the federal Safe and Drug Free Schools and Communities (SDFSC) Grant. California is also involved in national prevention program policy development initiatives.

In August 2002, the Governor established the Interagency Coordinating Council for the Prevention of Alcohol and Other Drug Problems (Council). The function of the Council will be to "coordinate the state's strategic efforts to achieve measurable reductions in the incidence and prevalence of the inappropriate use of alcohol and other drugs by youths and adults." The Council will serve as the advisory committee for the SIG program. Representatives on the Council are from the: Office of the Attorney General, Superintendent of Public Instruction, Department of Alcohol Beverage Control, Department of Health Services, Office of Criminal Justice Planning, Office of Traffic Safety, Office of the President University of California, Office of the Chancellor California State University. The Council will: assess shared prevention data, identify effective approaches, establish high-level prevention objectives, identify means of working more efficiently with alcohol and other drug-related issues, and implement resource coordination, leveraging or redirecting opportunities to achieve objectives.

The implementation of the SIG will provide critical training to build the capacities and competencies of California communities and prevention practitioners to plan, implement, and evaluate science-based, culturally-proficient, and effective prevention programs and services. Increasingly, federal funding agencies are gravitating towards performance-based accountability practices. It is anticipated that ADP's SAPT Block Grant will transition to a performance partnership grant within a few years. With this change, funding will be contingent on states' demonstrating achievement of stated performance outcomes. The SIG program provides an important opportunity for California to work directly with the Center for Substance Abuse Prevention (CSAP) in the design of system relevant to the evolving direction of the federal block

grant and further strengthening our state's capacity to develop outcome-based county prevention systems.

The cooperative arrangement between the DADP and the federal CSAP differs from a grant or contract in that federal program staff will be directly and substantially involved in designing and implementing all aspects of the program. According to the DADP, this necessitates a high level of interaction between the state program analyst (AGPA) and the federal program officer. Further, the SIG requires not only that the program includes state, county, and local program components, but that all states that receive SIG funds participate in a national cross-site evaluation directed by CSAP. DADP argues that this requirement warrants the need for the Research Program Specialist I. Finally, implementing the SIG will require substantial support for federal/state/local-level meeting, organization, coordination, and communication that cannot be provided with current support staff resources. DADP states that this necessitates an Office Technician dedicated to SIG-related support activities.

California is required to use at least 85 percent of their SIG funds to make awards to local community sub-recipients and may use up to 15 percent of the SIG funds to support state administration and other costs incurred by the cooperative agreement. This staffing proposal is consistent with other SIG-funded states, and in fact, DADP is proposing fewer staff than in others to meet the federal requirements of the program. DADP states that current staffing resources are not sufficient to support the workload required by the SIG. Prevention Services' staff have already been redirected due to an increase workload with the shift in significant oversight of the Safe and Drug Free Schools and Communities Program and the PSD Strategic Plan.

ITEM # 4200 DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS

ISSUE 5: SUBSTANCE ABUSE AND CRIME PREVENTION ACT OF 2000 (SACPA—PROPOSITION 36)

The Subcommittee will review the findings from the first annual report to the Legislature.

BACKGROUND:

The Report. DADP release its first annual study to evaluate the effectiveness and financial impact of Proposition 36, the Substance Abuse and Crime Prevention Act of 2000 (SACPA) in November 2002. The report was mandated by the Health and Safety Code (HSC) Section 11999.9. It covers the implementation period beginning November 2000 and contains early data and findings from July 1 through December 31, 2001.

The Act represented a major shift in the state's policy regarding nonviolent drug related use and possession offenses, and has resulted in a new model of collaboration among government sectors in treating drug offenders. The state purpose of the measure is to divert nonviolent offenders into community-based drug treatment, reduce prison costs for these offenders, increase public safety by reducing drug-related crime, and improve public health by reducing drug abuse through proven and effective treatment strategies. The Act provided $120 million annually for five years, concluding in fiscal year 2005-06.

Highlights. The following are the seven highlighted areas within the report.

- Despite the complexity of SACPA and the brief start-up period, the new statute was implemented quickly and efficiently.
- The initiative is operational in all 58 counties, and thousands of eligible drug offenders are being assessed, referred, and admitted to treatment services rather than jail or prison.
- Implementation has been a statewide collaborative effort, involving many state and local agencies. Representatives from the judiciary, law enforcement, health, drug treatment, social services, and government administration are working in concert to implement the initiative smoothly at the local level. So far, cooperation among state and local government sectors has been extremely positive.
- Treatment capacity across the state has expanded significantly since passage of SACPA, with a 42 percent increase in the number of programs licensed and certified to provide drug treatment services.
- New partnerships between universities and private foundations have been formed to support technical assistance to counties and to improve communication about SACPA to the pubic.
- To augment implementation of SACPA statewide, the Substance Abuse Treatment and Testing Accountability (SATTA) Program (SB 223) appropriated $8.4 million in federal Substance Abuse Prevention and Treatment (SAPT) Block Grant funds for drug testing of SACPA clients.
- A long-term evaluation, required by SACPA to evaluate program outcomes, has been designed and is already underway.

The long-term evaluation is being conducted by the Integrated Substance Abuse Programs Division of the University of California, Los Angeles. It examines patterns of: implementation, system impacts, net costs and adequacy of funding, offender outcomes related to criminal recidivism, substance abuse, employment, education, training, and health and family well-being.

The methodology of the evaluation includes analyses of cost-offset, client outcomes, program implementation, and lessons learned.

Preliminary Findings. The early data is relatively positive, but only covers a short start-up period and should not be viewed as conclusive. The findings are from data gathered between July 1 and December 31, 2001. They focus on seven key areas.

1. How many SACPA offenders were referred from criminal justice to treatment admission?

- Based on data from the 12 largest counties, which represent 77 percent of California's population, it is estimated that approximately 12,000 SACPA clients were processed through the criminal justice system and received treatment under SACPA during the first six months.

- It is important to note that not everyone who is eligible for Proposition 36 ends up in treatment. Though data is not available, some counties anecdotally report a higher percentage of individuals "opting out" of SACPA than anticipated. Based on the 12 largest counties, 60 percent of those individuals referred by the criminal justice system were admitted to treatment.

