File No. 170904 Committee Item No. 3
Board Item No. 18

COMMITTEE/BOARD OF SUPERVISORS

AGENDA PACKET CONTENTS LIST

Committee: Budget & Finance Committee **Date** September 28, 2017

Board of Supervisors Meeting **Date** October 17, 2017

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Completed by: Linda Wong **Date** September 22, 2017
Completed by: Linda Wong **Date** October 2, 2017

FILE NO. 170904 RESOLUTION NO.

[Mental Health Services Act - Program and Expenditure Plan (Integrated Plan)]

Resolution adopting the Mental Health Services Act Program and Expenditure Plan (Integrated Plan) for FY2017-2018 through FY2019-2020.

WHEREAS, The Mental Health Services Act (MHSA) was enacted through a ballot initiative (Proposition 63) in 2004 that provides funding to support new and expanded county mental health programs; and

WHEREAS, The MHSA specifies five major program components (Community Services and Supports; Capital Facilities and Technological Needs; Workforce, Education and Training; Prevention and Early Interventions; and Innovation) for which funds may be used and the percentage of funds to be devoted to each component; and

WHEREAS, In order to access MHSA funding from the State, counties are required to 1) develop Three-Year Program and Expenditure Plan (Integrated Plan), and Annual Updates, in collaboration with stakeholders; 2) post each plan for a 30-day public comment period; and 3) hold a public hearing on the plan with the County Mental Health Board; and

WHEREAS, The San Francisco Mental Health Services Act Integrated Plan FY2017-2018 through FY2019-2020, a copy of which is on file with the Clerk of the Board of Supervisors in File No. 170904, complies with the MHSA requirements above, and provides an overview of progress implementing the various component plans in San Francisco and identifies new investments planned for FY2017-2018 through FY2019-2020; and

WHEREAS, Recently enacted legislation, AB 1467, adds the requirement that MHSA Three-Year Integrated Plans, and Annual Updates, be adopted by County Boards of Supervisors prior to submission to the State; now, therefore, be it

RESOLVED, That the MHSA Integrated Plan FY2017-2018 through FY2019-2020 is adopted by the Board of Supervisors.

SEC. 62.

Section 5847 of the Welfare and Institutions Code is amended to read:

5847.

Integrated Plans for Prevention, Innovation, and System of Care Services.

(a) Each county mental health program shall prepare and submit a three-year program and expenditure plan, and annual updates, adopted by the county board of supervisors, to the Mental Health Services Oversight and Accountability Commission within 30 days after adoption.

(b) The three-year program and expenditure plan shall be based on available unspent funds and estimated revenue allocations provided by the state and in accordance with established stakeholder engagement and planning requirements as required in Section 5848. The three-year program and expenditure plan and annual updates shall include all of the following:

(1) A program for prevention and early intervention in accordance with Part 3.6 (commencing with Section 5840).

(2) A program for services to children in accordance with Part 4 (commencing with Section 5850), to include a program pursuant to Chapter 4 (commencing with Section 18250) of Part 6 of Division 9 or provide substantial evidence that it is not feasible to establish a wraparound program in that county.

(3) A program for services to adults and seniors in accordance with Part 3 (commencing with Section 5800).

(4) A program for innovations in accordance with Part 3.2 (commencing with Section 5830).

(5) A program for technological needs and capital facilities needed to provide services pursuant to Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850). All plans for proposed facilities with restrictive settings shall demonstrate that the needs of the people to be served cannot be met in a less restrictive or more integrated setting.

(6) Identification of shortages in personnel to provide services pursuant to the above programs and the additional assistance needed from the education and training programs established pursuant to Part 3.1 (commencing with Section 5820).

(7) Establishment and maintenance of a prudent reserve to ensure the county program will continue to be able to serve children, adults, and seniors that it is currently serving pursuant to Part 3 (commencing with Section 5800), the Adult and Older Adult Mental Health System of Care Act, Part 3.6 (commencing with Section 5840), Prevention and Early Intervention Programs, and Part 4 (commencing with Section 5850), the Children's Mental Health Services Act, during years in which revenues for the Mental Health Services Fund are below recent averages adjusted by changes in the state population and the California Consumer Price Index.

(8) Certification by the county mental health director, which ensures that the county has complied with all pertinent regulations, laws, and statutes of the Mental Health Services Act, including stakeholder participation and nonsupplantation requirements.

(9) Certification by the county mental health director and by the county auditor-controller that the county has complied with any fiscal accountability requirements as directed by the State Department of Health Care Services, and that all expenditures are consistent with the requirements of the Mental Health Services Act.

(c) The programs established pursuant to paragraphs (2) and (3) of subdivision (b) shall include services to address the needs of transition age youth ages 16 to 25. In implementing this subdivision, county mental health programs shall consider the needs of transition age foster youth.

(d) Each year, the State Department of Health Care Services shall inform the California Mental Health Directors Association and the Mental Health Services Oversight and Accountability Commission of the methodology used for revenue allocation to the counties.

(e) Each county mental health program shall prepare expenditure plans pursuant to Part 3 (commencing with Section 5800) for adults and seniors, Part 3.2 (commencing with Section 5830) for innovative programs, Part 3.6 (commencing with Section 5840) for prevention and early intervention programs, and Part 4 (commencing with Section 5850) for services for children, and updates to the plans developed pursuant to this section. Each expenditure update shall indicate the number of children, adults, and seniors to be served pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850), and the cost per person. The expenditure update shall include utilization of unspent funds allocated in the previous year and the proposed expenditure for the same purpose.

(f) A county mental health program shall include an allocation of funds from a reserve established pursuant to paragraph (7) of subdivision (b) for services pursuant to paragraphs (2) and (3) of subdivision (b) in years in which the allocation of funds for services pursuant to subdivision (e) are not adequate to continue to serve the same number of individuals as the county had been serving in the previous fiscal year.

SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

San Francisco Mental Health Services Act (MHSA) 2017-2020 Integrated Plan

The Mental Health Services Act of San Francisco is a program of the Department of Public Health – Behavioral Health Services

Table of Contents

County Compliance Certification

County: _____

Local Mental Health Director	Program Lead
Name:	Name:
Telephone Number:	Telephone Number:
Email:	Email:
County Mental Health Mailing Address:	

I hereby certify that I am the official responsible for the administration of county mental health services in and for said county and that the County has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this annual update, including stakeholder participation and nonsupplantation requirements.

This annual update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft annual update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on _____.

Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code section 5891 and Title 9 of the California Code of Regulations section 3410, Non-Supplant.
All documents in the attached annual update are true and correct.

_____ _____

Local Mental Health Director/Designee (PRINT) Signature Date

County:_____

Date:_____

County Fiscal Accountability Certification[1]

☐ Three-Year Program and Expenditure Plan

County/City: _____ ☐ Annual Report

☐ Annual Revenue and Expenditure Report

Local Mental Health Director	Program Lead
Name:	Name:
Telephone Number:	Telephone Number:
Email:	Email:
County Mental Health Mailing Address:	

I hereby certify that the Three-Year Program and Expenditure Plan, Annual Update or Annual Revenue and Expenditure Report is true and correct and that the County has complied with all fiscal accountability requirements as required by the law or as directed by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, and that all expenditures are consistent with the requirements of the Mental Health Services Act (MHSA), including Welfare and Institutions Code (WIC) sections 5813.5, 5830, 5840, 5847, 5891, and 5892; and Title 9 of the California Code of Regulations sections 3400 and 3410. I further certify that all expenditures are consistent with an approved plan or update and that MHSA funds will only be used for programs specified in the Mental Health Services Act. Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which are not spent for their authorized purpose within the time period specified in WIC section 5892(h), shall revert to the state to be deposited into the fund and available for other counties in future years.

I declare under penalty of perjury under the laws of this state that the foregoing and the attached update/report is true and correct to the best of my knowledge.

_____ _____

Local Mental Health Director/Designee (PRINT) Signature Date

I hereby certify that for the fiscal year ended June 30, _____, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated _____ for the fiscal year ended June 30, _____. I further certify that for the fiscal year ended June 30, _____, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

I declare under penalty of perjury under the laws of this state that the foregoing and the attached update/report is true and correct to the best of my knowledge.

_____ _____

County Auditor Controller/City Financial Officer (PRINT) Signature Date

[1] Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)
Three-Year Program and Expenditure Plan, Annual Update, and RER Certification (INSERT DATE)

Director's Message

The San Francisco Department of Public Health (DPH) continues to embrace the principles of the Mental Health Services Act (MHSA) that includes consumer and family member involvement, community collaboration, delivery of integrated services, and cultural responsiveness. The City and County of San Francisco is committed to providing quality healthcare services that are wellness and recovery driven, culturally and linguistically appropriate and client-informed. MHSA-funded programs continue to offer services at different levels of intensity that range from education in order to increase mental health awareness, to treatment services for individuals experiencing mental health challenges.

In the last Three-year Program and Expenditure Plan (Plan), in collaboration with our local stakeholders, DPH was successful in implementing most of the proposed programs that offer services around prevention and early intervention, vocational support for peers, peer-run activities, workforce development and innovative learning. This Three-year Plan (FY 17/18 – 19/20), continues to provide services under the aforementioned categories and explores innovative approaches to support consumers who are transitioning from high to low intensive levels of care. It is our goal to ensure consumers have the appropriate wellness tools and resources to support them in their recovery journey.

In support of the San Francisco Department of Public Health's mission, the MHSA program is committed to promoting and protecting the health of all San Franciscans. We will continue to work towards the reduction of health disparities, ensuring equal access for all and providing quality services that are culturally and linguistically appropriate.

We look forward to the years ahead.

Kavoos Ghane Bassiri
Director, SF Behavioral Health Services

Imo Momoh
Director, SF Mental Health Services Act

Introduction

In November 2004, California voters approved Proposition 63, now known as the Mental Health Services Act (MHSA), intended to expand and transform community mental health services throughout California. While the proposition passed with 54 percent of the vote statewide, San Francisco voted 74 percent in favor of the act. MHSA funding, revenue from a 1 percent tax on any personal income in excess of $1 million, is distributed to respective county mental health systems under regulations developed by the State.

The MHSA called upon local counties to transform their public mental health systems to achieve the goals of raising awareness, promoting the early identification of mental health problems, making access to treatment easier, improving the effectiveness of services, reducing the use of out-of-home and institutional care, and eliminating stigma toward those with severe mental illness or serious emotional disturbance. Counties were also required to collaborate with diverse community stakeholders in order to realize the MHSA's vision of recovery and wellness. This vision was based on the belief in the strengths and resiliency of each person with mental illness and has been fundamental to the development of more comprehensive, innovative, culturally responsive services for individuals and families served by local mental health systems.

WELLNESS • RECOVERY • RESILIENCE

As dictated by the law, the majority of MHSA funding that San Francisco receives is dedicated to the development and delivery of treatment services. In San Francisco, MHSA funding has allowed for expanded access to intensive treatment services, housing, employment services and peer support services for thousands of individuals with mental illness, 50 percent of whom are homeless or at-risk of becoming homeless. Promising outcomes from MHSA investments include declines in arrests, mental and physical health emergencies, school suspensions and expulsions, and the number of days in residential treatment.

Proposition 63 also stipulates that 20 percent of the funds support programs "effective in preventing mental illnesses from becoming severe" and "reducing the duration of untreated severe mental illnesses." This commitment to prevention and early intervention is historic and moves the mental health system towards a "help-first" instead of a "fail first" strategy.

It will not be money alone that transforms the public mental health system. The greatest promise of the MHSA: it is a vision of outreach and engagement, a philosophy of recovery and wellness, a belief in the strength and resiliency of each person with mental illness, and recognition that they are to be embraced as equal members of our community. Recovery from mental illness is not only possible, it is to be expected.

MHSA Guiding Principles

Five MHSA principles guide planning and implementation activities:

1. **Cultural Competence.**
   Services should reflect the values, customs, beliefs, and languages of the populations served and eliminate disparities in service access.

2. **Community Collaboration.**
   Services should strengthen partnerships with diverse sectors to help create opportunities for employment, housing, and education.

3. **Client, Consumer, and Family Involvement.**
   Services should engage clients, consumers, and families in all aspects of the mental health system, including planning, policy development, service delivery and evaluation.

4. **Integrated Service Delivery.**
   Services should reinforce coordinated agency efforts to create a seamless experience for clients, consumers and families.

5. **Wellness and Recovery.**
   Services should promote recovery and resiliency by allowing clients and consumers to participate in defining their own goals so they can live fulfilling and productive lives.

Kim Ganade, SF DPH MHSA Program Manager, leads a CPP meeting in FY16-17.

General Characteristics of San Francisco

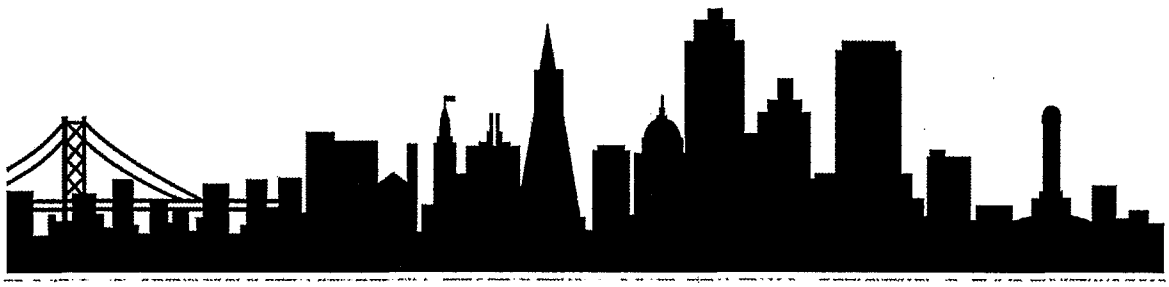
San Francisco ('the City') is a seven-by-seven square mile coastal, metropolitan city and county, located on the northern end of a peninsula that separates the San Francisco Bay from the Pacific Ocean. It is the cultural and commercial center of the Bay Area and is the only consolidated city and county jurisdiction in California. Though it is geographically small, it is the second most densely populated city in the nation (at 17,938 people per square mile) and fourth most populous city in the state (at 840,763 people). Between 2010 and 2015, the San Francisco population grew by 6.5%, outpacing California's population growth of 4.9% during this same time period. By 2030, San Francisco's population is expected to grow to nearly 970,000.

A proud, prominent feature of San Francisco is its culturally diverse neighborhoods, where 112 different languages are spoken. Currently, over one-third of the City's population is foreign-born and 44% of residents speak a language other than English at home. However, over the past 50 years, there have been notable ethnic shifts, including a steep increase in Asian/Pacific Islander population and decrease in Black/African American population. Over the next decade, the number of multi-ethnic and Latino residents is expected to rise, while the number of Black/African American residents is expected to continue to decline.

Housing in San Francisco is in increasingly high demand due to the recent tech industry boom. At the same time, due to geographic and zoning constraints, supply for housing is severely limited. These and other factors led to San Francisco becoming the most expensive rental housing market in the nation in 2015. This housing crisis, as it is commonly referred to today, is compounded by extremely high costs of living (at nearly 80% higher than the national average). Approximately 7,500 homeless individuals reside in San Francisco. High costs of living have contributed to huge demographic shifts in the City's population over the past decade, including a dramatic reduction in Black/African American populations and in the number of families with young children.

Although San Francisco was once considered to have a relatively young population, it has recently experienced a decrease of children and families with young children. Today it has the lowest percentage of children among all large cities in the nation. The high cost of living, prohibitive housing costs, and the young, often childless, composition of tech industry workers are assumed to be the leading causes of this population flight. In addition, it is estimated that the population of individuals over the age of 65 will increase to 20% by 2030 (from 14% in 2010). The projected growth in San Francisco's aging population has implications on the need for more long-term care options moving forward.

For additional background information on population demographics, health disparities, and inequalities, see the 2016 San Francisco Community Health Needs Assessment located at https://www.sfdph.org/dph/files/hc/HCAgen/HCAgen2016/May%2017/2016CHNA-2.pdf.



Community Program Planning & Stakeholder Engagement

The MHSA reflects a new and unique process of implementing public policy through collaboration with multiple stakeholders and advocates with a range of knowledge and experience.

From the Beginning

The San Francisco MHSA planning process began in 2005 with then-Mayor Gavin Newsom's creation of a 40-member, citywide Behavioral Health Innovation (BHI) Task Force, which was headed by the San Francisco Deputy Director of Health.

Client Council members discuss mental health needs of the community in FY16-17.

The BHI Task Force was responsible for identifying and prioritizing the greatest mental health needs of the community and developing a Three Year Program and Expenditure Plan to address these needs. The BHI Task Force held over 70 meetings over a five-month period with consumers, their families, behavioral health service providers, representatives from the criminal justice system, educational professionals, social support services providers and administrators, and members of the community. Information was collected through provider surveys, peer-to-peer interviews, penetration analyses, transcripts and summaries of meetings, as well as 80 position papers received from various constituents. This process resulted in the development of a Three Year Program and Expenditure Plan for the Community Services and Supports component. The plan was submitted to the California Department of Mental Health in November 2005 and approved in March 2006.

The planning process continued for the other MHSA funding components, following the successive releases of each component's Plan guidelines. Each of these planning processes built upon the recommendations of the respective committees and workgroups established during the 2005 community-wide planning meetings.

- **Workforce Development, Education, and Training (WDET)** planning meetings were held for eight months from April to December 2007. The Plan was submitted in March 2008 and approved in September 2008.

- **Prevention and Early Intervention (PEI)** planning meetings were held for six months from January 2008 to July 2008. The Plan was submitted to both the Department of Mental Health and the Oversight and Accountability Commission for their review and approval in February 2009. The plan was approved in April 2009.

- **Capital Facilities and Information Technology** planning processes were held separately. The Plan for the Capital Facilities component was submitted in April 2009, after a series of three community planning meetings held in February 2009. The Information Technology component CPP involved two informational meetings and six community planning meetings from November 2008 to April 2009. The Plan was submitted in March 2010 and was approved in August 2010.

- **Innovation** community meetings were held from April through August 2009. The Plan was submitted in March 2010 and approved in May 2010.

Community Program Planning & Stakeholder Engagement Activities

Exhibit 1 provides an overview of San Francisco's ongoing community program planning (CPP) activities. San Francisco MHSA employs a range of strategies focused on upholding the MHSA principles and engaging stakeholders in various ways at all levels of planning and implementation. Our CPP process provides a number of opportunities for stakeholders to participate in the development of our three-year plans and annual updates, and stay informed of our progress in implementing MHSA-funded programs.

Exhibit 1. Key Components of SF MHSA Program Planning Process

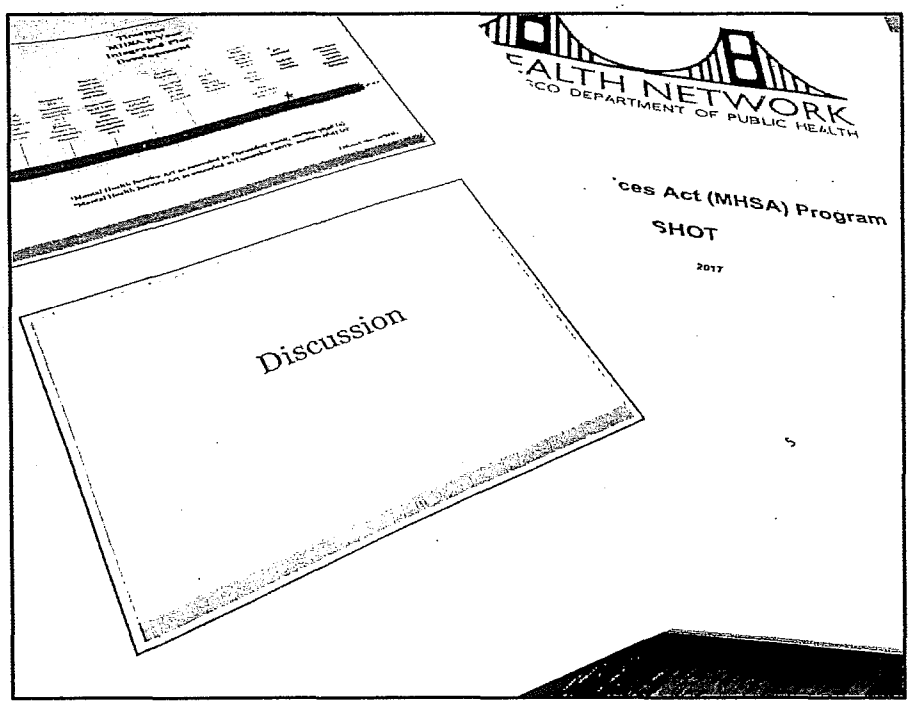
Communication Strategies	• SF BHS DPH MHSA website • Monthly CBHS Director's Report • Stakeholder updates
Advisory Committee	• Identify priorities • Monitor implementation • Provide ongoing feedback
Program Planning and Contractor Selection	• Assess needs and develop service models • Review program proposals and interview applicants • Select most qualified providers
Program Implementation	• Collaborate with participants to establish goals • Peer and family employment • Peer and family engagement in program governance
Evaluation	• Peer and family engagement in evaluation efforts • Collect and review data on participant satisfaction • Technical assistance with Office of Quality Management

MHSA Communication Strategies

San Francisco Department of Public Health seeks to keep stakeholders and the broader community informed about MHSA through a variety of communication strategies, including the SF BHS DPH MHSA website, regular communication with community groups, contributing content to the monthly Community BHS Director's Report, and providing regular updates to stakeholders.

The San Francisco MHSA webpage on the SF DPH website, https://www.sfdph.org/dph/comupg/oservices/mentalHlth/MHSA/default.asp, is in the process of being updated to incorporate a more user-friendly design, up-to-date information about MHSA planning processes, published documents and updates, and monthly meeting notices. The redesigned webpage hosted now through the San Francisco Department of Public Health website, will showcase frequent program highlights and successes.

The monthly BHS Director's Report provides another forum for sharing information about the implementation of MHSA with a broad group of stakeholders. Each month, MHSA provides updates about program implementation, upcoming meetings and other MHSA news.



MHSA Overview Presentation from Community Planning Meeting in FY16-17.

MHSA Advisory Committee & Our Commitment to Consumer Engagement

SF MHSA Advisory Committee

The SF MHSA Advisory Committee is an integral component of community engagement because it provides guidance in the planning, implementation, and oversight of the MHSA in San Francisco. In order to build on the previous and ongoing participation of local stakeholders, the purpose of the MHSA Advisory Committee includes the following:

SF DPH MHSA Advisory Council members meet to discuss community needs, program planning, and the MHSA 3-Year Plan in FY16-17.

- Work collaboratively with BHS to support broad community participation in the development and implementation of MHSA initiatives
- Guide MHSA resources to target priority populations as identified in existing MHSA plans
- Ensure that San Francisco's mental health system adheres to the MHSA core principles
- Hold meetings every two months
- Encourage community participation at meetings

The SF MHSA Advisory Committee's robust recruitment efforts focuses on engaging members from the mental health community, with an emphasis on the following underrepresented community members: those with expertise in law enforcement and substance use, Transitional Age Youth, transgender individuals, and family members. Our Advisory Committee currently consists of over 25 active members.

For FY 16-17, the SF MHSA Advisory Committee meeting schedule is as follows: August 17, 2016; October 19, 2016; December 7, 2016; February 15, 2017; April 19, 2017; and June 21, 2017. The purpose of these meetings are to gather Committee member feedback on MHSA programming and the needs of priority populations. Topics for these meetings include, but are not limited to, the following:

- MHSA Advisory Orientation to provide education for new committee members and explore ideas for the upcoming fiscal year
- Evaluation and Outcomes Planning
- FSP Outcomes and Input Gathering

- Transgender Health Services Outcomes and Input Gathering
- Innovations Outcomes and Input Gathering
- MHSA 3-Year Integrative and Community Planning
- MHSA Expenditure Planning
- RFQ/P Planning Efforts
- MHSA Year-End Reporting and Data Collection

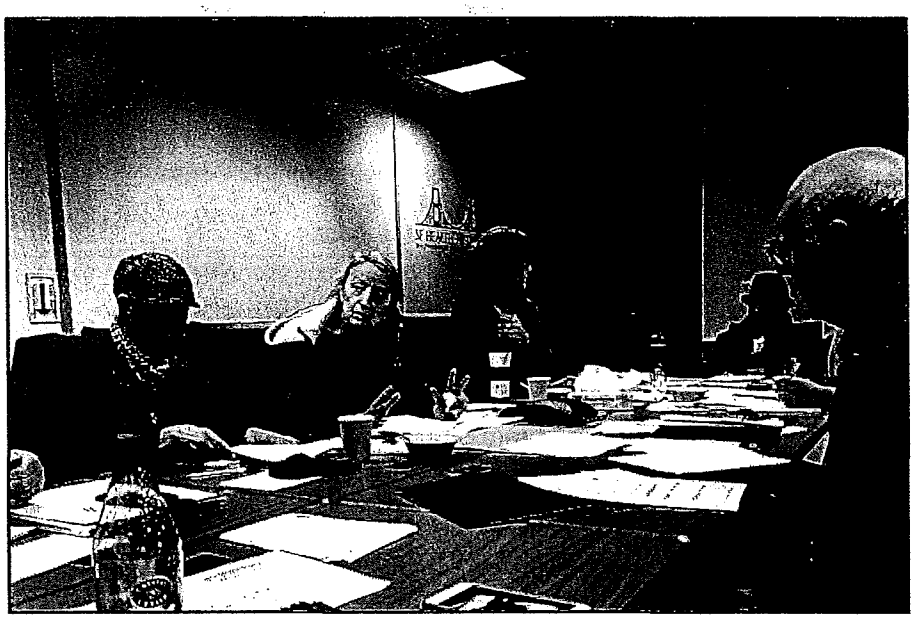
Increasing Consumer Engagement

SF MHSA continues to partner with the Mental Health Association of San Francisco (MHASF), with the goal of increasing consumer representation and participation in MHSA Advisory Committee meetings.

MHASF assists with the following objectives:

- Supporting the consumer Co-Chair of the MHSA Advisory Committee to participate in developing meeting agendas and presentations for each meeting
- Identifying strategic objectives, including policy issues related to stigma/awareness and developing partnerships with community-based organizations/business leaders to reduce stigma and discrimination as it relates to mental health.

SF MHSA has also been working to foster a stronger collaboration with the BHS Client Council. The Client Council is a 100 percent consumer/client driven and operated advisory body. The mission of the Client Council is to advance the cause of the San Francisco mental health consumer/client to protect their rights, advocate their issues, and ensure their participation in all phases of systematic changes in services, implementation of programs, and treatment development. The goal of the Client Council is to advise BHS regarding policies and practices that directly influence consumers/clients in mental health and substance abuse services. As a result of this new collaboration, the Client Council and MHSA Advisory committee share some members.



Client Council members discuss mental health needs of the community in FY16-17.

Recent Community Program Planning Efforts

Community and Stakeholder Feedback

> *"A good mental health system is like a family. Where you are cared about; where you can talk to someone."*
> - Community member

The San Francisco Department of Public Health has strengthened its' MHSA program planning for the 2017-2020 Integrative Plan by collaborating with mental and behavioral health consumers, their families, peers, and service providers to identify the most pressing mental and behavioral health-related needs of the community and develop strategies to meet these needs. In early 2017, SF MHSA hosted eleven (11) community engagement meetings across the City's eleven Supervisorial Districts to collect community member feedback on existing MHSA programming and better understand the needs of the community. Attendees included mental health and other service providers, consumers of mental health services and their families, representatives from local public agencies, community- and faith-based organizations, residents of San Francisco, and other community stakeholders. Five of the eleven meetings were open to the public and all meetings were advertised on the SF DPH website and via word-of-mouth and email notifications to service providers in the SF BHS, MHSA, and San Francisco Health Network distribution networks. Printed and electronic materials were translated into Spanish, Mandarin, and other languages, and interpretation was provided at all public community meetings, as needed. The eleven CPP meetings are described in the following table:

CPP Meetings	
Date	**CPP Location**
January 5, 2017	Samoan Community Development Center 2055 Sunnydale Ave San Francisco, CA 94134
January 19, 2017	Mo' Magic Meeting/African Arts Culture Complex 762 Fulton St San Francisco, CA 94102
February 10, 2017	Chinatown Child Development Center 720 Sacramento St San Francisco, CA 94108
February 13, 2017	Filipino Mental Health Initiative/Bayanihan Center 1010 Mission St San Francisco, CA 94103
February 15, 2017	MHSA Advisory Committee/Behavioral Health Services 1380 Howard St San Francisco, CA 94103
February 21, 2017	Client Council/Behavioral Health Services 1380 Howard St San Francisco, CA 94103
March 1, 2017	Chinatown community members at Cameron House 920 Sacramento St San Francisco, CA 94108

CPP Meetings	
Date	**CPP Location**
March 7, 2017	LEGACY Peer/Community Advisory 1305 Evans Ave San Francisco, CA 94124
March 15, 2017	MHSA Providers Meeting 1453 Mission St San Francisco, CA 94103
March 24, 2017	Latino and Mayan Community Meeting/ Instituto Familiar de la Raza 2919 Mission St San Francisco, CA 94110
April 12, 2017	The Village 1099 Sunnydale Ave San Francisco, CA 94134

In each of the community meetings, MHSA staff presented an overview of the Mental Health Services Act, including its core components, guiding principles, and highlights of existing programs and services. MHSA staff then asked meeting attendees a series of open-ended questions to engage the community members in discussion on the greatest needs of the community, with a focus on mental health needs and strategies to address these needs. These discussions also addressed how SF DPH can improve existing MHSA programming. Feedback from community members at the meetings were captured live, on flip charts and via transcription, in effort to maintain a high-level of transparency. MHSA staff addressed how the feedback would be incorporated into the SF MHSA 2017-2020 Integrated Plan and inform future MHSA programming. Community members were also provided with information on the 30-day local review process in approving the SF MHSA 2017-2020 Integrated Plan.

Following each meeting, attendees were asked to complete a questionnaire; hard copies were distributed and collected at the meetings and, in effort to increase response rates, meet language needs, and collect additional feedback. Electronic questionnaires were made available to community members and stakeholders to gather feedback using other modes to collect important data. These questionnaires asked attendees to share additional information on key needs of the community around mental health, strategies to address these needs, and general feedback on improving the MHSA CPP process.

Perhaps not surprisingly, the feedback collected throughout the various community planning efforts was fairly consistent. At each community meeting, whether it was a meeting of behavioral/mental health service consumers and their families, peers, service providers, community members, or other stakeholders, all echoed the same key behavioral and mental health-related needs of the community including, but not limited to, the following needs.

- The need for safe and stable (affordable) housing, particularly for those with serious mental illness, transitional age youth, and older adults.

