STEINBERG INSTITUTE

ADVANCING BEHAVIORAL HEALTH POLICY & LEADERSHIP

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COUNTY BEHAVIORAL HEALTH DIRECTORS ASSOCIATION
CALIFORNIA

MARCH 11, 2015 • SACRAMENTO, CALIFORNIA

In 2014, Senate President pro Tempore Darrell Steinberg (Ret.) founded the Steinberg Institute for Advancing Behavioral Health Policy & Leadership.

Together with the County Behavioral Health Directors Association of California (CBHDA), the Steinberg Institute undertook a survey to quantify what we know: The Mental Health Services Act (MHSA) created in 2004 by Proposition 63 is working.

Since Prop. 63 passed, hundreds of thousands of Californians suffering from the effects of mental illness – including children and families – have utilized local services funded by the Act. Data show that the services offered at the county level provide relief to people with mental illness and their families while also reducing the demands on the criminal justice, healthcare and social services systems.

The attached report summarizes publicly available data on MHSA from the 2011/12 fiscal year, including outcomes reported through June 2014.

By analyzing the life impacts of more than 35,000 Californians who received "Whatever-It-Takes" intensive services in 2011 from MHSA, in addition to the other outcomes produced in this report for 2012 and 2013, the evidence is clear that MHSA is reducing hospitalizations, jail time, out-of-home placement for children, and improving the lives of thousands of people.

This report offers a strong beginning to more regular reporting of outcome-based data that the public and state government can rely on for proper oversight. The authors of this report are committed to working with the California State Legislature and agencies to ensure that going forward there is no question as to the effectiveness of the MHSA program or the means by which the results are proven.

Everyone agrees that to build consensus for sustained mental healthcare funding, the state must demonstrate the effectiveness of existing programs in an objective and consistent way. Californians are entitled to data that shows thousands of real people are being helped as a result of Prop. 63, and that the quality of life is improved for everyone.

Our most important mission is to tell this story, help erase the stigma surrounding mental illness, and encourage those suffering in silence to seek help.

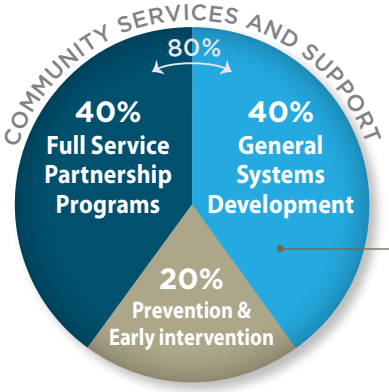
Darrell Steinberg
Founder, Steinberg Institute

Robert Oakes
Executive Director, County Behavioral Health Directors Association of California

Mental Health Services Act Delivering on Promise to Californians

California's counties, in partnership with the Steinberg Institute for Advancing Behavioral Health Policy & Leadership, present the first comprehensive, data-driven evaluation of the Mental Health Services Act (MHSA). The following evaluation draws from data reported by counties to state agencies for Fiscal Year 2011/12.

The evaluation represents approximately $500 million of the $947 million invested in 2011/12 in a range of services delivered at the county level into both full service partnerships: "Whatever-It-Takes" mental health services for the homeless and others with the most severe mental illnesses, and urgent care for those with more moderate conditions.



Mental Health Services Act Funding

Urgent Care and Other Approaches

One-time Investment for 10 Years

- Workforce, Education and Training
- Technology Needs
- Capital Facilities
- Housing

I. FULL SERVICE PARTNERSHIP PROGRAMS (40%)

"Whatever-It-Takes"

Forty percent of MHSA dollars allocated to counties are directed to intensive Full Service Partnership (FSP) programs. Another 15-20% is dedicated to system improvements such as urgent care for psychiatric emergencies and crisis diversion.

Full Service Partnership programs are intensive services delivered to individuals with the highest mental health needs, such as those who are homeless or at risk of homelessness.

- In FY 2011/12, 35,110 people were served through California county FSP.
- FSP programs produce dramatic improvements in clients' lives and invest in communities.

A full analysis of the three target populations enrolled in an FSP program for FY 2011/12, Transition Age Youth "TAY" (ages 16-25), Adults (ages 26-59), and Older Adults (60+), showed significant improvements in these categories:

1) Homelessness and Emergency Shelter Use
2) Emergency Medical and Psychiatric Services (including inpatient care)
3) Legal Involvement (arrests and incarcerations)
4) Independent Living

Homelessness
DOWN 47%

Homelessness and Emergency Shelter Use

Comparing the number of clients who were homeless (living on the street) or in an emergency shelter the year prior to entering an FSP program with those same clients at discharge from an FSP program.