2. How did the service delivery system respond to the anticipated increase in the demand for services?

- Treatment capacity across the state has expanded. The number of licensed or certified programs has increased by 42 percent since the Act's passage, with licensed residential programs increasing by 17 percent and certified outpatient programs increasing by 81 percent.

3. What do SACPA clients admitted to treatment services look like?

- More than 48% are white, 31% are Hispanic, and an estimated 15% are African-American.
- Approximately 71% are male.
- Courts referred approximately 93% of clients in treatment; about 7% are parolees referred by the Board of Prison Terms.
- More than 53% of clients were between 31 and 45 years old at admission to treatment.
- Almost 63% reported that they were younger than 20 years old when they first used their primary drug; more than 21% reported being younger than 15 years of age at first use.
- Methamphetamine was the drug of choice for nearly half of SACPA clients (48%).

4. What treatment services were received?

- Clients typically received outpatient treatment (76%) or long-term residential treatment (12%).
- Some counties are reporting that SACPA clients are requiring a substantially higher level of care than many expected.
- In some counties, residential treatment services are limited.

5. How much was spent for SACPA purposes?

- Analysis of data from the 12 largest counties shows approximately 15 percent of the $124.6 million total funds available for FY 2001-02 was expended during the first six months of implementation (July 1 through December 31, 2001).
- As a result of the implementation challenges of new procedures, processing of offenders took longer than anticipated. Thus, the expenditure rate for the first six months reflects the fact that many counties experienced a slow start-up of client flow into SACPA services. New

programs typically experience slower initial spending as new procedures are put into place, with full spending occurring later as the program matures.

6. How were the dollars distributed?

- The largest 12 counties estimated a 79 percent/ 21 percent split between treatment activities and criminal justice, respectively. However, actual expenditures for the first six months reflected a split of 64/36.
- Many counties expect a shift toward services as more clients enter treatment programs and criminal justice costs, which were more intensive at start-up, are distributed over the full year.

7. How do SACPA clients compare to other clients admitted to treatment?

- SACPA clients represent approximately 9 percent of the total treatment population.
- Clients look similar to other treatment populations in gender, ethnicity, and age.
- One significant difference between SACPA clients and other non-criminal justice treatment populations is their primary drug of choice—methamphetamines.

COMMENTS:

The Subcommittee would benefit from estimates on the following, considering two years of implementation:

- Distribution of dollars between treatment and criminal justice.
- Treatment services provided.
- Client demography.
- Number of clients diverted.
- Percent/amount of SACPA funds spent.

ITEM # 4200 DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS

ISSUE 6: SUBSTANCE ABUSE PREVENTION AND TREATMENT'S (SAPT) MAINTENANCE OF EFFORT COMPONENTS

The Subcommittee will learn about the federal block grant and the required state funding.

BACKGROUND:

The SAPT Block Grant. Each year the Department of Alcohol and Drug Programs (ADP) applies for and receives federal SAPT Block Grant funds from the Substance Abuse and Mental Health Services Administration.

Federal regulations define principal agency as the single state agency responsible for planning, carrying out and evaluating activities to prevent and treat substance abuse. As the Single State Agency, ADP is responsible to the Federal government for ensuring compliance with the requirements governing SAPT block Grant funds.

The Department of Alcohol and Drug Programs (ADP) must use SAPT Block Grant funds only for the purpose of planning, carrying out, and evaluating activities to prevent and treat substance abuse. The Department must execute various responsibilities:

- Submit an annual application and plan for substance abuse prevention and treatment services to obtain SAPT Block Grant funds.
- Ensure funds from an individual SAPT Block Grant award are obligated and expended within the period of availability.
- Collect and submit data to the Federal government on diagnosis and capacity, and treatment performance measures.
- Monitor the activities of sub-recipients to ensure that Federal awards are used for authorized purposes in compliance with laws, regulations, and the provisions of contracts or grant agreements, and that performance goals are achieved.
- Ensure that preference in admission to substance abuse treatment services is given to pregnant women and women with dependent children.
- Require substance abuse treatment programs, receiving SAPT Block Grant funds, to make available Tuberculosis Services.
- Expend not less than 20 percent of each SAPT Block Grant award for primary prevention services.
- Maintain a specified level of effort for substance abuse treatment services for pregnant women and women with dependent children ($26.349 million of which not less than $15.554 million must be from SAPT Block Grant funds).
- Ensure 5 percent of each SAPT block Grant is expended for HIV Early Intervention Services.
- Ensure the State maintains state expenditures for tuberculosis and HIV Early Intervention Services at $237,200 and $2,050,000 respectively, the responsibility for which is in other state agencies.

As a condition of receiving SAPT Block Grant funds, ADP must comply with a maintenance of effort (MOE) requirement. ADP, as the principal agency of the state, must maintain state expenditures for substance abuse prevention and treatment services at a specified level, which is derived from a mathematical computation. ADP's state expenditures for the current year cannot be less than its average state expenditures for the preceding two state fiscal years.

There is an MOE for pregnant and parenting women. ADP must maintain a specified level of effort for substance abuse treatment services for pregnant women and women with dependent children ($26.349 million of which not less than $15.554 million must be from SAPT Block Grant funds).

There is an MOE for tuberculosis services. The State must maintain state expenditures for tuberculosis (TB) services at $237,200. For TB services, ADP obtains expenditure and statistical data from the Department of Health Services. This amount is multiplied by the percentage of TB cases associated with substance abuse.

There is an MOE for HIV Early Intervention Services. The State must maintain state expenditures for HIV Early Intervention Services at $2,050,000. In the FFY 2003 SAPT Block Grant application, state expenditures for HIV Early Intervention services were $18,292,000. For HIV Early Intervention Services, ADP obtains expenditure data from the Department of Finance Report titled "California AIDS Funding Program Detail."

If states violate the MOE requirement, they are at risk of losing one federal dollar of SAPT block grant funding for every state dollar they spend below the required MOE level.

The Secretary of the U.S. Department of Health and Human Services may waive the SAPT MOE requirement if the State can demonstrate that extraordinary economic conditions in the state justify the waiver. Extraordinary economic conditions mean a financial crisis in which the total tax revenue declines at least one and one-half percent and either unemployment increases by at least one percentage point, or employment declines by at least one and one-half percent.

