Capitol Coalition Briefing Book

A Guide to the California Mental Health System

Prepared by NAMI California Legislation and Public Policy Department
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Introduction
This briefing book is designed to give an advocate in the mental health field a basic understanding of the funding sources for mental health in California, the agencies responsible for service delivery and capital projects, and the legislative process.

This book is to serve the NAMI California Capitol Coalition, a pool of committed advocates from around the state who wish to engage in advocacy at the state level. The purpose of the Capitol Coalition is to participate in important stakeholder processes, lend support for legislative efforts, and represent the viewpoint of clients and family/caregiver/providers. Working with NAMI California, the Coalition will bring informed, cogent feedback to stakeholder opportunities, and assist with the goal of better outcomes for those with mental health challenges and their loved ones.

The information contained in this book will give the reader an understanding of the various entities within the mental health systems of California and how they interact, detail their purpose, and place in perspective their impact on the delivery of mental health services. By describing the landscape, it is hoped that the reader will gain confidence in their advocacy efforts.
What is MHSA?

The passage of Proposition 63 (now known as the Mental Health Services Act or MHSA) in November 2004, provided the first opportunity in many years for the California Department of Mental Health (DMH) to provide increased funding, personnel and other resources to support county mental health programs and monitor progress toward statewide goals for children, transition age youth, adults, older adults and families. The Act addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support this system.

This Act imposes a 1% income tax on personal income in excess of $1 million. Statewide, the Act was projected to generate approximately $254 million in fiscal year 2004-05, $683 million in 2005-06 and increasing amounts thereafter. Much of the funding will be provided to county mental health programs to fund programs consistent with their local plans. Any uncommitted funds during FY 2005-06 will be used to establish county prudent reserve accounts as required by the Act.

To provide for an orderly implementation of MHSA, DMH (now within Department of Health Services - DHCS) planned for sequential phases of development for each of the six components of the Act. An extensive stakeholder process is being employed to inform the state’s implementation efforts. Improvement in client outcomes is a fundamental expectation throughout the implementation process.

Within the act, the Mental Health Services Oversight and Accountability Commission (MHSOAC) oversees the Adults and Older Adults Systems of Care Act; Human Resources; Innovative Programs; Prevention & Early Intervention Programs; and the Children’s Mental Health Services Act. The Commission replaced the advisory committee which had been established pursuant to Welfare and Institutions Code Section 5814.

The Mental Health Services Oversight and Accountability Commission (MHSOAC)

Section 10 of the MHSA (Welfare and Institutions Code Section 5845) established the Mental Health Services Oversight and Accountability Commission (MHSOAC) and defined the creation and composition of the Commission.

The role of the MHSOAC is to oversee the implementation of the Mental Health Services Act (MHSA). The MHSOAC is also responsible for developing strategies to overcome stigma. At any time, the MHSOAC may advise the Governor or the Legislature on mental health policy.

In the past, the MHSOAC has been responsible for review and approval of county plans for the Prevention & Early Intervention (PEI) and Innovation Program components of the MHSA. After the passage of AB100 in March 2011, the role of the Commission shifted from review and approval of county plans to providing training and technical assistance for county mental health planning as needed. Additionally, the Commission evaluates MHSA-funded programs throughout the State. When AB 1467 passed in June 2012, the MHSOAC’s role of training and technical assistance and evaluation expanded; approval of county Innovation plans by the MHSOAC was also reinstated. Each county is responsible for developing a roster of mental health services and detail their purpose, execution and funding within a
3–year plan. The MHSOAC receives all county 3-year plans, annual updates, and annual Revenue and Expenditure Reports.

The Mission Statement from the MHSOAC:

Provide vision and leadership, in collaboration with clients, their family members, and underserved communities, to ensure Californians understand mental health is essential to overall health. Hold public mental health systems accountable. Provide oversight for eliminating disparities; promote wellness, recovery and resiliency; and ensure positive outcomes for individuals living with serious mental illness and their families.

The Committees of the MHSOAC

The following are the various committees of the MHSOAC. Each committee has a specific perspective and charge. Capitol Coalition members are encouraged to participate in stakeholder opportunities with committees that most closely match their interests.

Client and Family Leadership Committee - Ensure the perspective and participation of diverse community members who have lived experience of severe mental health issues, including their parents/caregivers and family members. This committee most closely aligns with the perspective of clients and family/caregiver/providers.