"Mental illness should not be a mystery. We should all be able to recognize symptoms, move past stigma, and connect people to services."
- Community member

- The need for specific behavioral/mental health services, including but not limited to: crisis response services, substance use disorder treatment, early intervention services, trauma recovery services, and behavioral health workforce development services.
- The need for community education and stigma reduction around behavioral/mental health needs, particularly cultural and linguistic needs.
- The need for a clear understanding of what behavioral/mental health (MHSA-funded) programs and services already exist.
    - The DPH website is difficult to navigate and should include a Directory of Service Providers that is routinely updated so that consumers and service providers can understand what services are currently offered/where they are available.
    - Service providers need time to collaborate to discuss intake/discharge procedures and policies, share best practices, strategize ways to meet the needs of the consumers they serve and avoid duplication of services.
    - SF MHSA should increase its presence in the local community – through advertising at health fairs and strategizing additional opportunities to work directly with service providers, community-based organizations, schools, employers, faith-based institutions – in effort to increase awareness of existing resources.
- The need for ease of access to behavioral/mental health services.
    - Consumers with serious mental illness or other disorders may have significant obstacles in attending their appointments (e.g., lack of transportation, inability to manage schedules, health-related symptoms such as anxiety or delusions, medication management issues, crisis episodes, etc.).
    - Consumers may be dis-incentivized to pursue services if they have intake procedures or program policies that are burdensome (e.g., individuals may not complete paperwork that asks for personal information as they may not possess the information or because this is seen as 'yet another barrier' for individuals who are already reluctant to participate in mental health services/treatment for cultural or other reasons).
- The need for support services for families, particularly immigrant families and newcomer youth.
    - Parenting classes and workshops with topics on dealing with trauma and emotional/behavioral challenges.
    - Individual and family therapy.
    - Promatoras, cultural workers, and community healers should be embedded in schools, community organizations to conduct outreach to families and youth, link them to/provide them with culturally-humble support services.
- The need for continuous community engagement across community stakeholders and, most importantly, SF DPH BHS and MHSA current, former, and potential consumers.

> *"We should go out to the community to recruit people to work as a service provider. They are connected to their community – they can really get this type of work done."*
>
> - Client Council Member

While most community members readily agreed that these were amongst the most pressing needs of the community, with regard to behavioral/mental health, many other ideas were also shared throughout the CPP process. This feedback includes, among other things, ideas to further engage unserved/underserved populations, strategies to combat cultural stigma, the importance of qualitative as well as quantitative data evaluation for programming, sensitivity/cultural humility trainings for service providers, and the threat violence poses on the community.

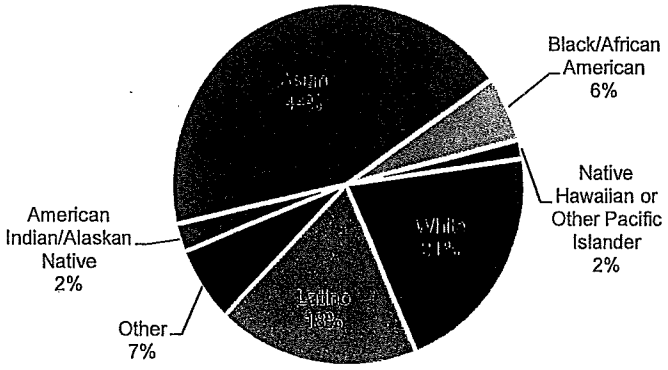
Other innovative ideas included partnering with other local counties to provide continued services, which is especially necessary with the cost of housing in San Francisco; collaborating with current and former consumers to design programs that support consumers who are transitioning from Intensive Case Management/Full Service Partnership programs to outpatient services; creating pop-up hubs across the City to promote MHSA programming and link people to services; and working with local philanthropic businesses (e.g., Twitter, Salesforce) to increase awareness and gain support of MHSA programming.

The feedback and input shared by our community stakeholders is under careful review and consideration by MHSA leaders and staff. This valuable feedback will be used to guide and refine MHSA-funded programming.

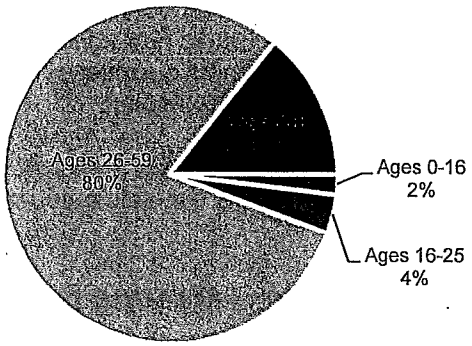
Community Program Planning Meeting Participation

Over 200 people participated in the eleven SF DPH MHSA community meetings held in early 2017. Of those attendees, SF DPH MHSA staff collected demographic data on 119 individuals and those data are reflected in the charts below.

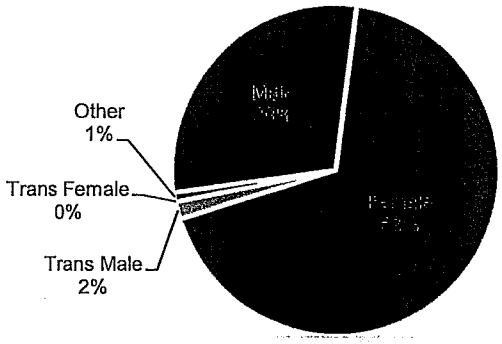
FY16-17 CPP Meeting Participant: Race/Ethnicity (n=119)



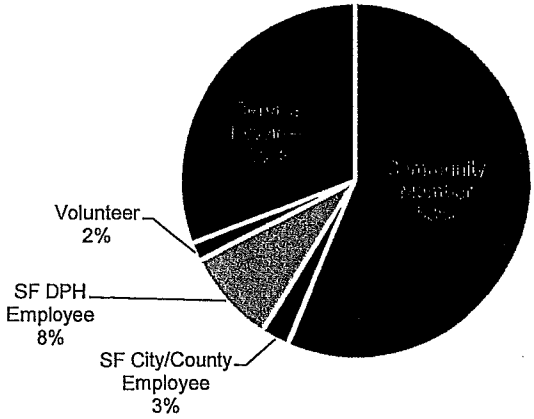
FY16-17 CPP Meeting Participant: Age Group (n=119)



FY16-17 CPP Meeting Participant: Gender (n=119)



FY16-17 CPP Meeting Participant: Affiliation (n=119)



CPP with Service Provider Selection

SF MHSA includes elements of the CPP in developing and refining each of our programs. Frequently, this takes the form of an ad hoc committee or planning groups made of various stakeholders, including people with expertise or lived experience of specific populations. The MHSA principle of engaging consumers and family members is applied to all programs. The following are examples of recent CPP efforts that took place in developing Request for Proposals and contracting with service providers.

- As part of the Population-Focused Request for Qualifications (RFQ) development process, SF MHSA staff collected information from mental health consumers, family members of mental health consumers, the broader community and MHSA-funded community based organizations to better understand San Franciscans' mental health needs and desired support services. SF MHSA held three focus groups/dinners among various communities to gather feedback. The feedback revealed the need for honoring the heritage, histories, cultural and spiritual beliefs of oppressed and marginalized communities regarding health and mental health, and the need to respect community-defined practices toward wellness. These focus groups also revealed that Population Focused services should be centered on acknowledging the healing practices, ceremonies and rituals of diverse communities with an emphasis on understanding the cultural context first and working in partnership with programs to design culturally relevant and appropriate services. Programs should honor participants' cultural backgrounds and practices of mental health while also making available a variety of non-clinical support services.

- In order to inform and drive the Workforce Development RFQ, MHSA and BHS leadership developed a 5-Year Workforce Development Plan. MHSA/BHS conducted several focus groups with workforce stakeholders, consumers, and peer staff. A Steering Committee was also created to gather feedback regarding the workforce needs. These meetings provided insight and input, and also described some of the challenges that they see people of color facing at BHS. Some of the feedback included, but not limited to, the following:
    - Accessing Services is a big barrier
    - Importance of providers representing the diversity of people they serve
    - Importance of cultural humility
    - Discussion about gap in licensed supervisors
    - Discussion about pipeline development
    - Discussion about how to motivate current staff to go back to school to pursue further education

  In addition, SF DPH conducted a workforce engagement survey in the spring of 2015 to understand the issues and perspectives of their staff. This input from staff was also used to develop goals and objectives in the Workforce Development RFQ.

- MHSA Peer-to-Peer Services staff conducted several focus groups to elicit feedback to redesign existing peer programming and inform the Peer-to-Peer Employment Program RFQ. The Peer-to-Peer Services department conducted six peer, consumer, and family member focus groups to assess the needs of the community in order to redesign and better integrate the BHS peer-to-peer programs. In addition, consumers, family members and advocates consistently participated in manager meetings, staff meetings and decision-making meetings to provide valuable input in all areas of policy development, program development, implementation, budgeting, and evaluation. As a result, a new peer model was designed including streamlined services, additional training opportunities,

better supervision, increased on-the-job support, and support/consultation groups for peers.

- MHSA collected extensive information from mental health consumers, peers, family members and the broader community to determine the community needs and drive the Peer Health and Advocacy Programs RFQ. One of the leading barriers to peer wellness and recovery in the Bay Area is the lack of available career opportunities for peers in our peer educator and support programs, affected in part by the attitudes and expectations of the medical and mental health professions towards peer employment. Stakeholders noted that peer advocacy programs should work to demonstrate the benefit that peers' unique abilities and lived experiences can add to the mental health field.

- To further understand the needs of consumers and inform the Community Drop-In and Resource Support Services RFQ, MHSA gathered feedback from current providers of the existing drop-in centers. The most commonly cited barrier to the progress of participants in working toward their own wellness and recovery was the lack of affordable, stable housing in and around the City. Even with the development of market-rate housing, demand for affordable housing exceeds supply. Beyond the dire need for affordable housing, service providers noted the lack of secure storage facilities for participants' belongings during program activities as an insurmountable barrier for those who would otherwise wish to participate in the programs. Because many participants are homeless, they often carry all of their belongings with them, in carts, suitcases, and bags, but do not have an option of bringing these belongings with them to the program sites due to fire safety restrictions, pest prevention protocol, and other logistical issues. Another barrier to program participation cited by service providers is the lack of access to hygiene supplies and sanitation stations for homeless individuals. This directly affects many individuals' willingness and ability to engage in social activities.

- As part of the School-Based RFQ development process, SF MHSA staff collected information from behavioral and mental health consumers, as well as their families, peers, teachers, and service providers to better understand the needs of the community with regard to School-Based community mental health services. These efforts, as well as a mixed methods evaluation, evaluation identified the following factors as contributing to successful School-Based Mental Health Programs.
    - Alignment with the needs and resources of the schools. This includes aligning program objectives with those of the schools and respecting the culture of the school and community.
    - Staffing tenure and consistency.
    - Maintaining role clarity.
    - Creating a "safe space" for students by ensuring confidentiality and consistent attention to the students' needs.
    - Creating a "safe space" for teachers and administrators to think about the challenges they are facing, to receive professional coaching and to try out new strategies with students.
    - Agency capacity to collect, analyze and report on data that are relevant to the evaluation.

Program Implementation

The active engagement of stakeholders in planning continues into implementation. Providers and consumers are partnering with stakeholder groups to ensure programs are collaborating with other initiatives. Examples of our stakeholder engagement in implementation include the following:

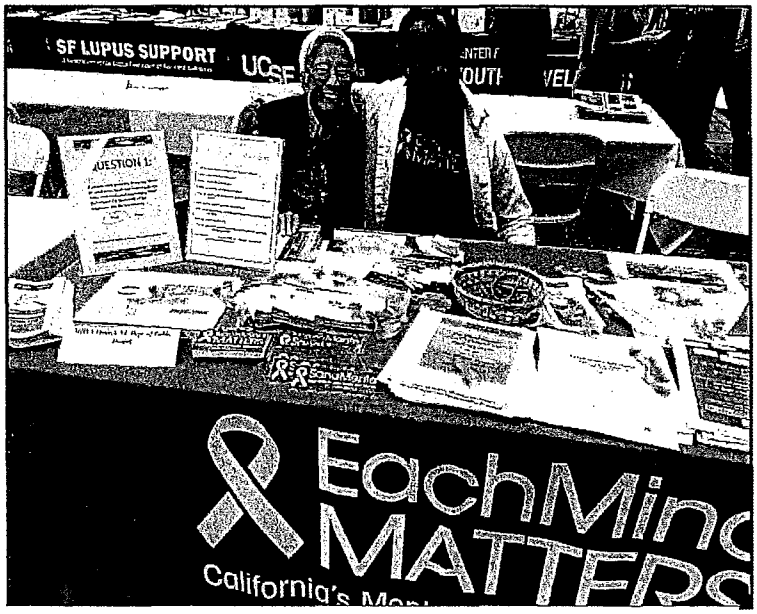
- Providers from MHSA-funded agencies meet on a regular basis to discuss local MHSA program activities and to provide feedback.
- Population-Focused Mental Health Promotion Contractors Learning Circles: In order to promote a culturally competent and inclusive process, SF MHSA is holding a series of meetings called 'Learning Circles' with population-focused programs to collectively discuss and agree on service types, activities and outcomes. The shared performance objectives that have been developed are measured and reported on for the next fiscal year. The Learning Circles also provide an opportunity for programs to share their progress on implementation, goals and strategies for evaluation.
- Consumers and peers are involved in all areas of the program life-cycle. Consumers and peers participate in RFQ/P review panels, provide input as a vital stakeholder during the program planning and contract negotiation phase, and support with technical assistance during implementation to ensure the program is meeting the appropriate deliverables.

Peer Employment is a Critical Element of Community Program Planning

In drafting the guidelines for Proposition 63, an emphasis was placed on the importance of consumer participation in the mental health workforce. Certification programs were created at both San Francisco State and City College of San Francisco. In addition, all programs are encouraged to hire peers as members of program staff. In FY 15-16, over half of all grantees/contracts indicated that their program employs consumers or participants through MHSA funding, totaling 174 peers as employees. Consumers could be found working in almost all levels and types of positions, including as: peer mentors, health promoters, community advocates, workgroup leaders, teaching assistants, and in management. Several programs have positions created specifically for clients and consumers, including mentoring, advocacy, and peer facilitators.

San Francisco's Integrated MHSA Service Categories

As discussed in the introduction to this report, San Francisco's initial MHSA planning and implementation efforts were organized around MHSA funding components (e.g., Community Services and Supports (CSS), Workforce Development Education and Training (WDET), Prevention and Early Intervention (PEI), and Innovation (INN)). In partnership with different stakeholders, Revenue and Expenditure Plans were developed for each of these components. The MHSA, however, required that these plans be ultimately merged into a single Integrated Plan. Through our community planning efforts, SF MHSA realized that developing an Integrated Plan with a common vision and shared priorities is difficult when funding streams were used as the framework. In partnership with our stakeholders, SF MHSA simplified and restructured the MHSA funding components into seven MHSA Service Categories in order to facilitate streamlined planning and reporting (see Exhibit 2 below).



2016 SF Community Health Fair

These MHSA Service Categories have allowed us to plan programs and services for specific populations and to expand our continuum of services with clear outcomes – including integration of peers into service delivery, promoting culturally competent care, increasing access to housing and employment, and developing high quality recovery-oriented treatment services.

It is important to note that the majority of our MHSA Service Categories include services funded by INN. INN funding is intended to provide our mental health system with an opportunity to learn from new practices or approaches that will support system change and improve client, consumer, and family outcomes.

Exhibit 2. SF MHSA Service Categories

SF MHSA Service Category	Description
Recovery-Oriented Treatment Services	• Includes services traditionally provided in the mental health system (e.g., individual or group therapy, medication management, residential treatment) • Uses strengths-based recovery approaches
Mental Health Promotion & Early Intervention Services	• Raises awareness about mental health and reduces stigma • Identifies early signs of mental illness and increase access to services

Exhibit 2. SF MHSA Service Categories	
SF MHSA Service Category	**Description**
Peer-to-Peer Support Services	• Trains and supports consumers and family members to offer recovery and other support services to their peers
Vocational Services	• Helps consumers secure employment (e.g., training, job search assistance and retention services)
Housing	• Helps individuals with serious mental illness who are homeless or at-risk of homelessness secure or retain permanent housing • Facilitates access to short-term stabilization housing
Behavioral Health Workforce Development	• Recruits members from unrepresented and under-represented communities • Develops skills to work effectively providing recovery oriented services in the mental health field
Capital Facilities/Information Technology	• Improves facilities and IT infrastructure • Increases client access to personal health information

Developing this Integrated Plan

This Three-Year Program and Expenditure Plan (Integrated Plan) was developed in collaboration with various consumers, peers and other stakeholders. Our Integrated Planning effort was coordinated by a planning group comprised of the SF MHSA Director and Program Managers, with independent consulting firms (Hatchuel Tabernik & Associates and Harder + Company Community Research) providing data analysis, program planning, report writing, and meeting facilitation services.

In these planning efforts, SF DPH MHSA incorporated the stated goals of MHSA and revisited the local priorities and needs identified in previous planning efforts. All of the Community Program Planning strategies outlined in the previous section were employed in developing this plan. Additional strategies in this process are listed below.

- Reviewed previous three-year Program and Expenditure plans submitted for each MHSA component. This was done to understand how well priorities identified in those plan have been addressed, as well as to determine if all programs had been implemented as originally intended.
- Reviewed MHSA regulations, laws and guidelines released by the State (e.g., DMH, OAC, CalHFA) to ensure all mandated information would be incorporated in this plan.
- Reviewed informational materials produced by CalMHSA, CMHDA, and OSHPD.
- Reviewed Annual Program Reports and demographic data submitted by contractors and civil service programs.
- Conducted program planning with service providers and consumers through robust RFQ and contracting efforts throughout the Department

Much of this Integrated Plan is made up of programs implemented through previous plans. Most of our CPP activities over the last year have been focused on the development of this plan.

Local Review Process

Our Community Planning Process involved various opportunities for community members and stakeholders to share input in the development of our Integrated Planning effort and learn about the process of our MHSA-funded programs, including MHSA Advisory Committee meetings, BHS client council meetings, and community engagement meetings. Please see the components on MHSA Communication Strategies and MHSA Advisory Committee for a specific list of meeting dates and topics.

30-Day Public Comment Period

In fulfillment of the provisions of the Welfare and Institutions (W&I) Code Section 5848, a 30-day public review and comment of San Francisco's MHSA 2017-2020 Integrated Plan was posted on the SF MHSA website at www.sfdph.org/dph. The 3-Year Plan was posted for a period of 30 days from July 17, 2017 to August 16, 2017. Members of the public were requested to submit their comments by email. Following the 30-day public comment and review period, a public hearing was conducted by the Mental Health Board of San Francisco on XXX. The 3-Year Plan was also presented before the Public Safety and Neighborhood Services Committee on XXXX.

Add public comments:

Public Hearing & Board of Supervisors Resolution

Insert Resolution Here

MHSA 3-Year Integrated Plan

As a result of the feedback we received during our Community Program Planning efforts and due to our successful evaluation outcomes, the following programs/projects will continue to operate as approved in the previous 3-Year Program and Expenditure Plan and previous Annual Updates:

- **Recovery-Oriented Treatment Services**
  - Strong Parents and Resilient Kids (SPARK)
  - San Francisco (SF) Connections
  - Family Mosaic Project
  - Transitional Age Youth Full-Service Partnership
  - San Francisco Transitional Age Youth Clinic
  - Adult Full-Service Partnership (Bayview, Oceanview, and Western Addition neighborhoods)
  - Adult Full-Service Partnership (Tenderloin neighborhood)
  - Assisted Outreach Treatment
  - San Francisco Fully Integrated Recovery Services (SF First)
  - Forensics
  - Older Adult Full-Service Partnership at Turk
  - La Cultura Cura/Trauma Recovery and Healing Services
  - Emic Behavioral Health Services
  - Assess, Identify Needs, Integrate Information & Match to services (AIIM) Higher
  - Prevention and Recovery in Early Psychosis (PREP)
  - Behavioral Health Access Center (BHAC)
  - WRAPS Dual Diagnosis Residential Treatment
  - Integration of Behavioral Health and Primary Care
- **Mental Health Promotion and Early Intervention**
  - Sharing Our Lives, Voices and Experiences (SOLVE)
  - School-Based Mental Health Services and Wellness Centers
    - Early Intervention at Burton High School
    - Behavioral Health Services at Balboa Teen Health Center
    - Mental Health Services
    - Youth Early Intervention
    - Wellness Centers
    - Trauma and Recovery Services
  - Senior Peer Recovery Center Program
  - Older Adult Behavioral Health Screening Program
  - Ajani Program
  - Black/African American Wellness and Peer Leadership Program (formerly referenced as SF Live D10 Wellness and African American Holistic Wellness)
  - African American Healing Alliance
  - Asian/Pacific Islander Youth Family Community Support Services
  - Asian/Pacific Islander Mental Health Collaborative
  - Indigena Health and Wellness Collaborative
  - Living in Balance

- South of Market Self-Help Center
- Tenderloin Self-Help Center
- Community Building Program
- Transitional Age Youth Multi-Service Center
- ROUTZ Transitional Age Youth Wellness
- Early Childhood Mental Health Consultation Initiative
  - Infant Parent Program/Day Care Consultants
  - Edgewood Center for Children and Families
  - Richmond Area Multi-Services
  - Homeless Children's Network
  - Instituto Familiar de la Raza
- Mobile Crisis
- Child Crisis
- Crisis Response

- **Peer-to-Peer Support Programs and Services**
  - Addressing the Needs of Socially Isolated Older Adults **(INNOVATIONS)**
  - Lifting and Empowering Generations of Adults, Children and Youth (LEGACY)
  - Peer Response Team
  - Peer to Peer, Family to Family
  - Peer Specialist Certificate, Leadership Academy and Counseling
  - Transgender Health Services
  - Hummingbird Peer Respite **(INNOVATIONS)**
  - Peer to Peer Employment
  - Peer Wellness Center
  - Transgender Pilot Project **(INNOVATIONS)**
  - Reducing Stigma in the South East (RSSE)
  - Peer-Run Warm Line
- **Vocational Services**
  - Department of Rehabilitation Co-op
  - i-Ability Vocational IT Program
  - First Impressions **(INNOVATIONS)**
  - SF Fully Integrated Recovery Services (SF First) Vocational Project
  - Peer Outreach, Engagement and Education
  - Assisted Independent Living Vocational Program
  - Janitorial Services
  - Café and Catering Services
  - Growing Recovery and Opportunities for Work through Horticulture (GROWTH)
  - Transitional Age Youth Vocational Program
- **Housing**
  - Emergency Stabilization Housing
  - Full Service Partnership Permanent Supportive Housing
  - Housing Placement and Support
  - ROUTZ Transitional Housing for TAY
- **Behavioral Health Workforce Development**
  - Community Mental Health Worker Certificate
  - Summer Bridge
  - Faces for the Future Program

- Medicinal Drumming Apprenticeship Pilot
- Trauma Informed Systems Initiative
- Adolescent Health Working Group – Adolescent Health Issues
- Fellowship for Public Psychiatry in the Adult/Older Adult System of Care
- Public Psychiatry Fellowship at SF General

- **Capital Facilities and Information Technology**
  - Recent Renovations – Capital Facilities
  - Consumer Portal – Information Technology
  - Consumer Employment - Information Technology
  - System Enhancements - Information Technology

In addition to continuing the program/project investments described above, SF MHSA will also focus efforts in a number of key areas. These areas of focus are detailed below:

- **We will take measures to respond to the upcoming No Place Like Home (NPLH) bond.** NPLH re-purposes statewide MHSA funds, and will provide $2 billion for the construction and rehabilitation of permanent supportive housing for homeless individuals with severe and persistent mental illness. In the coming months, we will monitor the roll-out of this legislation, and will prepare to participate in the competitive funding process. In the years ahead, we will work to develop and implement effective NPLH programming and services.

- **We will adjust the SF MHSA budget to more accurately align with state allocations.** These adjustments will focus on maintaining and enhancing existing programming, as no additional dollars are expected. In the years ahead, we do not anticipate any major expansions to the MHSA components outlined in this report.

- **We will place a strong emphasis on program evaluation across the MHSA components.** In the years ahead, we will work to enhance our monitoring and evaluation activities, in order to effectively meet the performance objectives of our MHSA-funded programs. SF MHSA is committed to pursuing innovative and dynamic methods of data-informed evaluation.

- **We will introduce new and innovative initiatives in programming.** These initiatives represent the only additional expenditures planned for the SF MHSA budget, and are spotlighted below.

PLANNING FOR NEW INNOVATION (INN) PROJECTS

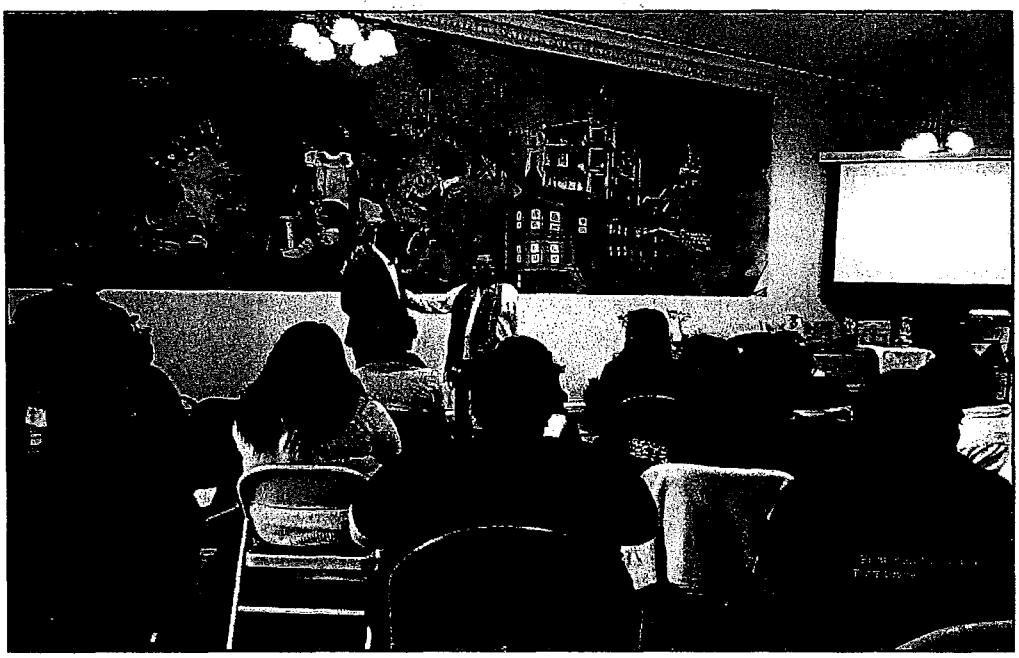
1. Family-Centered Behavioral Health Services

In collaboration with the California Mental Health Services Oversight and Accountability Commission (MHSOAC), Behavioral Health Services (BHS) is working to develop an innovative Family-Centered and Trauma-Based Program. The program model relies on a generational approach that establishes families as the center of our work and provides integrated care to families. This generational work is a pressing issue for San Francisco, as families are being pushed out of the City due to systematic changes in the economic environment. Developing a whole family approach will ensure that the family, not the individual, is the focus of support, empowerment, and sustainability. The plan is for this initiative to be funded using Innovation (INN) dollars, following the approval of the MHSOAC.

2. Intensive Case Management (ICM) Flow

The ICM Flow initiative is centered on the need to support behavioral health clients who no longer require the intensive level of care and service provided by the ICM and Full Service Partnership (FSP) programs. Clients who show progress toward recovery and engagement may be more appropriately and well supported at an outpatient clinic. Unfortunately, several factors can impede a successful transition—defined as linkage and engagement—to outpatient care. With ICM Flow, more clients will transition safely to outpatient care, living more self-directed lives that support their wellness and connection to a community that has meaning for them.

ICM Flow will be driven by providers, consumers, and BHS leaders working together to bridge the wide gap between ICM and outpatient levels of care, and more effectively support clients in the transition. We expect to convene a series of discussion and planning meetings for stakeholder engagement, then identify priority areas of practice improvement to define and test. Woven throughout the project will be the integration of volunteers and peer employees. We will recruit these peers to help inform the planning, testing, data collection, interpretation, and implementation of any and all practice changes. The plan is for this initiative to be funded using Innovation (INN) dollars, following the approval of the MHSOAC.



Organization of this Report

This report illustrates progress in transforming San Francisco's public mental health system to date, as well as efforts moving forward. The following seven sections describe the overarching purpose of each of San Francisco's MHSA Service Categories. Each program section includes an overview and description, the target population, highlights and successes for the following seven categories:

- Recovery-Oriented Treatment Services
- Mental Health Prevention & Early Intervention Services
- Peer-to-Peer Support Programs and Services
- Vocational Services
- Housing Services
- Behavioral Health Workforce Development
- Capital Facilities & Information Technology

Snapshot from behavioral health vocational program (GROWTH horticulture program) in FY16-17.

1. Recovery-Oriented Treatment Services

Service Category Overview

Recovery-Oriented Treatment Services include services traditionally provided in the mental health system, such as screening and assessment, clinical case management, individual and group therapy, and medication management.

The majority of MHSA funding for Recovery-Oriented Treatment Services is allocated to Full Service Partnership (FSP) Programs. The remaining funds are distributed to the following programs and initiatives.

- The Prevention and Recovery in Early Psychosis Program
- Trauma Recovery Programs
- Behavioral Health and Juvenile Justice Integration
- Dual Diagnosis Residential Treatment
- The Behavioral Health Access Center
- Behavioral Health and Primary Care Integration

Full Service Partnership Programs

Program Collection Overview

Full Service Partnership (FSP) programs reflect an intensive and comprehensive model of case management based on a client-and family-centered philosophy of doing "whatever it takes" to assist individuals diagnosed with severe mental illness (SMI) or severe emotional disturbance to lead independent, meaningful, and productive lives. FSP programs were designed under the leadership of the former California Department of Mental Health in collaboration with the California Mental Health Directors Association, the California Mental Health Planning Council, the Mental Health Services Oversight and Accountability Commission, mental health clients and their family members, mental health service providers, and other key stakeholders of the mental health system to implement more recovery-oriented treatment modalities for the clients in the public health system who require more intensive levels of support than regular outpatient clinics can provide. In existence since 2005, FSP programs continue to develop the distinguishing characteristics that lead to positive outcomes for mental health clients and their families.

Target Populations

Full Service Partnership (FSP) programs are designed to provide wraparound support services to individuals who are either not currently enrolled in the behavioral health treatment system or are not currently receiving adequate services and supports. These populations may include those who 1) are homeless or at-risk of homelessness or eviction; 2) make frequent visits to medical or psychiatric emergency services; 3) are involved in the adult criminal justice system; 4) are in Adult or Child Protective Services custody; 5) identify as Lesbian, Gay, Bisexual,

Transgender and Questioning; 6) are aging out of institutional care or foster care; 7) have been traumatized or ostracized by violence, abuse, discrimination, stigma, gang involvement, and isolation; and/or 8) have co-occurring mental health/substance use disorders.

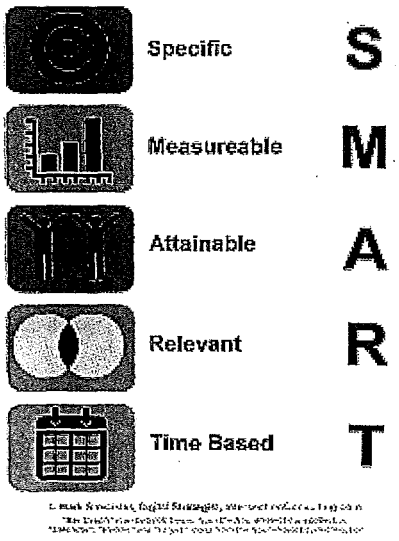
Update on FSP Evaluation

In San Francisco, the eleven FSPs are fully integrated into the children and adult systems of care. However, due to the enhanced funding provided by the Mental Health Services Act, and the regulatory requirement to complete client outcome data in the Data Collection and Reporting (DCR) system, Quality Management launched an extensive evaluation of the FSPs in 2016.