AGE GROUP	BEFORE FSP	AT DISCHARGE	% DECREASE
TAY	10%	7%	▼ 28%
Adults	21%	9%	▼ 54%
Older Adults	9%	4%	▼ 58%

Emergency Mental Health / Substance Abuse Care
DOWN 79%

Emergency Mental Health and Substance Use Intervention

Comparing the number of clients who utilized emergency care for a mental health and/or substance use condition (via an Emergency Department admission) the year prior to entering an FSP to the first year enrolled in an FSP program for those clients who were enrolled in FSP for one year or more.

AGE GROUP	BEFORE FSP	AFTER 1+ YEAR OF FSP	% DECREASE
Children	19.2%	4.1%	▼ 79%
TAY	45%	11%	▼ 76%
Adults	46.8%	9.6%	▼ 79%
Older Adults	36.5%	6.2%	▼ 83%

Psychiatric Hospitalizations
DOWN 42%

Psychiatric Hospitalizations

Comparing the number of clients who had one or more psychiatric hospitalizations the year prior to entering an FSP program to the number of clients with one or more psychiatric hospitalizations during the first year of FSP for clients who were enrolled in an FSP for one year or more.

AGE GROUP	BEFORE FSP	AFTER 1+ YEAR OF FSP	% DECREASE
Children	13%	8%	▼ 40%
TAY	28%	17%	▼ 41%
Adults	34%	20%	▼ 40%
Older Adults	28%	14%	▼ 50%

Arrests
DOWN 82%

Arrests

Comparing the number of clients who were arrested the year prior to entering an FSP to the number of clients with an arrest during the first year of FSP for those clients who were enrolled in FSP for one year or more.

AGE GROUP	BEFORE FSP	AFTER 1+ YEAR OF FSP	% DECREASE
TAY	28%	8%	▼ 71%
Adults	25%	4%	▼ 85%
Older Adults	8%	1%	▼ 90%

Above percentages averaged across all age groups.

Incarcerations
DOWN 27%

Incarcerations

Comparing the number of clients who were incarcerated in a county jail the year prior to entering an FSP with the number of clients incarcerated during the first year of FSP for clients who were enrolled in FSP for one year or more.

AGE GROUP	BEFORE FSP	AFTER 1+ YEAR OF FSP	% DECREASE
TAY	24%	19%	▼17%
Adults	21%	13%	▼41%
Older Adults	5%	4%	▼24%

Living Independently
UP 14%

Independent Living

Comparing the number of adults living independently (either in their own apartment or in a Single Room Occupancy unit) the year prior to FSP to the number of clients living independently after two years of FSP services for those clients who were enrolled in FSP for two or more years.

AGE GROUP	BEFORE FSP (living independently)	AFTER 2+ YEARS IN FSP (living independently)	% INCREASE
Adults	4,475	5,117	▲14%

CHILDREN

- In 2011/12, 8,968 children were served by Full Service Partnerships at the county level.
- Children enter an FSP program experiencing poor academic performance and residing in out-of-home placements.

A full analysis of children (ages 0-15) enrolled in an FSP program for FY 2011/12 showed significant improvement in the following categories:

1) Out-of-home Placement
2) Academic Performance

Child Out-of-Home Placements
DOWN 60%

Out-of-Home Placement

Comparing the number of children living in out-of-home placement (Group Home, Level 0-11, 12-14, or Community Treatment Facility) the year prior to FSP to the number of children in out-of-home placement who were enrolled in FSP for two or more years.

AGE GROUP	BEFORE FSP	AFTER 2+ YEARS IN FSP	% DECREASE
Children	808	485	▼60%

Academic Improvement
UP 22%

Academic Performance

Comparing the number of children with good or very good grades at the beginning of FSP with the number of children with good or very good grades after one year of FSP for those children who were enrolled in FSP for one or more years.

AGE GROUP	BEFORE FSP	AFTER 1+ YEAR IN FSP	% INCREASE in good grades
Children	21.5%	27.4%	▲22%

Data Open to Public Inspection

The data used to make the conclusions in this evaluation is reported by each county to the Department of Health Care Services (DHCS) and the Mental Health Services Oversight and Accountability Commission (MHSOAC) via the County's Annual Update for MHSA Three-Year Program and Expenditure Plan on an annual basis. This data is open to public review.

