Issue Paper

Reforming California's Mental Health System

EXECUTIVE SUMMARY

California's mental health system is a partnership involving shared responsibilities between the state and counties. The system is governed by the Short-Doyle Act, enacted in 1957. The act requires the Department of Mental Health to provide leadership in administering, planning, financing, and overseeing mental health services, including local programs. Mental health services are funded primarily from state funds, with a required county match for certain services.

The 1991-92 Governor's Budget *proposes to shift responsibility for funding and administration of local mental health programs to counties, and to increase the vehicle license fee and the alcohol surtax to provide counties with additional revenues that could be used to support these programs.*

Our review indicates the administration's proposal fails to recognize the state's interest in providing cost-effective mental health services in community-based settings. We find that the proposal would continue or exacerbate problems that have been identified in the current system, including (1) fragmented responsibility for patients, (2) counterproductive fiscal incentives, and (3) the lack of a single point of responsibility and accountability for cost-effective service delivery. The proposal also would effectively preempt reforms that have been implemented on a pilot basis in California with impressive results. Accordingly, we recommend that the Legislature reject the proposal.

We identify two options to the Governor's proposal that would allow the Legislature to (1) realize roughly equivalent General Fund savings (about $400 million) through a realignment of mental health programs and (2) implement a series of reforms that would lead to a more accountable and potentially more cost-effective service delivery system.

However, we believe a preferable approach is maintenance of state funding for mental health services and the enactment of various reforms. This would allow programmatic control and funding to be linked, thereby establishing a clear point of accountability for delivering cost-effective services that is consistent with an overriding state interest in the provision of mental health services.

Legislative Analyst's Office *March 26, 1991*

INTRODUCTION

The *1991-92 Governor's Budget* proposes a significant change in the state's mental health programs. Specifically, it proposes to (1) eliminate $432 million in General Fund local assistance for community-based treatment options, (2) transfer responsibility for the funding and operation of local mental health programs to counties, and (3) provide counties with increased revenues from the vehicle license fee and alcohol surtax that could be used to support these programs. The state would continue funding and retain the administrative responsibility for the state hospitals and institutions for mental diseases (IMDs).

The administration's mental health proposal is part of a broader "realignment" of program responsibilities between the state and counties that would, in a similar fashion, transfer funding and administrative responsibility for AB 8 county health programs from the state to counties. This proposal would reduce projected 1991-92 General Fund expenditures by an additional $503 million.

These proposals are a major component of the administration's overall strategy for addressing the state's approximately $10 billion budget funding gap and underlying structural budget problem. They represent about one-sixth of the net $5.4 billion in General Fund expenditure reductions that we estimate the Governor's Budget proposes.

Of the roughly $942 million in new revenues provided to counties under these proposals, about $770 million would result from the proposed increase in vehicle license fees and roughly $172 million would be from the proposed increase in the alcohol tax. The State Constitution requires that vehicle license fee revenues be allocated to local governments. The proposed revenues would be sufficient for counties to fund county health services at the projected budget-year level and mental health services at the current-year level.

In this analysis, we review problems that have been identified in the state's current system for delivering mental health services to the seriously mentally ill, identify various options for reform, and review the fiscal and programmatic implications of the administration's proposal. We then identify alternatives to the administration's proposal that would allow the Legislature to enact the significant reforms we believe are critically needed in the state's mental health care delivery system.

OVERVIEW OF CALIFORNIA'S MENTAL HEALTH SYSTEM

California's mental health system is governed by the Short-Doyle Act, which was originally enacted in 1957. Under the Short-Doyle Act, the state and the counties have specific responsibilities.

State Responsibilities. The Short-Doyle Act requires the Department of Mental Health (DMH) to provide leadership in planning, administering, financing, and overseeing mental health services, including local programs. The DMH also operates state hospitals and provides 100 percent of nonfederal funding for IMDs and board-and-care homes. These programs encompass the major long-term care options for the most chronically disabled county clients. The DMH also administers the Short-Doyle/

Medi-Cal Program, which the budget estimates will provide $130 million in federal funds to offset the cost of treating patients in community settings.

County Responsibilities. Counties are responsible for establishing and maintaining a community-based mental health system. Services include 24-hour care in local facilities, day treatment, short- or long-term counseling, outreach, and case management.

In addition, counties are responsible for submitting a county Short-Doyle plan for DMH approval and operating a quality assurance system that covers all county-operated and -contracted mental health facilities and programs.

Funding Arrangements for Short-Doyle Services

Short-Doyle mental health services are funded primarily from state funds (General Fund and Cigarette and Tobacco Products Surtax Fund) and county matching funds. Inpatient hospital services, including state hospital services, generally are funded 85 percent state/15 percent county. Other services generally are funded 90 percent state/10 percent county. Short-Doyle mental health services are supported from a variety of other funding sources as well, including federal grants, additional county funds above the required matching funds (referred to as "overmatch"), fees collected from patients who are able to pay them, and payments made on behalf of particular clients—for example, by Medicare, Medi-Cal, and insurance.