To justify a waiver, the State must submit information sufficient for the Secretary to make the determination, including the nature of the extraordinary economic circumstances, documented evidence and appropriate data to support the claim, and documentation on the year for which the State seeks the waiver. Per federal code, ***a SAPT MOE waiver is only applicable to the fiscal year involved. This means that the waiver is NOT permanent***. Thus, the portion of the SAPT MOE that is waived for a given fiscal year must be restored in the subsequent fiscal year.

SAMHSA has the discretionary authority to exclude from the SAPT Block Grant MOE expenditures for authorized activities, which are of a non-recurring nature and for a specific purpose.

ITEM # 4200 DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS

ISSUE 7: WOMEN AND CHILDREN'S RESIDENTIAL TREATMENT SERVICES (WCRTS) PROGRAM

The Subcommittee will consider budget control language for the preservation of the WCRTS program.

BACKGROUND:

The Women and Children's Residential Treatment Services (WCRTS) is a coalition of nine programs that were part of a national demonstration project and funded through a federal grant to develop a comprehensive service model that has been federally evaluated. The nine residential treatment programs are now designated as California's "best practice" model. However, the report on the findings and data from the federal demonstration project has not been formally released.

As stated, the nine programs were initially funded through the Center for Substance Abuse Treatment as federal demonstration projects. When the federal demonstration projects were completed, the state continued funding for these programs within the perinatal drug treatment services allocation. In the Budget Act of 2002, $6,408,000, of the $23,457,000 allocated for perinatal substance abuse treatment programs, was appropriated for the WCRTS programs. These programs are not subject to the county 10 percent match, and the funds were passed through the counties directly to the designated nine residential treatment programs in each county, respectively.

Perinatal services encompass all regular alcohol and drug treatment services plus, at a minimum, the following components: gender specific issues, comprehensive case management, cooperative child care, transportation, parenting skills building, health education, child development education, linkages to medical, HIV/TB testing and counseling, and educational, vocational, and other services.

COMMENTS:

There is significant evidence that alcohol and drug treatment for mothers accomplishes several societal goals, including reducing criminal recidivism of mothers and improving the life-course outcomes of their children.

The California Perinatal Treatment Network (CAPTN) states that "inclusion of the budget control language will assure current level of service [sic] so that the programs can continue to provide their highly effective and successful treatment for drug addicted women and their children. The investment in these specialized treatment services pays off beyond cost savings. Every state dollar spent for residential treatment programs leverages another nine in reducing costs for health, criminal justice, foster care, and social welfare programs. " The report to back up this data, however, has not been released. The CAPTN organization is urging the adoption of the budget control language, which mirrors language in the annual Budget Act since 1998, in order to retain the nine WCRTS program as a separate budget item.

CAPTN is proposing the following budget control language, which is the same as that included in the Budget Act of 2002, Line Item 4200-104-0001. The Budget Act of 2002 appropriated $6.408 million for the WCRTS:

Of the funds appropriated in this item, $_____, shall be used to fund existing residential perinatal treatment programs that were begun through the federal Center for Substance Abuse Treatment grants but whose grants have since expired and currently are constituted as Women and Children's Residential Treatment Services. For counties in which there is such a provider, the Department of Alcohol and Drug Programs shall include language in those counties' allocation letters that indicates the amount of the allocation designated for the provider during the fiscal year.

Pursuant to Section 11840.1 of the Health and Safety Code, the treatment programs that were established through the federal Center for Substance Abuse Treatment grants are not subject to the county 10 percent match. All of the funds allocated for programs shall be passed through those counties directly to the designated nine residential treatment programs in each county, respectively.

Notwithstanding any specified amount in other provisions of this Item, any general reduction in Item 4200-104-0001 shall be made proportionately between the Women and Children's Residential Treatment Services and other perinatal programs.

ITEM # 4440 DEPARTMENT OF MENTAL HEALTH

ISSUE 1: MENTAL HEALTH MANAGED CARE PROGRAM NEW FEDERAL REGULATIONS

The Governor's Budget includes an augmentation to implement new federal regulations.

BACKGROUND:

Governor's Budget proposes an increase of $6.2 million ($1.7 million General Fund and $4.5 million in reimbursements from the DHS—federal Medicaid funds). This appropriation for the budget year is to support the costs of implementing new federal regulations governing the Medi-Cal Specialty Mental Health Services Consolidation (SMHSC) program and a two-year limited-term Associate Mental Health Specialist position to support federally required External Quality Reviews (EQRs) of the County Mental Health Plans (MPHs) and related activities to ensure that the program is brought into compliance with new federal regulations.

In addition, the Administration is proposing trailer bill language to adopt ***new*** emergency regulations implementing the new federal requirements on an emergency basis because of the federal implementation timeline (August 13, 2003)

Of the amount proposed, (1) $5.6 million is for a contract to conduct EQRs of the MHPs, (2) $50,000 is for a contract to conduct an actuarial analysis, (3) $500,000 is for client information materials, and (4) $75,000 is for the position and related operating expenses.

The DMH states that the requested two-year limited-term position is needed to review and revise existing state and MHP systems to comply with the new regulations. Specifically, it would be used to review current state regulations, MHP contracts, DMH Letters to Counties and Information Notices, Waiver documents and other materials for compliance with the new federal regulations.

Background of the Waiver. The SMHSC is a waiver program in which an MHP in each county provides access to specialty mental health services to Medi-Cal beneficiaries of that county. Federal waivers are granted by the Centers for Medicare and Medicaid for two-year periods, renewable subject to CMS approval. The SMHSC waiver program is approved to operate through November 2002. A renewal request for the SMHSC waiver program is currently in process. DMH was operating under the SMHSC program via a 90-day extension of the previous waiver.

Effective November 1, 1997, the DMH adopted emergency regulations for Medi-Cal Mental Health Managed Care as provided for in Section 5775 of Welfare and Institutions Code. However, this authority was never intended to be on-going.

Since this time, the DMH has obtained authority to continue the emergency regulations through annual Budget Act Language, including language adopted in 1998, 1999, 2000, 2001 and 2002. This authority will expire as of June 30, 2003, unless action is taken to extend this authority.

Implementation of the New Federal Regulations for the Medi-Cal Mental Health Managed Care Program. California's Medi-Cal Mental Health Managed Care Program operates under a federal Waiver. Our Waiver enables a County Mental Health Plan (MHPs) to limit client access to a specific pool of services and practitioners. The Waiver promotes MHP improvement in three significant areas—access, quality, and cost containment/neutrality.