II. URGENT CARE AND OTHER APPROACHES (20%)

In addition to the 40% invested in Full Service Partnership programs, an additional 15-20% of MHSA funds allocated to counties are directed to meet a wide range of client needs from crisis response, employment support, housing, and strategies to identify at-risk individuals and connect them with support needed before a crisis event.

Each county develops a plan based on its unique ends, in consultation with stakeholders and has this plan approved by the local Board of Supervisors. Below is a sample of the diverse ways counties respond to local needs, and the results delivered by local communities.

Urgent Care and Crisis Stabilization: Three Representative California Counties

LOS ANGELES COUNTY

Mental Health Urgent Care Centers (UCC)

In Los Angeles County in FY 13-14, Mental Health Urgent Care Centers served 26,350 clients and achieved the following outcomes:

- Only 6% of clients visiting a Mental Health Urgent Care Center are seen in a psychiatric emergency department within 30 days of the UCC visit
- Only 11% of clients visiting a Mental Health Urgent Care Center are admitted to a psychiatric inpatient facility within 30 days of the UCC visit

SAN BERNARDINO COUNTY

Psychiatric Triage Diversion Program

In San Bernardino County, the Psychiatric Triage Diversion program was created to address and minimize inappropriate and/or unnecessary admissions to the county Arrowhead Regional Medical Center inpatient psychiatric unit, as well as provide linkages to an array of community mental health services and supports.

- In FY 2012/13 to FY 2013/14, 7,563 people were screened/assessed by the Triage Diversion Team.
- Of those screened, 82% were diverted from unnecessary hospitalization.

Mental Health Urgent Care Centers *provide an array of mental health crisis services such as screening, assessment, crisis intervention, medication services, referrals, and short-term treatment for adolescents and adults. These centers also provide linkages to services and support.*

SAN BERNARDINO COUNTY *(continued)*

Community Crisis Response Team

The Community Crisis Response Team (CCRT) in San Bernardino County utilizes specially trained mobile crisis response teams to provide crisis interventions, assessments, case management, relapse prevention, medication referrals, and linkage to resources through collaboration with law enforcement, hospitals, Children and Family Services, Adult Protective Services, schools, and other community organizations.

- The CCRT receives over 7,000 calls per year.
- Approximately 60% of the calls received are crisis calls.
- Of those crisis calls, nearly 50% of the clients were diverted from unnecessary hospitalization.
- Only 32% of clients receiving services from CCRT are admitted to a psychiatric inpatient facility within 30 days of the visit.

BUTTE COUNTY

Crisis Stabilization

The Crisis Stabilization Program in Butte County immediately connects individuals 24 hours a day, 7 days a week to a mental health professional for telephone intervention, information or referrals. Walk-in counseling is also available 8:00 am to 5:00 pm for individuals to receive face-to-face crisis intervention and assessment.

An average of 61% of consumers who were in the Crisis Stabilization Program were not admitted to an inpatient setting (Psychiatric Health Facility or out-of-county hospitalization) within the same fiscal year. In the first year of the Crisis Stabilization Program (2008-09), 100 were assisted in alternatives to inpatient care. In 2013-14, the program diverted 515 individuals from hospitalization, a four-fold change within the six fiscal years.

Youth hospitalizations decreased by 75% from July 2008 through June 2014.

Total
Cost Savings
$87,479,568

III. OTHER KEY FINDINGS

Full Service Partnership Programs: Dramatic Cost Savings

The Mental Health Services Oversight and Accountability Commission (MHSOAC) contracted with the University of California, Los Angeles in 2012 to perform a cost analysis of FSP programs in each California county, comparing per-client program expenditures with cost offsets realized through the program. The study reviewed data from two fiscal years: FY 2008/09 and FY 2009/10. The cost offsets are not exhaustive, and they only include reductions in expenditures for:

- Inpatient Psychiatric Hospitalizations
- Long Term Psychiatric Care
- Juvenile Hall and Camp Involvement
- Skilled Nursing Facilities
- Emergency Room Use
- Jail