Categorical Funding. In addition to broad allocations of funds to counties, the Legislature has appropriated funds to serve particular populations with special needs, such as homeless persons and children receiving special education. These "categorical" funds are provided to counties in the same way as other funds; that is, counties must generally provide a 10 percent match.

CONCERNS WITH THE CURRENT SYSTEM

Figure 1 (next page) summarizes four major concerns we have identified with the current mental health system. These are discussed below.

Legislative Mandate Overly Broad

Our review indicates that the Short-Doyle Act's mandate is overly broad, given the limited state resources that have historically been available for local mental health services. The act directs counties to serve persons with a very wide range of illnesses, including those which are temporary and those which are life-long in nature. For example, counties could interpret the act as requiring them to provide mental health services both to persons suffering from acute psychoses involving hallucinations and to persons suffering from job stress.

The effect of the overly broad mandate is that the mental health delivery system lacks explicit goals. This has two implications: (1) counties lack clear expectations from the Legislature regarding the groups of mentally ill persons who should have priority in receiving services, and (2) the department has no clear direction regarding the focus of its oversight function in order to assure that the Legislature's objectives in providing mental health services are realized.

In addition, no data are available that allow the Legislature to review whether state funding is being used efficiently and effectively. Although the DMH collects data from counties on the types of services provided, the number of persons served, and the costs of specific services provided, the data are not comparable between counties and do not measure the effectiveness of

Figure 1

Concerns With the Current Mental Health System

- ***Overly broad legislative mandate*** inhibits accountability for effectiveness in service delivery.
- ***Fragmented system*** results in (1) poor coordination between the state and counties in providing treatment to patients and (2) little effective oversight by the state regarding the cost-effectiveness of county programs.
- ***Current funding arrangements provide counterproductive fiscal incentives*** that (1) restrict county flexibility and (2) result in treatment decisions that conflict with the goals of the Short-Doyle Act.
- ***State funding levels vary widely among counties,*** raising concerns about equity in access to mental health services.

various treatment options provided to the mentally ill.

Due to the overly broad mandate and the serious data limitations, the current system does not allow the Legislature to determine whether the types of services counties are providing (1) represent the most cost-effective approach to delivering treatment services or (2) reflect its priorities for serving mentally ill persons.

A Fragmented System

Our review of California's current array of mental health programs indicates that, since 1968, programs have been patched together in response to service needs and availability of funding. This has resulted in a fragmented system where it is not clear which level of government has overall responsibility for the programs.

For example, the state is responsible for providing services in the most expensive long-term care options for chronically mentally ill patients—state hospitals and IMDs. However, the counties are responsible for providing the types of services that often can reduce the use of these long-term care options, with little effective oversight by the state.

We identify two problems that have resulted from this arrangement.

- *There is little coordination between the state and counties in providing treatment to patients.* Counties appear to have little involvement in programmatic decisions affecting county clients in the state hospitals, or clinical decisions regarding their state hospital patients' readiness for transfer to a community setting. This may partially explain why the department reports that patient stays are routinely extended for substantial lengths of time (sometimes exceeding one year) while awaiting a community placement, and counties express frustration that their patients are kept in state hospitals longer than their patients' illnesses require.
- *The state exercises little effective oversight regarding the cost-effectiveness of county programs.* The Short-Doyle Act requires the department to review the effectiveness of county Short-Doyle plans, but provides little specific authority to review program configurations. As a result, the review process is essentially pro forma, with little attention given to the cost-effectiveness of county resource allocation plans.

Current Funding Arrangements Provide Counterproductive Fiscal Incentives

The funding and resource allocation mechanisms established under the Short-Doyle Act were intended to encourage the least restrictive (that is, the least institutionalized) and least costly treatment options for the mentally ill. Our review indicates that, due to a variety of factors, the present cost-sharing ratios and resource allocation mechanisms restrict county

flexibility with regard to treatment choices and result in treatment decisions that conflict with the goals of the Short-Doyle Act. Following are some examples of how these incentives work.

State Hospital and IMD Beds: Use 'em or Lose 'em. State hospital beds are allocated to counties as a resource for the most severely mentally ill patients. The annual cost for one state hospital bed for county patients is $96,000 (generally funded 85 percent state, 15 percent county). Counties' ability to trade a state hospital bed for additional funds that could be used to expand treatment options in the community has been limited because (1) the DMH generally has been unwilling to approve such trades and (2) such a trade might be financially detrimental to the county over the longer term because funding for the state hospital system has been much more stable in recent years than funding for local programs. Accordingly, in any given year, counties must use their state hospital beds or lose the share of their resources the bed allocation represents.