New federal managed care regulations were issued in June 2002 and must be implemented by the state and MHPs by August 13, 2003. According to the DMH, the new regulations require significant changes in the operation of the program.

Specifically, the regulations would require the following:

1. The DMH must arrange for annual "External Quality Reviews" (EQRs) of the quality outcomes and timeliness of access to services covered by each MHP (56 MHPs—there are two MHPs that cover two counties);
2. The methodology used to reimburse the MHPs must be validated annually by a qualified actuary. The DMH notes that the actuarial studies may result in the need to revise current methods since the method currently used for distributing state General Fund support to the MHPs is not actuarially determined.
3. The state must provide extensive information to clients about the MHPs and client rights available under the Waiver, including detailed explanations of federal regulations written in a language that can be easily understood by all clients.
4. The state must conduct expedited state fair hearings (a decision within three business days of filing) in situations in which a client may suffer harm if the process follows the normal 90-day time frame. According to the DMH, there are about 100 mental health-related fair hearings per year and currently, the hearing process frequently takes more than the allowed 90-days.
5. The County MHPs will be required to (a) establish advance directive systems, (b) establish formal compliance plans and systems, (c) finalize and distribute informational materials, (d) comply with new administrative requirements related to provider contracts, (e) maintain additional documentation of the adequacy of the MHP's provider networks, (f)adopt formal practice guidelines, and (g) establish a more complex grievance and appeal system.

COMMENTS:

It is recognized that this is an important function that needs to be completed; however due to implementation timeframes (i.e., August 2003) it is unlikely that the DMH would be able to hire someone for a new position and have the activities accomplished. Furthermore, DMH staff is working on this issue now and therefore, have been redirecting resources already for this purpose.

ITEM # 4440 DEPARTMENT OF MENTAL HEALTH

ISSUE 2: MENTAL HEALTH MANAGED CARE PROGRAM-FUNDING ADJUSTMENTS

The Subcommittee will review the proposed 10 percent "provider rate reduction" for the Managed Care program.

BACKGROUND:

Governor's Budget Proposal to Reduce Funding of the Waiver
Governor's Proposed Mid-Year Reduction: The Administration proposed a reduction of $8 million ($4 million General Fund) in the Mid-Year Reduction proposal for 2002-03. This proposal assumed a 10 percent "provider rate" decrease effective April 1, 2003. This proposal was denied by the Legislature.

The budget for 2003-04 proposes a total state General Fund appropriation of $207.1 million (General Fund) for allocation to the County MHPs to assist in funding the Waiver Program. This reflects a *net* decrease of $12.2 million ($6.1 million General Fund) in the amount the state provides to the counties for Mental Health Managed Care. It should also be noted that the medical CPI is being funded and has not been funded since the Budget Act of 2000; This equates to another $13.4 million ($6.7 million General Fund) loss to the County MHPs.

This net decrease consists of the following proposed *key* adjustments:

1. Decrease of $46 million ($23 million General Fund) in the base County allocation amount. The Administration is referring to this as a ten percent Medi-Cal provider rate reduction; however, it should be noted that the counties already negotiate rates with their providers so in real terms, it is a reduction to the County allocation.
2. Augmentation of $17 million for various technical reasons, such as increased caseload and the increase in provider rates completed after the Budget Act of 2002.

In addition, the Governor assumes there is no Cost of Living Adjustment (COLA) provided in the budget, and scores those savings.

3. No adjustment for the medical Consumer Price Index (CPI) was provided. According to the DMH, it would be about 3.4 percent in the budget year for an expenditure of $13.4 million ($6.7 million General Fund). It should be noted that the medical CPI has not been funded for Mental Health Managed Care since the Budget Act of 2000.

Background—State & County Realignment Funds Used to Draw Federal Match*:* As discussed above, the state's Mental Health Managed Care Program operates under a federal Waiver whereby County Mental Health Plans (MHPs) are responsible for the provision of public mental health services, including those for Medi-Cal recipients.

An annual state General Fund allocation is provided to County MHPs, though counties also use a substantial amount of County Realignment funds - Mental Health Sub-account - to draw down federal matching dollars. For example,

Based on the most recent estimate of expenditure data for 2001-02, of California's state share of cost for Mental Health Managed Care, County MHPs provided a 46 percent match while the state provided a 54 percent match. (Adding these two funding sources together equates to 100 percent of the state's match in order to draw down the federal Medicaid funds.)

The state General Fund allocation is usually updated each fiscal year to reflect adjustments as contained in Chapter 633, Statutes of 1994 (AB 757, Polanco). These adjustments have typically included, changes in the number of eligibles served, factors pertaining to changes to the consumer price index (CPI) for medical services, and other relevant cost items.

However, the state's allocation is contingent upon appropriation through the annual Budget Act. As such in more difficult fiscal years, state General Fund support has not been provided for the medical CPI, or the base level of funding has been proposed for reduction (such as this year).

COMMENTS:

The proposed reduction will likely result in County MHPs serving fewer individuals and having difficulty in meeting statutory and contractual responsibilities related to the provision of Medi-Cal Mental Health Managed Care services.

Both the short-term and long-term effect of this action is to cost shift mental health services more to the counties. This proposal continues the Administration's direction to substantially reduce General Fund support for mental health services, other than the State Hospitals. About $164 million (General Fund), or 34 percent of the General Fund, was reduced from community-based mental health services in the Budget Act of 2002.

The California Mental Health Director Association notes that as Medi-Cal Mental Health Plans, counties already negotiate rates with their providers under the Specialty Mental Health Managed Care program. CMHDA cites that "in real terms, the 10 percent reduction is a reduction to the county allocation for managing this program."

ITEM # 4440 DEPARTMENT OF MENTAL HEALTH

ISSUE 3: MENTAL HEALTH MANDATE DEFERRALS FROM BUDGET ACT OF 2002

The Subcommittee will be updated on the status of programs and services under the deferred mandates situation the counties face.

BACKGROUND:

Governor's Budget proposes to continue the moratorium on all mandate reimbursement claims for local government, including funds provided for mental health services to special education pupils. At this time, it is unclear when the moratorium may end.