Cultural and Linguistic Competence Committee - Ensure the perspective and participation of members of racial, ethnic, and cultural communities, are significant factors in all MHSOAC decisions and recommendations. This committee is in charge of cultural competence efforts as well as addressing unserved and underserved communities.

Evaluation Committee - Provide input, assistance, and advice as needed in the finalization of the MHSOAC Evaluation Master Plan, work being done and recommendations made by evaluators. This committee is charged with measuring the efficacy and effectiveness of MHSA programming throughout the system.

Financial Oversight Committee - Provide reports, proposed policies and recommendations regarding anticipated MHSA revenue cycles, as well as strategies and roadmaps to expand services by timely expenditure and leveraging of MHSA funds. This committee provides financial oversight and planning for the entire system.

MHSOAC Services Committee - Ensure compliance with State Welfare and Institutions Code (WIC) Sections 5846 and 5847. This committee works most closely with the Department of Health Care Services (DHCS) is defining programs and services within the system.
MHSA Service Delivery Components Explained

Proposition 63, also known as the Mental Health Services Act (MHSA), is made up of 5 components; Community Services and Supports, Prevention & Early Intervention, Innovation, Capital Facilities and Technological Needs, and Workforce Education and Training.

Community Services and Support

Community Services and Supports (CSS) is the largest component of the MHSA. The CSS component is focused on community collaboration, cultural competence, client and family driven services and systems, wellness focus, which includes concepts of recovery and resilience, integrated service experiences for clients and families, as well as serving the unserved and underserved. Housing is also a large part of the CSS component.

Prevention & Early Intervention

The MHSA controls funding approval for the Prevention & Early Intervention (PEI) component of the MHSA. The goal of Prevention & Early Intervention is to help counties implement services that promote wellness, foster health, and prevent the suffering that can result from untreated mental illness. The Prevention & Early Intervention component requires collaboration with consumers and family members in the development of PEI projects and programs.

Innovation

The MHSA controls funding approval for the Innovation (INN) component of the MHSA. The goal of Innovation is to increase access to underserved groups, increase the quality of services, promote interagency collaboration and increase access to services. Counties select one or more of the above mentioned goals and use those goals as the primary priority or priorities for their proposed Innovation plan.

Capital Facilities and Technological Needs

The Capital Facilities and Technological Needs (CFTN) component works towards the creation of a facility that is used for the delivery of MHSA services to mental health clients and their families or for administrative offices. Funds may also be used to support an increase in peer-support and consumer-run facilities, development of community-based settings, and the development of a technological infrastructure for the mental health system to facilitate the highest quality and cost-effective services and supports for clients and their families.

Workforce Education and Training

The goal of the Workforce Education and Training (WET) component is to develop a diverse workforce. Clients and families/caregivers are given training to help others by providing skills to promote wellness and other positive mental health outcomes, they are able to work collaboratively to deliver client-and family-driven services, provide outreach to unserved and underserved populations, as well as services that are linguistically and culturally competent and relevant, and include the viewpoints and expertise of clients and their families/caregivers.
The Department of Health Care Services (DHCS)

The mission of the California Department of Health Care Services (DHCS) is to provide low-income Californians with access to affordable, high-quality health care, including medical, dental, mental health, substance use disorder services, and long-term services and supports. DHCS’ mission is to preserve and improve the physical and mental health of all Californians. DHCS works closely with federal officials, health care professionals, legislators, county governments, and health plans to provide an accessible health care safety net for individuals in need.

DHCS programs serve nearly 9.2 million Californians. One in five people in the state receive health care services financed or organized by DHCS, making the department the largest health care purchaser in California. DHCS invests more than $70 billion in public funds to provide health care services for low-income families, children, pregnant women, seniors, and persons with disabilities, while helping to maintain the health care delivery safety net.

Mental Health Services Becomes a Division of DHCS

AB 102, which Governor Brown signed into law on June 28, 2011, requires the transfer of Medi-Cal-related mental health functions from the Department of Mental Health (DMH) to the Department of Health Care Services (DHCS) by July 1, 2012. This is not a change in mental health benefits or eligibility. Medi-Cal-related mental health functions are now handled by the Mental Health Services Division (MHSD) of DHCS.