Similarly, IMD beds for county clients are funded *entirely* through state and federal funds at an annual cost per bed of roughly $21,000, and counties cannot use state IMD funds for other treatment options. Thus, counties have an incentive to utilize IMD beds, whether or not patients they place in that setting could be more appropriately treated in a less restrictive and less costly long-term care treatment alternative.

Incentives Encourage Counties to Place Children in AFDC-Foster Care (AFDC-FC) Group Homes. Services for seriously emotionally disturbed children are often provided in one of two ways. First, counties may place a child in an AFDC-FC group home that provides intensive psychiatric services. Placements in this setting cost an average of $34,000 annually. The system is funded as an entitlement; that is, the state and federal governments reimburse counties for 95 percent of the costs for all children who meet statutory eligibility requirements.

In many cases, the more appropriate treatment approach for these children is a package of mental health treatment services that support them in their home environment, including counseling in school-based settings, family counseling, and other family services. Under the Short-Doyle Act, counties must pay a *10 percent match* to provide mental health services, and the amount of funding available to each county is *capped*.

The effect of these program arrangements is that counties wishing to provide services to as many children as possible effectively pay a financial penalty for utilizing less restrictive and less costly preventive treatment options such as school-based and family services. To the extent that counties choose the more costly and restrictive setting—foster care homes—they are able to obtain essentially *unlimited* state funds for only a *5 percent share* of the total cost. This compares to the 10 percent share and limited funding associated with the less costly, less restrictive options.

This may be one of a variety of factors that has contributed to the dramatic growth in expenditures for foster care group homes in recent years. Between 1983-84 and 1990-91, foster care group home expenditures, including those for seriously emotionally disturbed children, have increased from $139 million to $546 million, an increase of 293 percent. In contrast, state funding for all county mental health programs during the same time period has increased from $317 million to $516 million, for an increase of $199 million, or 63 percent.

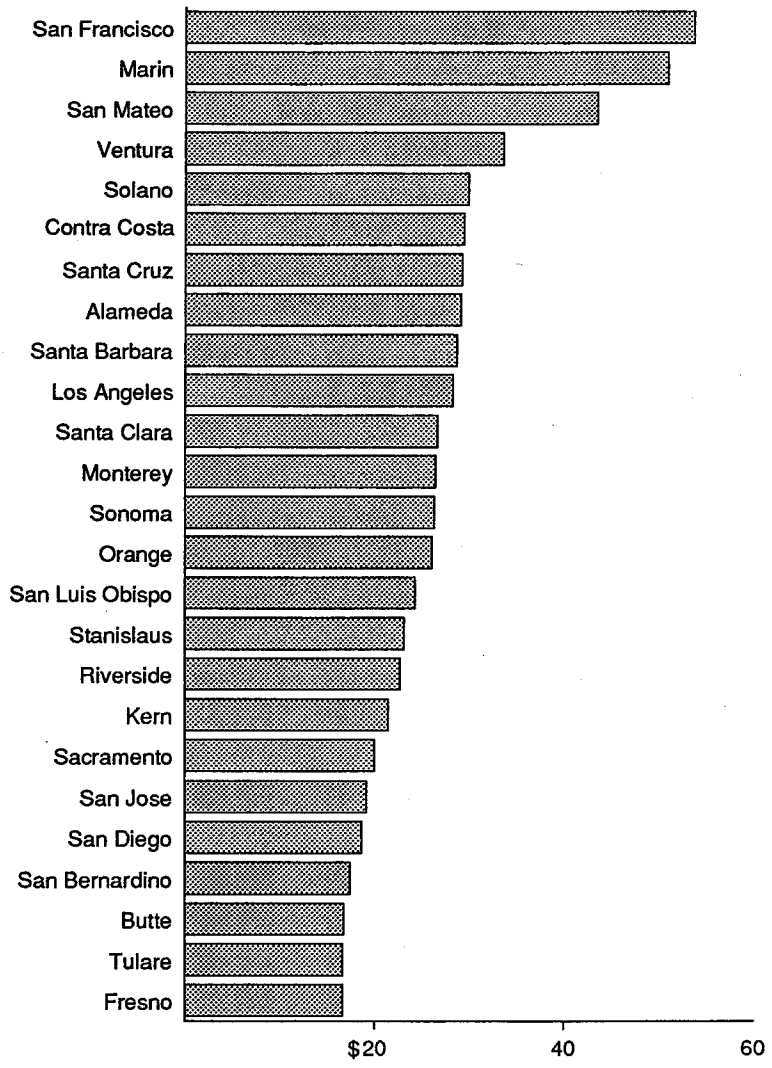
Access to Mental Health Services Varies Widely Among Counties

The amount of state funds allocated for local mental health programs varies widely across counties. The variation is due in large part to the level of county expenditures at the time counties chose to enter the Short-Doyle system. That is, counties that opted into the program earlier generally were spending more per person compared to counties that started later.