Service Background - Federal. Federal law (PL 94-142 of 1975-- the Education for All Handicapped Children Act—and the later Individuals with Disabilities Education Act (IDEA)) mandates states to provide services to children enrolled in special education, including all related services as required to benefit from a free and appropriate education. Related services include mental health services, occupational and physical therapy and residential placement.

Service Background - State. In California, County MHPs are responsible for providing mental health services to students when required in the pupil's Individualized Education Program (IEP). This is because AB 3632 (W. Brown), Statutes of 1984, shifted responsibility for providing these services from School Districts and transferred them to the counties.

These services are an entitlement and children can receive services irrespective of their parent's income-level. In addition, County MHPs cannot charge families for these services because the children are entitled to a free and appropriate public education under federal law. Based on statistics from 2001-02, there are about 27,000 special education pupils who receive mental health services provided by County MHPs.

A student's IEP include services to be provided, including initiation of service, duration and frequency of service and must be provided as indicated. Services can only be discontinued on the recommendation of the County MHP and the approval of the IEP team, or by parental decision. Among other things, mental health services include assessments, and all or a combination of individual therapy, family therapy, group therapy, day treatment, medication monitoring and prescribing, case management, and residential treatment.

Funding Background for AB 3632 (Prior to 2002): For the past decade or so, counties have paid for the cost of the program through a combination of the following:
(1) Categorical funding provided by the DMH as appropriated through the state budget process (about $12 million annually);
(2) Mandate reimbursement claims as obtained via the State Commission on State Mandates process (referred to as the SB 90 process;
(3) Realignment funds; and
(4) Third-party health insurance when applicable, though parents can chose not to access their insurance for this purpose if they so decide (federal law).
It is estimated that about $100 million in total funds is expended annually.

Funding Background in the Budget Act of 2002 and AB 2781: The Budget Act of 2002 eliminated the $12 million (General Fund) of categorical funding and directed the counties to obtain these funds through the mandate claims reimbursement process.

As such AB 2781 (Section 38 of the legislation), the omnibus education trailer bill to the Budget Act of 2002, requires the state to reimburse counties for all allowable costs incurred by counties in providing certain services to handicapped and disabled pupils. Reimbursement by the state would be provided either through the annual Budget Act or other statute.

While AB 2781 provided for the reimbursement process, the Budget Act placed a moratorium on all mandate reimbursement claims for local government, including funds provided for these mental health services to special education pupils. As such, no funds are available in the current year for these mandated services. The statute provides that counties are not required to provide any share of these costs or to fund the cost of any part of these services with money received from the Local Revenue Fund (i.e., County Realignment Funds) for those reimbursement claims for services delivered in the 2001-02 fiscal year and thereafter to these pupils. In addition, counties have not been reimbursed for prior year claims for these services.

COMMENTS:

The California Mental Health Directors Association (CMHDA) is extremely concerned that funding for past claims have not been paid and that any future payment is unknown at this time (i.e., there is no statutory timeframe as to when mandate reimbursements will resume).

Since July 1, 2002 counties have not received any funding for mental health services provided as an entitlement to special education pupils. According to the CMHDA, counties must advance about $8 million per month (about $100 million annually) of County General Fund support to maintain these services. Further they contend that over $130 million is owed to counties for these services since the state has not yet paid claims from 2001-02 and some prior years.

Some counties may be able to provide some portion of funding for these services; however, the CMHDA believes this would create a “catch-22” situation whereby if counties use County Realignment funds for this purpose, they may not submit mandate reimbursement claims for their costs. In addition, County Realignment funds are intended to serve their “target” population (low-income and uninsured population of children diagnosed as being Seriously Emotionally Disturbed).

The CMHDA also states that a lack of funding is also causing service slow-downs in some areas and parents and Special Education Local Program Agencies (SELPAs) are becoming frustrated.

The Senate Subcommittee considered that California currently receives about $781 million in federal funds from the Individuals with Disabilities Education Act (IDEA), Part B grant. These funds are expended for a variety of special education functions. According to recent federal funding information, California is slated to receive an increase of about $151.5 million (federal funds) in this grant for the budget year which will bring total funding to $933 million.

A portion of these new federal funds may be available for expenditure for the mental health services provided by the counties for special education pupils. Based on current information, the provision of mental health services to special education pupils (i.e., a related service needed

to ensure the success of the child's special education services) would be an appropriate expenditure of these funds, especially since these services are mandated by the IDEA.

It should be noted that California does have a federal "maintenance of effort (MOE)" problem with respect to the state's General Fund contribution to special education. Specifically, the state must increase General Fund support by $28.5 million or seek a federal waiver from this requirement. As such, discussion regarding the full expenditure of the pending federal increase of $151.5 million will need to occur in a more comprehensive forum, such as in Senate and Assembly Subcommittees on Education Finance.

ITEM # 4440 DEPARTMENT OF MENTAL HEALTH

ISSUE 4: EARLY PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) CASELOAD METHODOLOGY

The Governor's Budget includes an augmentation for this Medi-Cal program for children's mental health care.

BACKGROUND:

The Governor's Budget requests an increase of $150 million ($142.4 million in Reimbursements from the DHS of which $69.7 million is General Fund and $72.7 million is federal Medicaid funds, and $7.5 million in County Realignment funds) for the EPSDT Program, including Therapeutic Behavioral Services (TBS). This increase reflects a proposed change in estimating methodology by the Administration in an effort to more accurately reflect expenditures.

By 2003-04, the total state cost for the program would reach $381 million, which is an increase of 16 percent above the 2002-03 level of funding. The Department of Finance states that the full effect of cost control measures implemented by the Legislature through AB 442, Statutes of 2002, trailer bill to the Budget Act of 2002, will not be realized until 2004-05. However, the proposed $230.4 million increase does assume a smaller growth rate.

The DMH has changed its methodology for estimating future costs. It indicates that the budget proposal reflects its collection of more recent information about the costs and caseload of EPSDT and an expected slowdown in program growth due to cost-containment efforts at the county level. The 2003-04 budget plan is based on a new projection method that the DMH believes more fully reflects the base level of funding needed for EPSDT services, since the previous methodology often turned out to be significantly below the actual level of expenditures. One key change is that the DMH's revised method takes into account specific data on EPSDT growth trends in each county, while the previous expenditure projection method was based on cost data that was aggregated on a statewide basis.