Each county is responsible for developing a roster of mental health services and detail their purpose, execution and funding within a 3-year plan. In accordance with the Department of Health Care realignment, the DHCS approves county three-year implementation plans, upon comment from the MHSOAC and passes programmatic responsibilities to the counties. In the first few months immediately following its passage, the DMH has:

- Obtained federal approvals and Medi-Cal waivers, State authority, additional resources and technical assistance in areas related to implementation
- Established detailed requirements for the content of local three year expenditure plans
- Developed criteria and procedures for reporting of county and state performance outcomes
- Defined requirements for the maintenance of current State and local efforts to protect against supplanting existing programs and their funding streams
- Developed formulas for how funding will be divided or distributed among counties
- Determined how funding will flow to counties and set up the mechanics of distribution
- Established a 16 member Mental Health Services Oversight and Accountability Commission (MHSOAC), composed of elected State officials and Governor appointees, along with procedures for MHSOAC review of county planning efforts and oversight of DMH implementation
- Developed and published regulations and provide preliminary training to all counties on plan development and implementation requirements

The DMH has directed all counties to develop plans incorporating five essential concepts:

- Community Collaboration
- Cultural Competence
• Client/family-driven mental health system for older adults, adults and transition age youth and family-driven system of care for children and youth
• Wellness focus, which includes the concepts of recovery and resilience
• Integrated service experiences for clients and their families throughout their interactions with the mental health system

The Office of Statewide Health Planning and Development (OSHPD)
The Office of Statewide Health Planning and Development (OSHPD) was created in 1978 to provide the State with an enhanced understanding of the structure and function of its healthcare delivery systems. Since that time, OSHPD's role has expanded to include direct delivery of various services designed to promote healthcare accessibility within California. OSHPD is the leader in collecting data and disseminating information about California's healthcare infrastructure, promoting an equitably distributed healthcare workforce, and publishing valuable information about healthcare outcomes.

OSHPD also monitors the construction, renovation, and seismic safety of hospitals and skilled nursing facilities and provides loan insurance to facilitate the capital needs of California’s not-for-profit healthcare facilities. These programmatic functions are distributed across five divisions and one foundation, are advised by five boards and commissions, and are supported by the Office’s Administrative Services Division.

California Mental Health Planning Council (CMHPC)
The California Mental Health Planning Council is mandated by federal and state statute to advocate for children with serious emotional disturbances and adults and older adults with serious mental illness, to provide oversight and accountability for the public mental health system, and to advise the Administration and the Legislature on priority issues and participate in statewide planning.

Vision Statement

The CMHPC envisions a mental health system that makes it possible for individuals to lead full and productive lives. The system incorporates public and private resources to offer community-based services that embrace recovery and wellness. The services are client and family driven, responsive, timely, culturally competent, and accessible to all of California’s populations.

Mission Statement

The CMHPC evaluates the mental health system for accessible and effective care. It advocates for an accountable system of responsive services that are strength-based, recovery-oriented, culturally competent, and cost-effective. To achieve these ends, the Council educates the general public, the mental health constituency, and legislators.
California Mental Health Services Authority (CalMHSA)

CalMHSA’s impetus is evolving as we provide counties an independent administrative and fiscal intergovernmental structure for jointly developing, funding, and implementing mental health services and educational programs at the state, regional, and local levels.

As an on-going efficient delivery mechanism for statewide and other California mental health projects, a central component of CalMHSA’s vision is to continually promote systems and services arising from a commitment to community mental health, and to the values of the California Mental Health Services Act.

Vision

CalMHSA serves California Counties and Cities in the dynamic delivery of mental health and supportive services. A nationally recognized leader, CalMHSA inspires the service community through its commitment to results and values. Successful statewide and regional programs enable the voice of many to be heard.

Purpose

Promoting Efficiency, Effectiveness and Enterprise among Counties and Cities

Mission

The mission of CalMHSA is to provide member counties a flexible, efficient, and effective administrative/fiscal structure focused on collaborative partnerships and pooling efforts in:

- Development and implementation of common strategies and programs
- Fiscal integrity, protections, and management of collective risk
- Accountability at state, regional, and local levels

The MHSOAC approved a combined funding level of $40 million per year for four years for these projects:

- Suicide Prevention (SP) $10 million per year (25%)
- Stigma and Discrimination Reduction (SDR) $15 million per year (37.5%)
- Student Mental Health Initiative (SMHI) $15 million per year (37.5%)

The Office of Health Equity (OHE)

The Office of Health Equity (OHE) was established, as authorized by Section 131019.5 of the California Health and Safety Code to provide a key leadership role to reduce health and mental health disparities to vulnerable communities.