Phase I of the FSP evaluation, the first of many, covers the following:

- FSP program descriptions of services
- Results of interviews with clients, staff and directors about the services provided
- Demographics of clients actively enrolled in FY 15-16
- Outcomes drawn from DCR data and interviews with clients, clinicians and directors from the TAY, adult and older adult FSPs

The Phase I evaluation is going through its community review process and will be disseminated to San Francisco stakeholders and the California Mental Health Services Act Oversight and Accountability Commission in May 2017. Phase II of the evaluation includes interviews and focus groups with directors, clinicians, clients and family members from the Children, Youth and Families (CYF) FSP programs and is scheduled for completion in the fall of 2017.



The FSP Evaluation Advisory Committee meets regularly (usually monthly) to decide evaluation priorities, design evaluation plans, create and review data collection methods and tools, discuss findings and generate recommendations. Members of the committee represent clinicians, program directors, peer employees and consumers with lived experience.

Priorities for evaluation to be addressed in upcoming phases are likely to include successful transitions from FSP to outpatient care, process and outcomes related to MHSA Housing, integration of peer employees into FSP programs, and evaluating the role of substance use and treatment within the FSPs.

Full Service Partnership Programs		
Target Population	**Program Name**	**Services**
Children 0-5 & Families	Strong Parents and Resilient Kids (Instituto Familiar de la Raza)	Provides trauma focused dyadic therapy, intensive case management and wraparound services to the 0 – 5 population
Children & Adolescents	SF Connections (Seneca)	Offers wraparound services to help children and their families achieve stability and increase access to community resources
	Family Mosaic Project (DPH)	Provides intensive case management and wraparound services in the Bayview, Mission, and Chinatown neighborhoods
Transitional Age Youth	TAY FSP (Family Services Agency)	Provides physical health care, mental health treatment, medication management, employment assistance, housing support, and peer support
	SF TAY Clinic (DPH)	Conducts intensive services (e.g., training on independent living skills, mental health and substance abuse counseling) with youth transitioning out of foster care and child welfare system
Adults	Adult FSP (Family Services Agency)	Conducts wellness and creative arts workshops, holds community cultural events, offers support groups, and organizes healing circles for African Americans living in the Bayview, Oceanview, and Western Addition neighborhoods
	Adult FSP (Hyde Street Community Services)	Implements mental health promotion efforts to homeless individuals in the Tenderloin who have not successfully engaged with outpatient services and frequently experience multiple co-occurring disorders
Adults/Older Adults	Assisted Outpatient Treatment (SF Behavioral Health Services & UCSF Citywide Case Management)	Improves the quality of life of participants, supports them on their path to recovery and wellness, and prevents cycling through acute services and incarceration with a particular focus on providing community-based services and multiple opportunities for an individual to engage in voluntary treatment
	SF Fully Integrated Recovery Service Team (DPH)	Provides services (e.g., individual or group therapy, medication management) to individuals with SMI who have been homeless for an extended time
	Forensics (UCSF Citywide Case Management Forensics)	Provides consultation, services, screening and assessment, and other mental health services to adults who are engaged with the Behavioral Health Court
	Older Adult FSP at Turk (Family Services Agency)	Serves older adults age 60 and above who need specialized geriatric services related to mental health and aging

Spotlight Program - Assisted Outpatient Treatment Program (AOT)

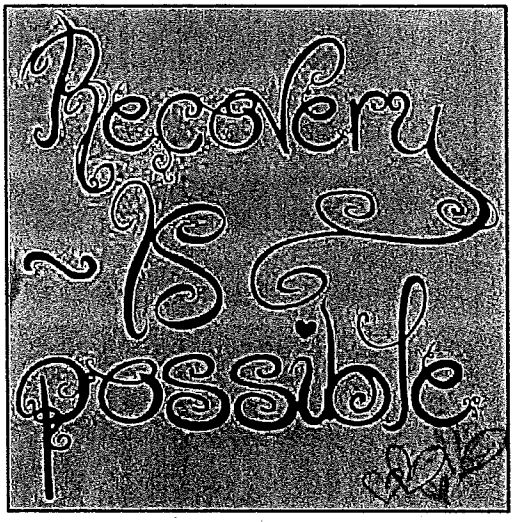
In July 2014, San Francisco's Board of Supervisors authorized Assisted Outpatient Treatment (AOT), most commonly referred to as Laura's Law, as a response to Mayor Ed Lee's 2014 Care Task Force. Laura's Law allows a relative, roommate, mental health provider, or police or probation officer to petition the courts to compel outpatient treatment of a person with mental illness. Implemented November 2, 2015, the San Francisco AOT Model is utilized as an intervention and engagement tool designed to assist and support individuals with mental illness (www.sfdph.org/aot). The program has been constructed to employ principles of recovery and wellness, and has a particular focus on community-based services and multiple opportunities for an individual to engage in voluntary treatment. The ultimate goal of the program is to improve the quality of life of participants and support them on their path to recovery and wellness, as well as prevent decompensation and cycling through acute services (e.g., psychiatric hospitalization) and incarceration.

On average, the AOT Care Team has a 1:1 rate of successful contact of referred individuals.

In its first year of implementation, the program has seen tremendous success in engaging people in voluntary mental health support services. Almost all of the 108 people referred to the program were flagged by relatives or mental health providers and 40% had been homeless in the past three years. Sixty percent of those referred accepted the voluntary services and, of the remaining 40 percent, some did not meet the criteria for Laura's Law and DPH opted to take the seven most severe courses to court. Three people agreed to treatment, DPH withdrew one case, and the remaining three cases were ordered into treatment by a judge. DPH relies on the court petition only in the most severe cases as a last resort. In addition to supporting positive changes for program participants and their families, San Francisco's AOT model may catalyze enhancements to various systems that affect persons prioritized by the program.

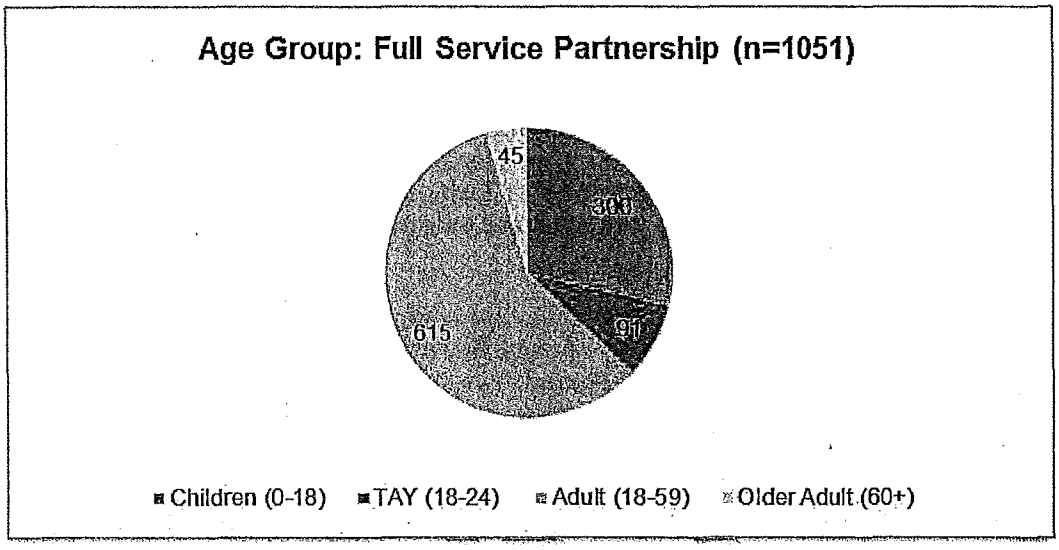
As the AOT program progresses into its second year of implementation, we intend to expand evaluation components to include the following:

- Rates of and influences on successful treatment adherence among AOT participants.
- Social functioning and independent living among current and former AOT participants.
- Strategies to expand family support and to achieve acceptable balance between family expectations and program goals.
- AOT impact on substance use by AOT participants and substance use disorders.
- Use and results of employment service programs by AOT participants.
- Victimization and violence reduction effects of AOT.
- Best practices for engagement and intervention efforts.

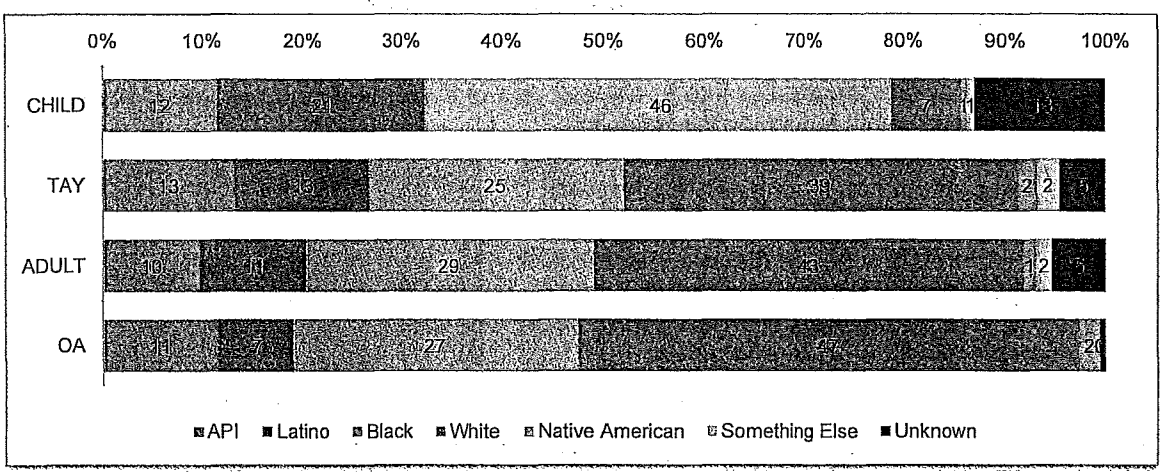


Participant Demographics, Outcomes, & Cost per Client

Demographics: Full Service Partnership



Ethnicity (%) of Clients Active FY15-16, by Age Group



FSP Population	FY15-16 Key Outcomes and Highlights
Children, Youth, and Families	• For those children living with non-parental family, total days in restrictive residential treatment decreased 62% from baseline year to 1st year in FSP. • Days living in shelters and temporary housing decreased 43% for child clients. • Emergency events for child clients—such as physical health emergencies, suspensions, and expulsions—all decreased by at least 89% from baseline year to 1st year in FSP.
Transitional Age Youth (TAY)	• TAY clients enrolled in FSP showed an increase in supervised placement of 172% and an increase in SRO (lease) placement of 281%, from baseline year to 1st year. • Among TAY clients, mental health emergencies decreased from 113 events per 100 clients in baseline year, to 33 events per 100 clients in 1st year in FSP. • Arrests among TAY clients decreased 88% from baseline year to 1st year in FSP.
Adults	• From baseline year to 1st year in FSP, adult clients showed a 67% decrease in days homeless, a 55% decrease in days in a justice setting, and a 28% decrease in days hospitalized. • For adult FSP clients, days in an SRO (lease) increased 32%, and days in residential treatment increased 56%, from baseline year to 1st year in FSP. • Among adult clients, arrests decreased from 53 events per 100 clients in baseline year, to 7 events per 100 clients in 1st year in FSP. • Mental health emergencies among adult clients decreased 79% from baseline year to 1st year in FSP, while physical health emergencies decreased from 82 per 100 clients, to 14 per 100 clients.

Older Adults

- From baseline year to 1st year in FSP, older adult clients showed a 77% increase in days in residential treatment, and a 37% increase in days in supervised placement.
- Days in shelter and temporary housing decreased 16% and days homeless decreased 41%, from baseline year to 1st year in FSP.
- Among older adult clients, mental and physical health emergencies decreased 77% and 75%, respectively, from baseline year to 1st year in FSP.
- Total arrests among older adult clients decreased from 20 in baseline year, to 0 in 1st year of FSP.

Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[2]**
Full Service Partnership (Children)	300 clients	$1,315,782	$4,386
Full Service Partnership (TAY)	91 clients	$921,401	$10,125
Full Service Partnership (Adult)	615 clients	$4,130,918	$6,717
Full Service Partnership (Older Adult)	45 clients	$609,367	$13,541

Trauma Recovery Programs

Program Collection Overview

Children and youth impacted by trauma, including community violence, face serious risk for multiple health and social problems including physical injury, post-traumatic stress syndrome, incarceration, and social isolation. Cultural, linguistic and socially relevant services serve as vehicles in the engagement, assessment, differential diagnosis and recidivism of youth and their families. Services that integrate various interventions – e.g., crisis intervention, family support, case management and behavioral change – within the context of values, beliefs and norms rooted in the community being served have been well-documented and underscore the importance of providing culturally proficient models of service.

Target Populations

The Trauma Recovery programs serve youth ages 12 to 25, as well as their families, with a focus on youth of color, particularly Latinos who reside in the Mission District, and youth who come from low-income and/or immigrant families. Program participants are typically individuals

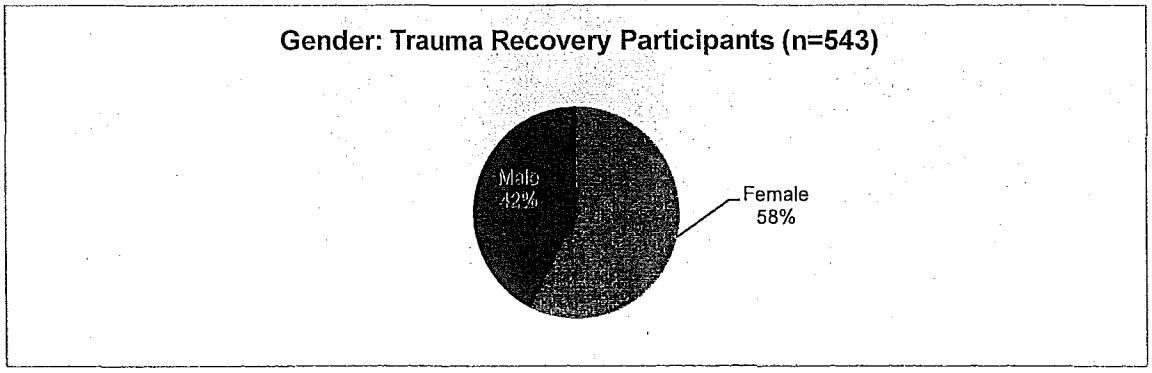
[2] Cost per client is calculated by dividing the program annual budget by the total number of unduplicated clients served.

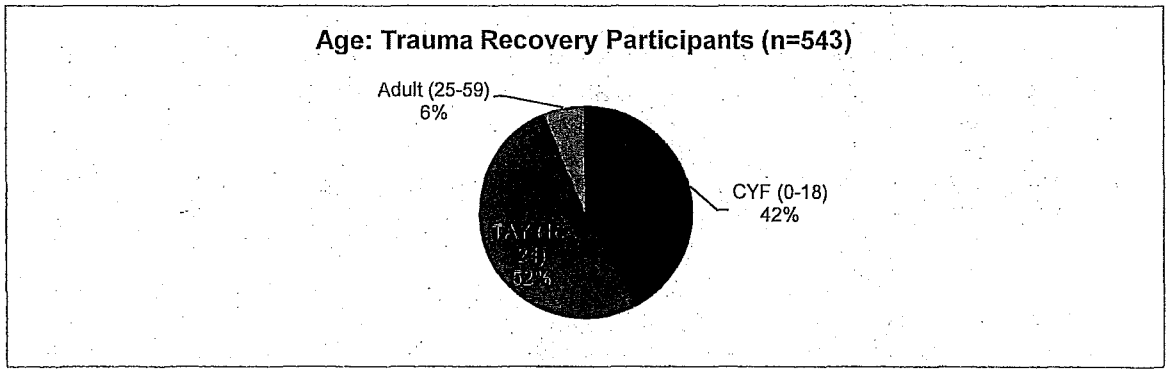
who have been affected by violence. Most often, these youth are faced with a number of additional risk factors, including lack of educational success/withdrawal from school, familial mental health and substance use disorders, multi-generational family involvement in crime, community violence, and extreme poverty.

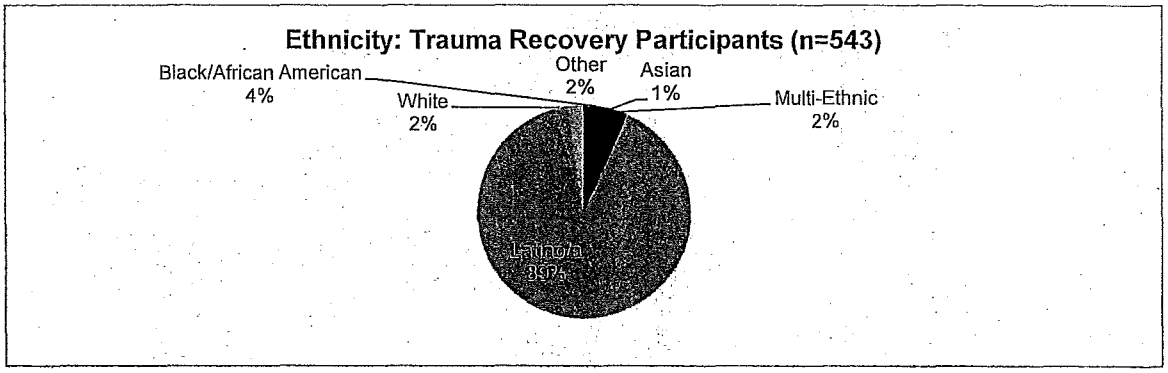
Trauma Recovery Programs	
Program Name	**Services Description**
La Cultura Cura/Trauma Recovery and Healing Services	Instituto Familiar de la Raza provides trauma recovery and healing services through its Cultura Cura Program to individuals ages 12 to 25 and their families, with an emphasis upon Mission District youth and Latinos citywide. Services include prevention and intervention modalities to individuals, agencies and the community.
Emic Behavioral Health Services	Horizon Unlimited's Emic Behavioral Health Services (EBHS) program provides services to meet the unmet mental health needs of youth and families whose problems place them at significant risk, and impede adequate functioning within their family, school, community and mainstream society. The EBHS treatment model combines culturally informed, evidence based substance abuse and mental health principles and practices that are linguistically sensitive, strength based, family focused and bio-psychosocially-oriented.

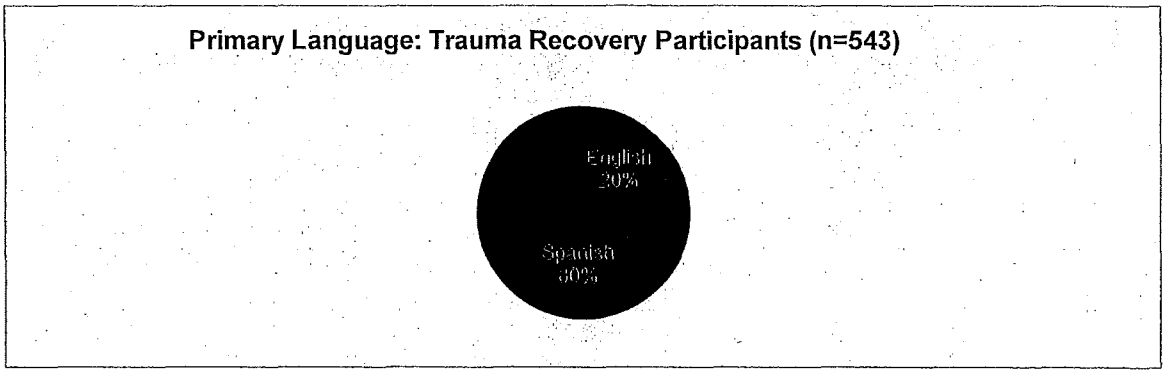
Participant Demographics, Outcomes, and Cost per Client

Demographics: Trauma Recovery




Age: Trauma Recovery Participants (n=543)
Adult (25-59)
6%
CYF (0-18)
42%
TAY (19-24)
52%


Ethnicity: Trauma Recovery Participants (n=543)
Black/African American
4%
Other
2%
Asian
1%
White
2%
Multi-Ethnic
2%
Latino/a
89%


Primary Language: Trauma Recovery Participants (n=543)
English
20%
Spanish
80%

Program	FY15-16 Key Outcomes and Highlights
	• In FY15-16, IFR provided trauma screening to determine eligibility for services to 267 unduplicated clients, 100% of whom received resource information, access to treatment, or triage to other programs.
La Cultura Cura – Instituto Familiar de la Raza	• 27 youth were served through individual treatment services, with 70% of youth receiving 12 months of ongoing service. • IFR's behavioral health specialists provided over 40 care manager development sessions for violence prevention case managers from La Cultura Cura and Roadmap to Peace, group facilitators, substance use treatment providers, and employment development specialists.
Horizons Unlimited – Emic Behavioral Health Services	• 94% of participants in wellness activities completed at least 10 sessions and reported an increase in their quality of life, as measured by the Quality of Life survey. • 58 clients in total received non-clinical case management services, and were referred to behavioral health and/or social services. 100% of the clients receiving non-clinical case management services completed at least one of their care goals. • EBHS attended over 10 community tabling events in FY15-16, connecting with community members, youth, and families. Staff also spoke with SFUSD Wellness Coordinators at various high schools, reaching 1,439 unduplicated students in total.

Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[3]**
Trauma Recovery Programs	3,071 clients	$363,552	$118

Behavioral Health and Juvenile Justice System Integration

Program Overview

Assess, Identify Needs, Integrate Information, and Match to services (AIIM) Higher serves as a single point of entry for youth involved in the San Francisco Probation System to get connected to community-based behavioral health services. AIIM Higher is a partnership among the San Francisco Juvenile Probation Department, the Child, Youth and Family System of Care, and

[3] Cost per client is calculated by dividing the program annual budget by the total number of unduplicated clients served.

Seneca. The AIIM Higher team is comprised of mental health clinicians who conduct clinical assessments and facilitate community behavioral health linkages for probation-involved youth in San Francisco.

AIIM Higher and its affiliated programs operate citywide and serve youth and their families wherever they feel most comfortable whether it is at home, school, or in the community. Services are also offered at the Juvenile Justice Center and in Juvenile Hall.

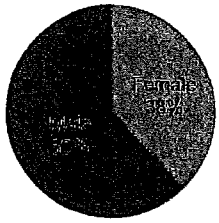
Target Populations

The programs making up the Integration of Behavioral Health and Juvenile Justice serve youth ages 11- 21 and their families. African American and Latino youth are overrepresented in the juvenile justice system and make up the majority of who is served. AIIM Higher and its affiliated programs operate citywide and serve youth and their families wherever they feel most comfortable whether it is at home, school, or in the community. Services are also offered at the Juvenile Justice Center and in Juvenile Hall.

Participant Demographics, Outcomes, and Cost per Client

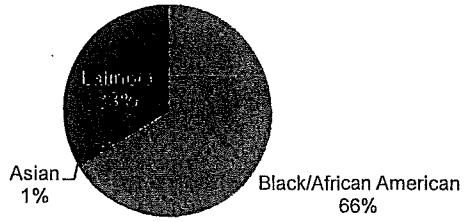
Demographics: Behavioral Health and Juvenile Justice Integration

Gender: Behavioral Health & Juvenile Justice Participants (n=329)

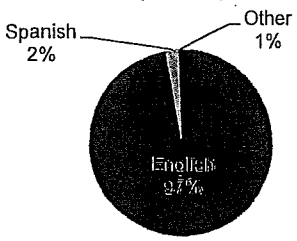


Age:Behavioral Health & Juvenile Justice Participants (n=329)

Ethnicity: Behavioral Health & Juvenile Justice Participants (n=204)



Primary Language: Behavioral Health & Juvenile Justice Participants (n=309)



Program	FY15-16 Key Outcomes and Highlights
AIIM Higher – Seneca Center, and City and County of San Francisco	• In FY15-16, of 119 eligible youth, 57 youth and their families were provided with Child Adolescent Needs & Strengths (CANS) assessment, planning, linkage and engagement services. • Of the youth who received CANS assessments and were successfully linked to services, 100% engaged in at least three follow up sessions with the newly identified provider. • In FY15-16, 100% of AIIM Higher participants indicated that services were thorough and therapeutic in nature, and that linkages were appropriate.

Cost per Client

Program	Clients Served	Annual Cost	Cost per Client[4]
Behavioral Health & Juvenile Justice Integration	329 clients	$466,070	$1,417

[4] Cost per client is calculated by dividing the program annual budget by the total number of unduplicated clients served.

Spotlight Program – Prevention and Recovery in Early Psychosis (PREP)

Program Overview

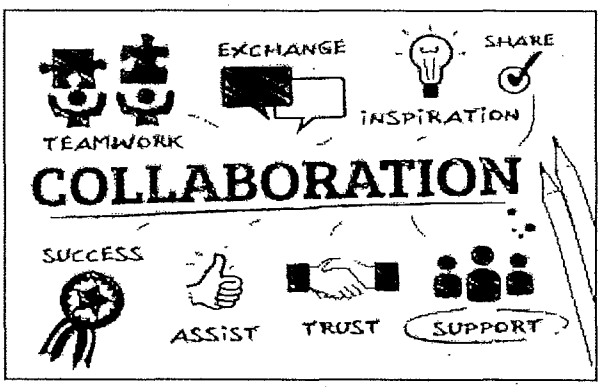
Roughly half of all lifetime mental disorders have been shown to start by the mid-teens and three-fourths by the mid-20s. Severe disorders like schizophrenia are typically preceded by earlier behavioral, social and emotional signs and symptoms that seldom receive clinical attention. Research shows that intervening during the early stages of psychosis improves outcomes. However, treatment is often not accessed until a number of years later. Missing this critical window for early intervention can lead to greater suffering, trauma, and functional deterioration.

PREP is an early intervention treatment program for schizophrenia and early psychosis for individuals between the ages of 16 and 30 to support symptoms remission, active recovery, and full engagement with family, peers, and coworkers. This model is based on established programs internationally in Australia and the United Kingdom, and nationally in the state of Maine, among other sites. PREP treatment services include the following: algorithm-based medication management, cognitive rehabilitation, cognitive behavioral therapy for early psychosis, multi-family groups (MFG), strengths-based care management, and neuropsychiatric and other advanced diagnostic services. PREP has a significant outreach component that obtains referrals of appropriate clients into the program, and that is designed to reduce the stigma of schizophrenia and psychosis in general and promote awareness that psychosis is treatable.

Since its launch in 2010, the PREP program has shown positive outcomes with participants demonstrating reductions in mental health symptoms and increases in functioning, quality of life, engagement in services and satisfaction with services.

Target Populations

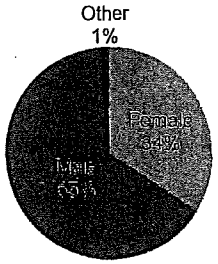
PREP serves youth and young adults between the ages of 14-35, with most clients being transitional age youth (TAY) who fall between the ages of 16 and 24. The program targets individuals who had their first psychotic episode within the previous two years or who, as identified in the PREP diagnostic assessment, are at high risk for having their first episode within two years.



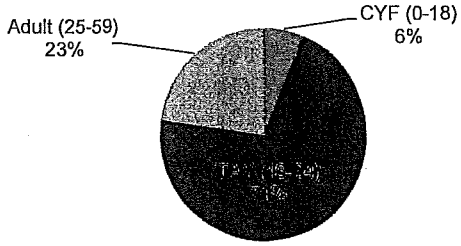
Participant Demographics, Outcomes, and Cost per Client

Demographics: PREP

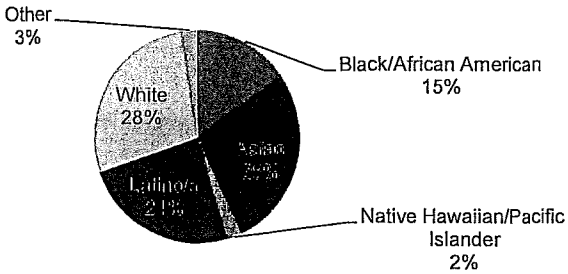
Gender: PREP Participants (n=79)

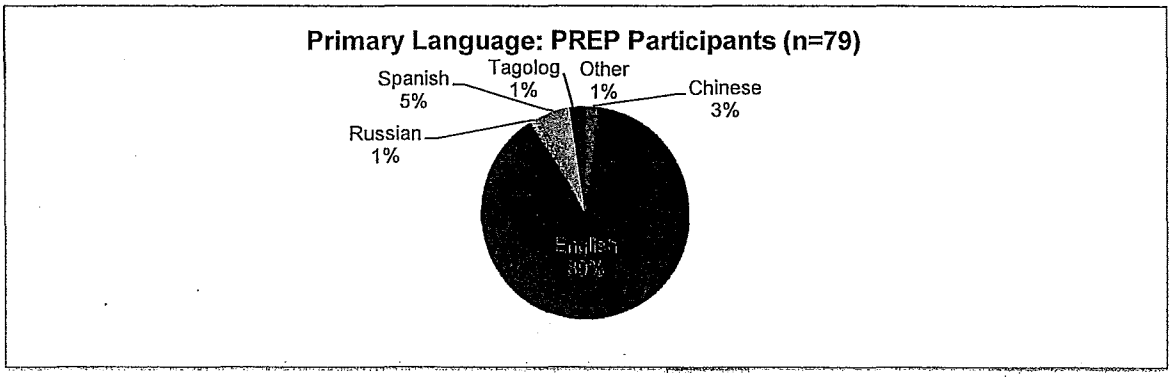


Age: PREP Participants (n=79)



Ethnicity: PREP Participants (n=79)





Program	FY15-16 Key Outcomes and Highlights
PREP	• In FY15-16, 41 clients were enrolled in PREP for 12 months or more. Based on CIRCE and AVATAR records, 13 of these clients (32%) were enrolled in new educational and vocational activities. • By the end of FY15-16, clients with a history of acute inpatient episodes showed a 70% reduction in acute inpatient setting episodes and an 89% reduction in days hospitalized during the first 12 months of enrollment in PREP. • Of the 41 clients enrolled in FY15-16 for 12 month or more, 29 (77%) showed improvement in PCI Domain Analyses.

Cost per Client

Program	Clients Served	Annual Cost	Cost per Client[5]
Prevention and Recovery in Early Psychosis (PREP)	79 clients	$915,724	$11,591

Behavioral Health Access Center (BHAC)

Program Overview

Designed and implemented in 2008, with the goal of ensuring more timely access to behavioral health services and better coordinating intake, placement authorization, and referral processes for individuals seeking care, the Behavioral Health Access Center (BHAC) was one of the first projects funded by MHSA. The BHAC is a portal of entry into San Francisco's overall adult and older adult system of care and co-locates the following five behavioral health programs:

[5] Cost per client is calculated by dividing the program annual budget by the total number of unduplicated clients served.

1) Mental health access for authorizations into the Private Provider Network
2) The Treatment Access Program for assessment, authorization, and placement into residential treatment
3) The Offender Treatment Program to place justice mandated clients into addiction and dual diagnosis treatment
4) Centralized Opiate Placement Evaluation (COPE) and Office-Based Buprenorphine Induction Clinic (OBIC) for evaluation and placement into Opiate Replacement Therapy
5) The BHS Pharmacy that provides buprenorphine for Integrated Buprenorphine Intervention Services (IBIS) clients, methadone maintenance for Office-Based Opioid Treatment (OBOT) clients, ambulatory alcohol detoxification medications for Treatment Access Program clients, naloxone for opiate overdose prevention, specialty behavioral health medication packaging and serves as a pharmacy safety net for all BHS clients

As a program that serves clients on both a drop-in and appointment basis, BHAC seeks to provide the necessary care coordination for all San Franciscans in need of behavioral health care.