Although the Legislature has required that changes in state funding levels be allocated to counties in order to mitigate these varying service levels, progress toward "equity" in funding has been limited. ("Equity" is defined as eliminating variation in resources across counties, given a county's population and its share of the state's poverty population.) Per capita county allocations in the current year, weighted by the poverty level, range from approximately $17 per person (Fresno and Tulare County) to $56 per person (Mono County). Figure 2 shows this variation in funding for the 25 largest counties. The result of the variation in county resources is that access to mental health services varies widely from one county to the next.

Figure 2

Per Capita State-Allocated Resources for County Mental Health Services[a]



[a] Data are for the 25 largest counties in terms of population, and are adjusted for county poverty levels.

WHAT WORKS: PILOT PROGRAMS IN CALIFORNIA AND REFORMS IN COLORADO

In recent years, the Legislature has utilized two strategies for enhancing Short-Doyle mental health services: categorical programs and pilot programs. In addition, the Legislature has (1) established a task force with a broad mandate to identify options by October 1991 for reforming the mental health system, and (2) directed the Departments of Health Services and Mental Health to develop options for revising Medi-Cal services.

In the section that follows, we discuss some alternative structures for delivering mental health services that have been implemented (1) through legislation establishing pilot programs within California and (2) more broadly in Colorado, which is generally considered a leader in the mental health field.

Pilot Programs in California

The Legislature has enacted three major pilot programs to improve the effectiveness of local mental health programs.

Chapter 1207, Statutes of 1983 (SB 900, Maddy), allows the state and counties to negotiate a fixed funding amount for the provision of specified treatment services. Under the "SB 900 process," to the extent counties are able to provide services more cheaply than the negotiated amount, the funds can be "rolled over" into the next fiscal year for mental health-related activities. The Legislature made the SB 900 program permanent in 1990.

Chapter 1361, Statutes of 1987 (AB 377, Wright), and Ch 982/88 (AB 3777, Wright) established pilot programs to test, for children and adults respectively, how communities can more effectively and economically coordinate a comprehensive array of services for seriously mentally ill children and adults. These two pilot programs are designed to provide more structure and accountability in the provision of mental health treatment and support services.

As part of these pilot programs, the state and contractors have developed methods for measuring client outcomes, services, and costs. The results obtained from the projects to date suggest that the framework established for the pilots can dramatically improve the cost-effectiveness of the present system.

For example, the children's pilot program in Ventura County has reported successes on all of the outcome measures incorporated in the program's performance contract with the state. The two most significant outcomes are as follows: (1) the number of arrests after treatment of juvenile offenders has been reduced by roughly half, and (2) Ventura's growth rate for group home placements has been substantially lower than that for the state as a whole. Figure 3 (next page) shows that Ventura County's experience with group home placements has been better than the state's overall experience.

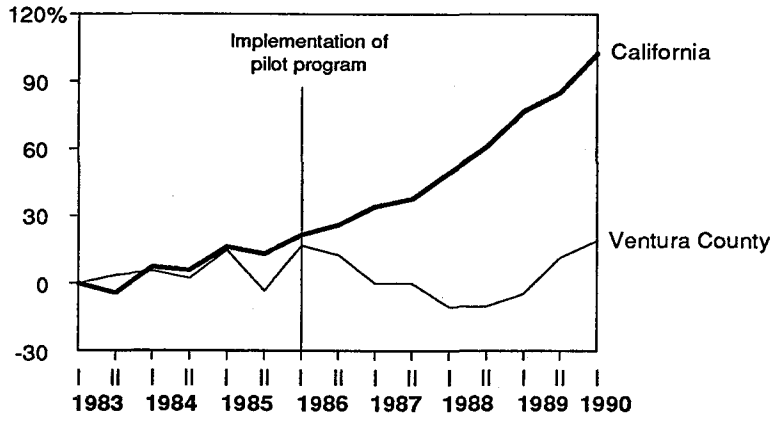
It is unclear which of the specific programming approaches implemented in Ventura and at other pilot program sites are the most effective. However, our review indicates that the broad framework established for the pilot programs points to specific reforms that would improve the delivery of mental health services in California. Specifically, the legislation implementing the pilots ensured that all of the pilot sites would share the following characteristics:

- A single point of responsibility and accountability.
- Clearly defined target populations.
- Specific data collection requirements.

Figure 3

Pilot Program Reduces Growth in AFDC-Foster Care Group Home Placements[a]

Percent change from 1983 level



[a] Data show percent change for each half-year period relative to the first half of 1983. Data for 1986 through 1990 are six-month averages; data for 1983 through 1985 are averages of two months from each period (February and May, September and October).