The EPSDT, a federally mandated program, requires states to provide a broad range of screening, diagnosis, and medically necessary treatment services to Medi-Cal beneficiaries under age 21, even if the treatment is an optional service under the state's Medicaid plan. The requirements apply to mental health as well as physical health.

Most children receive Medi-Cal services through the EPSDT Program. Specifically, EPSDT is a federally mandated program that requires states to provide Medicaid (Medi-Cal) recipients under age 21 *any* health or mental health service that is medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition identified by an assessment, including services not otherwise included in a state's Medicaid (Medi-Cal) Plan. EPSDT services are required by federal law but are not otherwise covered under the state Medi-Cal Plan for adults. Examples of services include family therapy, crisis intervention, medication monitoring, and behavioral management modeling.

Though the DHS is the "single state agency" responsible for the Medi-Cal Program, mental health services including those provided under the EPSDT, have been delegated to be the responsibility of the Department of Mental Health (DMH). Further, counties are responsible for providing, arranging and managing Medi-Cal mental health services under the supervision of the DMH and DHS. However, eligibility and the scope of services to which eligible children are entitled, are *not* established at the local level.

Due to litigation (T.L. v Belshe' 1994), the DHS was required to expand certain EPSDT services, including outpatient mental health services. The 1994 court's conclusion was reiterated again in 2000 with respect to additional services (i.e., Therapeutic Behavioral Services—TBS) being mandated. Prior to these case, a 1990 national study found that California ranked 50th among the states in identifying and treating severely mentally ill children.

The funding process for EPSDT originally required County MHPs to provide a "baseline" amount using County Realignment Funds (essentially a county "maintenance-of-effort") and then the state was responsible for providing the nonfederal share of the growth in the program.

The baseline amount is established for each county based on a formula. For 2003-2004, the baseline is $66.3 million plus an additional 10 percent county match ($5.9 million for the budget year) which was instituted in the Budget Act of 2002. The state will provide funding (via Medi-Cal) for costs above this amount (above the baseline and 10 percent match).

The General Fund dollars and accompanying federal matching funds are budgeted in the DHS and are transferred to the DMH as reimbursements. The DMH distributes EPSDT funds to the County MHPs responsible for the provision of specialty mental health in each county. Final payment is based on cost settled actual allowable costs, or rates.

In response to concerns that the program is growing dramatically, the administration is requiring counties, which were previously obligated to provide a base level of funding but bore no share of the cost of the growth of the program, to be financially responsible for a 10 percent share of the nonfederal cost of program growth. The action is intended to establish a financial incentive at the county level to ensure that funds are spent efficiently for medically necessary services to the EPSDT eligible population. In addition to this cost-control mechanism, the Legislature adopted statutory language last year directing the DMH to assist counties in implementing managed care principles that would help slow the growth in the program. The DMH states that it is applying the provisions (Welfare and Institutions Section 5767). It believes that it will have an unspecified future impact on the growth in program costs.

A variety of factors have contributed to the continued expansion of EPSDT, including legal decisions, recent Medi-Cal Program expansions, recent Medi-Cal reimbursement adjustments for Psychologist and Psychiatrist services, and the fact that several counties were delayed in initially expanding their EPSDT services in the first place.

It should be noted that when counties agreed to administer the EPSDT Program in 1995, a part of the understanding was that counties would endeavor to expand the program to meet the state's legal obligations under EPSDT (due to the litigation).

After the 2000 court decision regarding Therapeutic Behavioral Services (TBS), counties were once again urged by the state to act and assure that TBS services were available to any Medi-Cal eligible child in need of the service.

Further, in a 2001 report to the Legislature by the DMH entitled Utilization of the EPSDT Benefit, the DMH notes:

"At least preliminarily, it appears that during the initial years of EPSDT implementation, County MHPs focused on increasing access to services for those EPSDT eligible children who needed them; thus the number of clients served increased. As the program has matured, counties are finding that they need to increase the intensity of services to many young clients with the most severe emotional disturbances in order to achieve positive outcomes and to keep youth in their homes, functioning in school and out of the juvenile justice system. This has resulted in higher paid claims per client in a number of counties that were unable to provide these levels of service prior to EPSDT."

Based on a number of studies which estimate the prevalence of children exhibiting various levels of functional impairment, it is estimated that 20 percent of children suffer from a diagnosable mental disorder, and up to 13 percent of these children are estimated to be seriously emotionally disturbed. Given these estimates it is likely that between 500,000 to 1.3 million children and adolescents in California have a severe emotional disturbance.

As a comparison, the statewide average EPSDT penetration rate is about 5.2 percent (as of 2001-02) for all ages. This varies from county to county and by age group. For example, for Los Angeles for children ages 9 to 17 years has a penetration rate of 7.7 percent, Sacramento has a rate of 9.4 percent and Solano has a rate of 8.7 percent for the same group.

It should be noted that the Little Hoover Commission's report (October 2001) on the existing inadequacies in the children's mental health system considered the potential savings if children's mental health utilization increased by 10 percent—the estimated prevalence rate. In one year, they estimated that California would save $44 million in juvenile justice, $27 million in CYA costs, $78 million in residential treatment and $1.4 million at Metropolitan State Hospital. A total of $110 million in savings.

COMMENTS:

The LAO believes that there is merit to the DMH's attempt to budget more accurately for EPSDT, and agrees that the new projection method of looking at county by county expenditure trends is likely to prove more accurate than its previous approach.

DMH PROJECTIONS—VALIDATION TEST
(IN MILLIONS)

Fiscal Year	Estimate with:		Total Actual Claims Paid
	Previous Method	Proposed New Method	
1998-99	$178.6	$332.6	$299.8
1999-00	$369.5	$423.6	$395.5
2000-01	$469.2	$540.0	$525.5

The DMH's new method is consistently more accurate in projecting prior year expenditure needs than the previous methodology. Yet, it also consistently errs on the side of providing more funding for the program than was actually claimed by counties. For the three years tested in the validation study, the average error amounted to about $25 million for all fund sources. However, there is no way to know at this time, whether this is a standard result from the projection method, or just a coincidental result of other factors affecting the three years of EPSDT expenditures that were reviewed.