Target Populations

The BHAC target population includes multiple underserved and vulnerable populations including those with serious, chronic, and persistent mental illness, substance use disorder and dual diagnosis clients. A substantial number of clients are indigent, homeless, non-English speaking, and/or in minority populations. One of the pharmacists is bilingual and provides direct client treatment for medication management, medication review, and smoking reduction services to the Cantonese-speaking population at Chinatown North Beach Clinic and Sunset Mental Health Center. One of the Eligibility Workers is tri-lingual and able to serve clients speaking English, Spanish, and Tagalog.

Program Outcomes, Highlights and Cost per Client

Program	FY15-16 Key Outcomes and Highlights
Behavioral Health Access Center	• Provided 1,814 unduplicated care episodes with access to behavioral and physical health care in FY15-16. • BHAC staff received 20,560 calls from residents of San Francisco seeking access to mental health services. • Conducted 712 face-to-face contacts with clients accessing care and in need of concurrent primary care services. • In FY15-16, BHAC implemented enhanced overnight and out-of-hours interventions for clients in crisis, and/or in need of services during nights, weekends and holidays, creating a truly 24/7, 365 day intervention. • The BHAC Offender Treatment Program (OTP) served 309 clients referred by the Adult Probation Department and in need of behavioral health services in FY15-16.

Cost per Client			
Program	Clients Served	Annual Cost	Cost per Client[6]
Behavioral Health Access Center	1,814 clients	$934,728	$515

Dual Diagnosis Residential Treatment

Program Overview

HealthRight 360 (HR 360) WRAPS provides brief residential psychiatric stabilization, designed for clients who might otherwise be diverted to Psychiatric Emergency Services or an Acute Diversion Unit setting. WRAPS is a well-established resource for clients who require residential stabilization. Clients participate in the larger structure of groups, individual services and care management that all clients in the facility receive. Groups include Wellness Recovery Action Plan, Dialectical Behavioral Therapy, Grief and Loss, Skills Training, etc. Individual services include Drug and Alcohol Counseling, Individual Therapy if needed, access to psychiatric services through the four medical clinics, case management, linkage and referral to community services.

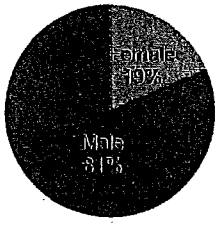
Target Populations

Dual diagnosis residential treatment services are provided to individuals who do not have Medi-Cal coverage and who would otherwise not be eligible for services. As a result of the Affordable Care Act (ACA), more individuals are now eligible to enroll in Medi-Cal than ever before. SF MHSA intends to partner with the service provider and other stakeholders to evaluate how ACA may impact the target population for this program.

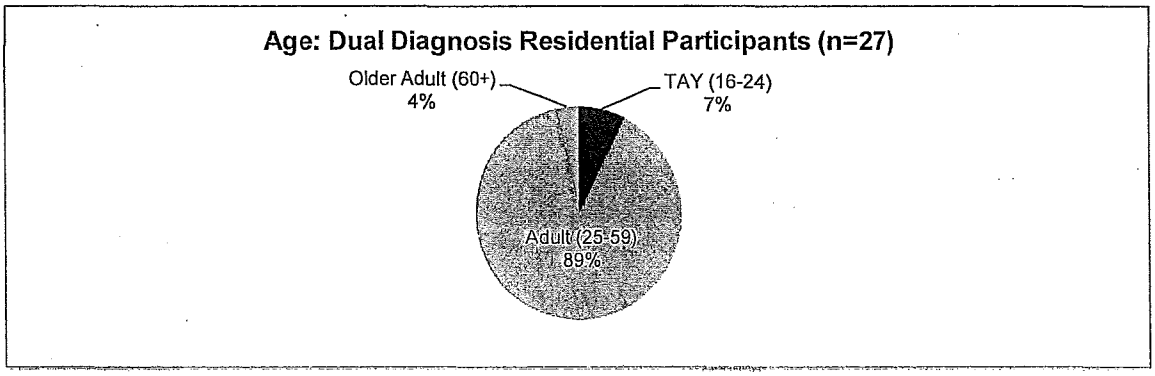
Participant Demographics, Outcomes, and Cost per Client

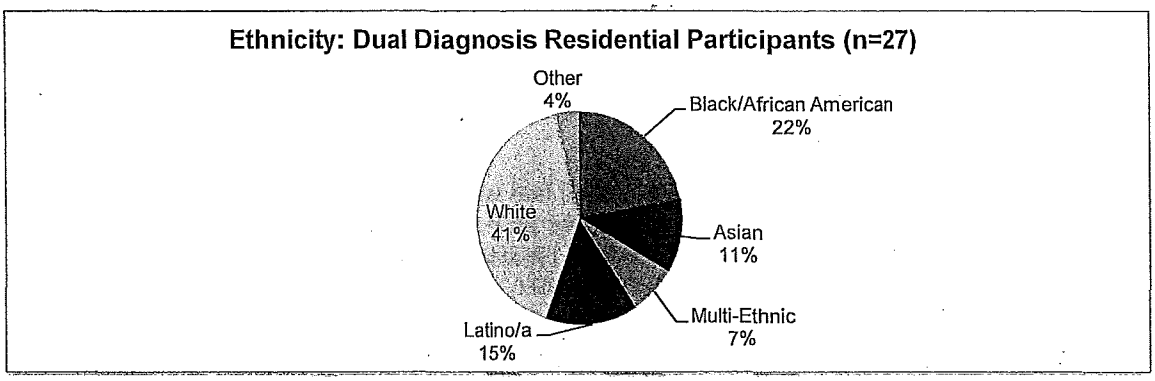
Demographics: Dual Diagnosis Residential

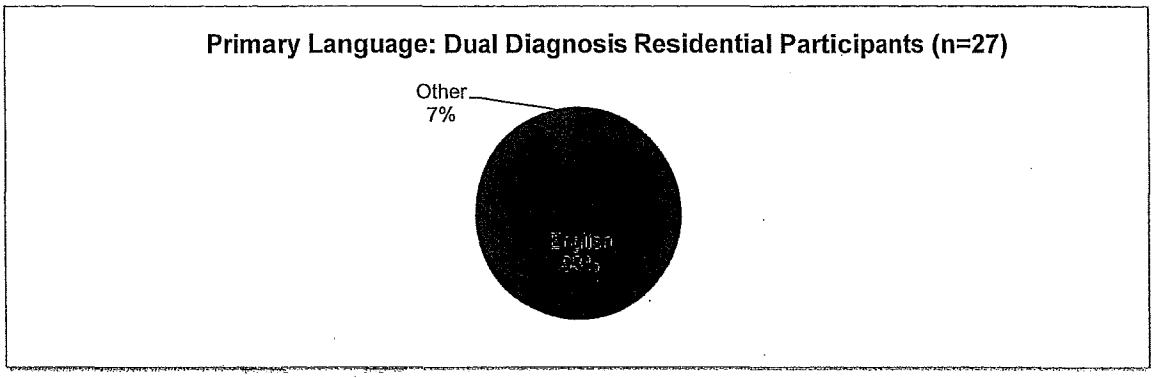
Gender: Dual Diagnosis Residential Participants (n=27)



[6] Cost per client is calculated by dividing the program annual budget by the total number of unduplicated clients served.







Program	FY15-16 Key Outcomes and Highlights
HR360 - WRAPS	• During FY15-16, 79% of clients who completed service were linked to an appropriate level of continuing care and support, as measured by internal outcome measurement system and documented in client files. • 85% of clients who completed service in FY15-16 were linked to a primary care home.

Program	FY15-16 Key Outcomes and Highlights
	• 93% of clients avoided hospitalization for mental health reasons for the duration of their stay in the program.

Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[7]**
Dual Diagnosis Residential Treatment	27 clients	$68,172	$2,525

Integration of Behavioral Health and Primary Care: San Francisco Health Network

Program Overview

The San Francisco Department of Public Health has worked toward fully integrated care in various forms for the last two decades. In 2009, after an extensive community planning process, SF DPH implemented the Primary Care Behavioral Health (PCBH) model in the majority of SF DPH primary care clinics. In this model, behavioral health clinicians work as members of the primary care team providing services to patients in primary care clinics. Services include the delivery of brief, evidence-based therapeutic interventions, consultation to primary care team members, and participation in population-based care "pathways," and self- and chronic-care management. (e.g., class and group medical visits).

MHSA supports behavioral health staff stationed at the following Primary Care Clinics:

- Chinatown Public Health Clinic – Disability Clinic
- Cole Street Clinic
- Larkin Street Youth Services – Medical Clinic
- Curry Senior Center Primary Care Clinic
- Southeast Health Center

MHSA also supports primary care staff stationed at the following mental health clinics:

- South of Market Mental Health
- Behavioral Health Access Center
- Chinatown Child Development Center

Target Populations

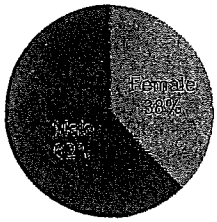
The target populations for these services are individuals and families served in primary care clinics with unidentified behavioral health concerns, as well as individuals and families served in mental health clinics with complex physical health issues or unidentified physical health concerns.

[7] Cost per client is calculated by dividing the program annual budget by the total number of unduplicated clients served.

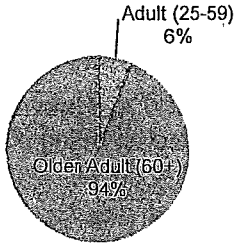
Participant Demographics, Outcomes, and Cost per Client

Demographics: Primary Care Integration

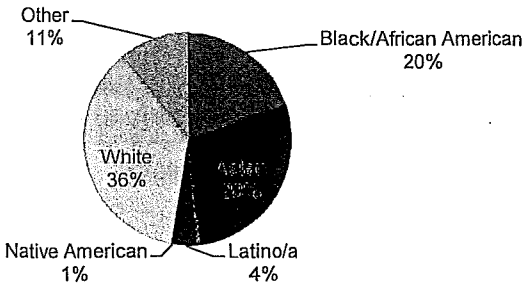
Gender: Primary Care Integration Participants (n=364)

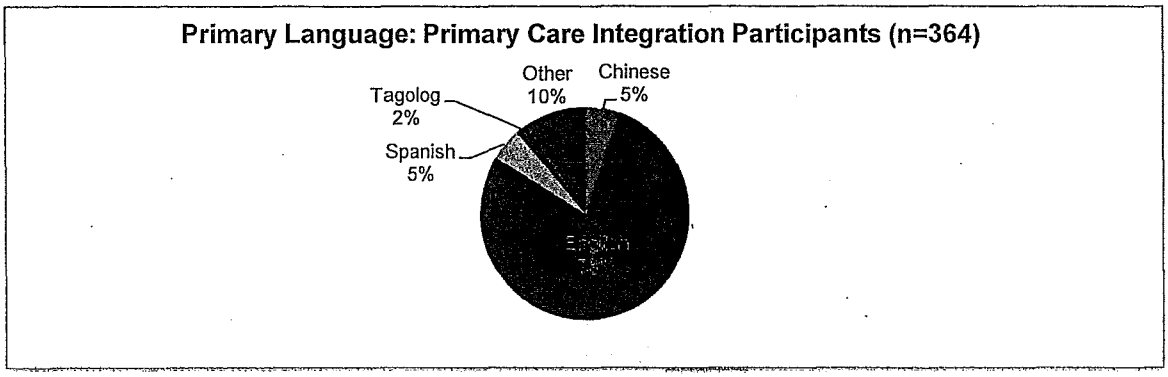


Age: Primary Care Integration Participants (n=364)



Ethnicity: Primary Care Integration Participants (n=364)





Program	FY15-16 Key Outcomes and Highlights
Primary Care Integration	• In FY15-16, 100% of MHSA clients received screening for behavioral health issues, as indicated in staff logs and notes in the clients' charts • 82% of case management program participants demonstrated an increased ability to manage symptoms, as evidenced in participants' self-report and documented in progress notes and staff logs • 100% of participating MHSA clients indicated a 'good' or higher rating of satisfaction, as measured by results from the annual Consumer Satisfaction Survey • Curry Senior Center gained access to a new rental subsidy, allowing for an (up to three-year) monthly subsidy for seniors who pay 80% or more of their monthly income for rent. This has allowed some homeless seniors to gain housing, and some seniors at-risk of losing their housing to remain living in their own room or apartment

Cost per Client

Program	Clients Served	Annual Cost	Cost per Client[8]
Integration of Behavioral Health and Primary Care	2,100 clients	$1,474,531	$702

Moving Forward in Recovery-Oriented Treatment Services

Full Service Partnership (FSP) Programs

DPH MHSA staff are currently developing a proposal to present to the California MHSA Oversight and Accountability Commission to receive Innovations funding for a new program that

[8] Cost per client is calculated by dividing the program annual budget by the total number of unduplicated clients served.

would provide support services to clients who are transitioning from ICM-FSP programs into outpatient care. This proposed ICM-FSP Flow Program comes out of a need to support Behavioral Health clients who no longer need the intensive level of care and service provided by the ICM-FSP programs but do not successfully connect to outpatient programs and services. Read more about the proposed ICM Flow program in the "Looking Ahead" section at the end of this Integrated Plan.

In addition to this project, SF DPH MHSA staff, in collaboration with the Adult/Older Adult System of Care staff, issued a Full-Service Partnership/Intensive Case Management Request for Proposals (RFP) in the spring of 2017 and are working to contract with selected service providers. This RFP and contracting process includes most MHSA-funded FSP programs.

Behavioral Health Access Center

The Behavioral Health Access Center (BHAC) engages with vulnerable populations who seek access to care in San Francisco. BHAC has served thousands of people since 2009 and continues to be a high profile portal of entry into the system of care.

In FY17-18, BHAC will play an important part in the implementation of Drug Medi-Cal in San Francisco. As the principal point of entry for Medi-Cal beneficiaries seeking access to substance use disorder treatment, BHAC will be responsible for:

- Initial assessment and screening of clients
- Determining appropriate levels of care
- Facilitating linkages into treatment through placement and placement authorization
- Conducting utilization management and review to ensure appropriate and suitable treatment planning consistent with nest practices

The implementation of the Drug Medi-Cal waiver will establish a parity in services bringing together the strengths of the behavioral health system of care in being responsive to individuals' unique needs. BHAC will create an Eligibility Unit to provide individuals with assistance in enrolling in health care entitlements and, in partnership with the Adult Probation Department, will extend services to the Community Assessment and Services Center, which acts as a community reentry center for the formerly incarcerated. As always, BHAC will continue to take decisive steps to reduce barriers to accessing care, and to how care is provided to consumers. BHC will also continue to innovate and support people with multiple health conditions, not just a single disease.

2. Mental Health Promotion and Early Intervention

Service Category Overview

The Mental Health Promotion and Early Intervention (PEI) service category is comprised of the following five program areas:

1) Stigma Reduction,
2) School-Based Mental Health Promotion,
3) Population-Focused Mental Health Promotion,
4) Mental Health Consultation and Capacity Building, and
5) Comprehensive Crisis Services.

In half of the lifetime cases of mental health disorders, symptoms are present in adolescence (by age 14); in three-quarters of cases, symptoms are present in early adulthood (by age 24). However, there are often long delays between the onset of mental health symptoms and treatment. Untreated mental disorders can become more severe, more difficult to treat, and cause co-occurring mental illness and/or substance use disorders to develop. Currently, the majority of individuals served by BHS enter the system when a mental illness is well-established and has already done considerable harm (e.g., prison, hospitalization or placement in foster care) despite the fact that many mental health disorders are preventable and early intervention has been proven to be effective in reducing the severity of mental health symptoms.

With a focus on underserved communities, the primary goals of PEI services are to raise awareness about mental health, address mental health stigma, and increase access to services. PEI builds capacity for the provision of early intervention services in community-based settings where mental health services are not traditionally provided (e.g., community-based organizations, schools, ethnic specific cultural centers and health providers). Innovation funding also supports several programs in this MHSA service category.

Stigma Reduction

Program Overview

Sharing Our Lives, Voices and Experiences (SOLVE) is a stigma elimination program. SOLVE trains people in the community ("peer educators") who have been living with mental health challenges to share their personal experiences to help to reduce the social barriers that prevent people from obtaining treatment.

Target Populations

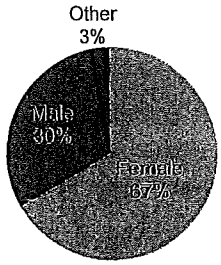
SOLVE peer educators serve a wide range of community members, including BHS consumers, public policy makers, corporate and community leaders, students, school leaders, law enforcement, emergency response service providers, health care providers, and behavioral health and social service providers. The current SOLVE team is comprised of Transition Age Youth, adults and older adults who reside in communities that are severely underserved and less likely to access or obtain support for prevention, wellness, and recovery. These areas include the Tender-

loin, Mission, Bayview/Hunter's Point, Excelsior, Chinatown, and Visitacion Valley neighborhoods in San Francisco. SOLVE also targets diverse gender-variant communities within San Francisco.

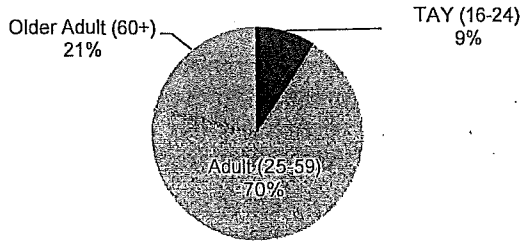
Participant Demographics, Outcomes, and Cost per Client

Demographics: Stigma Reduction

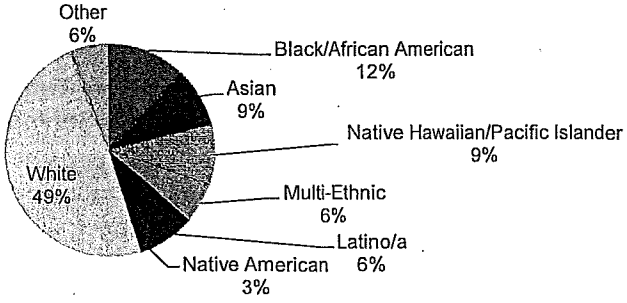
Gender: Stigma Reduction Participants (n=33)

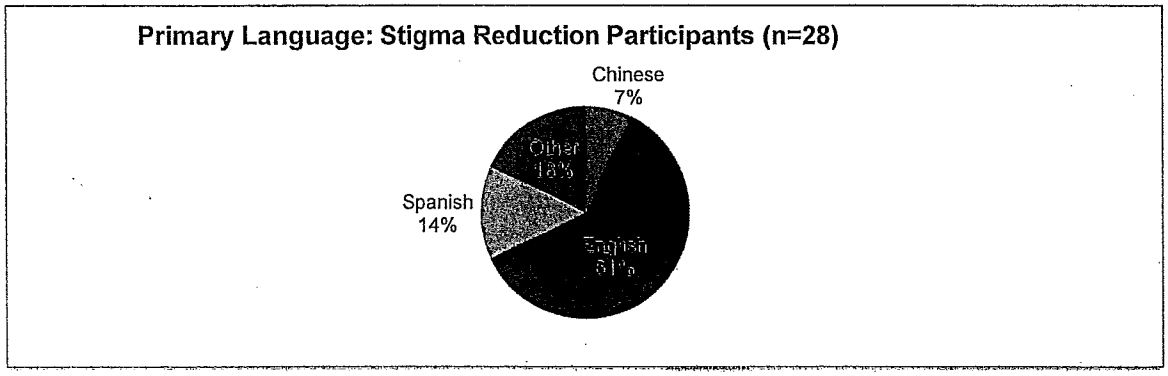


Age: Stigma Reduction Participants (n=33)



Ethnicity: Stigma Reduction Participants (n=33)





Program	FY15-16 Key Outcomes and Highlights
SOLVE	• Completed 2 NPE trainings and graduated 7 new Peer Educators in FY15-16 • Conducted 48 community presentations with over 1000 attendees • 97% of service providers and professionals who attended anti-stigma presentations delivered by Peer Educators demonstrated a better understanding of the effects of stigma on people with mental health challenges and conditions • 96% of community members who attended anti-stigma presentations delivered by Peer Educators demonstrated a better understanding of the effects of stigma on people with mental health challenges and conditions • In FY15-16 SOLVE partnered with the San Francisco Police Department's specialized Crisis Intervention Team (CIT) and the San Francisco Public Library system, to address structural stigma within systems like education, health care, and law enforcement

Cost per Client

Program	Clients Served	Annual Cost	Cost per Client[9]
Stigma Reduction	1,018 clients	$173,149	$170

[9] Cost per client is calculated by dividing the program annual budget by the total number of unduplicated clients served.

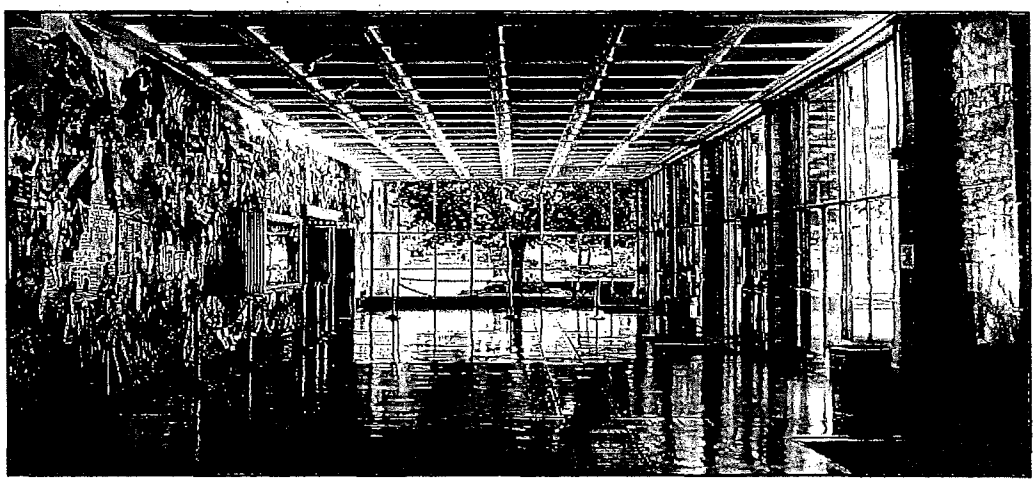
School-Based Mental Health Promotion

Program Collection Overview

School-Based Mental Health Promotion programming – a collaboration of community-based organizations and San Francisco Unified School District (SFUSD) K-12 school campuses – applies best practices that address non-academic barriers to learning. These programs offer students and their families a range of support services, which are offered on-campus during and after the school day so that they are accessible to students and their families. This coordinated, collaborative approach supports students' academic and personal successes by providing a full spectrum of prevention and early intervention behavioral health services, as well as linkages to additional support services. These programs build on the strengths of community partners and existing school support services to incorporate a wide variety of philosophies, which are rooted in a prevention or resiliency model, such as youth development, peer education, cultural or ritual-based healing, and wraparound family supports.

Services offered at the schools include leadership development, outreach and engagement, screening and assessment, crisis intervention, training and coaching, mental health consultation, and individual and group therapeutic services. Current school-based mental health programs include School-Based Wellness Promotion services at high schools, and Early Intervention Program Consultation at elementary and middle schools.

An overall goal of the school-based mental health promotion programs is to support the physical, mental, and emotional needs of the students and enhance their perception of school connectedness in effort to improve attendance, graduation rates, academic performance, and the overall school climate. To this end, these programs provide direct services to students and their families/caregivers, such as screening and assessment, community outreach and engagement to raise awareness about behavioral health topics and resources, support service resource linkages, wraparound case management, behavior coaching, crisis intervention, individual and group therapeutic services, school climate and wellness promotion workshops and activities, and family engagement and education. These programs also provide regular mental health consultation to teachers, support staff, and administrators, with particular focus on teachers and staff who are challenged by students' emerging mental health and behavioral needs.



Lowell High School, mural in hallway.

Target Populations

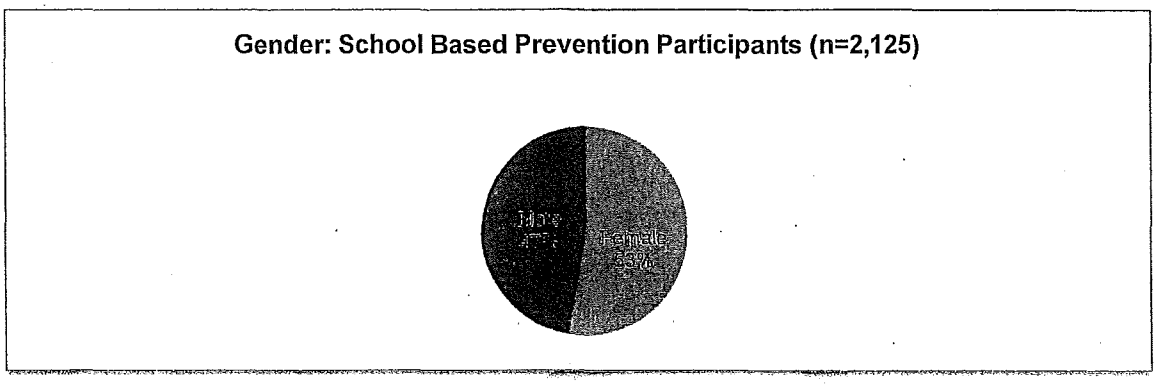
The target population for School-Based Mental Health Promotion Programs is students who are experiencing school difficulties due to trauma, immigration stress, poverty, and family dysfunction. These programs also provide services to students' families and caregivers. School-Based Mental Health Promotion programs also provide mental health consultation to school personnel.

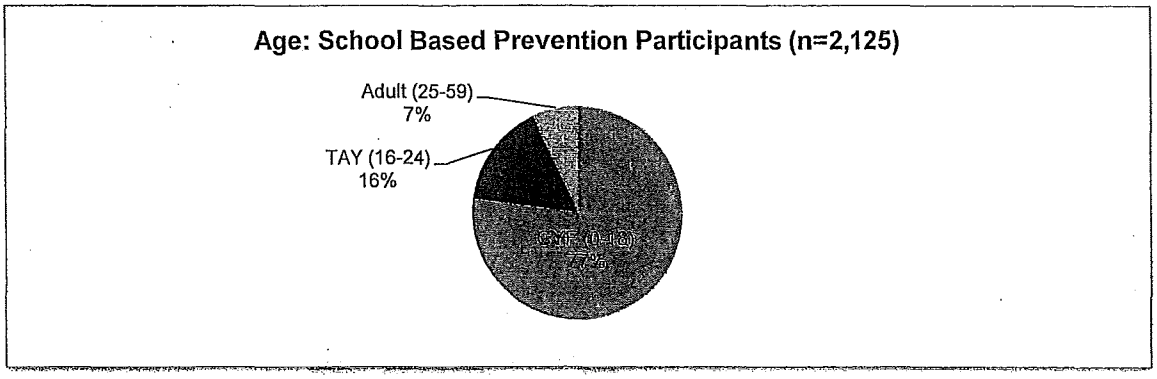
These programs are offered at the following SFUSD schools:

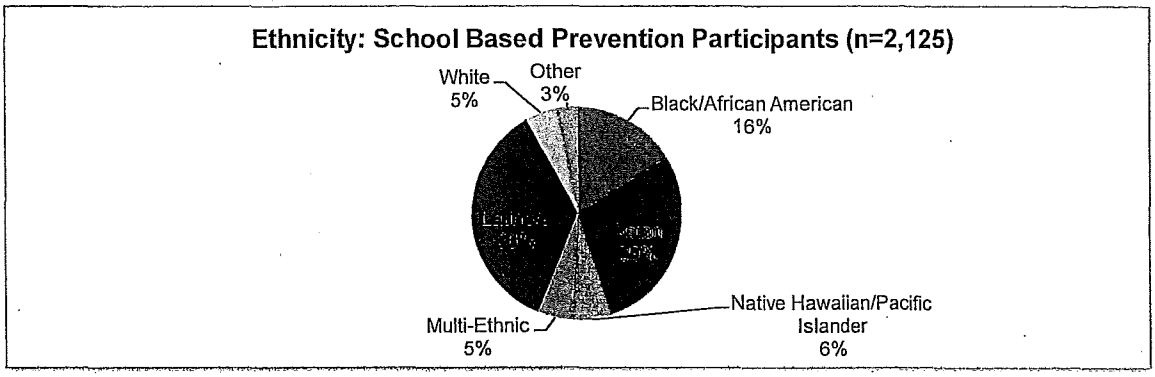
School-Based Mental Health Promotion Programs
Abraham Lincoln High School
Academy of Arts & Sciences
Balboa High School
Dr. Charles R. Drew College Preparatory Academy
Downtown High School
Galileo High School
George Washington High School
Hillcrest Elementary School
Ida B. Wells Continuation High School
James Lick Middle School
John O'Connell High School
June Jordan High School
Lowell High School
Mission High School
Philip & Sala Burton High School
Raoul Wallenberg High School
Ruth Asawa San Francisco School of the Arts High School
San Francisco International High School
School of the Arts
Thurgood Marshall High School

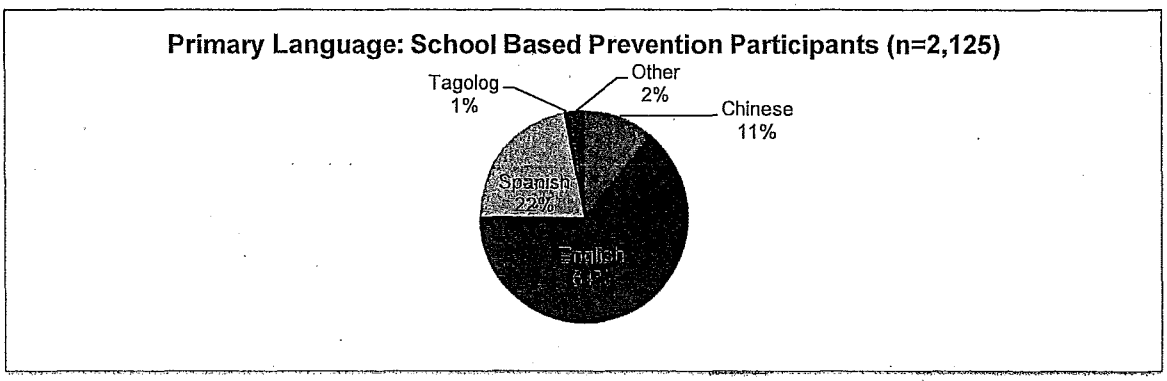
Participant Demographics, Outcomes, and Cost per Client

Demographics: School Based Prevention









Program	FY15-16 Key Outcomes and Highlights
YMCA Bayview – School Based Early Intervention at Burton High School	• 12 educational and skill building workshops were conducted for students and adults in FY15-16. • Staff provided 586.5 hours of case management to students. • 100% of students in academic and intensive Case Management showed increased ability to skillfully deal with difficulties in their lives. • 90% of participants in Healthy Workshops showed increased ability to skillfully deal with difficulties in social settings.
Bayview Hunter's Point Foundation – Behavioral Health Services at Balboa Teen Health Center	• Multilingual Behavioral Health Clinicians made Early Intervention/ Mental Health presentations at 8 English Language Learner classes in FY15-16, reaching a total of 66 students. • Behavioral Health Clinicians screened a total of 141 youth. • Group and individual Crisis Interventions were provided to 61 youth. • 100% of students surveyed who accessed 3 or more sessions of early intervention counseling services were able identify one or more skills they successfully used to reduce stress or other related symptoms, and one positive goal they are currently putting time into. • Bayview Hunter's Point Foundation provided over 2000 hours of MHSA programming to students, staff, and faculty at Balboa Teen Health Center.