- Concrete outcome measures.
- Performance-based contracts with the state.
- Financial incentives to prevent costly and restrictive institutional forms of treatment.

Colorado's Experience

Colorado has implemented on a statewide basis an approach for delivering mental health services that incorporates components of (1) the SB 900 process and (2) performance-based contracts with nonprofit organizations (as is the case with some of California's pilot sites for seriously mentally ill adults). In Colorado, the state is responsible for identifying target populations and funding services. Local mental health services are delivered under performance contracts with 19 nonprofit organizations and one county government. Colorado defines explicit performance objectives for service delivery, and has established financial incentives for local mental health service providers to deliver cost-effective services.

For example, local service providers are allocated a specific number of state hospital beds. If the provider uses an amount above its allocation, it must pay the full cost of the placement. If the provider uses less than its allocation, a portion of the state's avoided costs are treated as a credit due to the provider in future years if the Legislature appropriates additional funds for mental health services.

As a comparison to California's approach to providing state hospital services, we reviewed state hospital utilization in Colorado. Colorado has established a system for close coordination between local program administrators and the state hospitals. For example, local mental health program administrators in Colorado are involved in all decisions regarding patient stays and discharges.

This state-local coordination may be one of many potential factors that account for the much lower average length of stay for state hospital patients in Colorado than in California. At the time of our analysis, Colorado reported that roughly 30 of 600 patients, or 5 percent, had been residing in its hospitals for more than six months. In contrast, the DMH reports that of 2,478 county patients in the state hospitals during November 1990, 1,858 patients, or *three-quarters* of the total, had been residing in the hospital for at least six months.

It is important to note that Colorado's per capita expenditures from all sources for public mental health services are slightly less than per capita expenditures for such services in California, which suggests that the Legislature can initiate improvements in the quality of services apart from increasing funding levels. In addi-

tion, we note that Colorado's approach is a variation on similar frameworks implemented on a statewide basis in Ohio, Rhode Island, Vermont, and Wisconsin. Accordingly, the Legislature has evidence that these approaches are workable.

COMMENTS AND RECOMMENDATIONS ON THE ADMINISTRATION'S PROPOSAL

Although the administration's proposal would represent a significant step in addressing the state's structural budget problem and may offer benefits from increased county flexibility, our review indicates that the mental health portion of the proposal, as it is presently formulated, has significant negative aspects. *Accordingly, we recommend that it be rejected.*

We discuss below (1) our findings on the proposal, (2) the principles we believe the Legislature should follow to implement comprehensive reform of the state's mental health system, and (3) alternatives to the proposal that follow those principles and allow for a transfer of funding responsibility to local governments.

Comments on the Proposal

Fiscal Benefits for Counties Uncertain. The Governor's proposal offers a fiscal benefit to counties in that it would provide them with a relatively stable funding source. As Figure 4 indicates, state funding for county mental health programs has varied considerably from year to year over the last 10 years. In contrast, the total vehicle license fee and alcohol tax revenues included in the administration's realignment proposal are not likely to fluctuate significantly from year to year. However, we estimate that the expected growth rate will not be sufficient to maintain current service levels in future years. Accordingly, the proposal is not likely to guarantee current levels of mental health services over the longer term.

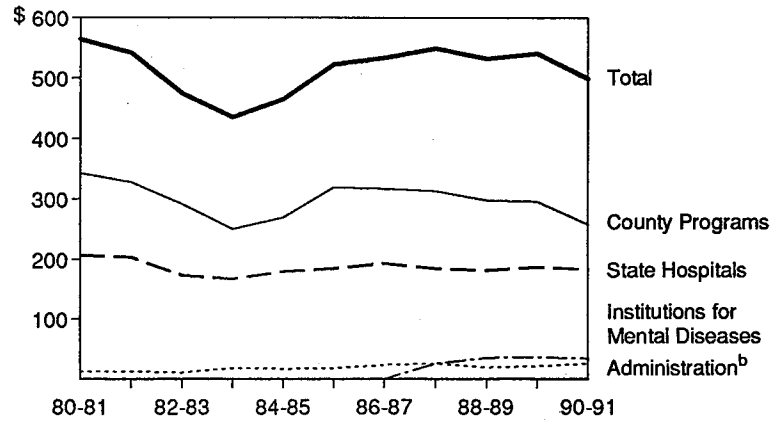
Increase in County Flexibility Unclear. The administration's proposal may result in increased county flexibility, depending on the requirements that are established in the legislation that will be necessary to allocate the vehicle license fee and alcohol tax funds to counties.