Comprised of three units, Community Development and Engagement Unit, Policy Unit, and Health Research and Statistics Unit, OHE will include a Deputy Director, who is appointed by the Governor or the State Public Health Officer, and is subject to confirmation by the Senate. The Deputy Director of the OHE will report to the Director at CDPH and work closely with the Director of Health Care Services.
A priority of this groundbreaking office will be the building of cross-sectoral partnerships. The work of OHE will be directed through their advisory committee and stakeholder meetings. The office will consult with community-based organizations and local governmental agencies to ensure that community perspectives and input are included in policies and any strategic plans, recommendations, and implementation activities.

Aligning state resources, decision making, and programs, OHE will accomplish all the following:

- Achieve the highest level of health and mental health for all people, with special attention focused on those who have experienced socioeconomic disadvantage and historical injustice, including, but not limited to, vulnerable communities and culturally, linguistically, and geographically isolated communities.
- Work collaboratively with the Health in All Policies Task Force to promote work to prevent injury and illness through improved social and environmental factors that promote health and mental health.
- Advise and assist other state departments in their mission to increase access to, and the quality of, culturally and linguistically competent health and mental health care and services.
- Improve the health status of all populations and places, with a priority on eliminating health and mental health disparities and inequities.

Duties of OHE include, but are not limited to, the following:

- Establish a comprehensive, cross-sectoral strategic plan to eliminate health and mental health disparities (updated every two years).
- By October 1, 2013, establish an advisory committee.
- Establish an interagency agreement between the State Department of Public Health and the Department of Health Care Services to outline the process by which the departments will jointly work to advance the mission of the OHE.
- Conduct demographic analyses on health and mental health disparities and equities (updated periodically, but not less than every two years).
- Build upon and inform the work of the Health in All Policies Task Force.
- Assist and consult with state and local governments, health and mental health providers, community-based organizations and advocates, and various stakeholder communities.

California Health Facilities Financing Authority CHFFA
Investment in Mental Health Wellness Act of 2013

The Investment in Mental Health Wellness Act of 2013 establishes a new grant program to disburse funds to California counties or to their nonprofit or public agency designates for the purpose of developing mental health crisis support programs. Specifically, funds will “increase capacity for client assistance and services in crisis intervention, crisis stabilization, crisis residential treatment, rehabilitative mental health services, and mobile crisis support teams.” The grants from the California Health Facilities Financing Authority (CHFFA) will support capital improvement, expansion and limited start-up costs.
The California Mental Health Directors Association (CMHDA)
The California Mental Health Directors Association (CMHDA) is a non profit advocacy association representing the mental health directors from each of California's 58 counties, as well as two cities (Berkeley and Tri-City).

AB 109 (Realignment)
AB 109 shifts the responsibility for incarcerating many low-risk inmates from the state to counties. This shift from state to county is also being called “prison realignment.” As part of this law, the state will continue to incarcerate offenders who commit serious, violent, or sexual crimes, but the counties will supervise, rehabilitate and manage low-level offenders. Up to 30,000 state prison inmates could be transferred to county jails over three years, under the bill. Alternatives include transferring some offenders to other jurisdictions, diverting nonviolent inmates to jails and reforming parole so that fewer violators are returned to prison.

Prior to Realignment, more than 60,000 felon parole violators returned to state prison annually, with an average length of stay of 90 days. On September 30, 2011, the felon parole violator population was 13,285; by the end of November 2013, that population was down to 25 due to the fact that most felon parole violators now serve revocation time in county jail.

Under Realignment, newly-convicted low-level offenders without current or prior serious or violent offenses stay in county jail to serve their sentence; this has reduced the annual admissions to less than 36,000 a year. Prior to Realignment, there were approximately 55,000 to 65,000 new admissions from county courts to state prison.

Overall, the diversion of low-level offenders and parole violators to county jail instead of state prison since October 2011 has resulted in a population decrease of about 25,000.

NAMI Public Policy – Realignment/Justice System
Humane and effective treatment for serious mental illnesses while in correctional settings is the constitutional right of inmates with severe mental illnesses. NAMI California strongly urges the enactment of state statutes expanding treatment programs within prison and jail settings, including first line access to new generation medications whenever clinically indicated.