ITEM # 4440 DEPARTMENT OF MENTAL HEALTH

ISSUE 5: AB 947 (GALLEGOS) CHAPTER 717 STATUTES OF 1998 PSYCHOLOGISTS SCOPE OF PRACTICE

The Subcommittee will hear the status of the implementation of AB 947.

BACKGROUND:

AB 947 was approved by the Legislature in 1998 to establish rules for staff privileges for licensed clinical psychologists. The statute recasts facilities' requirements concerning psychologists' medical staff privileges, and instead conforms to the existing statutes providing for staff privileges for other licensed health care practitioners. Additionally, it prohibits discrimination on the basis of licensure. The author stated that the statute was also necessary in order to provide for the full implementation of earlier legislation.

The DMH has issued a Special Order specifying which functions may be performed by a psychologist under the supervision of a psychiatrist. The Department believes that this is a first step towards implementation.

COMMENTS:

The California Psychological Association (CPA) is concerned that the provisions of AB 947 have not been fully implemented. The CPA states that the "DMH does not have the authority to limit in any way the independent practice of a psychologist when the activities are part of the patient's approved treatment plan."

The CPA is concerned about the limitation in the scope of practice of psychologists, as stated:

> Despite the clear calling for equity in consideration, this law has been largely ignored, resulting in millions of dollars of waste and inefficiency in the treatment of patients in this system. The scope of practice for psychologists (B&P Section 2903) is defined as the ". . . diagnosis, prevention, and treatment . . . of psychological problems and emotional and mental disorders. . ." Despite this clear language, in state hospitals psychologists are not allowed to independently: 1) diagnose mental disorders; 2) serve as "team leaders" in the coordination of patient treatment; and 3) authorize orders routine to treating a patient's mental disorder, such as the ordering of a suicide watch, ground pass, seclusion and/or restraint, and orders for nursing care.

ITEM # 4440 DEPARTMENT OF MENTAL HEALTH

ISSUE 6: ADULT SYSTEMS OF CARE/ INTEGRATED SERVICES FOR HOMELESS ADULTS

The Subcommittee will hear the status of the Adult Systems of Care and Integrated Services for Homeless Adults programs.

BACKGROUND:

AB 3777 (Wright), Chapter 982, Statutes of 1988, authorized two types of pilot programs for delivering mental health services to seriously mentally ill adults: a system of care model, which has been piloted in Ventura County and the integrated services agency model, piloted in Stanislaus and Los Angeles Counties. These programs have helped clients become functional through coordinated services to address multiple problems, such as mental illness, substance abuse, and homelessness. SB 659 (Wright) re-authorized the demonstration projects, and required DMH to issue requests for proposals for additional projects in any year in which the state provides funds for that purpose.

AB 34 (Steinberg) 1999 and AB 2034 (Steinberg) 2000 revised county mental health service standards to include access to integrated services, and established fiscal incentives for counties to engage in outreach to mentally ill individuals. The revised standards include coordination and access to medication, substance abuse services, supportive housing, veterans' services, and vocational rehabilitation services.

The services provided in the Integrated Services for Homeless Adults provide comprehensive services to adults who have severe mental illness and who are homeless, at risk of being homeless, recently released from a county jail or state prison, or others who are untreated, unstable, and at significant risk of incarceration or homelessness unless treatment is provided to them. Services offered by local programs include assessment of the individual's needs, providing shelter/housing, establishing identification and legal assistance needs, and providing food, clothing, showers, medical, psychiatric and dental care, alcohol and drug treatment and social rehabilitation.

The AB 34 pilot programs collected data that showed that the programs were both successful in getting homeless individuals the services they needed, and extremely cost-effective. Outcome data indicate that those enrolled in the program experienced a 65.5 percent drop in the number of hospital days; an 81.5 percent drop in the number of days spent in jail; and a 79.1 percent drop in the number of days spent homeless. AB 2034 helped to expand from the three pilot programs into 32- 34 counties, for which the state provides funding. The Administration and Legislature have shown strong support of these programs and they are an integral part of the Governor's Homeless Prevention Initiative.

COMMENTS:

The Budget Act of 2002 eliminated funding for the Adults Systems of Care program in the amount of $7 million. In the Governor's proposed budget, he continues the elimination of the funding for these programs. The programs are concerned that without the state funding, they will be unable to keep their doors open for these model programs for integrated services.

The Modesto Bee included an article last week related to the closure of the Stanislaus Integrated Service Agency (SISA). SISA is one of the model programs set up by AB 3777 and continued with AB 34/2034 funding. It currently has 250 people in the program and 75 full- and part-time employees. The state had provided about $1.7 million annually for SISA, while the county provided the remaining $200,000. However, the 24-hour-a-day outpatient services and psychological rehabilitation program is set to close on June 30.

ITEM # 4440 DEPARTMENT OF MENTAL HEALTH

ISSUE 7: EARLY MENTAL HEALTH INITIATIVE

The Early Mental Health Initiative has been proposed for elimination.

BACKGROUND:

The Administration proposed to revert $549,000 (Proposition 98 General Fund) in unexpended funds in 2002-03 and to eliminate the program in 2003-04 for savings of $15 million (Proposition 98 General Fund

The budget proposes to eliminate the Early Mental Health Initiative for savings of $15 million (Proposition 98 General Fund), and modify existing statutory language which would make the program subject to the availability of funding each year.

Under the Early Mental Health Initiative, the state awards grants (for up to three-years) to Local Education Agencies (LEAs) to implement early mental health intervention and prevention programs for students in Kindergarten through Third Grade. Schools that receive grants must also provide at least a 50 percent match to the funding provided by the DMH. Schools use the funds to employ child aides who work with students to enhance the student's social and emotional development.

Students in the program are generally experiencing mild to moderate school adjustment difficulties. Students must have parental permission to participate in the program. In addition, all Early Mental Health Initiative programs are required to contract with a local mental health agency for referral of students whose needs exceed the service level provided in this program.

The Early Mental Health Initiative is a cost-effective school-based program. It serves children experiencing school adjustment issues who are not otherwise eligible for special education assistance or county mental health services. The students' conditions are usually not severe enough to meet the eligibility criteria in other programs such as the Children's System of Care program or EPSDT services.