On one extreme, the legislation could allow counties to use the revenues for *any* county

Figure 4

California Department of Mental Health Appropriations, by Program

1980-81 through 1990-91 (in millions)[a]



[a] Appropriations adjusted for inflation and population growth since 1980-81.
[b] Includes Conditional Release Program.

programs. In this case, counties would experience major gains in flexibility. However, we note that if the counties wish to continue to receive approximately $130 million in federal Medi-Cal funds, it is unlikely that counties will experience significantly greater flexibility in operating their mental health programs than the Short-Doyle Act already allows. This is because provisions in federal law require "statewideness" (that is, services must be consistently available throughout the state), quality assurance programs, and various additional standards to be maintained for programs where costs are being offset with federal funds.

Alternatively, the legislation could eliminate categorical program requirements. Our review indicates that the benefit from increased flexibility that would result in this case is somewhat limited. The majority of counties have funding needs that exceed the amount they are required to spend for services to specific populations. For example, most urban counties report funding needs for services to the homeless mentally ill that exceed the categorical level they are allocated for such services. In addition, the proportion of county allocations earmarked for specific purposes is fairly small. In the current year, categorical programs only represent roughly 10 percent of total state funding for county mental health programs.

Proposal Would Not Protect State's Interest in Ensuring Effective Mental Health Programs. Our review indicates that the state has an interest in ensuring effective mental health programs for two reasons.

First, to the extent that service levels vary widely from one local jurisdiction to another, there are significant concerns regarding (1) equity in access to a minimum level of service for citizens, regardless of where they happen to live, and (2) the possibility that local governments offering enhanced services will be burdened by "migration" from jurisdictions offering more limited services. Concerns regarding migration are especially significant in the case of mental health services because of the geographically mobile nature of the seriously mentally ill population.

At the time of this analysis, it was unclear how or whether the administration's proposal would seek to ensure minimum service levels across counties.

Second, very seriously mentally ill persons who do not receive treatment can become dangerous to themselves and to others, due to the nature of severe mental illnesses. Mental health and law enforcement professionals have long contended that severely and chronically mentally ill persons who do not receive effective treatment in hospital and community-based settings frequently become incarcerated in jails and prisons. This hypothesis has not been proven. Several studies, however, have presented data that appear to offer strong support for it. For example, studies attempting to quantify the incidence of serious mental illness among jail and prison inmates have consistently found prevalence rates that exceed the rate that would be expected in the general population for those illnesses.

The administration's proposal, in our view, is not consistent with a view that the state holds an overriding interest in ensuring effective mental health programs because responsibility would be transferred to counties. Specifically, enactment of the administration's proposal would:

- Be inconsistent with the Legislature's recent efforts at implementing system reforms that may lead to better care for patients in a more cost-effective manner.
- Make permanent, for all intents and purposes, the existing system's lack of a single point of responsibility and accountability for effective delivery of mental health services.
- Preclude statewide replication of the framework that has produced impressive results in California's pilot programs and in other states such as Colorado.

Fragmented Responsibility for Patients Would Continue. The administration's proposal would also continue the fragmented responsibility for patients that characterizes the current system. Under the proposal, the state would continue to have responsibility for two of the three long-term care options, while the counties would assume complete responsibility for serving patients in the community. The administration's proposal does not address how it would resolve the problems we identified earlier in this analysis that result from program fragmentation. These include (1) poor coordination between the state and counties in providing treatment to patients and (2) little effective oversight regarding the cost-effectiveness of county programs.

Proposal Establishes Counterproductive Fiscal Incentives. The administration's proposal would exacerbate the existing counterproductive fiscal incentives we discussed earlier in this analysis. Under the proposal, county costs for the most expensive and institutionalized forms of treatment would continue to be 15 percent of total costs for state hospitals and zero for treatment provided in IMDs. (In addition, placements in AFDC-FC group homes for children would continue to be available as an entitlement with a 5 percent county match.) At the same time, county costs for community-based services, which are less restrictive, generally more cost-effective, and used to *prevent* the need for institutionalized placements in the first place, could only be provided at 100 percent county expense.

Consequently, rather than encouraging alternatives to costly and restrictive institutionalized placements in state hospitals, IMDs, and foster care group homes, the budget proposal's financial incentives would encourage such placements. Over time, then, the administration's proposal would likely result in increased public costs for providing mental health services and additional General Fund pressures at the state level to expand state hospitals, IMDs, and AFDC-FC group homes.

The administration's proposal, in our view, is not consistent with a view that the state holds an overriding interest in ensuring effective mental health programs. It would also make permanent, for all intents and purposes, the existing system's lack of a single point of responsibility and accountability.

Uncertainties. Several aspects of the administration's proposal were not clear at the time of this analysis. For example, it is unclear (1) whether the administration proposes a mechanism to ensure minimum service levels across counties, (2) how the proposal would provide for movement towards equity in funding levels across counties as vehicle license fee revenues increase over time, and (3) how the state will continue to receive $130 million in federal Medi-Cal funds for community-based treatment.