NAMI California endorses state laws and policies establishing systems of community treatment for offenders with serious mental illnesses who are released on parole and/or are in the community on probation or parole status.

Jail Diversion
NAMI California believes that persons who have committed offenses due to states of mind or behavior caused by a serious mental illness do not belong in penal or correctional institutions. Such persons require treatment, not punishment. A prison or jail is never an optimal therapeutic setting.

NAMI California supports a variety of approaches to diverting individuals from unnecessary incarceration into appropriate treatment, including pre-booking (police-based) diversion, post-booking
court-based) diversion, alternative sentencing programs, and post-adjudication diversion (conditional release).

OVERVIEW OF LEGISLATIVE PROCESS
The process of government by which bills are considered and laws enacted is commonly referred to as the Legislative Process. The California State Legislature is made up of two houses: the Senate and the Assembly. There are 40 Senators and 80 Assembly Members representing the people of the State of California. The Legislature has a legislative calendar containing important dates of activities during its two-year session.

Idea
All legislation begins as an idea or concept. Ideas and concepts can come from a variety of sources. The process begins when a Senator or Assembly Member decides to author a bill.

The Author
A Legislator sends the idea for the bill to the Legislative Counsel where it is drafted into the actual bill. The draft of the bill is returned to the Legislator for introduction. If the author is a Senator, the bill is introduced in the Senate. If the author is an Assembly Member, the bill is introduced in the Assembly.

First Reading/Introduction
A bill is introduced or read the first time when the bill number, the name of the author, and the descriptive title of the bill is read on the floor of the house. The bill is then sent to the Office of State Printing. No bill may be acted upon until 30 days has passed from the date of its introduction.

Committee Hearings
The bill then goes to the Rules Committee of the house of origin where it is assigned to the appropriate policy committee for its first hearing. Bills are assigned to policy committees according to subject area of the bill. For example, a Senate bill dealing with health care facilities would first be assigned to the Senate Health and Human Services Committee for policy review. Bills that require the expenditure of funds must also be heard in the fiscal committees: Senate Appropriations or Assembly Appropriations. Each house has a number of policy committees and a fiscal committee. Each committee is made up of a specified number of Senators or Assembly Members.

During the committee hearing the author presents the bill to the committee and testimony can be heard in support of or opposition to the bill. The committee then votes by passing the bill, passing the bill as amended, or defeating the bill. Bills can be amended several times. Letters of support or opposition are important and should be mailed to the author and committee members before the bill is scheduled to be heard in committee. It takes a majority vote of the full committee membership for a bill to be passed by the committee.
Each house maintains a schedule of legislative committee hearings. Prior to a bill's hearing, a bill analysis is prepared that explains current law, what the bill is intended to do, and some background information. Typically the analysis also lists organizations that support or oppose the bill.

Second and Third Reading

Bills passed by committees are read a second time on the floor in the house of origin and then assigned to third reading. Bill analyses are also prepared prior to third reading. When a bill is read the third time it is explained by the author, discussed by the Members and voted on by a roll call vote. Bills that require an appropriation or that take effect immediately, generally require 27 votes in the Senate and 54 votes in the Assembly to be passed. Other bills generally require 21 votes in the Senate and 41 votes in the Assembly. If a bill is defeated, the Member may seek reconsideration and another vote.

Repeat Process in Other House

Once the bill has been approved by the house of origin it proceeds to the other house where the procedure is repeated.

Resolution of Differences

If a bill is amended in the second house, it must go back to the house of origin for concurrence, which is agreement on the amendments. If agreement cannot be reached, the bill is referred to a two house conference committee to resolve differences. Three members of the committee are from the Senate and three are from the Assembly. If a compromise is reached, the bill is returned to both houses for a vote.

Governor

If both houses approve a bill, it then goes to the Governor. The Governor has three choices. The Governor can sign the bill into law, allow it to become law without his or her signature, or veto it. A governor's veto can be overridden by a two thirds vote in both houses. Most bills go into effect on the first day of January of the next year. Urgency measures take effect immediately after they are signed or allowed to become law without signature.

California Law

Bills that are passed by the Legislature and approved by the Governor are assigned a chapter number by the Secretary of State. These Chaptered Bills (also referred to as Statutes of the year they were enacted) then become part of the California Codes. The California Codes are a comprehensive collection of laws grouped by subject matter.