Program	FY15-16 Key Outcomes and Highlights
Edgewood Center for Children and Families – School Based MH Services	• In FY16-16, 50 parents were served by the Family Advocate, who provided referrals, resources, and support for a range of services and needs. • 71% of parents reported reduced stress, increased control, and increased wellness. • 86% of teachers responding to the Year-End Teacher Satisfaction Survey reported they "feel better able to manage the stress of teaching now than earlier in the school year". • 79% of teachers reported they "feel more successful now than earlier in the school year in dealing effectively with challenging student behaviors on my own". • In FY15-16, A mindfulness initiative brought mindfulness practices into staff meetings and 7 classrooms at Edgewood Center for Children and Families.
Instituto Familiar de la Raza – School Based Youth Early Intervention	• 79% of staff at Hillcrest Elementary School and 90% of staff at James Lick Middle School, who received consultation services reported that services were beneficial for their work. • 93% of staff at Hillcrest Elementary School and 79% of staff at James Lick Middle School, who received consultation services reported that services helped them to better respond to students' behavior.
Richmond Area Multi-Services, Inc. (RAMS) – Wellness Centers	• 91% students in FY15-16 reported they had met or somewhat met their desired quality-of-life goals, as collaboratively developed between the provider and youth. • 84% of students reported improvement in coping with stress. • 83% of students reported improvements in social connections with family and friends. • 439 hours of mental health consultation were provided to 695 individuals in FY15-16, including capacity building work with school administrators, faculty, and staff, with the intention of increasing their ability to identify mental health concerns and respond appropriately.

Program	FY15-16 Key Outcomes and Highlights
YMCA Urban Services – Trauma and Recovery Services	• Staff served 38 unduplicated clients in FY15-16, 13 of whom also received targeted case management services, providing mental health assessment and treatment, as well as street outreach and community outreach interventions. • By the end of the school year, the majority of the 38 clients had reduced chronic school absenteeism by at least 50%. • By the end of the school year, 74% of clients were engaged in school.

Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[10]**
School-Based Mental Health Promotion	4,304 clients	$1,014,166	$236

Population-Focused Mental Health Promotion

Program Collection Overview

SF MHSA Population-Focused Mental Health Programs provide the following services:

- Outreach and engagement: Activities intended to establish/maintain relationships with individuals and introduce them to available services; and raise awareness about mental health
- Wellness promotion: Activities for individuals or groups intended to enhance protective factors, reduce risk-factors and/or support individuals in their recovery; promote healthy behaviors (e.g., mindfulness, physical activity)
- Screening and assessment: Activities intended to identify individual strengths and needs; result in a better understanding of the health and social concerns impacting individuals, families and communities, with a focus on behavioral health issues.
- Service linkage: case management, service coordination with family members; facilitate referrals and successful linkages to health and social services, including specialty mental health services
- Individual and group therapeutic services: Short-term (less than 18 months) therapeutic activities with the goal of addressing an identified behavioral health concern or barrier to wellness

[10] Cost per client is calculated by dividing the program annual budget by the total number of unduplicated clients served.

Target Populations

As a component of the SF MHSA Prevention and Early Intervention (PEI) program planning processes, a number of underserved populations were identified, including, but not limited to, the following:

- Socially isolated older adults
- Transitional Age Youth (TAY)
- Lesbian, Gay, Bisexual, Transgender, and Questioning
- Individuals who are homeless or at-risk of homelessness
- Native Americans
- Asians and Pacific Islanders
- African Americans
- Mayan/Indigenous

Many of these populations experience extremely challenging barriers to service, including but not limited to: language, culture, poverty, stigma, exposure to trauma, homelessness and substance abuse. As a result, the SF MHSA planning process called for proposals from a wide variety of qualified organizations in order to break down barriers and improve the accessibility of services through culturally tailored outreach and services. These population-focused services acknowledge and incorporate participants' cultural backgrounds, including healing practices, rituals and ceremonies, in order to honor the cultural context and provide non-clinical services that incorporate these practices. These population-focused programs focus on raising awareness about mental health needs and available services, reducing stigma, the importance of early intervention, and increasing access to services. As a result, all of the programs emphasize outreach and engagement to a very specific population group.

Population-Focused Mental Health Promotion Programs

Target Population	Program Name	Services
Socially Isolated Older Adults	Senior Peer Recovery Center Program	The Senior Peer Recovery Center program reaches hard-to-engage participants with informal outreach and relationship building; assists participants with housing, addiction treatment groups, socialization and cultural activities, and making linkages to more formal behavioral health services when feasible.
	Older Adult Behavioral Health Screening Program	The Older Adult Behavioral Health Screening program provides home-based, routine, multi-lingual and broad spectrum behavioral health screening. Screening participants also receive culturally competent clinical feedback, prevention-focused psycho-education, and linkage support to appropriate behavioral health intervention services.

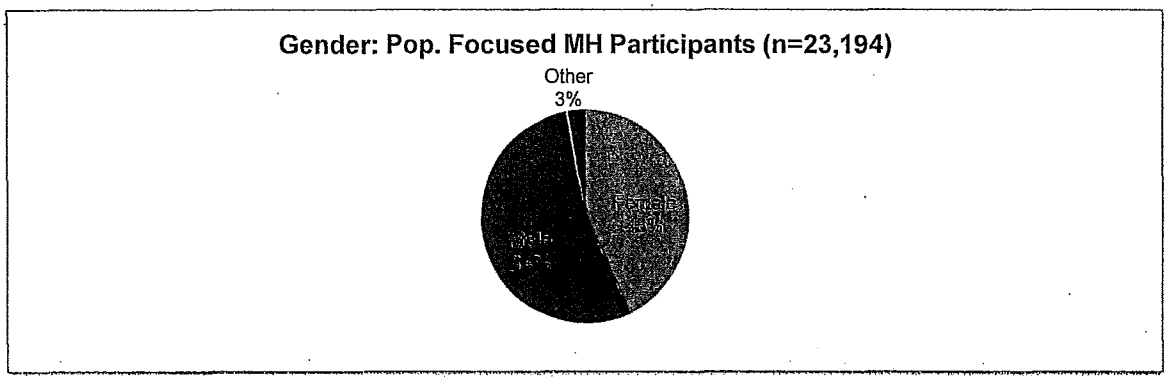
Population-Focused Mental Health Promotion Programs		
Target Population	**Program Name**	**Services**
Blacks/African Americans	Ajani Program	The Ajani program helps to build strong families by providing an understanding how healthy families function and by encouraging them to develop leadership, collective responsibility and mentoring skills.
	African American Healing Alliance	This program serves Black/African-American residents of San Francisco who have been exposed to violence and trauma. Program leaders convene a monthly AAHA membership meeting and collaboratively plan with other stakeholders such as the school district, the Department of Housing and Urban Affairs and the SF Department of Public Health.
	SF Live D10 Wellness/ Rafiki Coalition	This program delivers activities to individuals and groups who reside in District 10 of San Francisco. The program focuses on enhancing protective factors, reducing risk factors, supporting individuals in their recovery, promoting health behaviors (e.g., mindfulness, physical activity), increasing awareness and understanding of the healing effects of cultural, spiritual and traditional healing practices through walking groups, Tai Chi, water aerobics, and other activities.
	African American Holistic Wellness Program	The African American Holistic Wellness Program builds a stronger sense of community and decreases the impact of trauma among African Americans by promoting healthy lifestyles through fostering physical, mental, emotional and spiritual fitness; encouraging healthy social connections; and providing opportunities to make a meaningful contribution. Services include individual counseling, evidences based and peer-to-peer support groups, educational workshops, cultural events, and movement classes. All of our services reflect the following guided principles: trauma informed, holistic health approaches, cultural/racial humility, and outcome driven.
Asians/Pacific Islanders	API Youth Family Community Support Services	The program primarily serves Asian/Pacific Islander and Lesbian, Gay, Bi-sexual, Transgender, and Questioning youth ages 11-18 and their families. The program provides screening and assessment, case management and referral to mental health services.
	API Mental Health Collaborative	The program serves Filipino, Samoan and South East Asian community members of all ages. The API Mental Health Collaborative formed three work groups representing the Filipino, Samoan

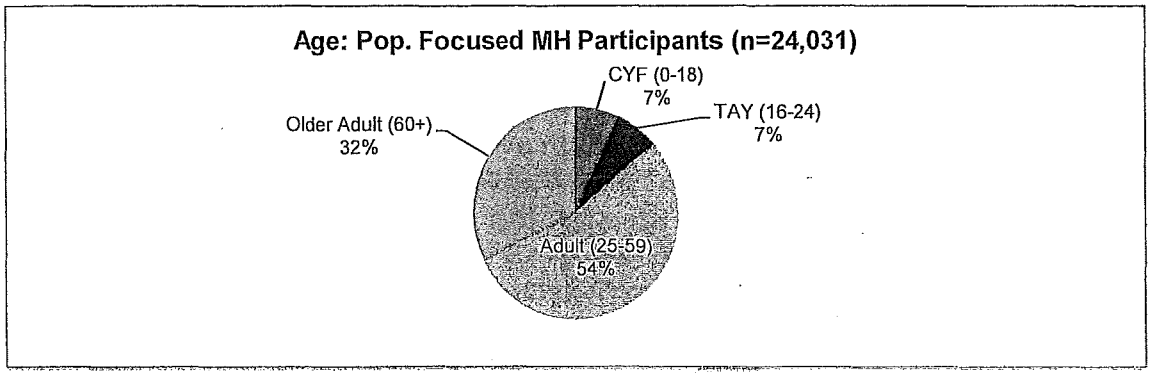
Population-Focused Mental Health Promotion Programs		
Target Population	**Program Name**	**Services**
		and Southeast Asian communities, with the Southeast Asian group serving San Francisco's Cambodian, Laotian and Vietnamese residents. Each workgroup is comprised of six to eight culturally and linguistically congruent agencies; and the Collaborative as a whole has engaged in substantial outreach and community education.
Mayans/Indigena	Indigena Health and Wellness Collaborative	The program serves Indigena immigrant families, mostly newly arrived young adults. The program works to increase access to health and social services, to support spiritual and cultural activities and community building, and social networks of support. The program also helps with early identification and interventions in families struggling with trauma, depression, addiction and other challenges.
Native Americans	Living in Balance	The program serves American Indian/Alaska Native adults and older adults who have been exposed to or at-risk of trauma, as well as children, youth, and TAY who are in stressed families, at risk for school failure, and/or at risk of involvement or involved with the juvenile justice system. The program included extensive outreach and engagement through cultural events such as Traditional Arts, Talking Circles, Pow Wows, and the Gathering of Native Americans. Services also include NextGen Assessments, individual counseling, and traditional healers.
Adults who are Homeless or At-Risk of Homelessness	6th Street Self-Help Center	The program serves adult residents facing behavioral health challenges and homelessness in the 6th Street, South of Market neighborhood. Program provides a low-threshold engagement that includes peer programs, case management, primary care access, support groups and socialization. Many are referred to mental health services prior to assessment due to the acuity of their needs.
	Tenderloin Self-Help Center	The program serves adults with behavioral health challenges and homelessness who live in the Tenderloin neighborhood. Program provides a low-threshold engagement that includes peer programs, case management, primary care access, support groups and socialization. Many are referred to mental health services prior to assessment due to the acuity of their needs.

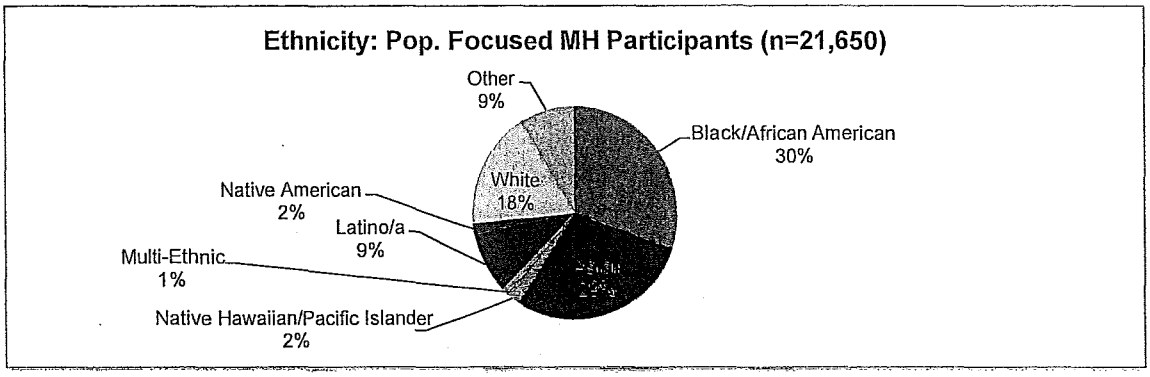
Population-Focused Mental Health Promotion Programs		
Target Population	**Program Name**	**Services**
	Community Building Program	The program serves traumatized, homeless and dual-diagnosed adult residents of the Tenderloin neighborhood. The program conducts outreach, screening, assessment and referral to mental health services. It also conducts wellness promotion and a successful 18-week peer internship training program.
TAY who are Homeless or At-Risk of Homelessness	TAY Multi-Service Center	The program serves low-income African American, Latino or Asian Pacific Islander TAY (ages 16-24) who have been exposed to trauma, are involved or at-risk of entering the justice system and may have physical and behavioral health needs. Program participants may be involved with the City's Community Assessment and Resource Center (CARC) which focuses on 16 and17 year old youth. The program conducts street outreach, mental health assessments and support, case management and positive youth development services.
	ROUTZ TAY Wellness	The program serves TAY youth with serious mental illness from all of San Francisco. This high intensity, longer term program includes supportive services, including wraparound case management, mental health intervention and counseling, peer-based counseling, and life skills development.

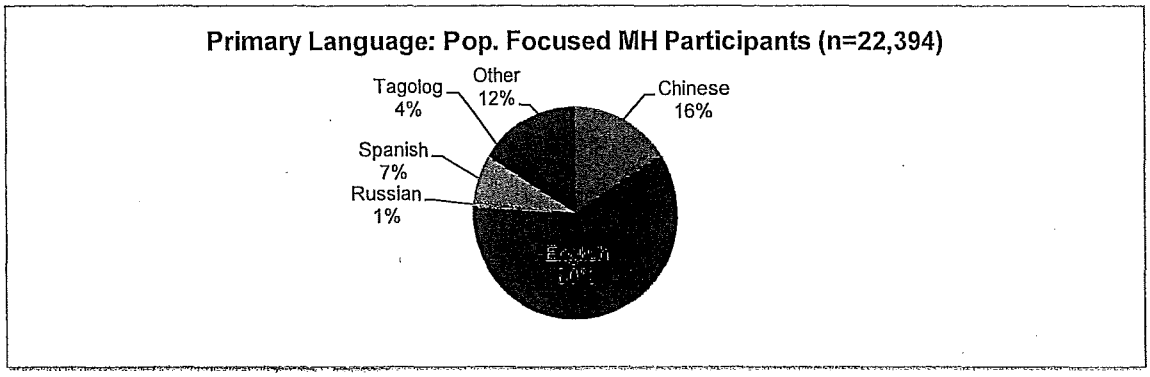
Participant Demographics, Outcomes, and Cost per Client

Demographics: Population Focused Mental Health




Age: Pop. Focused MH Participants (n=24,031)
CYF (0-18)
7%
TAY (16-24)
7%
Older Adult (60+)
32%
Adult (25-59)
54%


Ethnicity: Pop. Focused MH Participants (n=21,650)
Other
9%
Black/African American
30%
White
18%
Native American
2%
Latino/a
9%
Multi-Ethnic
1%
Native Hawaiian/Pacific Islander
2%


Primary Language: Pop. Focused MH Participants (n=22,394)
Tagolog
4%
Other
12%
Chinese
16%
Spanish
7%
Russian
1%

Socially Isolated Older Adults	FY15-16 Key Outcomes and Highlights
Felton Institute	• Felton's Bingo socialization activity served more than 450 seniors in FY15-16, with 56% of participants noting an increase in social connectedness. • The Senior Peer Recovery Center team held 15 events throughout the City, reaching an estimated 120 people, including approximately 60 staff. • 22 guests receiving case management services developed a care plan, and 100% of those participants accomplished at least one of their stated care plan goals.
Institute on Aging – Older Adult BH Screening Program	• In FY15-16, 80 individuals received culturally competent feedback about their mental health, prevention focused psycho-educational resources, and referrals to appropriate behavioral health intervention. • 462 individuals received first line "gating screening," identifying symptom domains of depression, anxiety, social isolation, chronic pain, substance abuse, sleep quality, and cognition. • 103 individuals received intensive, behavioral health screening follow up after screening positive on the "gating screen," and 100% of these clients were offered formal feedback, treatment recommendations, and referrals.

Black/ African-American	FY15-16 Key Outcomes and Highlights
Westside Community Services – Ajani Program	• At least 210 African Americans received mental health promotional information, and linkages to culturally appropriate services via outreach and engagement activities in FY15-16. • Outreach was conducted at Western Addition and Southeast housing projects, including the distribution of program information materials and referral forms, reaching 150 individuals.

	• Reached 144 new individuals in FY15-16, through outreach and engagement practices.
YMCA Bayview – African American Holistic Wellness	• 100% of participants regularly attending support groups maintained or increased their social connection, as self-declared on social connection surveys. • 112 participants regularly attended 5 or more specified Wellness promotion activities.
Bayview Hunters Point Foundation – SF Live D10 Wellness **Rafiki Coalition**	• In FY15-16, more than 90% of participants demonstrated increased education on disparities within the context of African American health outcomes. • Feedback from Rafiki Coalition for Health and Wellness class participants ranged from "great" to "excellent" for nearly every class offering.

Asian/ Pacific Islander	FY15-16 Key Outcomes and Highlights
Community Youth Center – API Youth and Family Community Support Services	• Nearly 100% of A&PI youth with identified mental health diagnoses were successfully linked to appropriate internal/external mental health services in FY15-16. • Over 90% of the 120 program participants surveyed reported neutral or an increased quality of life. • Over 120 A&PI youth and families enrolled in case management services have successfully attained at least one of their treatment goals.
RAMS – API Mental Health Collaborative	• APIMHC's culturally-relevant efforts reached and engaged 23,259 individuals during FY15-16. • Staff screened and assessed 148 AA & PI individuals identified as needing services/resources. • 144 individuals received basic case management, 148 individuals completed a basic case service plan, and 143 individuals had at least one stated objective or goal in their case/care plan met.

Mayan/Indígena	FY15-16 Key Outcomes and Highlights
IFR – Indígena Health and Wellness Collaborative	• 466 self-identified Mayan/indigenous individuals participated in outreach and engagement activities in FY15-16.

	• 480 self-identified Mayan/indigenous individuals participated in spiritual ceremonies and cultural activities. • 160 hours of training and coaching were provided to Peer consumers/health Promotoras.

Native American	FY15-16 Key Outcomes and Highlights
Native American Health Center – Living in Balance	• In FY15-16, 39 individuals were screened using the NextGen Intake & Assessment Tool, and 100% of screened individuals were referred to behavioral health services. • 83% of wellness promotion participants surveyed reported that they get out more and participate with community because of talking circle groups, 83% of participants have more people they can trust because of these prevention groups, and 79% of wellness promotion participants report an in increase in learning new ways to maintain wellness.

Adults who are Homeless or At-Risk for Homelessness	FY15-16 Key Outcomes and Highlights
Central City Hospitality House – 6th Street Self-Help Center	• In FY15-16, 4,809 unduplicated participants were contacted through participation in a range of socialization and wellness services (e.g., survival and support services, wrap-around services, cultural activities, case management, housing assistance). • 108 unduplicated participants attended Harm Reduction support groups, with 56% of group participants demonstrating reduced risk behaviors. • 36 unduplicated participants were screened and/or assessed for behavioral health concerns, and 100% of participants screened and/or assessed were referred to behavioral health services. • 99 unduplicated participants of behavioral health groups were referred to behavioral health services.

Central City Hospitality House – Community Building Program	• In FY15-16, 16 community events (community violence prevention events, increasing community cohesion, strength, and the ability to respond to and recover from trauma) were held, reaching 345 unduplicated participants. • 80 unduplicated participants were screened and/or assessed for behavioral health concerns, and 98% of participants screened and/or assessed were referred to behavioral health services. • 84 unduplicated individual therapy participants have a stated case plan, and 75% of participants completed at least one case plan goal.
Central City Hospitality House – Tenderloin Self-Help Center	• In FY15-16, 12,484 unduplicated participants were contacted through participation in a range of socialization and wellness services, such as immediate survival and support services, wrap-around services, socialization and cultural activities, case management, housing assistance fund, holistic behavioral health services, primary care triage. • 246 unduplicated participants attended Harm Reduction support groups conducted by the Harm Reduction Therapy Center, with 66% of participants demonstrating reduced risk behaviors. • 95 unduplicated participants were screened and/or assessed for behavioral health concerns, and 99% of participants screened and/or assessed were referred to behavioral health services as measured by creation of a harm reduction plan.

Homeless or System Involved TAY	FY15-16 Key Outcomes and Highlights
Huckleberry Youth Programs – TAY Multi-Service Center	• In FY15-16, 355 TAY were screened for behavioral /mental health concerns, 294 TAY were referred for behavioral health services, 131 TAY and/or their families had a written plan of care, and 60 TAY and/or their families achieved at least one case/care plan goal. • 4,951 duplicated TAY were engaged in street outreach and 1,821 duplicated TAY (but unduplicated by site) accessed services at the three partner sites. • 813 unduplicated TAY participated in group activities including community events, health fairs, conferences, and workshops.

Larkin Street Youth Services – ROUTZ TAY Wellness

- In FY15-16, 45 youth were screened for behavioral health needs with the Mental Status Exam.
- 73% (33 of 45) of youth screened/assessed for behavioral health received subsequent referrals to internal and external behavioral health services.
- 130 youth participated in Wellness Promotion activities under the Routz Day Program.
- 69% of surveyed participants said they agreed or strongly agreed that they felt an increase in their social connection as a result of attending the Fruity Wednesday wellness group.

Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[11]**
Population-Focused Mental Health Promotion	52,549 clients	$3,149,296	$60

Mental Health Consultation and Capacity Building

Program Collection Overview

Mental health consultation and capacity building services include case consultation, program consultation, training and support/capacity building for staff and parents, referrals for specialized services (e.g., developmental and learning assessments, occupational therapy, help with Individualized Education Plans, and psychotherapy), therapeutic play groups, direct psychotherapeutic intervention with children and families, crisis intervention, parent education and support groups, and advocacy for families. These services are designed to capitalize on the important role of early intervention in enhancing the success of children and families facing early developmental challenges.

The San Francisco Early Childhood Mental Health Consultation Initiative (ECMHCI) is

[11] Cost per client is calculated by dividing the program annual budget by the total number of unduplicated clients served.

grounded in the evidence-based work[12] of mental health professionals who provide support to children, parents and caregivers of San Francisco's youngest residents (ages 0-5) and are delivered in the following settings: center-based and family child care, homeless and domestic violence shelters, permanent supportive housing facilities, family resource centers, and substance abuse treatment centers. The Initiative is made possible through a partnership between four county agencies: San Francisco's Department of Public Health/Behavioral Health Services; the Office of Early Care and Education; the Department of Children, Youth, and Their Families; and First 5 San Francisco. Funding for the Initiative is contributed by all four county departments, as well as funds provided by the MHSA.

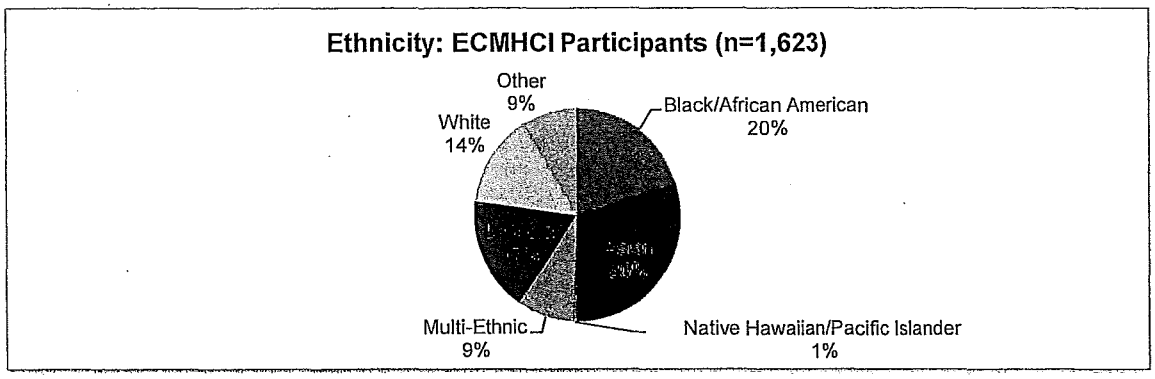
Services may include case consultation, program consultation, training and support for staff and parents, referrals for specialized services (e.g., developmental and learning assessments, occupational therapy, help with Individualized Education Plans, psychotherapy), therapeutic play groups, direct psychotherapeutic intervention with children and families, crisis intervention, parent education and support groups, and advocacy for families. These services are meant to underscore the importance of early intervention and enhance the child's success.

Target Populations

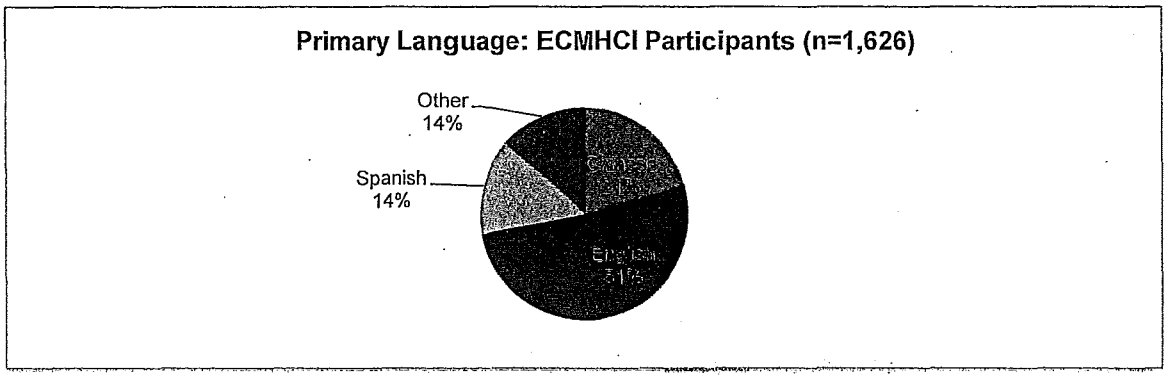
The San Francisco Early Childhood Mental Health Consultation Initiative (ECMHCI) provides support to children, parents and caregivers of San Francisco's youngest residents (ages 0-5). This program works with clients who experienced trauma, substance abuse, homelessness, and other challenges. The program works with children and families facing early developmental challenges.

Participant Demographics, Outcomes, and Cost per Client

Demographics: Early Childhood Mental Health Consultation Initiative



[12] Alkon, A., Ramler, M. & MacLennan, K. Early Childhood Education Journal (2003) 31: 91



Program	FY15-16 Key Outcomes and Highlights
Early Childhood Mental Health Consultation Initiative	• 98% of care providers surveyed at MHSA funded sites in FY15-16 reported that the mental health consultation increased their understanding and response to children's emotional and developmental needs. • 91% of care providers surveyed at MHSA funded sites reported that mental health consultation helped them improve their relationship with parents when communicating about their children's strengths and needs. • 71% of programs at MHSA funded sites reported that their mental health consultant is actively working with them to increase program flexibility to better accommodate each child's individual needs. • 89% of programs at MHSA funded sites think that mental health consultation was helpful in retaining children in their program who are at risk of expulsion. • 100% of parents surveyed at MHSA funded sites reported that mental health consultation helped them as a parent. • 94% of parents surveyed at MHSA funded sites reported that if their child received services from the consultant, they showed an improvement in behavior.

Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[13]**
Mental Health Consultation and Capacity Building	1,626 clients	$585,119	$360

[13] Cost per client is calculated by dividing the program annual budget by the total number of unduplicated clients served.

Comprehensive Crisis Services

Program Collection Overview

Comprehensive crisis response and stabilization services have long been considered a crucial element of public behavioral health systems. There is a considerable body of evidence suggesting that comprehensive crisis services can improve outcomes for consumers, reduce inpatient hospital stays and costs, and facilitate access to other necessary behavioral health services and supports. Crisis response to incidents of violence can reduce the long-term impact of complex trauma exposure. Due to the pressing need for services to address the needs of children, youth, adults and families impacted by violence and mental health crisis—a need that has been highlighted through various MHSA Community Program Planning efforts—MHSA PEI funding supported a significant expansion of crisis response services in 2009.

SF MHSA funds a portion of Comprehensive Crisis Services (CCS), which is a mobile, multidisciplinary, multi-linguistic agency that provides acute mental health and crisis response services. CCS is comprised of three different teams. These teams provide caring and culturally competent assistance throughout the San Francisco community. Services include: follow up contact within a 24-48 hour period of the initial crisis/incident; short term case management; and therapy to individuals and families that have been exposed to trauma. MHSA funds four members of the crisis response team.

Target Populations

The target population includes children, adolescents, adults and older adults. The program serves individuals who have been impacted by community violence and critical incidents; and works with individuals who are suicidal, homicidal, gravely disabled and out of control.

Comprehensive Crisis Services	
Program Name	**Services Description**
Mobile Crisis Services	Provides behavioral health crisis triage, in-the-field crisis assessments/interventions and short-term crisis case management for individuals age 18 years or older.
Child Crisis Services	Offers 5150 assessments & crisis intervention for suicidal, homicidal, gravely disabled and out of control children and adolescents regardless of health insurance status. Clients with publically funded health insurance or have no health insurance are provided crisis case management, hospital discharge planning, and medication support services.
Crisis Response Services	Provides mobile response to homicides, critical shootings, stabbings, and suicides; provides clinical support, therapy, and crisis case management services to individuals and families affected by community violence and critical incidents.

Program Outcomes, Highlights and Cost per Client

Program	FY15-16 Key Outcomes and Highlights
Mobile Crisis, Child Crisis, and Crisis Response	• Participants learned and used effective coping strategies to address acute mental health crisis, grief, loss, and trauma exposure. • Participants accessed mental health services within a 30-day period from being exposed to a traumatic event or an acute mental health crisis. • Staff noted an increase in participants wanting to access services, and number of clients served in FY15-16. • CRT staff provided more coordinated services to victims at SFGH by developing weekly rounds. • After being notified of a trauma exposed individual by San Francisco Police and/or San Francisco General Hospital, CRT conducted outreach within a 24-hour period. This early identification and referral led to timely intervention and a reduction in the burden of suffering caused by delay in, or lack of access to, services.

Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[14]**
Comprehensive Crisis Services	3240 clients	$405,221	$125

Moving Forward in Mental Health Promotion and Early Intervention

'Innovations' Project
In collaboration with the California MHSA Oversight and Accountability Commission, BHS is working to develop an innovative Family-Centered and Trauma-Based Program. Read more about this project in the "Looking Ahead" section at the end of this Integrated Plan.

Contracting with Service Providers
SF MHSA issued/will issue several Request for Qualifications (RFQs) under the Mental Health Promotion and Early Intervention Services in the spring and summer of 2017. Most of the programs in these RFQs include Prevention and Early Intervention (PEI) funding. The RFQs include the following:

- Community Drop-In and Resource Support Services RFQ
- Transitional Age Youth RFQ

SF MHSA also issued a School-Based RFQ and a Population-Focused RFQ in the fall of 2016 and has contracted with several service providers for these programs. SF DPH MHSA staff are

[14] Cost per client is calculated by dividing the program annual budget by the total number of unduplicated clients served.

currently working with these contractors, as well as consumers, peers, and other community stakeholders, to develop program designs and outcome goals.

TAY System of Care

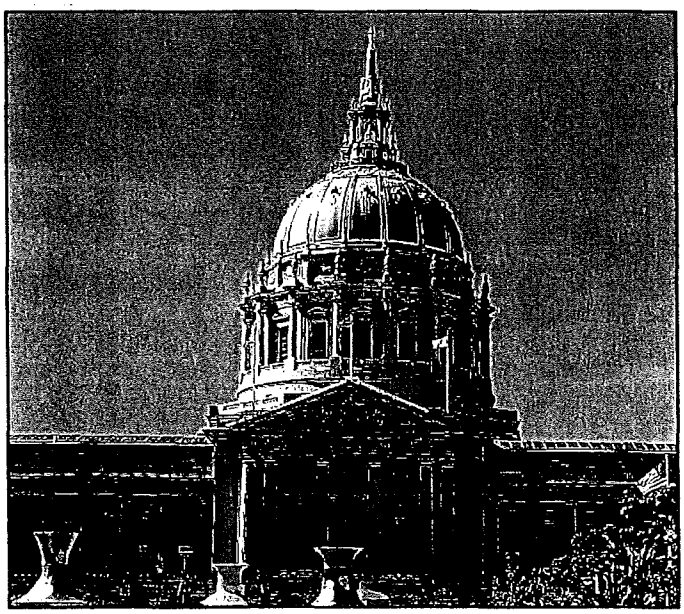
BHS has recently merged all Transitional-Age Youth (TAY) programs under the oversight of the BHS Deputy Director in order to create a TAY System of Care. Many community stakeholders are collaborating in the strategic planning process for this new system. The TAY System of Care will share best practices, leverage resources and streamline protocol in order to strengthen all of the SF DPH MHSA TAY programming. Please refer to the above section titled, "Program and Populations Planning and Service Provider Selection" for more information about this project and the corresponding CPP activities.

Technical Assistance for PEI Funding Reporting Regulations

SF DPH MHSA managers have partnered with the DPH Office of Quality Management to provide technical assistance workshops regarding the new PEI reporting regulations for all providers receiving PEI funding (these PEI regulations were passed in October 2015). These workshops will continue into the new fiscal year to ensure that proper data reporting expectations are reached.

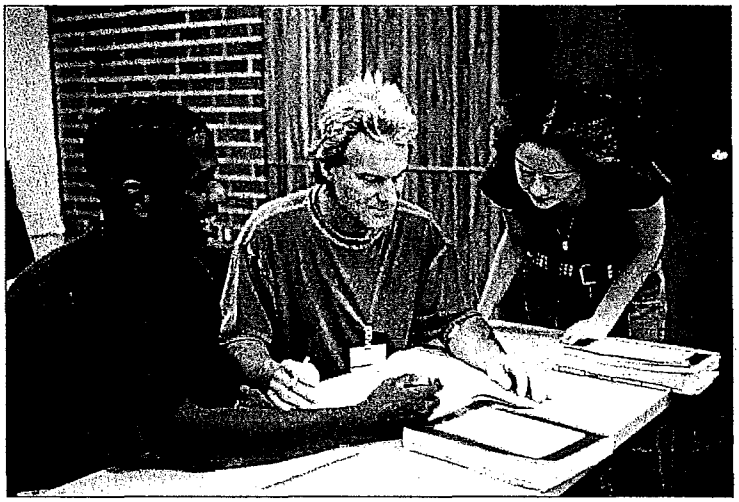
Population-Focused Service Modalities

In the coming years, Population-Focused programming will maintain its service modality framework (Outreach & Engagement, Screening & Assessment, Wellness Promotion, Individual & Group Therapeutic Services and Service Linkage). Beginning in FY 17-18, all Population-Focused programming will provide each of these services - either by themselves, within their parent organization, or in collaboration with community program partners. These programs will continue serving our Black/African American, Latino, Mayan, Asian, Pacific Islander, Native American and Transgender communities across the lifespan, in addition to other unserved/underserved populations.



3. Peer-to-Peer Support Programs and Services: Clinic and Community Based

Service Category Overview



Peer-to-Peer Support Services are an integral part of a wellness and recovery-oriented mental health system, as individuals who have participated in mental health services, either as a consumer or as a family member, bring unique skills, knowledge, and lived experience to consumers who are struggling to navigate the mental health system. Peers also support consumers in dealing with stigma and facing economic and social barriers to wellness and recovery. These MHSA-funded services are largely supported through the Community Services and Supports and Innovations funding streams.

The scope of peer-to-peer support services includes:

- Peer training and certificate programs that provide various levels and intensity of trainings for consumers
- Peer outreach to underrepresented and underserved populations who typically face challenges in accessing services due to stigma, lack of linguistic or cultural representation, economic pressures, substance abuse, and age- or gender-related barriers
- Peer support for a variety of demographic groups, such as children and youth, non-English speakers, underrepresented ethnic groups, transgender individuals, and people with collecting challenges
- Supports for consumers who are facing legal, housing, employment, child support and other challenges
- Serving as a role model and beacon of hope to inspire consumers that wellness and recovery are attainable

There is also a key role for peer-based strategies in the ongoing work of educating the public on stigma reduction. Peer-to-Peer Support Service programs reach out to a wide range of public venues, such as health fairs, senior centers, and youth service centers, in order to demonstrate that consumers can recover and make positive contributions to the community. Through presentations and dialogue with community residents, consumers can offer a vision for wellness, especially to communities that are facing stigma and hopelessness about the possibility of recovery. The stigma of mental illness is often culturally influenced, which makes it that much more essential that peers reflect the gender, language, age groups and culture of the City and County of San Francisco.

Target Populations

Population for Peers: Peers are defined as individuals with personal lived experiences who are consumers of behavioral health services, former consumers, or family members or significant others of consumers. Peers utilize their lived experience in peer-to-peer settings, when appropriate, to benefit the wellness and recovery of the clients and communities being served.

Population Served by Peers: Peers will conduct culturally and linguistically congruent outreach, education and peer support to consumers of residential, community, mental health care and primary care settings within the Department of Public Health.

Peer-to-Peer Support Programs	
Program Name	**Services Description**
Addressing the Needs of Socially Isolated Older Adults **(INN Funded)**	The Curry Senior Center's Addressing the Needs of Socially Isolated Older Adults program provides peer outreach and engagement services along with screening and assessment services to reduce isolation among the older adult population.
Lifting and Empowering Generations of Adults, Children, and Youth	The San Francisco Department of Public Health's Lifting & Empowering Generations of Adults, Children, and Youth (LEGACY) program offers family and youth navigation services and education with a focus on stigma reduction.
Peer Response Team	The Mental Health Association of San Francisco (MHASF) Peer Response Team provides interventions and access to services that address collecting challenges. Peer Responders with lived experience with cluttering behaviors work to support individuals with similar needs. The peers use their experience to provide non-judgmental, harm reduction-based, one-on-one peer support, often including multiple home visits. In addition, the team gives community presentations that message anti-stigma and discrimination, empowerment, and the possibility of recovery.
Peer-to-Peer, Family-to-Family	The National Alliance on Mental Illness (NAMI) Peer-to-Peer, Family-to-Family program utilizes trained peers to provide outreach, engagement, navigation in the community. Peer mentors meet with an assigned person who has requested a mentor prior to leaving an acute care psychiatric hospital. Mentors are supportive of the participant by meeting weekly for 1 hour and assisting the participant with their wellness and recovery journey. Mentors also act as a community resource for helping a participant direct their own path to wellness and recovery.
Peer Specialist Mental Health Certificate and Leadership Academy	The Certificate Program (Entry and Advanced courses) prepares BHS consumers and/or family members with skills & knowledge for peer specialist/counseling roles in the systems-of-care. In addition, the program offers the Leadership Academy which is a monthly training series designed to support and educate peer providers in the behavioral health field. Trainings will also focus on building skills for participation in a variety of activities that request peer provider/consumer input (e.g., boards and advisory committees, review panels, policy development, advocacy efforts, etc.).

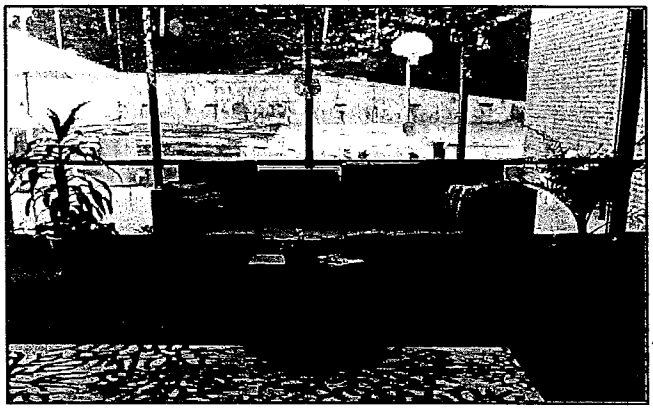
Peer-to-Peer Support Programs	
Program Name	**Services Description**
Transgender Health Services	The San Francisco Department of Public Health Transgender Health Services program provides access for medically necessary transition surgery to eligible uninsured residents of San Francisco through Healthy San Francisco. MHSA began funding the peer counselor positions only, to support this program as a supplemental enhancement. Peer counselors ensure proper coordination of behavioral health services and ensure all behavioral health needs are addressed.
Hummingbird Peer Respite **(INN Funded)**	*See program description below.*
Peer-to-Peer Employment Program	The Peer Counseling & Outreach facilitates wellness activities and enhances treatment services by providing peer counseling and supportive case management & resource linkage to clients of BHS clinics/programs. The services, offered by individuals with lived experience, aim to improve the level of engagement with clients, foster feelings of hope, and promote recovery & wellness. The Peer Internship offers entry-level placements in peer direct services and administrative support roles. In a collaborative learning and supported environment, peer interns work with other peer providers in a variety of SFDPH programs. The paid internships are nine months (20 hours/week) in duration.
Peer Wellness Center	The Peer Wellness Center is for adult/older adult consumers of BHS in need of additional support, with services provided by peer counselors and wellness staff who have lived experience. Consumers gain empowerment skills, engage in mindfulness practices, and participate in whole health wellness within a safe environment that utilizes empathy & peer support to help promote and inspire recovery. Also, the Center offers information for supportive services and linkages to a variety of behavioral health and primary health care resources in San Francisco.
Transgender Pilot Program **(INN Funded)**	The Transgender Pilot Program is designed to increase evaluation planning in order to better collect data on the strategies that best support Trans women of color with engaging in behavioral health services. TPP entered the pilot year of operations in FY15-16 as a MHSA Innovations Project. The two primary goals involve increasing social connectedness and providing well-ness and recovery based groups. The ultimate goal of the groups is to support clients with link-age into the mental health system and services.
Reducing Stigma in the Southeast (RSSE)	The San Francisco Department of Public Health Reducing Stigma in the Southeast program engages faith-based organizations and families in Bayview/Hunter's Point and Visitaction Valley in order to increase mental health awareness, decrease stigma, and provide social support for consumers, community members, and peers.
Peer-Run Warm Line	MHASF Mental Health Peer-Run Warm Line connects a person in emotional distress to a Peer Counselor through a phone call or chat session. The Warm Line is the first line of defense in preventing mental health crises by providing a compassionate, confidential and

Peer-to-Peer Support Programs	
Program Name	**Services Description**
	respectful space to be heard. The Warm Line existence continues to alleviate over-burdened crisis lines, law-enforcement, and mental health professionals.

Spotlight Program – Hummingbird Peer Respite

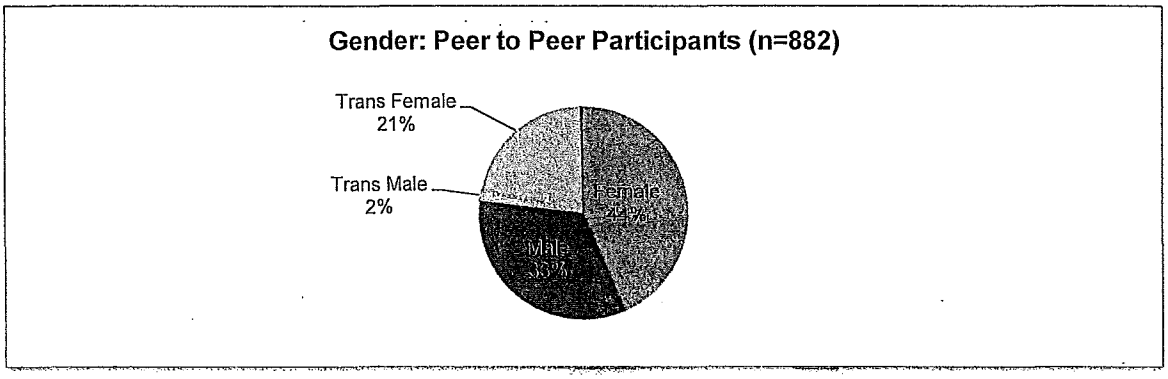
The San Francisco Department of Public Health ***Hummingbird Peer Respite*** program is a peer-run and peer-led program provides a respite and an alternative to crisis/PES services for those individuals who may inappropriately use emergent and emergency services. This program provides one-on-one peer counseling, groups, art and other peer modalities to engage individuals in need of support.

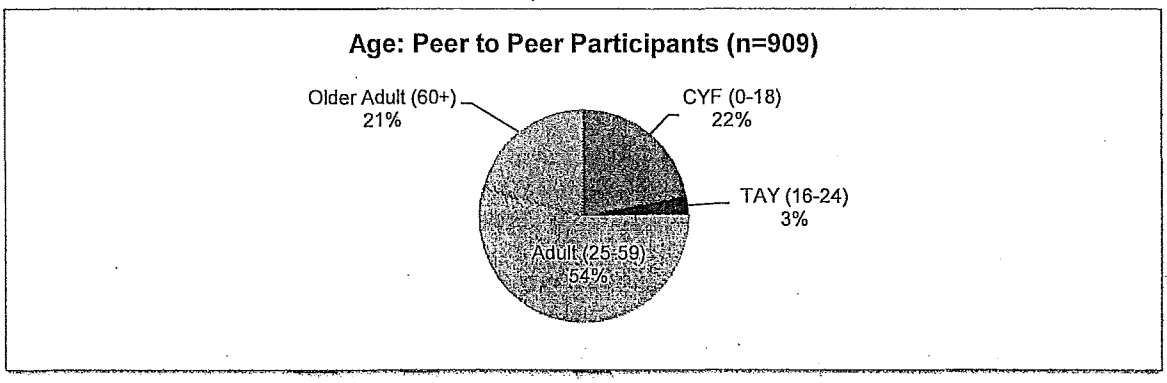
In FY 16-17, several changes took place within The Hummingbird Peer Respite. During recent program evaluation efforts, it became evident from discussions with the clients/guests that they were not interested in attending groups. One guest noted, "We are forced to attend groups everywhere." Participants wanted a safe place where they could engage with peer counselors on their own timetable. In fact, the respite staff found a mix of responses as some participants were seeking a quiet space to be alone, while others wanted to talk with a counselor. Due to an issue with the initial plan of leveraging funding with another department, the Peer Respite was not able to launch a 24-hour operation. This setback has reduced the scope of what was originally planned. The program operates daily from 10:00 a.m. to 6:00 p.m., Monday through Saturday. The daytime operation continues to show an increase in attendance and active participation of guests. Evaluation efforts continue to increase in FY 16-17.

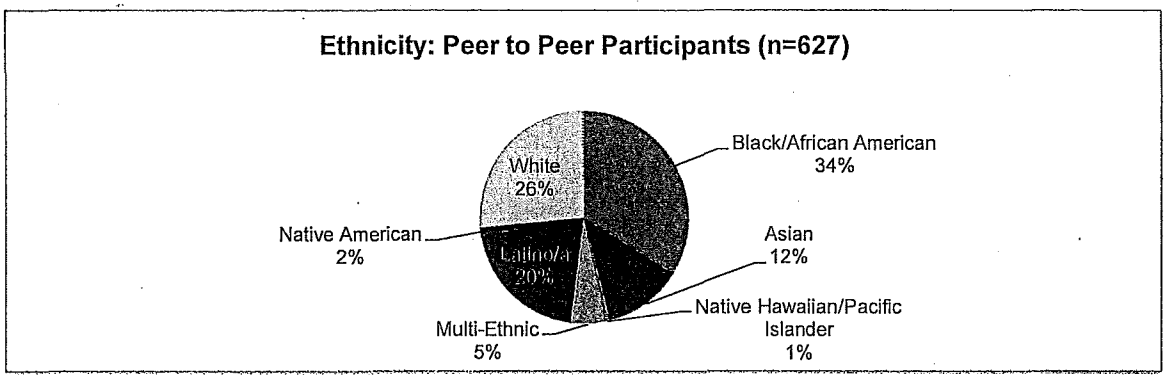


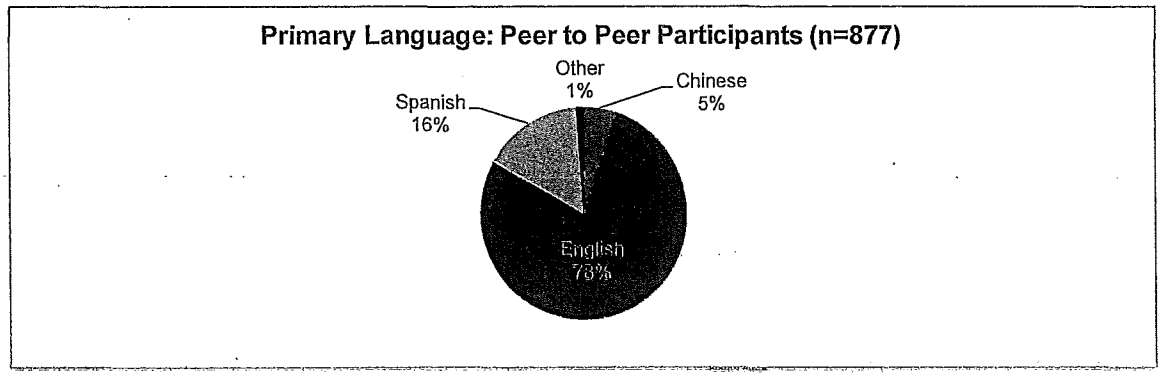
Participant Demographics, Outcomes, and Cost per Client

Demographics: Peer to Peer









Program	FY15-16 Key Outcomes and Highlights
Curry Senior Center (INN) – Addressing the Needs of Socially Isolated Older Adults	• Of the 31 isolated seniors who met with a service provider at least ten times in FY15-16, 17 (55%) were assessed at baseline and six months using the isolation scale developed by the Curry Peer Outreach Program. These data indicated a 20.8% decrease in isolation, as well as a 52% increase in social engagement. • 808 client visits were completed in FY15-16.
SF DPH - LEGACY	• In FY15-16, 12 training sessions were held for FIT, and 6 were held for the Youth Team. In addition, 2 Trauma Informed Systems workshops were held. • A total of 11 peers were employed by LEGACY in multiple and various capacities.
MHASF – Peer Response Team	• In FY15-16, 58 individuals received 1:1 support from Peer Responders. • 84% of responding project participants who engage in 1:1 support services and/or support groups reported an increase in their willingness to access services. • 82% of responding participants reported an increase in their ability to manage their collecting behavior.

Program	FY15-16 Key Outcomes and Highlights
NAMI – Peer to Peer, Family to Family	• By the end of FY15-16, 100% of Peer-to-Peer participants indicated that they had learned to recognize the signs and symptoms of their mental illness. • 93% of family members enrolled in Family-to-Family program indicated that they had learned to recognize the signs and symptoms of mental illness. • By the end of FY15-16, 86% of Peer-to-Peer participants had developed a working Relapse Prevention Plan.
RAMS – Peer Specialist Mental Health Certificate and Leadership Academy	• In FY15-16, 30 participants were enrolled in the Peer Specialist Mental Health Certificate Entry Course, with 26 graduating. In addition, 24 participants were enrolled in the Peer Specialist Mental Health Certificate Advanced Course. • In a post-program evaluation, 100% of participants indicated that they "Strongly Agree" or "Agree" with the statement: After graduation, I am planning on pursuing a career in the field of health and human services by obtaining or maintaining a job, a volunteer position, further education in the field, and/or engaging in advocacy activities. • 90% of graduates reported that they had been engaged within the health and human services field through employment, volunteer positions, career advancements, and/or pursuing further education within six months of graduation.
SF DPH – Transgender Health Services	• In FY15-16, THS processed a total of 96 referrals, and completed 73 surgeries. • Peer Navigators co-facilitated numerous transgender 101 trainings for SFDPH staff in FY15-16, as well as community education workshops for SFDPH programs.
SF DPH (INN) – Hummingbird Peer Respite	• Of Hummingbird Peer Respite's surveyed guests in FY15-16, 93% reported being satisfied with the service they had received. • 86% of guests reported an increased ability to take care of themselves, as a result of their stay with Hummingbird. • 87% of guests reported improved social connections, and 93% reported improved sense of safety.

Program	FY15-16 Key Outcomes and Highlights
RAMS – Peer to Peer Employment	• 86% of RAMS Peer to Peer clients/participants expressed overall satisfaction with services in FY15-16. • During FY15-16, 93% of program employees reached their one year employment anniversary, or advanced in their career trajectory or education.
RAMS – Peer Wellness Center	• 81% of Peer Wellness participants reported improvement in their overall quality of life in FY15-16. • Approximately 79% of clients/participants reported that they had maintained or increased feelings of social connectedness as a result of working with Peer Counselors. • 93% of participants in FY15-16 expressed overall satisfaction with services.
SF DPH (INN) – Transgender Pilot Project	• In FY15-16, the TPP served 189 unduplicated clients in group settings. • Staff also organized the Trans Health and Wellness fair, a large outreach event that drew over 120 participants. • As a result of participation in the TPP, over 75% of respondents indicated that they were more aware of services available to the transgender community, felt more connected to the transgender community, and felt more hopeful in general.
SF DPH – RSSE	• Conducted 4 workshops in FY15-16, to increase competence and awareness of mental illness, violence, and trauma. • Participated in 20 community events, and delivered 10 community presentations.

Cost per Client

Program	Clients Served	Annual Cost	Cost per Client[15]
Peer-to-Peer Programs	3,427 clients	$2,210,926	$645

[15] Cost per client is calculated by dividing the program annual budget by the total number of unduplicated clients served.

Moving Forward in Peer-to-Peer Programs and Services

SF MHSA issued a Peer Health and Advocacy Request for Qualifications (RFQ) in the Spring of 2017. This RFQ includes peer advocacy projects and peer programs that promotes education and linkage to services. The primary goals of these programs are to reduce stigma associated with mental health conditions; advocate for the rights of mental health consumers and their families; and improve and coordinate health and mental health service delivery for consumers throughout the Behavioral Health system. The Peer Health and Advocacy Programs support underserved and disenfranchised residents of San Francisco, which include individuals and their families who have lived experience dealing with mental/behavioral health challenges. The program development for these projects will take place in the summer of 2017 in collaboration with peers and peer leaders.

In addition, one of the goals of the BHS 5-Year Workforce Plan will be to "successfully integrate peers across the workforce", which has been a long-term goal of BHS. The plan has specific strategies which highlights efforts to:

- Increase capacity to provide youth-to-youth, parent-to-parent and family-to-family services
- Ensure that peers have the knowledge and skills appropriate to thrive and grow within their roles
- Double the number of qualified peers with lived experience in leadership roles within the BHS workforce
- Improve peer supervision skills

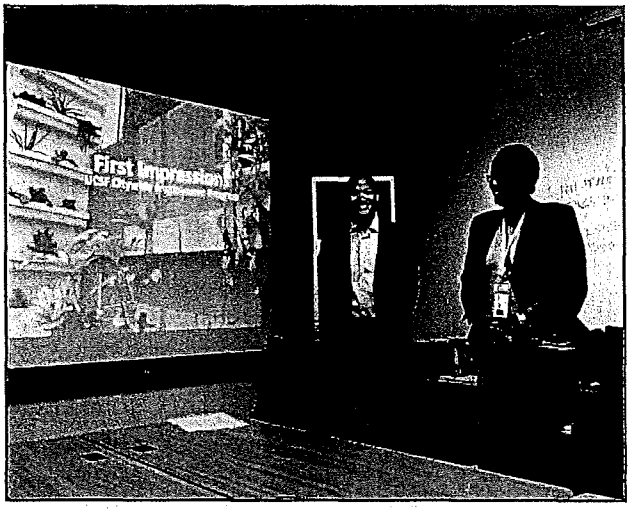
Lastly, Peer-to-Peer Services has planned the following activities to support, improve, and enhance its programming over the next three years:

- Continued expansion of peers in the mental health workforce, as peers advance into job positions that are not designated as "peer positions"
- Continued educational support and training through the RAMS entry level and advanced mental health certificate program, leadership trainings, and through the City College Mental Health Certificate Program
- A select group of peers will be providing service and billing through Medi-Cal
- An increase in community-based Peer Navigation
- An increase in Peer linkage for individuals exiting locations such as the jails, inpatient psychiatry, and stepping down from Full Service partnerships

4. Vocational Services

Service Category Overview

The San Francisco Department of Public Health incorporates vocational services within its mental health programming through MHSA funding. These vocational services ensure that individuals with serious mental illness and co-occurring disorders are able to secure meaningful, long-term employment. Research shows that supported employment programs help individuals with mental illness achieve and sustain recovery.



Presentation by First Impressions staff.

In collaboration with The California Department of Rehabilitation, the San Francisco Department of Public Health has identified a need for various training and employment support programs to meet the current labor market trends and employment skill-sets necessary to succeed in the competitive workforce. These vocational programs and services includes vocational skill development and training, career/situational assessments, vocational planning and counseling, service coordination, direct job placement, ongoing job coaching, and job retention services. These MHSA-funded services are largely supported through the Community Services and Supports and Innovations funding streams.

Target Population

The target population consists of San Francisco. Particular outreach is made to underserved populations and those interested in job readiness programs, on-the-job training, internships, competitive employment and meaningful activities leading to work.

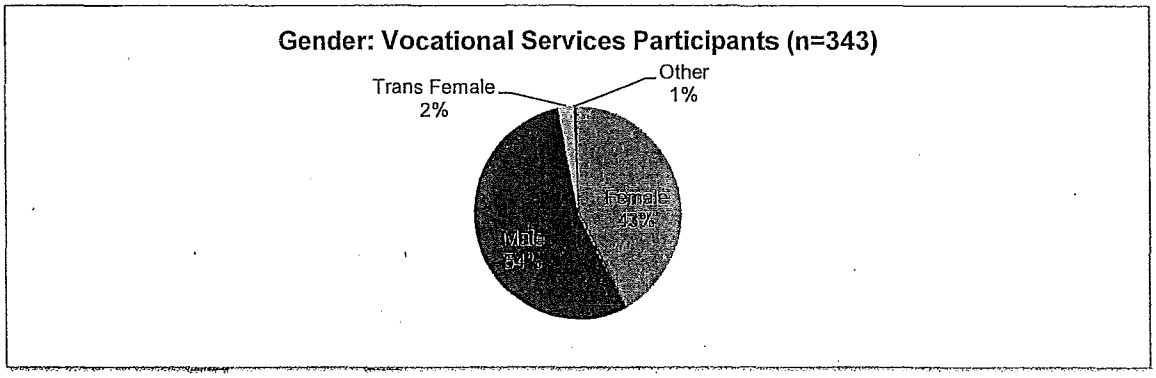
Vocational Services	
Program Name	**Services Description**
Department of Rehabilitation Vocational Co-op (The Co-op)	The San Francisco Department of Rehabilitation (DOR) and the City and County of San Francisco's Behavioral Health Services (BHS) collaborate to provide vocational rehabilitation services to consumers of mental health services. Services offered by this program include vocational assessments, the development of an Individualized Plan for Employment, vocational planning and job coaching, vocational training, sheltered workshops, job placement, and job retention services.
i-Ability Vocational IT Program	The i-Ability Vocational Information Technology training program prepares consumers to be able to provide information technology (IT) support services (e.g., Help Desk, Desktop support) at the BHS IT Department. The program includes three components:

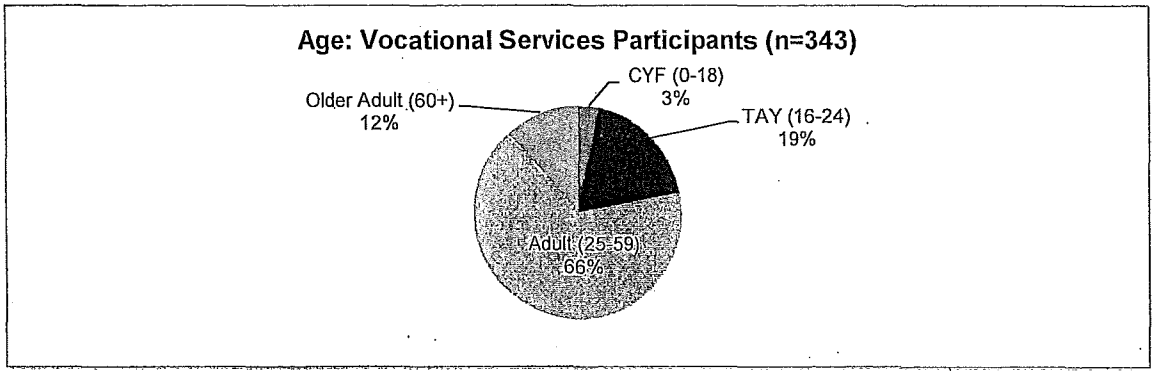
Vocational Services	
Program Name	**Services Description**
	• Desktop: a single point of contact for end-users of BHS computers and hardware to receive support and maintenance within BHS computing environment. • Help Desk: a single point of contact for end-users of the BHS electronic health record system ("Avatar") to receive technical support. • Advanced Help Desk: a single point of contact for end-users of the BHS electronic health record system ("Avatar") to receive advanced technical support. Services offered by the program include vocational assessments, vocational counseling and job coaching, vocational skill development and training.
First Impressions **(INN Funded)**	First Impressions is a vocational program that offers training in basic construction and remodeling skills, such as painting and patching walls, ceilings, and doors; changing/applying window dressings; installing and disposing of furniture and accessories; building furniture; cleaning and repairing flooring; hanging décor; and minor landscaping. Vocational services offered by this program include vocational assessments, vocational planning and job coaching, vocational training and workshops, job placement, and job retention services.
Alleviating Atypical Antipsychotic Induced Metabolic Syndrome (AAIMS)	The Alleviating Atypical Antipsychotic Induced Metabolic Syndrome (AAIMS) program provides nutrition, exercise, and health education and training. The program educates program participants on the connection between diet and health, provides healthy cooking and exercise classes, information on shopping for healthy food based on local availability with the goal of decreasing participants metabolic syndrome issues and increasing their social connectedness. AAIMS peer leaders also advocate for neighborhood food access.
SF Fully Integrated Recovery Services (SF First)	The SF Fully Integrated Recovery Services Team (FIRST) Vocational Training Program offers training and feedback regarding both practical work skills and psychosocial coping skills for job retention. Practical work skills will include learning the skills needed to work as a clerk, janitor, café worker, packaging and assembly line worker, peer group activity facilitator, as well as other positions. Supportive counseling for job retention addresses issues such as organizational skills, time management, delaying gratification, communication skills, conflict resolutions skills, goal setting and hygiene maintenance for the workplace.
Assisted Independent Living Vocational Program	The Assisted Independent Living Vocational Program supports consumer employees in building skills related to clerical/administrative support and mail distribution. This supported employment project is located on-site at Baker Places and provides training, supervision and advanced support to a team of consumers with an emphasis on professional development. The Assisted Independent Living project aims to help consumers to identify professional development goals and breakdown barriers in reaching their goals. The project also

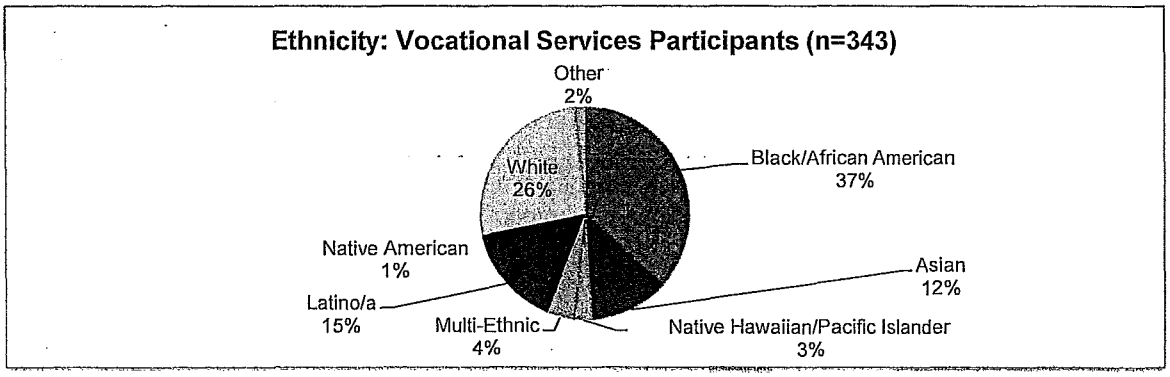
Vocational Services	
Program Name	**Services Description**
	links consumers to the Department of Rehabilitation's job placement services and other vocational programs within the BHS system.
Janitorial Services	The Janitorial Services program provides janitorial and custodial vocational training to behavioral health consumers.
Café and Catering Services	The Café and Catering Services program provides café, barista, catering and customer service vocational training to behavioral health consumers.
Growing Recovery and Opportunities for Work through Horticulture (GROWTH)	The Growing Recovery and Opportunities for Work through Horticulture (GROWTH) is a landscaping and horticultural vocational program that assists mental health consumers in learning marketable skills through on-the-job training and mentoring to secure competitive employment in the community.
TAY Vocational Program	The Transitional Age Youth (TAY) Vocational Program offers training and paid work opportunities to TAY with various vocational interests.