Irrespective of how these issues are addressed, we find that on balance, the proposal would result in serious fiscal and programmatic problems.

Rather than encouraging alternatives to costly and restrictive institutionalized placements, the budget proposal's financial incentives would encourage such placements.

PRINCIPLES AND RECOMMENDATIONS TO GUIDE REFORM

Given a state interest in ensuring effective mental health services, and based on the preceding discussions of (1) problems with the current mental health delivery system and the administration's proposal and (2) the strengths of California's pilot programs and programs in other states, we believe the following principles would assist the Legislature in implementing needed reforms:

- *Make it Clear.* Establishing clear system goals and specific target populations ensures that (1) all levels of government know what is expected of them and (2) the Legislature's priorities for delivering mental health services are implemented consistently across the state. California's pilots require that first priority for community-based mental health services be given to seriously mentally ill persons (1) who are at greatest personal risk, (2) who are a public responsibility, and (3) for whom alternative treatment options would be the most costly.
- *Put Someone in Charge.* Mental health delivery systems that place final authority for programmatic direction at a single level of government have demonstrated success in achieving results. We believe programmatic control and funding should be linked. Our review indicates this is a crucial step in order for the Legislature to ensure accountability.

- *Allow Flexibility—Expect Results.* Many successful programs allow those responsible for delivering services at the local level some flexibility in determining what specific treatment options they wish to implement. However, local program administrators remain responsible for demonstrating clear standards for service delivery and for achieving results. This approach allows the Legislature to balance the value it has placed on local innovation with the need to ensure that state funds are used effectively.

- *Make Better Services Cheaper to Provide.* Through incentives for avoiding acute hospitalization and amendments in their state Medicaid plans, several states have developed fiscal incentives that are in line with sound programmatic approaches. Appropriate fiscal incentives allow the Legislature to rely on the cost of services to help it achieve programmatic results.

- *Expect People to Work Together.* Children and adults with serious mental illnesses generally have other health and social service needs. They enter the public social welfare system through schools; county welfare, health, and mental health departments; and the courts. A successful system needs to require formal interagency collaboration to combine resources and to ensure that mentally ill persons meeting target population definitions receive mental health services.

- *Establish Regional Agencies When Appropriate.* An efficient system must allow for regional service delivery to maximize economies of scale. Colorado has 20 regional "catchment areas," of which only one is a single county. We believe this is especially important in California, given that county populations range from 1,200 in Alpine to 8 million in Los Angeles.

- *Get Results.* California's pilots and other states have established concrete outcome measures that are closely linked to their target populations. For example, for the children's pilot program, the target population includes those seriously emotionally disturbed children who are at risk of (1) being separated from their families, (2) dropping out of school, or (3) going to jail. Accordingly, the outcome measures used to evaluate the pilot's success include whether the pilot has significantly reduced (1) out-of-home placements, (2) school drop-out rates, and (3) jail "recidivism." In addition, the pilot sites are required to collect data that link service costs and outcomes in order to track the cost-effectiveness of treatment strategies. A results-oriented system not only benefits clients but establishes a mechanism for achieving accountability and cost-effectiveness.

Reforms Should Be Implemented Now

Whether or not the Legislature includes mental health programs in a state-county realignment, we recommend that the Legislature enact legislation to implement comprehensive reform of the current mental health delivery system. Specifically, based on the principles we have identified above, *we recommend that the programmatic framework established under the pilot programs be enacted on a statewide basis.*

Given the state's interest in ensuring effective mental health services, such legislation should identify the DMH as having final responsibility for ensuring effective mental health services in the state. To accomplish this, we recommend that the legislation specify (1) clear target populations, (2) detailed data collection requirements, and (3) concrete outcome measures. The legislation should also require case management services for mentally ill persons fitting the target population definition. This will ensure a single point of responsibility for coordinating services at the local level for every patient. These recommendations are consistent with the findings of the pilot projects, the experience of other states, and our observations in site visits to various counties.

In addition, we recommend that the legislation modify and expand the SB 900 contract framework, which provides fiscal incentives to provide appropriate services in the least expensive manner possible. We recommend that the reform legislation modify the SB 900 framework to require *performance-based* contracts with all counties in the state, based on specific target populations and outcome measures contained in the legislation.

Legislation with these components would (1) give clear legislative direction regarding priorities for mental health service delivery, (2) allow the Legislature to hold the DMH accountable for effective mental health services throughout the state, (3) ensure a clear point of responsibility at the county level for integrated service delivery to each patient, and (4) give counties a financial incentive to provide cost-effective services. This approach also would maintain the Legislature's ability to move toward equity among counties over time, and make further reforms based on data showing which program configurations produce desired results.