The California Constitution sets forth the fundamental laws by which the State of California is governed. All amendments to the Constitution come about as a result of constitutional amendments presented to the people for their approval.
APPENDIX

Appendix 1: CSS Programs
Appendix 2: WET, PEI, INN and CFTN Programs

WET – WORKFORCE, EDUCATION & TRAINING

- TRAINING & TECHNICAL ASSISTANCE
- PEER RECOVERY SPECIALIST / SUPERVISOR TRAINING
- ANNUAL TRAINING
- RESIDENCY & INTERNSHIP
- INTERNSHIP SUPPORT

PEI – PREVENTION, EARLY INTERVENTION

- SAP – STUDENT ASSISTANCE PROGRAM
- EMPLOYMENT ASSISTANCE
- PROJECT CARE
- VSOP – VOLUNTEER SENIOR OUTREACH PROGRAM

INN – INNOVATION

- FREISE H.O.P.E. HOUSE

CFTN – CAPITAL FACILITIES & TECHNOLOGY NEEDS

- PROJECT 2: TECHNOLOGY
- PROJECT 3: E-PRESCRIBING
- PROJECT 1: NETWORK INFRASTRUCTURE IMPROVEMENT
- PROJECT 5: CFLC
- PROJECT 7: PERSONAL HEALTH RECORD
Appendix 3: MHSA Fact Sheet

FACT SHEET

Elaine M. Howle State Auditor

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Mental Health Services Act
The State's Oversight Has Provided Little Assurance of the Act's Effectiveness, and Some Counties Can Improve Measurement of Their Program Performance

BACKGROUND
Because untreated mental illness is the leading cause of disability and suicide and affects state and local government, California voters approved in 2004 the Mental Health Services Act (MHSA), which levies a 1 percent income tax on individuals earning more than $1 million to provide funding for programs within five mental health service components. These funds expand services and programs that serve California’s mentally ill and use innovative methods more likely to identify, mitigate, prevent, and treat mental illness. The responsibility of overseeing MHSA programs was primarily assigned to the California Department of Mental Health (Mental Health) and the Mental Health Services Oversight and Accountability Commission (Accountability Commission). However, changes in law effective June 2012 transferred nearly all remaining MHSA functions from Mental Health to the California Department of Health Care Services (Health Care Services), the Accountability Commission, or the Office of Statewide Health Planning and Development.

KEY FINDINGS
During our review of the MHSA, we noted the following:

• Although the MHSA has funded many programs and served numerous individuals, Mental Health and the Accountability Commission did not provide the oversight needed to demonstrate whether the MHSA is effective.
  ✓ We found no evidence that Mental Health conducted systematic monitoring to ensure that counties appropriately implemented their state-approved MHSA plans.
  ✓ Mental Health did not provide explicit direction to counties on how to effectively evaluate their programs and did not issue regulations for three of the five MHSA components.
  ✓ Despite its charge to evaluate the MHSA, the Accountability Commission has been slow to establish a necessary framework and did not believe it had a clear responsibility to evaluate until 2009, even though its purpose has not changed since 2004 when the MHSA was approved.

• Mental Health required counties to report extensive MHSA data, but the data was incomplete and of limited value in measuring MHSA program effectiveness.

• The counties' MHSA funding allocations may not be appropriate—the methodology used to calculate the funding levels was developed in 2005 and the demographic factors used to calculate the funding have not been updated since 2008.

• Each of the four county departments we reviewed used different and inconsistent approaches in assessing and reporting on their MHSA programs, and the county departments rarely developed specific objectives to assess the effectiveness of the programs.

• Although each of the four county departments we visited included stakeholders and community representatives throughout the MHSA planning process, some counties did not document or describe in their plans of the MHSA programs certain aspects of the public review process.

KEY RECOMMENDATIONS
We made several recommendations to Health Care Services—the new oversight entity—to monitor counties to the fullest extent, including that it conduct comprehensive on-site reviews, draft performance contracts with counties that assure effective oversight, and adopt best practices when possible. We also recommended that performance contracts with counties specify program goals and data to measure performance. Further, Health Care Services should collaborate with the Accountability Commission to develop needed guidance or regulations on evaluating and reporting on county program performance. Also, we recommended that certain counties review and amend their current contracts as needed to include plan goals.