Total Full Service Partnership Services: Costs and Cost Savings

AGE GROUP	NEW FSP ENROLLEES	TOTAL COST FOR NEW FSP ENROLLEES	TOTAL COST SAVINGS	PERCENT SAVINGS
TAY (16-25)	2,977	$ 18,681,553	$ 27,501,007	147%
Adults (26-64)	4,702	$ 56,212,502	$ 56,120,875	100%
Older Adults (65+)	645	$ 5,325,034	$ 3,857,684	72%
TOTAL	**8,324**	**$80,219,091**	**$87,479,568**	**109%**

IV. MENTAL HEALTH WORKFORCE DEVELOPMENT

When voters passed Proposition 63, they called on California to address the long-standing shortage of qualified mental health workers who reflect the rich array of cultures and ethnicities in our state. A 2008 University of California San Francisco (UCSF) report on the mental health workforce in California found that the vacancy rate for mental health providers in California was 20-25%; these numbers are higher in rural areas.

An influx of new students in the mental health professions will be needed in order to serve a growing number of Californians. In addition, a more diverse mental health workforce is desired in order to better reflect the increasing diversity in California's population.

To build a stronger and more diverse mental health workforce, a 10-year investment of $444.5 million in MHSA funds was set aside for programs to recruit and train employees at all levels. About half ($228 million) of these funds are for local and regional strategies, and the other half ($216.5 million) for statewide approaches.

To attract new people to work in the mental health field, efforts are being made throughout California to recruit high school students into these careers, and offer loan repayment, scholarships, and stipends to people who want to pursue mental health careers. Since FY 2008/09, 4,110 individuals have benefited from a new mental health loan assumption program, and 2,687 graduate students have received stipends to help with the cost of their schooling (1,838 Master's in Social Work students, 474 Master's in Marriage and Family Therapy students, 283 Clinical Psychology PhD students, and 92 psychiatric nurse mental health practitioners).

V. MHSA STATEWIDE HOUSING PROGRAM

The Mental Health Service Act Housing Program was developed to create permanent supportive housing opportunities for Californians with mental illness, who are either homeless or at risk of homelessness. A number of research studies have demonstrated the benefits of permanent supported housing for individuals living with a mental illness including reductions in hospitalizations and improved clinical outcomes.

In 2007, a one-time allocation of $400 million was set aside for a statewide housing program. With interest, the fund has grown to $422.8 million. These program funds are managed by the California Department of Health Care Services and the California Housing Finance Agency.

With 51 counties participating, 82% ($350.8 million) of the MHSA Housing Program funds have been allocated to provide capital loans and long term operating subsidies for the development of affordable rental housing for 2,270 individuals, some of whom are veterans and Transition Age Youth leaving the foster care system. Each county's Department of Behavioral Health provides the tenants with an array of supportive services needed for recovery and the opportunity to become fully functioning community members.

The majority of funding and projects are still in development. It is estimated that the program funds allocated to date will leverage over $2.8 billion dollars for the development of more than 9,000 affordable units in 157 rental housing properties throughout California.

VI. THE EVALUATION PROCESS

The Full Service Partnership outcome data referenced in this report are collected by providers of FSP services. Upon each client's entry into an FSP program, the provider team gathers information on the client's living arrangements, employment/education status, utilization of emergency mental health and substance use services as well as other data for the year prior to the client entering the program. When a client's status changes in any of these areas, that information is entered into a data collection and reporting system.

State regulations for MHSA Community Services and Supports dictate the data that must be collected and reported for each FSP client served and data submitted meets verification criteria.

CBHDA and the Steinberg Institute will update this data on a bi-annual basis for County MHSA programs and expand the analysis to include Prevention and Early Intervention programs which account for 20% of county MHSA dollars.

How Client Progress was Evaluated

35,110 clients were tracked from the year before they received services to one full year after receiving services.

Upon enrollment in an FSP program, a history is taken of each client's living arrangements, hospitalizations, legal involvement, income, employment, and education status, as well as access to healthcare, for the year prior to entering an FSP. As any of those statuses change after enrollment, the FSP provider enters the status change into the state database.

As a result of this data collection approach, the impact of FSP services on the clients served can be clearly tracked and documented.

This information is reported by each county to the Department of Health Care Services (DHCS) and the Mental Health Services Oversight and Accountability Commission (MHSOAC) on an annual basis.

Plans for Updating Data

The County Behavioral Health Directors Association of California and the Steinberg Institute will update this data in six months and annually thereafter.