COMMENTS:

Both the short-term and long-term effect of this reduction is that children with mild to moderate school adjustment problems will likely not receive services and may, as a consequence, need more intensive services later. Further, these students may end up doing poorly in school and developing other problems.

ITEM # 4440 DEPARTMENT OF MENTAL HEALTH

ISSUE 8: SALINAS VALLEY STATE PRISON PSYCHIATRIC FACILITY

The opening of the mental health facility at Salinas Valley State Prison has been delayed.

BACKGROUND:

The scheduled opening of a new mental health facility at Salinas Valley State Prison was delayed repeatedly due to construction problems. The 2002-03 Budget Act and a subsequent budget adjustment provide about $5.4 million in General Fund support to the California Department of Corrections, with an equivalent amount of reimbursement authority to the DMH, to open a new 64-bed psychiatric facility at the prison. The Governor's budget plan proposes to provide full-year funding of $7.2 million for the operation of the facility during 2003-04 plus an augmentation to the CDC budget of $100,000 for various additional operating expenses.

The arrangement between the two departments will mirror the long-standing relationship CDC and DMH have had with the California Mental Facility at Vacaville. The new Salinas facility will be staffed and managed by the DMH to exclusively serve CDC inmates at the prison.

The level of funding provided to CDC and DMH to open the facility during 2002-03 took into account the previous construction-related delays. It assumed that the DMH would have to postpone taking control of the new building from April 2002 until September 2003. However, there have been further delays. CDC has told DMH that DMH staff would not be able to occupy the building until February 2003, and would not receive patients until April 2003.

The Governor's budget included an additional $100,000 for various estimated operating expenses, but these same funds were not included as additional reimbursements within the DMH budget for the support of the mental health facility.

COMMENTS:

LAO was advised that despite the series of delays, the DMH proceeded to hire 61 of the 103 authorized staff positions for the facility. The latest construction delays mean that this newly hired DMH staff would temporarily have no place to accomplish the work for which they were hired. The LAO was advised in January by DMH that, until the situation was resolved, perhaps by last month, the new hired were being directed to perform other medical and non-medical work in the prison.

The LAO states that the DMH estimates that as a result of the slowdown in the activation schedule, it will not spend about $1.5 million of the funds allocated for the operation of the Salinas Valley facility in the current fiscal year. However, the Governor's budget plan did not propose any financial adjustments to either the CDC or the DMH budgets to reflect the delay. The CDC budget for Salinas Valley State Prison also has not been adjusted to reflect the additional funding available to them as a result of the delay in the opening of the mental health facility but not accounted for in the budget of that institution.

The Subcommittee would benefit from understanding:

1) the status of the occupation of the facility by DMH staff;
2) the reasons for not adjusting the CDC and DMH budgets to reflect the additional funding available to them as a result of the delay in the opening of the mental health facility;
3) the savings the CDC could score as a result of the availability in the current year of unbudgeted additional DMH staff;
4) the need for the additional operating expense funding for CDC.

ITEM # 4440 DEPARTMENT OF MENTAL HEALTH

ISSUE 9: STATE HOSPITAL PATIENT CASELOAD AND OPERATING EXPENSES

The Governor's Budget proposes to increase funding for the state hospitals for population changes and operating expenses.

BACKGROUND:

For the budget year, the spending plan requests a net increase in General Fund support of about $30 million compared to the revised proposed level of spending for the state hospital system. This is comprised of:

1) $14.8 million in funding adjustments to account for the full fiscal effect in 2003-04 of population growth which DMH projects will gradually occur in the hospitals during the current fiscal year;
2) $5.6 million to care for a projected net gain of 88 patients during the budget year;
3) $9.5 million for deficiencies in funding for operating expenses and equipment.

The proposed caseload for each State Hospital is as follows:

Hospital & Patient Type	Budget Act of 2002	Proposed Current Year	Revised 2002-03	Proposed Adjustment	Proposed 2003-04
Atascadero	1,187	12	1,199	33	1,232
Sexually Violent Predators	506		506	33	539
Penal Code	681	12	757		693
Metropolitan	833	10	843	4	847
County Patients	457		457	-16	441
Penal Code	376	10	386	20	406
Napa	1,201	1	1,202	38	1,240
County Patients	240		240	-10	230
Penal Code	961	1	962	48	1,010
Patton	1,304	4	1,308	13	1,321
County Patients	79		79		79
Penal Code	1,225	4	1,229	13	1,242
TOTALS	4,525	27	4,552	88	4,640
LPS	(776)	(0)	(776)	(-26)	(750)
Penal	(3,749)	(27)	(3,776)	(114)	(3,890)

The DMH contends that the OE&E funds are needed for patient drugs, food, utilities, outside medical services and related items. The DMH notes that the State Hospital OE&E budget for 2001-02 spent about $11.4 million more than expected and as such, needs additional funding in this area to compensate for increased expenditures and usage for some of the OE&E items. They note that their requested increase of $11.4 million ($9.5 million General Fund) is preliminary and that a revision on this estimate may be forthcoming at the May Revision.

COMMENTS:

The Legislative Analysts Office believes that of the $30 million increase in General Fund for the state hospitals, the recent hospital census data indicates that the General Fund support for the hospital caseload is probably over-budgeted by about $3.6 million in the current year and $14.1 million in the budget year. Consequently, the LAO recommends reducing state operations by $14.1 million.

The Governor's 2003 Budget's spending plan is based on hospital census counts though the beginning of October. The LAO's analysis reflects population data through the end of December. The Administration will also update their caseload estimates at the May Revise.

The LAO argues that the overall population count so far in the current year has remained fairly level and has not grown in line with the caseload funding provided in the 2002-03 Budget Act. The Governor's budget assumes that the overall hospital population will reach 4,552 by June 2003 and 4,640 by June 2004. The LAO believes that this seems unlikely, given the actual census count at the end of December of 4,238, which is a net drop of 12 patients since the current fiscal year began. Moreover, there has been a modest decline of the state hospital population during the past two years.

The Subcommittee would benefit from understanding:

1) how, if at all, the operating expenses and equipment augmentation could be offset with excess funding from vacant positions in the state hospital system this year;
2) how the state hospital budget could be restructured to more appropriately align the funding needed for personnel and OE&E needs;
3) the fiscal ramifications of improving the standard caseload budgeting methodology to more accurately reflect hospital system needs for OE&E.