Date: August 15, 2013
Report: 2012-122
## Appendix 4: Acronyms

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<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>3M</td>
<td>Quarterly Assessment</td>
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<td>AB</td>
<td>Assembly Bill</td>
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<td>CF</td>
<td>Capital Facilities</td>
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<td>CF-TW</td>
<td>Capital Facilities and Technological Needs</td>
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<td>CMHDA</td>
<td>California Mental Health Directors Association</td>
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<td>CSA</td>
<td>Corrections Standards Authority</td>
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<td>CSI</td>
<td>Client Services Information System</td>
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<td>CSS</td>
<td>Community Services and Support</td>
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<td>CYF</td>
<td>Children, Youth and Families</td>
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<td>DCR</td>
<td>Data Collection and Reporting System for MHSA FSP</td>
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<td>DMH</td>
<td>Department of Mental Health</td>
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<td>DMR</td>
<td>Agency did not report costs</td>
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<td>Evaluation Advisory Group</td>
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<td>Emergency Room</td>
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<td>FFP</td>
<td>Federal Financial Participation</td>
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<td>FSP</td>
<td>Full Service Partner</td>
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<td>Fiscal Year</td>
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<td>General System Development</td>
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<td>IMDS</td>
<td>Institution for Mental Diseases</td>
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<td>IMPACT</td>
<td>Improving Mood—Promoting Access to Collaborative Treatment</td>
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<td>JHC</td>
<td>Juvenile Halls and/or Camps</td>
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<td>KET</td>
<td>Key Event Tracking</td>
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<td>LAO</td>
<td>Legislative Analyst’s Office</td>
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<td>LGBTQ</td>
<td>Lesbian, Gay, Bi-Sexual, Transsexual/Transgender and Questioning</td>
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<td>Mental Health Services Act</td>
</tr>
<tr>
<td>MHSCOC</td>
<td>Mental Health Services Oversight and Accountability Commission (also OAC)</td>
</tr>
<tr>
<td>OA</td>
<td>Older Adults</td>
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<tr>
<td>OSHPD</td>
<td>Office of Statewide Health Planning and Development</td>
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<tr>
<td>PAF</td>
<td>Partnership Assessment Form</td>
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<tr>
<td>PEI</td>
<td>Prevention and Early Intervention</td>
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<tr>
<td>POQI</td>
<td>Performance Outcomes and Quality Improvement</td>
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<tr>
<td>RER</td>
<td>Revenue and Expenditure Reports</td>
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<td>RFA</td>
<td>Request for Applications</td>
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<td>RFP</td>
<td>Request for Proposal</td>
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<td>SAMHSA</td>
<td>Substance Abuse and Mental Health Services Administration</td>
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<td>SB</td>
<td>Senate Bill</td>
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<tr>
<td>SED</td>
<td>Seriously Emotionally Disturbed</td>
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<td>SGF</td>
<td>State General Fund</td>
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<td>Statewide Maximum Allowance</td>
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<td>SMHA</td>
<td>State Mental Health Authority</td>
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<td>SPSS</td>
<td>Statistical Package for the Social Sciences</td>
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<td>TAY</td>
<td>Transition-Age Youth</td>
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<td>TN</td>
<td>Technological Needs</td>
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<td>WET</td>
<td>Workforce Education and Training</td>
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<td>WIC</td>
<td>Welfare and Institutions Code</td>
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<td>YSS</td>
<td>Youth Services Survey</td>
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<td>YSS-F</td>
<td>Youth Services Survey for Families</td>
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Prevention and Early Intervention: California’s Investment to Prevent Mental Illness from becoming Severe and Disabling: Fiscal Year 2011-12
Appendix 5: Bookmarks

The MHSOAC Meeting Page:
Check out meeting agenda items and supporting materials for each meeting
http://www.mhsoac.ca.gov/Meetings/Meetings.aspx

NAMI California Advocacy Page:
Check out the links to 2014 Bill List and Position Papers

The NAMI California Facebook Page:
https://www.facebook.com/namicalifornia?fref=ts

NAMI California on Twitter
https://twitter.com/namicalifornia

NAMI National Advocacy Page:
http://www.nami.org/template.cfm?section=About_Public_Policy

The Sacramento Bee Capitol Alert Page:
Read the latest news from the Capitol
http://blogs.sacbee.com/capitolalertlatest/