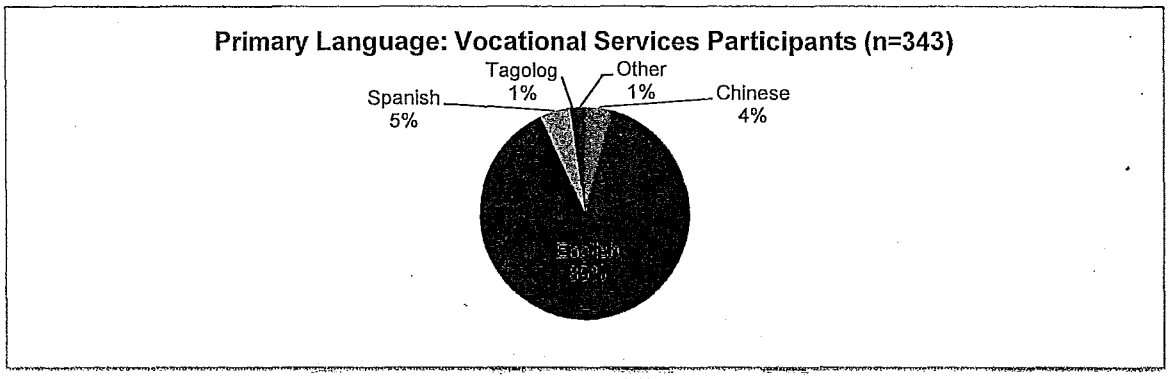
Participant Demographics, Outcomes, and Cost per Client

Demographics: Vocational Services









Program	FY15-16 Key Outcomes and Highlights
RAMS – i-Ability Vocational IT Program	• In FY15-16, 100% of trainee graduates (37 out of 37) met their vocational goals, which were collaboratively developed between the Vocational Rehabilitation Counselor and trainees. • 86.5% (32 out of 37) of trainee graduates indicated improvements to their coping abilities, which is reflected by post-program evaluations and satisfaction surveys. • 86% (37 out of 43) i-Ability trainees successfully completed the training or exited the program early, due to obtaining gainful employment or finding volunteer positions related to their vocational interests.

Program	FY15-16 Key Outcomes and Highlights
UCSF – Citywide First Impressions (INN)	• 18 consumers were enrolled in, and 8 consumers successfully graduated from, the First Impressions Program in FY15-16. • Each participant received individualized strengths-based assessments and person-centered treatment planning. • 100% of graduates met their vocational goals. • 100% of graduates indicated improvements in their coping skills.
API Wellness - AAIMS Project	• Made approximately 500 outreach contacts via rooftop garden healthy cooking program in FY15-16. • Prepared and served a total of 3,000 healthy snacks in TWUH clinic, for 60 unduplicated patients.
SF DPH – SF First Vocational Project	• Stipended Vocational Services Program served 19 participants in FY15-16, with 4 completing the program. • At 9-month program completion date, 75% of trainees had reduced barriers to employment. • SF FIRST Stipended Vocational Training Program added a doll-making project this past year. Skills learned by participants in this project include sewing, design, attention to detail, following a sequence of steps and effective communication.
Baker Places - Assisted Independent Living Vocational Program	• 0% of psychiatric inpatient hospital discharges occurring during FY15-16 had a readmission within 30 days. • 82% of consumers improved on their actionable ANSA items. • 100% of clients with an open episode had an initial Treatment Plan of Care finalized in Avatar within 60 days of episode opening. • 11 individuals successfully transitioned from co-operative living into independent living within the community.
UCSF – Citywide Café and Catering Services	• 13 BHS consumers enrolled in the Food and Catering Services Program in FY15-16. • 100% of graduates reported an improvement in development of skills.

Program	FY15-16 Key Outcomes and Highlights
	• 100% of graduates reported an improvement in confidence to use newly learned skills.
UCSF – Citywide GROWTH	• 10 BHS consumers were accepted into the training program and 9 consumers completed the classroom portion of the training. • 8 of the 9 graduates were accepted into paid work experience. • 100% of graduates of classroom portion of the program reported an improvement in skills.
RAMS – TAY Vocational Program	• In FY15-16, RAMS held 5 focus groups with high school students at SFUSD Wellness Centers, and 4 focus groups with high school students at BHS Clinic/ CBO locations.

Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[16]**
Vocational Programs	695 clients	$1,010,302	$1,454

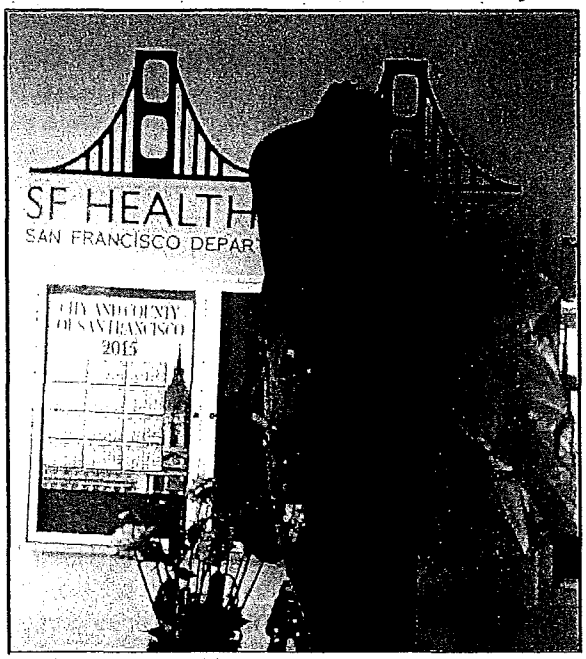
Moving Forward in Vocational Services

Over the next three years, the Vocational Services has planned the following to support, improve, and enhance its programming.

- Implementation of the Consumer Portal Help Desk. The help desk will provide support for behavioral health consumers with the use of the portal, which will grant access to view selected clinical information and scheduled appointments.
- Recruitment process. The department will be reviewing the recruitment process to ensure all communities are engaged and served.
- Community Advisory Group (CAG). The department will review and restructure the format of the CAG meeting in order to improve its benefits to the Vocational Training Programs.
- Training for Staff. Additional training will be provided to program and peer staff with the goal of providing them with the tools needed to succeed in their current roles and prepare for career advancement.
- Implementation of a new Help Desk ticketing application. The implementation of the new ticketing application will provide us with information that will guide the delivery of services by our various programs.

[16] Cost per client is calculated by dividing the program annual budget by the total number of unduplicated clients served.

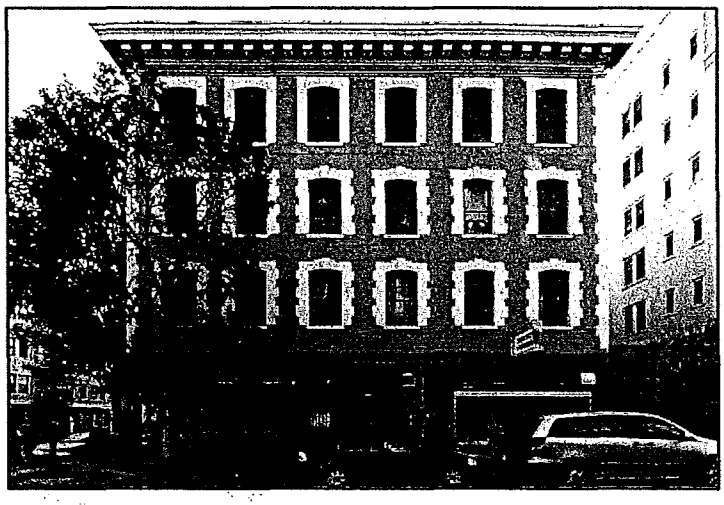
- Internships. Create time-limited internship opportunities for graduates of the training programs while they are looking for work.
- Employment Opportunities. Create additional part-time and/or full-time positions for gradates of GROWTH and RAMS vocational programs.
- Administrative Support. Add a vocational employment position to work at the 1380 Howard Street Administrative Office and other BHS sites for continued maintenance of plants and other tasks, supporting the GROWTH and First Impressions programs.
- Enhanced Workforce Pipeline. Continue to increase the number of consumers moving through the vocational workforce pipelines by establishing needed training and support to ensure they have what they need to advance to the next career of their choice.
- Evaluation. Work with the Department of Rehabilitation and DPH Quality Management to develop evaluation tools to better assess a client's work and wellness status after 90 days of successful employment.
- Website Enhancements. Enhance the current vocational website (http://bit.ly/SFVOC) to be a one-stop shop for consumers, Co-op alumni, and providers to learn about (1) the services offered by the different Co-op programs (2) job leads (3) additional trainings relevant to job development (4) support groups in the community for work ready consumers, and (5) client advocacy groups within BHS such as the Client Council, Stigma Busters, the MHSA Award Ceremony, etc.
- Support Groups. Create a monthly support group facilitated by working consumers to network and socialize with each other. This will also be a forum to give consumer feedback to BHS administration about emerging needs.
- Consumer Success Stories Booklet. Consumers will be provided the opportunity to submit stories or quotes regarding their vocational journey to wellness. This will be published in a simple booklet to be read at outreach and community events, with clients' signed consent.



First Impressions Vocational Construction Program

5. Housing Services

Service Category Overview



MHSA-funded housing helps address the need for accessible and safe supportive housing to help clients with serious mental illness or severe emotional disorders obtain and maintain housing. This service category includes Emergency Stabilization Housing, FSP Permanent Supportive Housing, Housing Placement and Support, ROUTZ Transitional Housing for TAY, and other MHSA Housing Services.

In 2016, BHS facilitated several population-specific resource training sessions. These sessions covered resources for preventing and ending homelessness. Provider groups participating this year included the Population Focused PEI providers, Full Service Partnerships, and the Transgender Advisory Group.

No Place Like Home (AB 1618)

On July 1, 2016, Governor Jerry Brown signed legislation enacting the No Place Like Home (NPLH) Program to dedicate $2 billion in bond proceeds to invest in the development of permanent supportive housing for persons who are living with a severe mental illness (SMI) and are in need of mental health and/or substance use services and are experiencing chronic homelessness, or are at-risk of chronic homelessness, or homelessness. The bonds are repaid by funding from the Mental Health Services Act (MHSA) Fund. Some key features of this program include: (1) counties are eligible applicants (either solely or with housing development sponsor); (2) utilization of low-barrier tenant selection; and (3) counties must commit to provide mental health services and coordinate access to other supportive services.

The NPLH program is still being developed by the State Department of Housing and Community Development. As of January 2017, the application process is still yet to be finalized. The NPLH Proposed Program Framework provides a tentative schedule of winter 2018 for the release of Notice of Funding Availability.

In San Francisco, the Mayor's Office of Housing and Community Development (MOHCD) and the Department of Homelessness and Supportive Housing (HSH), will be taking the lead on this project. The San Francisco Department of Public Health will work in partnership with MOHCD and HSH, to develop and implement the supportive services portion of the NPLH program.

The San Francisco Mental Health Services Act program will continue to monitor the development of the NPLH program and its impact on the County's Annual MHSA Revenue Allocation due to the bond repayment.

Target Population

MHSA-funded housing helps clients with serious mental illness or severe emotional disorders obtain and maintain housing. These programs serve individuals who are chronically homeless, at-risk for homelessness, enrolled in Full-Service Partnership programs, TAY, LGBTQ (Lesbian, Gay, Bisexual, Transgender, Questioning) individuals, veterans, individuals with disabilities, older adults, extremely low income, and individuals with other needs. Some housing programs emphasize working with individuals with co-occurring mental health issues, alcohol and substance abuse problems, and/or complex medical conditions.

Housing Services	
Program Name	**Services Description**
Emergency Stabilization Housing	Emergency stabilization units (ESUs) provide short-term housing stability for clients who are homeless or have been discharged from the hospital or jail. The twenty ESUs are located within several single room occupancy (SRO) hotels in San Francisco. The units are available to Full Service Partnership clients, Intensive Case Management clients and Central City Hospitality House's housing support staff. In 2015-2016, many of the units that were previously used for ESUs have been pulled from the program. The buildings that contracted with DPH for these units have been able to lease out individual units or the entire building for higher amounts in the current rental market in San Francisco. As such, interim housing options for MHSA clients are severely limited.
FSP Permanent Supportive Housing	In 2007, the state provided counties with a one-time allocation of MHSA funds to pay for capital costs to develop 10,000 units of housing, as well operating reserves for each new unit created. San Francisco expended its full initial housing allocation of $10 million by creating many units of housing for MHSA clients that are still being operated within the provision of the MHSA. In addition, San Francisco added $2.16 million from CSS to housing in 2007-08. Currently there are a total of 66 MHSA housing units dedicated to those who are homeless or at risk of homelessness developed with capital funding located in various neighborhoods of San Francisco including the Tenderloin, Rincon Hill, and Ingleside. MHSA units are available to the transitional-aged youth and seniors in addition to single adults. Additionally, MHSA utilizes units that are scattered through a number of older affordable housing sites. This includes 21 units at three sites of the Tenderloin Neighborhood Development Corporation (TNDC); and, eight units at the Community Housing Partnership's Cambridge Hotel. The scattered site units at CHP and TNDC are part of the Direct Access to Housing (DAH) Program, now part of the Department of Homelessness and Supportive Housing (HSH) – Adult Housing Programs division.
Housing Placement and Supportive Services	Established by the San Francisco Department of Public Health in 1998, **the DAH program** is a permanent supportive housing program targeting low-income San Francisco residents who are homeless and have serious behavioral health and/or complex physical health needs. As a "low threshold" program that accepts

Housing Services	
Program Name	**Services Description**
	single adults into permanent housing directly from the streets, shelters, hospitals and long-term care facilities, DAH strives to help tenants stabilize and improve their health outcomes despite co-occurring mental health issues, alcohol and substance abuse problems, and/or complex medical conditions. DAH expanded capacity to serve MHSA clients alongside FSPs and other ICM service providers. The DAH program includes an administrative and a clinical staff person who assesses and refers clients to the most appropriate DAH individual referral prioritization system and its varied portfolio of housing sites to allow for tailored placement based on the physical and clinical needs of the population such as: • Level of medical acuity • Substance use severity • Homeless situation • Match between clients' needs and available on-site services • Availability and match of a DAH unit
ROUTZ Transitional Housing for TAY	Youth with mental health and substance abuse issues have unique and complex needs for housing. To expand the availability of housing for this population, San Francisco allocated additional General System Development (GSD) funds to develop housing for transitional- aged youth with Larkin Street Youth Services (LSYS). The MHSA ROUTZ TAY Housing Partnership provides 40 housing slots at the Aarti Hotel (located at 391 Leavenworth Street) and 10 additional slots at scattered housing sites in SF. In Fall 2011, the Aarti Hotel completed its renovation and LSYS began providing supportive services for TAY with serious mental illness including intake and assessment, life skills training, wrap-around case management, mental health interventions, and peer based counseling.

Other MHSA Housing Services
MHSA Permanent/Transitional Housing List 2016

MHSA Housing Site	Owner/ Operator	MHSA Units	Target Population	Services	Type of Project	Referral Source
1100 Ocean	Mercy	6	TAY	FSP + FPFY	MHSA Capital	BHS Placement
Aarti/Routz	Larkin St.	40	TAY	Larkin - All	MHSA GF - TH	BHS Placement
LeNain	DISH	0-5	Adults	DPH	DAH	DAH
Pacific Bay Inn	DISH	0-5	Adults	DPH	DAH	DAH
Windsor Hotel	DISH	0-5	Adults	DPH	DAH	DAH
Empress	DISH	0-5	Adults	DPH	DAH	DAH
Camelot	DISH	0-5	Adults	DPH	DAH	DAH
Star	DISH	0-5	Adults	DPH	DAH	DAH

Other MHSA Housing Services
MHSA Permanent/Transitional Housing List 2016

MHSA Housing Site	Owner/ Operator	MHSA Units	Target Population	Services	Type of Project	Referral Source
San Cristina	CHP	0-14	Adults	FSP + CHP	DAH	DAH
Cambridge	CHP	0-15	Adults	FSP + CHP	DAH	DAH
Hamlin	CHP	0-14	Adults	FSP + CHP	DAH	DAH
Richardson	CHP	12	Adults	FSP + Citywide	MHSA Capital	DAH
Rene Cazaneve	CHP	10	Adults	FSP + Citywide	MHSA Capital	DAH
Rosa Parks II	TNDC	3	Seniors	FSP + TNDC	MHSA Capital	DAH
Polk Senior	TNDC	10	Seniors	FSP + TNDC	MHSA Capital	DAH
Kelly Cullen	TNDC	17	Adults	FSP + TNDC	MHSA Capital	DAH
Ritz	TNDC	2	Adults	FSP + TNDC	DAH	DAH
Ambassador	TNDC	8	Adults	FSP + TNDC	DAH	DAH
Dalt	TNDC	13	Adults	FSP + TNDC	DAH	DAH
Veterans Commons	Swords	8	Veterans	FSP + Swords/VA	MHSA Capital	BHS Placement
TOTAL		**150-200**				

Program Outcomes and Highlights

FY15-16 Key Outcomes and Highlights

FSP Permanent Supportive Housing

- In FY15-16, BHS began referring people to reserved MHSA units within the Community Housing Partnership portfolio. These 43 units in non-profit housing include access to services coordination staff through a contract expansion with the Community Housing Partnership. This program targets single adults with serious mental illnesses who are currently homeless.

FY15-16 Key Outcomes and Highlights

Housing Placement and Support

- Developed by the Tenderloin Neighborhood Development Corporation and completed in FY15-16, Rosa Parks II Senior Housing (RPII) is a planned 98-unit, five-story affordable senior housing development, with three units set aside for older adults under MHSA.
- The Ocean Avenue development, completed in FY15-16, is a new construction project that includes 70 units of

housing for families and transitional aged youth (TAY) and one property manager unit. The building has a mix of studios, one, two and three-bedroom units available to residents making no more than 50 percent of the area median income. Twenty-five units are restricted at 20 percent of the area median income.

FY15-16 Key Outcomes and Highlights

ROUTZ Transitional Housing for TAY

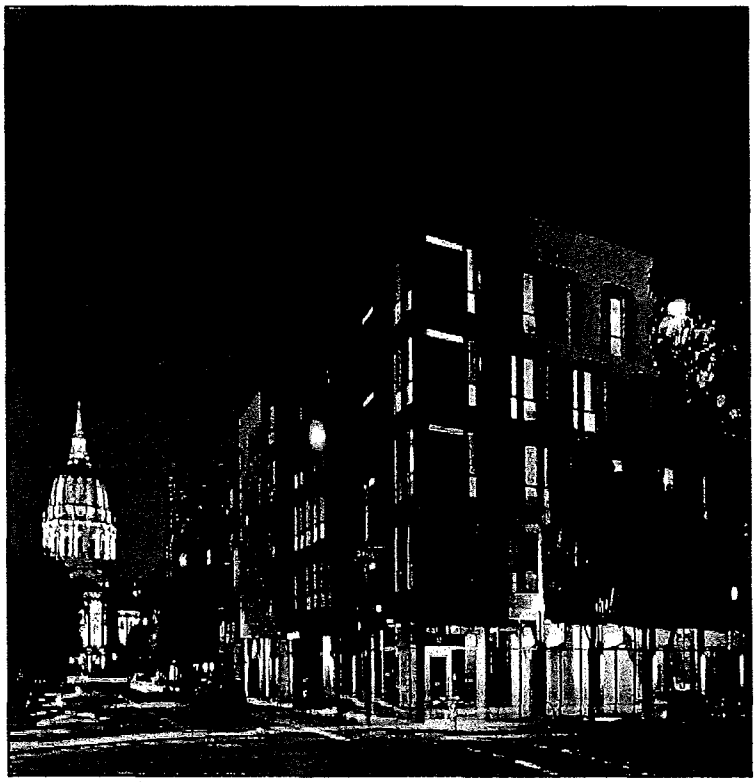
- Eighty-eight percent (88%) of placements in this program maintained housing or had a stable exit after one year, exceeding the performance goal.
- By the end of FY15-16, 90% (44 of 49) of youth remained in housing or exited to stable housing.
- 63% (13 of 20) of youth housed for at least one year showed an improvement in their ability to manage mental health issues.
- 82% (40 of 49) of youth received an average of 3 case management sessions per month they were housed.
- 92% (45 of 49) of youth received individual or group mental health services.
- 92% (45 of 49) youth had a case plan completed or updated at least once during the fiscal year.

Moving Forward in Housing Services

In November 2015, the Mayor announced the need for a central department in SF to focus exclusively on homelessness issues. As a result, the Department on Homelessness and Supportive Housing (HSH) was created and officially started in July 2016. HSH, with support from SF MHSA, now oversees the Housing Placement and Supportive Services for MHSA units. BHS work-orders its housing-specific funds to the new department to expedite placement of homeless FSP clients. This move promotes the MHSA principle of community collaboration and working with our City partners to provide the best housing services. HSH is also actively planning a Coordinated Entry System to continue providing integrated services for all permanent supportive housing programs in SF that will begin with families in 2017 and implement for single adults in 2018.

The San Francisco Moving On Initiative (MOI) is a collaboration between HSH and the SF Housing Authority (SFHA). This program is for PSH residents, who are ready to move on from supportive housing and into affordable housing with SFHA. To qualify for a referral to the SFHA Waiting List and preference points, applicants must meet certain eligibility criteria and complete an application. Participants who are eligible for the Supportive Housing preference as reviewed by HSH staff will have their names referred to the SFHA 's Waiting List. This initiative allows

people who no longer need on-site services the opportunity to move on, and makes available those Permanent Supportive Housing units for people leaving homelessness who would need that level of support. Tenants can speak to their staff at their current housing site for more information.



SF MHSA has financed MHSA Housing Projects and, as part of this 3-Year Integrative Plan, SF MHSA is submitting a "MHSA Housing Loan Program Ongoing Annual MHSA Fund Release Authorization For Future Unencumbered Funds" form **(see Attachment A)** to describe how the SF MHSA wishes to handle such funds in the future. Per attachment A, the City and County of San Francisco is requesting the annual release of MHSA funds in the City and County of San Francisco's CalHFA account be returned to the City and County of San Francisco. This may include, but not limited to; COSR funds that are no longer required by a project, funds approved for a loan that is never funded, MHSA residual receipt loan payments, and accrued interest.

6. Behavioral Health: Workforce Development

Service Category Overview

The Behavioral Health Workforce Development service category addresses the shortage of qualified individuals who provide services in San Francisco's public mental health system. This includes developing and maintaining a culturally humble/competent workforce that includes individuals with client and family member experience who are capable of providing client- and family-driven services that promote wellness, recovery, and resiliency. This service category includes 1) the Mental Health Career Pathways Program, 2) Training and Technical Assistance, and 3) Residency and Internship Programs.

In 2009, MHSA received an initial $4.6 million allocation of MHSA funding to support Workforce, Development, Education and Training (WDET) activities. San Francisco has developed a strong collection of activities and programs designed to achieve WDET goals. Through Career Pathway Program (CPP) activities, the decision was made to sustain MHSA WDET activities, described below, with CSS funds. SF MHSA's goal is to develop a behavioral health pipeline to increase the number of individuals that are informed about, choose to prepare for, and are successful in entering and/or completing behavioral health training programs. This work involves collaboration between MHSA, BHS, SFUSD, City College of San Francisco, San Francisco State University, and California Institute of Integral Studies.

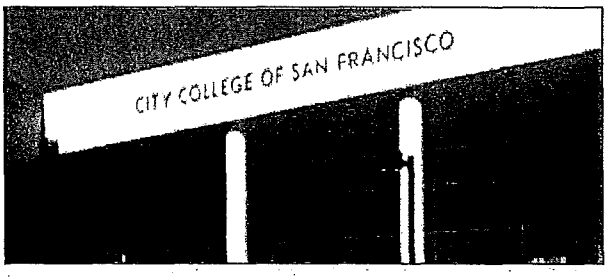
Target Populations

These programs work with college students with populations who are currently underrepresented in licensed mental health professions,: high school students who express career interests in the health care/behavioral health care industries; and mental health consumers, family members and individuals who come from ethnic groups that are not well represented in the mental health/behavioral professions (e.g., African American; Latino; Native American; Asian; Pacific Islander; Lesbian, Gay, Bisexual, Transgender, and Questioning communities).

Mental Health Career Pathway Programs	
Program Name	**Services Description**
Summer Bridge	The Summer Bridge Program is an eight-week summer mentoring program for youth ages 16-20 who are enrolled in or recently graduated from San Francisco Unified School District high schools. The program aims to 1) educate youth about people's psychological well-being; 2) reduce the stigma associated with mental health; and 3) foster youth's interests in the fields of psychology and community mental health.
Community Mental Health Worker Certificate	*See program description on below.*
California Institute of Integral Studies (CIIS) MCP Project	CIIS seeks to advance the development of a diverse and culturally competent mental health workforce by engaging and supporting communities who are underrepresented in licensed mental health professions. CIIS recruits and enrolls students from un-

Mental Health Career Pathway Programs	
Program Name	**Services Description**
	derrepresented communities in the university's Masters in Counseling Psychology (MCP) program, provides them support services, and organizes trainings, workshops and lectures to attract individuals of color, consumers of mental health services and family members of consumers so that they will graduate with a psychology education and gain licensure. In addition, each MCP student completes an extensive year-long practicum in a public or community mental health agency.
FACES for the Future Program	Faces for the Future program (FACES) is nationally recognized for healthcare career preparation work with high school students. The FACES program introduces John O'Connell High School students to career pathways in healthcare, public health and mental and behavioral health while supporting them with academic interventions, coordination of wellness services, referrals to outside agencies when needed and youth leadership development opportunities.
San Francisco State University: Student Success Program	The Student Success Program is offered through SFSU's Student Affairs and Enrollment Management, and is designed to increase student access and enrollment, enhance student retention and maximize graduation rates among mental health consumers, family members of consumers and members of underserved and underrepresented communities (e.g., Black/African American; Latino; Native American; Asian; Pacific Islander; Lesbian, Gay, Bisexual, Transgender, and Questioning), who are preparing for careers in the public behavioral health system. Workforce Development activities within the program focus on providing information about the mental health field and its professions, outreaching to underrepresented communities, and offering career exploration opportunities.

Spotlight Program – Community Mental Health Worker Certificate Program



The Community Mental Health Worker Certificate (CMHC) program at City College of San Francisco (CCSF) is a 16-unit program based on the mental health wellness and recovery model, which focuses on the process of recovery through consumer-directed goal setting and collaboration between mental health service consumers and mental health providers. The program educates and trains culturally and linguistically diverse consumers of mental health, family members of consumers and mental health community allies to enter the workforce as front-line behavioral health workers who are able to deliver culturally congruent mental health care to underrepresented populations (e.g., African American; Asian; Pacific Islander; Latino; Native American; Lesbian, Gay, Bisexual, Transgender, Questioning; and immigrant communities).