REALIGNMENT ALTERNATIVES

If, in light of the state's structural budget problem, the Legislature chooses to include mental health programs in a state-county realignment to achieve General Fund savings of roughly the amount proposed by the administration, we have identified two options that the Legislature may wish to consider in lieu of the administration's proposal. These options would allow the Legislature to avoid most of the serious programmatic and fiscal problems we have identified above. Both options would involve:

- Increasing county costs for mental health programs.
- Offsetting such costs with the revenues that are incorporated in the administration's proposal.
- Maintaining a significant level of state funding for community-based programs in order to implement the broader system reforms we have recommended.

We discuss these options below.

Transfer Funding for 24-Hour Care Services

First, the Legislature could transfer to counties responsibility for 24-hour care and case management services. Specifically, the budget proposes the following expenditures that could be incorporated in a transfer to counties to achieve General Fund savings:

- $322.6 million for state hospitals and the IMDs.
- $3.7 million for case management services.
- $18.4 million for the board-and-care home supplemental rate program. Of this amount, $16.6 million is incorporated in the administration's realignment proposal.
- At least $50 million for 24-hour care provided in acute county hospitals, also incorporated in the administration's proposal.

A transfer of these program costs would result in a General Fund savings of at least $394.7 million for 1991-92.

This option would provide fiscal incentives for counties to deliver the least restrictive and less expensive mental health services. This is because counties would pay only 10 percent of the costs for providing community-based treatment, while they would incur 100 percent of the costs for providing treatment in institutional settings.

However, enacting this option would create fiscal disincentives for counties to deliver institutional care to patients who may require that type of care. To counteract this, the Legislature could require that the transferred funds be earmarked for the purpose of providing acute 24-hour care, long-term care, or case management services for seriously mentally ill patients. This would not create a mandate under the State Constitution as long as no specific service levels are imposed, and would ensure that current funding levels for long-term care would be maintained within the state.

required sharing ratios for most counties range from zero for IMD placements to 15 percent for 24-hour hospitalization. However, the Legislature could increase the sharing ratios to require a 50 percent county match for *all* mental health services. Based on proposed expenditures for 1991-92 (including those incorporated in the administration's proposed transfer), this option would result in General Fund savings of approximately $391.5 million in 1991-92 (roughly the amount proposed by the administration).

Given the state's interest in ensuring sound, cost-effective mental health programs and the importance of linking programmatic direction with funding responsibility, we believe it would be preferable for the Legislature not to transfer mental health programs to the counties.

Finally, by incorporating case management in the transfer, to the extent counties may be able to reduce costs for institutional 24-hour and long-term care through additional case management services, they would retain the flexibility to do so.

Require a 50 Percent County Match for All Mental Health Services

Alternatively, the Legislature could enact changes in the current sharing ratios for mental health services. Under current law and practice,

Under this option, the Legislature could require that the transferred funds be expended only for the purposes of providing mental health services in accordance with county performance contracts. In addition, the Legislature could allow counties to purchase on an annual basis the number of state hospital, IMD, and board-and-care home beds they require for long-term care.

This option would establish programmatically sound fiscal incentives because counties would incur the proportionate cost of various treat-

ment options for the mentally ill. The Legislature could also ensure, as part of this option, that current service levels for the delivery of mental health services are maintained throughout the state. It is important to note, however, that to the extent the Legislature might in the future appropriate additional funds for mental health services in excess of the roughly 5 percent to 7 percent annual growth rate for the revenue sources proposed for transfer, this option may require the Legislature to fund 100 percent of county costs specifically associated with any such program growth due to the mandate provisions of the State Constitution.

Conclusion

Adoption of either of these options would allow the Legislature to enact the specific reforms we have identified and would lead to improvements relative to the current system. However, it is important to note that both of these options would transfer some degree of funding responsibility to counties, due to the legal requirement that vehicle license fee revenues be distributed to local governments.

Given the state's interest in ensuring sound, cost-effective mental health programs and the importance of linking programmatic direction with funding responsibility, we believe it would be preferable for the Legislature *not* to transfer mental health programs to the counties. Rather, we believe the Legislature should (1) maintain state funding for all components of the mental health system and (2) enact reforms to establish:

- A clear mandate for mental health programs.
- A single point of responsibility and accountability for effective service delivery.
- Performance-based contracts for local service delivery.
- Additional flexibility for counties in providing 24-hour long-term care services to the chronically mentally ill.

This approach would lead to the more comprehensive changes we believe are warranted. ❖

This Issue Paper was prepared by Bill Wehrle under the direction of Donna Watkins Olsson and Carol Bingham, (916) 445-6061. It is based on a discussion that originally appeared in the Analysis of the 1991-92 Budget Bill. *For additional copies, contact the Legislative Analyst's Office, State of California, 925 L Street, Suite 610, Sacramento, California, 95814, (916) 445-2375.* ❖