The curriculum promotes the workforce skills needed to be gainfully employed as a mental health worker, and to enhance the knowledge base of existing mental health employees. In addition, students have access to critical supports designed to facilitate student retention and success in the program, including the following:

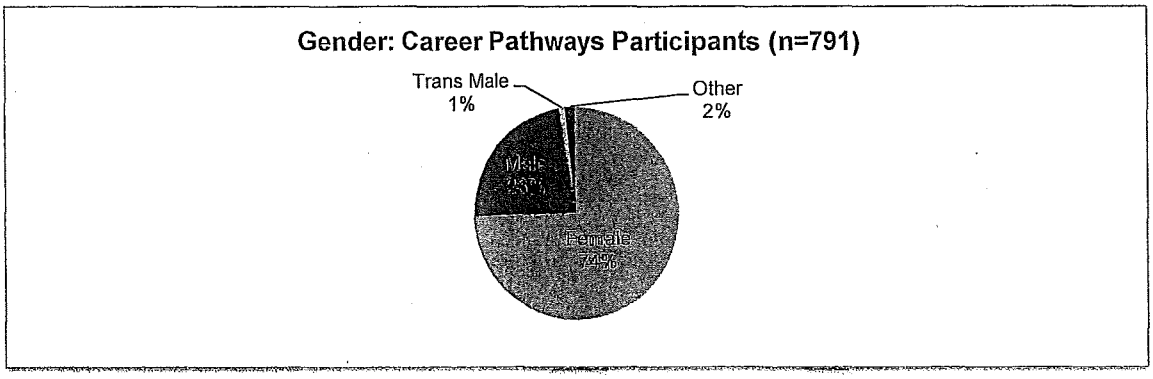
- Peer Care Manager who helps students navigate the college system, make linkages with other services, and develop personalized and comprehensive wellness and recovery action plans to support their academic participation and success
- Behavioral Health Specialist Intern who helps manage any mental health related needs
- Financial Aid Counselor who is available at the beginning and end of each semester to streamline processing of CMHC students' financial aid needs
- CCSF's Disabled Students Programs and Services (DSPS), which dedicates one DSPS counselor to CMHC so that students have expedited access to appointments
- A Career Development and Placement Center counselor, who helps students develop their resume, interview skills, and a professional portfolio, as well as provides assistance with internship placement

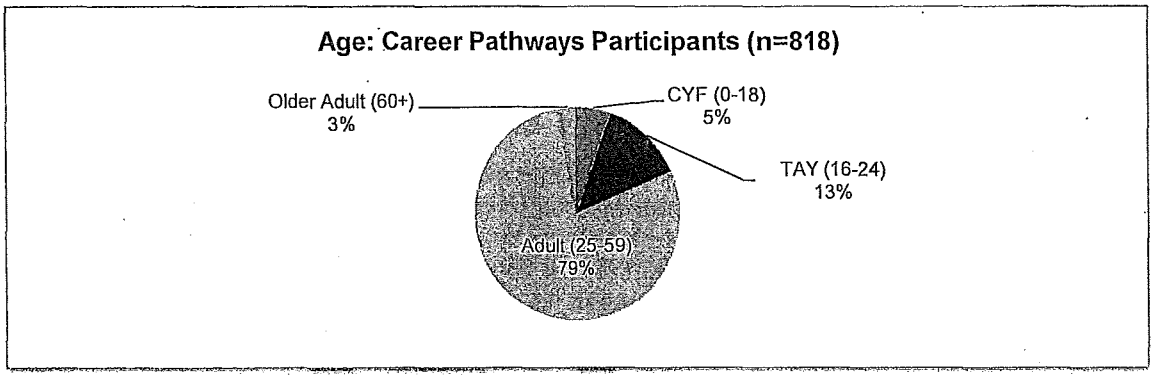
Target Population

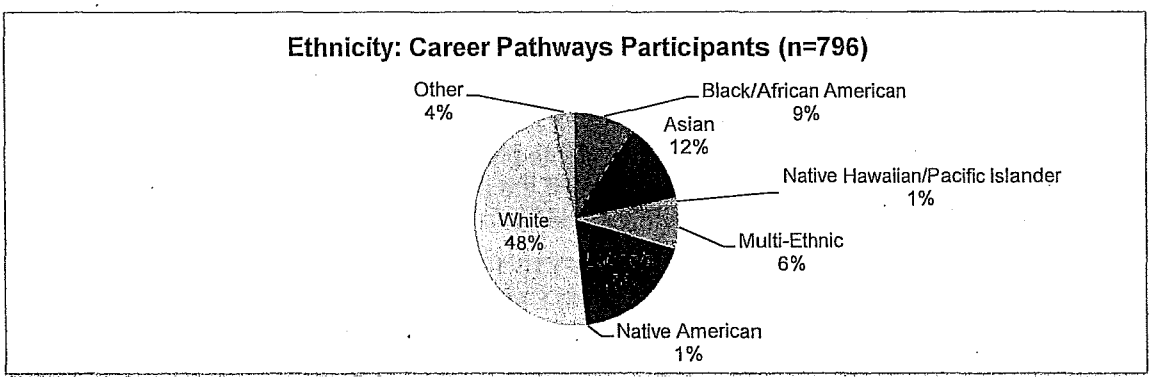
The program focuses on engaging people interested in a career in behavioral health or employment as a mental health care worker.

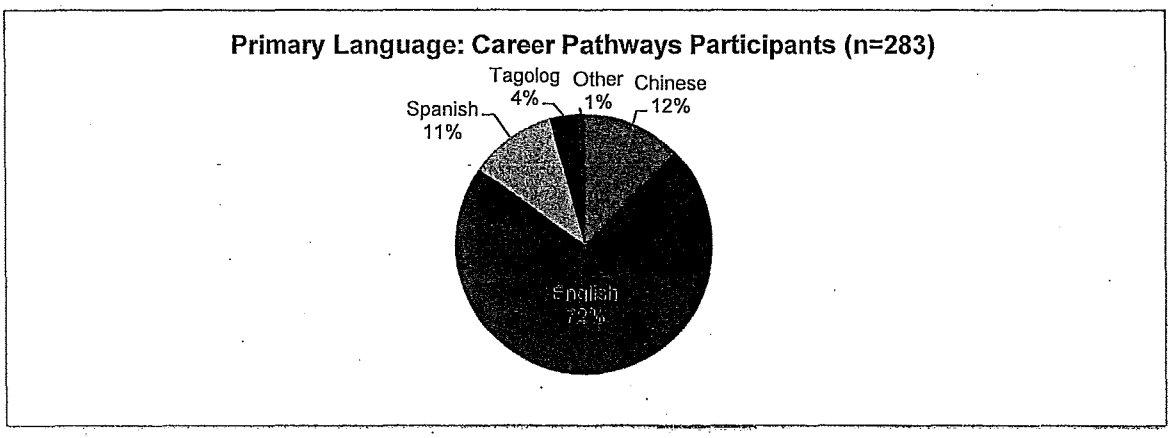
Participant Demographics, Outcomes, and Cost per Client

Demographics: Career Pathways









Program	FY15-16 Key Outcomes and Highlights
RAMS – Summer Bridge	• During FY15-16, the Summer Bridge program served 58 students and provided 120-hours of career exploration, field learning and basic counseling skills development. • In FY15-16, 100% of Summer Bridge 2015 participants (22 out of 22) completed the program and graduated. • 100% of Summer Bridge 2015 participants surveyed agreed or strongly agreed with the statement, "I know how to refer family and/or friends for mental health support and/or services" on the 2015 post-program questionnaire, vs. 26% in the pre-program questionnaire. • 82% of Summer Bridge 2015 participants surveyed agreed or strongly agreed with the statement, "I have found role models in the health & human services field" on the 2015 year-end evaluation.
City College of San Francisco – Community Mental Health Worker Certificate	• During FY15-16, the program witnessed 15 graduates, 23 students primed for internships, 66 students who completed the program's introductory course, and 27 new students in the CMHC Program's FY16-17 cohort. • During FY15-16, in collaboration with students and PCM, the CMHC facilitated 3 workshops: one in the community, and two at CCSF for students and community members. • CMHC Program graduates have obtained new employment at the RAMS Peer Wellness Center, University of California San Francisco's Citywide program, NAMI (National Alliance on Mental Illness), and the HIV/STI Education Office Management Assistant with the Health Education Department at City College of San Francisco.

California Institute of Integral Studies – MCP Program

- In the 2015-16 school year, CIIS recruited and enrolled 14 students from underrepresented groups into the MCP program.
- Staff organized eight on-campus events in FY15-16 to attract community members of color and individuals with "mental health system" lived experiences, which drew in approximately 400 participants.
- CIIS provided academic and career development services to 139 students, linked 523 students to on and off-campus resources, counseled 148 students on educational, professional, and personal goals, provided peer-counselor support to 98 students, and held 15 campus events that challenged faculty and staff to broaden their understanding of the diverse student body.

Public Health Institute – FACES for the Future

- In FY15-16, the program served 45 students (12 juniors and 33 seniors).
- 100% of the graduating seniors have enrolled in post-secondary programs beginning in Fall 2016: 67% will attend community colleges, 24% will attend state colleges, and 6% will attend University of California schools.
- During the school year, 100% of FACES students received psychosocial progress monitoring and support, which was carried out through weekly check-ins, and 100% of students participated in a two hour workshop on emotional triggers, self-care and crisis management.
- All senior students engaged in 24 hours of work-based learning internships, which were spread out over 13 sites and supervised by 16 preceptors, with each preceptor investing an average of 40 hours.

Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[17]**
Mental Health Career Pathways	13,429 clients	$972,924	$72

[17] Cost per client is calculated by dividing the program annual budget by the total number of unduplicated clients served.

Training and Technical Assistance Programs	
Program Name	**Services Description**
Trauma-Informed Systems Initiative	The Trauma Informed Systems (TIS) Initiative focuses on the system-wide training of a workforce that will develop a foundational understanding and shared language, and that can begin to transform the system from one that asks "What is wrong with you?" to one that asks "What happened to you?." The initiative strives to develop a new lens with which to see interactions that reflect an understanding of how trauma is experienced in both shared and unique ways.
Adolescent Health Working Group	The purpose of adolescent/TAY provider capacity building is to improve communication and coordination of health related activities and services among youth/young adult providers across service sectors – including CBOs, DPH, UCSF, SFUSD, Juvenile Justice, workforce development and housing – while also building provider capacity and support systems.
Medicinal Drumming Apprenticeship Pilot	The Medicinal Drumming Apprenticeship is a pilot project designed to train community based behavioral health service providers in a culturally affirming wellness and recovery therapeutic methodology. This approach allows program participants to be supported in a culturally congruent manner, as they build and apply new skills that promote personal and community empowerment.
Street Violence Intervention and Prevention (SVIP)	The nine-month SVIP Professional Development Academy builds upon the existing skills and talents of San Francisco's brave and courageous street outreach workers/crisis responders and educates them in the areas of community mental health, trauma, vicarious trauma and trauma recovery within the frameworks of cultural sensitivity, responsiveness and humility. Participants complete a nine-month long training program, and this Academy's unique learning and application setting allows the SVIP staff to build upon their already existing talents for working with and alongside of communities. The SVIP Professional Development Academy is built upon the core curriculum of the MHSA-funded Community Mental Health Certificate Program and has additional emphases on trauma, vicarious trauma and trauma recovery.

Program Outcomes, Highlights and Cost per Client

Program	FY15-16 Key Outcomes and Highlights
SF-DPH – Trauma Informed Systems Initiative	• Coordinated 93 live trainings in FY15-16 for the DPH workforce and key community based organizations, training over 2,600 employees and contractors in the basics of trauma. • Conducted mapping, surveying, and stakeholder engagement in the planning and development of a San Francisco TAY behavioral health system of care. • Provided consultation and support for implementation of Instituto Familiar de la Raza's S.P.A.R.K. program, a Full Service Partnership designed to support the stabilization and recovery of families in crisis.
Adolescent Health Working Group – Adolescent Health Issues	• Provided over 300 hours of service in FY15-16 around capacity building among youth and young adult provider networks. • The AHWG Steering Committee met 11 times in FY15-16. An average of 15-20 members attended, giving the meetings an approximate attendance rate of 75%. • Convened annual retreat with 20 attendees for the purpose of strategic planning and brainstorming current and upcoming provider needs. • The AHWG provided 3 Trauma Trainings to more than 30 agencies in FY15-16. • AHWG convened an advisory group for the next provider toolkit that focuses on Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Health. The toolkit contains clinical guidelines, best practices in care, clinical tools and resources, as well as resources for families and youth. The toolkit's expected publication date is late 2017 and AHWG will roll out training modules to promote the implementation of the toolkit.

SF-DPH – Street Violence and Intervention Program

- 14 outreach workers, coordinators and directors were trained in FY15-16, 7 who graduated and another 7 on track to graduate in early 2017.
- As a result of participation in the SVIP Professional Development Academy, 1 staff member enrolled and graduated from City College of San Francisco's Community Mental Health Certificate program, 1 applied to graduate school, and 1 re-enrolled in a bachelor's program.

Cost per Client			
Program	**Clients Served**	**Annual Cost**	**Cost per Client[18]**
Training and Technical Assistance	4,000 clients	$1,232,293	$308

Residency and Internship Programs	
Program Name	**Services Description**
Fellowship Program for Public Psychiatry in the Adult System of Care	The goal of the Fellowship Program for Public Psychiatry in the Adult System of Care is to further develop fellows' knowledge and skills in behavioral health research (e.g., smoking cessation for Asian Pacific Islanders; health care utilization by Lesbian, Gay, Bisexual, Transgender, and Questioning individuals) and services for adults diagnosed with severe mental illness. In order to address San Francisco's behavioral health workforce shortages and supplement its existing workforce, the MHSA funds psychiatric residency and internship programs.
UCSF Public Psychiatry Fellowship at Zuckerberg SF General Hospital	The mission of the UCSF Public Psychiatry Fellowship at Zuckerberg San Francisco General Hospital is to train the next generation of public mental health care leaders who will provide patient-centered care to vulnerable populations with severe mental illness through: 1) understanding and implementing relevant, evidence-based psychosocial rehabilitation and psychopharmacological treatments, 2) promoting recovery, and 3) developing rewarding public-academic partnerships to examine their work. The UCSF Public Psychiatry Fellowship has developed a strong curriculum, which promotes leadership opportunities, a sense of community, and mentoring.

[18] Cost per client is calculated by dividing the program annual budget by the total number of unduplicated clients served.

Cost per Client			
Program	Clients Served	Annual Cost	Cost per Client[19]
Psychiatry Residency and Fellowships	261 clients	$391,002	$1,498

Moving Forward in Behavioral Health Workforce Development

In the coming years, the Behavioral Health Workforce Development program will transform our behavioral health workforce so that it better reflects and better serves San Francisco's communities. We will build a career pipeline with multiple entry, exits and re-entry points from high school through post-secondary education. This pipeline will have key components of 1) education and career support and 2) barrier mitigation and removal.

MHSA completed a BHS 5-Year Workforce Development Strategic Plan in the spring of 2017. The objectives of this Strategic Plan include:

- Integrating behavioral health career pipeline programs and existing training initiatives
- Establishing priorities for new workforce development initiatives within BHS
- Being driven by System of Care and staff needs
- Aligning with DPH, San Francisco Health Network, and Ambulatory Care (AC) WDET goals and priorities
- Leveraging AC WDET expertise and resources
- Identifying staffing and resources needed to implement strategies
- Defining measurable objectives and mechanisms for monitoring success

A Request for Qualifications (RFQ) including the MHSA Workforce Development programs was also published in the spring of 2017. This RFQ includes key components of the BHS 5-Year Workforce Development Plan. Implementation of the 5-Year Plan will take place in the summer of 2017.

In addition, various workforce development stakeholders made a decision to sunset the San Francisco State University's Student Success Program and the California Institute of Integral Studies' Masters in Counseling Psychology Project. These programs provided invaluable insight about best practices for mental health career pathways. The lessons learned and the successful components of the programs have been integrated into existing workforce programming to further increase capacity and best serve the San Francisco community.

[19] Cost per client is calculated by dividing the program annual budget by the total number of unduplicated clients served.

7. Capital Facilities and Information Technology

Service Category Overview

MHSA funding for Capital Facilities allows counties to acquire, develop, or renovate buildings to support the delivery of MHSA programs. Funds may also be used to develop community-based, less restrictive settings that will reduce the need for institutionalization or incarceration. MHSA funding for Information Technology (IT) supports upgrades to clinical and administrative information systems as well as improvements to consumers' and family members' access to personal health information within various public and private settings.

The 2014 – 17 Integrated Plan included projects to renovate three buildings – Silver Avenue Health Center, Redwood Center and Sunset Mental Health. Subsequent proposals were approved to support renovation projects at Southeast Health Center and a new integrated clinic at 220 Golden Gate. The plan also called for an annual investment of $300,000 in capital improvements, beginning in FY 14-15 with the South of Market Mental Health Center. The majority of the work for this project began in FY 15-16. The table below provides an update regarding the Capital Facilities and IT projects through June 30, 2017.

Capital Facilities	
Program Name	**Services Description**
Recent Renovations	On February 1st 2016, South of Market Mental Health Services (SOMMHS) resumed full operation in their newly remodeled space located at 760 Harrison Street. The SOMMHS remodel transformed an older leased clinic by applying MHSA funding and negotiated tenant improvements. The remodeled space ultimately benefits the clients' and staffs' experiences at the South of Market Clinic. This renovation allows for integrated health services and supports the Public Health Department's goal of offering seamless access to Behavioral Health and Primary Care services. The facility closed in June 2015 and clients were provided services at several locations. Offices at 1380 Howard Street, Mission Mental Health, OMI Family Center, and Tom Waddell Urgent Care Clinic at 50 Ivy were shared collaboratively. Thanks to the support of the directors and staff at sister clinics, we completed our project in a timely manner. Seven months of construction yielded the complete interior and exterior painting of the building and offices, the addition of a Wellness Center, additional offices and medical exam space, new flooring, a remodeled Pharmacy, and ADA upgrades. Additionally, upgrades to the phone systems were included.

Information Technology	
Program Name	**Services Description**
Consumer Portal	DPH decided to move forward with the NetSmart Consumer Portal, which plans to launch in FY 16-17. Current efforts include a scheduler that will be the primary source of collecting relevant data for clients. Roll-out efforts are pending and may include the implementation of kiosks. The Consumer Portal project expected outcomes include: • Increase consumer participation in care • Improve communication between consumers and/or family members and their care team • Reduce medication errors • Improve appointment attendance • Help keep consumer information up-to-date • Promote continuity of care with other providers
Consumer Employment	The Consumer Information Technology (IT) Support: Desktop and Help Desk project was modified to focus on desktop support, in order to provide participants with a more specialized and targeted vocational experience. Participants learn skills related to the steps required to deploy new workstations, including imaging, logistics of deployment, removal of old hardware, break-fix and equipment tracking.
System Enhancements	The System Enhancements program provides vital program planning support for IT system enhancements. Responsibilities include the following: • Project management of the Meaningful Use EHR implementation across BHS Division by facilitating meetings and other communications between IT staff, administrative staff and clinical staff who are responsible for EHR deployment • Ensuring that timelines and benchmarks are met by the entire EHR team • Manage dependencies by helping to ensure that equipment, personnel and other resources are deployed efficiently and according to timeline • Creating, maintaining and updating the Meaningful Use implementation plan • Managing EHR-related professional development for all BHS staff in an effective and timely manner to ensure smooth implementation across the Division. Two Peer Interns provided system enhancement support at the San Francisco Study Center in FY 15-16. Responsibilities included the following: • Preparing desktops for deployment • Removal of old hardware • Supporting Homeless Connect events • Other duties related to hardware support In FY 16-17, two Psychiatric Social Workers (Clinical Implementation Specialists) were hired on to support system enhancements. Responsibilities include the following:

Information Technology	
Program Name	**Services Description**
	• Represent System of Care (SOC) programs and administrators at the various EHR committees • Play a key role in the implementation of EHR products: Appointment Scheduling, Client Portal and Meaningful Use, among others • Clinic workflow analysis, development and implementation • Provide clinical documentation support related to project • Collaborate with clinical and administrative staff • Provide end-user training related to the projects • Provide leadership and guidance to the implementation team (HIT Coaches) • Conduct data analysis related to the projects

Program Outcomes and Highlights

FY15-16 Key Outcomes and Highlights	
Capital Facilities	• In FY15-16, South of Market Mental Health Services (SOMMHS) resumed full operation in their newly remodeled space located at 760 Harrison Street. This renovation allows for integrated health services and supports the Public Health Department's goal of offering seamless access to Behavioral Health and Primary Care services.
Information Technology	• In FY15-16, the Consumer Portal Analyst led implementation efforts for the Appointment Scheduler in the electronic health records system (EHR), Avatar, supported general Consumer Portal project initiation, developed training videos, developed forms for the collection of client information, and developed reports. • Two Peer Interns provided system enhancement support at the San Francisco Study Center in FY15-16. Responsibilities included: Preparing desktops for deployment, removal of old hardware, supporting Homeless Connect events, and other duties related to hardware support. • In FY16-17, two Psychiatric Social Workers (Clinical Implementation Specialists) will be brought on to support system enhancements. Responsibilities included: Represent SOC programs and administrators at the various EHR committees; play a key role in the implementation of EHR products, clinic workflow analysis, development and implementation; provide end-user training related to the projects; conduct data analysis; and other duties.

Moving Forward

Moving Forward in Capital Facilities

The Capital Facilities Plan for FY17 – 20 will be a working plan dependent upon available funding. Several BHS mental health clinics in San Francisco have a significant need for Capital Improvements. This tentative plan calls for capital improvements at the Chinatown North Beach Mental Health Clinic. The balance of the annual capital investment will be made available pending additional CPP activities and available funding.

Below is a list of needs that were identified during the Community Planning Process. The projects will be coordinated with appropriate stakeholders to validate priority and need.

Chinatown North Beach Clinic- 729 Filbert Street

- *Remodel and Tenant Improvements of the Chinatown North Beach:* Reconfigure space to create a Primary Care examination room. Remodel the lobby and pharmacy area to provide greater access and security for the clients and staff.
- *Install ADA upgrades to the clinic for access:* Install a new motorized entry door and replace the common corridor doors, and upgrade restroom fixtures and hardware adhering to current Mayor's Office on Disability Standards.

Child Crisis and Comprehensive Mobile Crisis – 3801 Third Street

- Identify a budget to replace 3 City vehicles that support the Comprehensive Crisis Response team and the City's Intervention Team that provides 24 hour x 7 day a week activities in the community.
- Reconfigure and build out client meeting spaces for Comprehensive Crises Services and Foster Care Mental Health Team. Build out a client phone center and client meeting spaces transforming the open office space into an appropriate space for client engagement and call center activities.

Transitional Aged Youth/South Van Ness Adult Behavioral Health - 755 South Van Ness

- Reconfigure space to create 3 client engagement rooms. Resurface and install new play structure for youth engagement.

Community Justice Center / Violence intervention Program – 555 Polk St

- Reconfigure offices to accommodate a group activity space and private client engagement offices for programs relocating to this property.

Sunset Mental Health (Community Oriented Primary Care Clinic) – 24th Avenue 2nd Floor

- Remodel and configure the space for better flow for client intake and consultation activities. Remodel rooms to create a welcoming reception space that has three new client centered interview spaces.

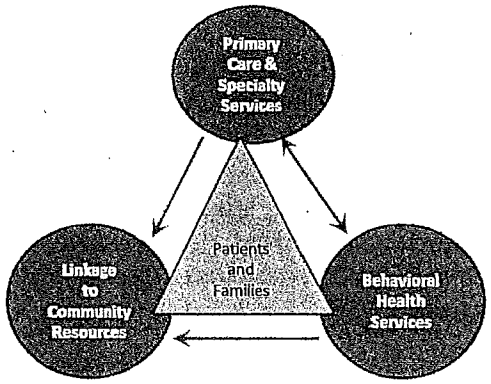
Southeast Health Center Expansion and Behavioral Health Integration Project – 2401 Keith St
This project was included in the FY16/17 Annual Update and the proposal will continue throughout the next three years. The Southeast Health Center (SEHC) is a DPH primary care clinic serving the City's historically underserved Bayview-Hunters Point neighborhood. With the goal of better and more holistically meeting the needs of Bayview-Hunters Point patients and their families, this priority DPH project will renovate and expand upon the existing facility, bringing a fuller and more integrated complement of DPH's healthcare resources and programs to one convenient campus, creating a Family Wellness Hub.

The renovation and expansion of the Southeast Health Center will implement a family-centered model of care that integrates DPH's primary care services, including office-based specialty services that target the most pressing health needs of the community, with behavioral health services and linkages to community resources.

SEHC FAMILY WELLNESS HUB

Primary Care and PC Specialty Services:
- Primary care
- Dental
- Optometry
- Non-specialty behavioral health
- Podiatry
- Targeted office-based specialty care (i.e. Pulmonary, etc.)
- Urgent care
- Geriatric care
- Wrap around HIV services

Community Resources (to be determined based on community needs and space):
- Workforce development
- Family resource center & parenting support
- Legal services
- Family support (i.e. parenting groups)
- Cooking and nutrition classes
- Therapeutic food pantry



Behavioral Health Services:
- Depression, anxiety, and other specialty mental health
- Family and individual therapy
- Family and individual case management
- Foster care and linkage
- Substance use treatment and prevention
- Older adult mental health services
- LGBT services
- Coordination with psychiatry inpatient and emergency services, and community partner agencies

Program Evaluation for All MHSA Programs

In any given year, there are between 85-95 actively funded MHSA programs. MHSA -funded staff within the BHS Office of Quality Management play an active role in supporting evaluation activities for MHSA, providing another opportunity to actively engage stakeholders. One highlight of this work, the MHSA Evaluation Impact Group, is detailed below.

The MHSA Evaluation Workgroup, renamed to the MHSA Impact Group, provides technical assistance (TA) on evaluation and program improvement activities for non-full service partnership MHSA-funded programs in a group setting. Specifically, the Impact Group is a workshop where programs come to design evaluations, develop measurement tools and learn how to carry out evaluation activities. As needed, MHSA evaluators also follow-up with programs on a one-on-one basis to increase a program's capacity in carrying out specific evaluations. The evaluators also conduct workshops to enhance communication, reporting and dissemination of outcomes and program impact, particularly to the client community.

The Impact Group has created a collaborative, supportive forum for BHS to facilitate high quality evaluation activities in a peer discussion format. The program representatives have expressed their appreciation for technical training that is delivered in a conversational, understandable format, as well as the peer-to-peer support and engagement between programs. Impact Group meetings allow the MHSA program evaluation team from Quality Management providing technical assistance (TA) on county or state requirements, evaluation and program improvement activities. Impact Group meetings also provide an opportunity for program providers and consumers to learn about various MHSA programs, share challenges to program implementation, lessons learned, evaluation plans, and consumer success stories with one another. Consumers are invited to present on their experience with the program, highlighting the program's successful impacts on their lives.

Impact Group meeting attendance usually ranges from 20-30 people, including program providers and consumers. A list of meeting topics in FY 2016-17 include:

- July: MHSA Orientation session for new MHSA funded staff
- August: TA session to Vocational Programs in preparation for the Vocational Summit
- September: Presentation by the Alleviating Anti-psychotic Induced Metabolic Syndrome Program
- December: Presentation by Community Youth Center's Asian Pacific Islander Youth and Family Support Services
- January: State regulations TA session and discussion with PEI Programs
- February: State regulations TA session and discussion with INN Programs
- March: How to do Focus Groups
- April: Collection of consumer social identity data
- May: Client Satisfaction & data-driven program improvement activities
- June: Completing MHSA Year-End Program Reports

Statewide Evaluation Efforts

MHSA funded staff within the BHS Office of Quality Management also play an active role in supporting statewide evaluation efforts and activities for MHSA, providing another opportunity to actively engage a broader range of stakeholders. Notable activities in 2015-16 are listed below.

- Serving on the MHSOAC Evaluation Committee, representing San Francisco DPH, for a two-year term
- Serving on an advisory group for an evaluation contracted by the MHSOAC to University of California, San Diego of the Recovery Orientation of MHSA programs across California
- Participating, as one of three counties, in the MHSOAC-contracted evaluation of the Recovery Orientation of Community Services & Support (CSS) Programs
- Serving on an advisory group for an evaluation contracted by the MHSOAC to design and pilot and new system to replace the existing Data Collection and Reporting (DCR) and CSS data collection systems
- Serving on the CalMHSA Statewide Evaluation Expert (SEE) Team to provide research and evaluation guidance and consultation to CalMHSA programs and RAND.
- Participating in a Latino stakeholders' focus group as part of the California Reducing Disparities Project's Strategic Plan for Reducing Mental Health Disparities
- Contributing actively to the County Behavioral Health Directors Association (CBHDA) effort to identify MHSA activities and measureable outcomes for the Measurements, Outcomes and Quality Assessment (MOQA)
- Attending and contributing to MHSOAC-sponsored discussions in Sacramento and the Bay Area to address new requirements in the regulations regarding demographic and outcome data collection for Prevention and Early Intervention (PEI) programs

National Evaluation Efforts

The BHS Office of Quality Management presented at the Feb 2-5, 2017 USPATH Inaugural Conference, sponsored by the US branch of the World Professional Association for Transgender Health (WPATH), in Los Angeles. The presentation focused on the department's evaluation efforts of the MHSA-funded Transgender Health Services program.

"Looking Ahead for SF-MHSA"

In the three years ahead, we will continue in our mission of transforming San Francisco's public mental health system. The MHSA will play an important role in strengthening and expanding the provision of mental health services locally, and throughout the state of California. Our future efforts will include the dissemination of the 2017-20 Integrated Plan, which brings together a vision for implementation of all the MHSA components.

In the next three years, SF MHSA will work to implement and enhance the programming described in detail in this report. We will also strive to integrate all of the valuable feedback received in CPP meetings and other stakeholder engagements. We are committed to weaving this feedback into the core of MHSA programming.

In implementing the MHSA components over the next three years, we will also focus efforts in a number of key areas. These areas of focus are detailed below:

- **We will take measures to respond to the upcoming No Place Like Home (NPLH) bond.** NPLH re-purposes statewide MHSA funds, and will provide $2 billion for the construction and rehabilitation of permanent supportive housing for homeless individuals with severe and persistent mental illness. In the coming months, we will monitor the roll-out of this legislation, and will prepare to participate in the competitive funding process. In the years ahead, we will work to develop and implement effective NPLH programming and services.

- **We will adjust the SF MHSA budget to more accurately align with state allocations.** These adjustments will focus on maintaining and enhancing existing programming, as no additional dollars are expected. In the years ahead, we do not anticipate any major expansions to the MHSA components outlined in this report.

- **We will place a strong emphasis on program evaluation across the MHSA components.** In the years ahead, we will work to enhance our monitoring and evaluation activities, in order to effectively meet the performance objectives of our MHSA-funded programs. SF MHSA is committed to pursuing innovative and dynamic methods of data-informed evaluation.

- **We will introduce three new and innovative initiatives in programming.** These three initiatives represent the only additional expenditures planned for the SF MHSA budget, and are spotlighted below.

Family-Centered Behavioral Health Services

In collaboration with the California Mental Health Services Oversight and Accountability Commission (MHSOAC), Behavioral Health Services (BHS) is working to develop an innovative Family-Centered and Trauma-Based Program. The program model relies on a generational approach that establishes families as the center of our work and provides integrated care to families. This generational work is a pressing issue for San Francisco, as families are being pushed out of the City due to systematic changes in the economic environment. Developing a whole family approach will ensure that the family, not the individual, is the focus of support, empowerment, and sustainability. The plan is for this initiative to be funded using Innovation (INN) dollars, following the approval of the MHSOAC.

Intensive Case Management (ICM) Flow

The ICM Flow initiative is centered on the need to support behavioral health clients who no longer require the intensive level of care and service provided by the ICM and Full Service Partnership (FSP) programs. Clients who show progress toward recovery and engagement may be more appropriately and well supported at an outpatient clinic. Unfortunately, several factors can impede a successful transition—defined as linkage and engagement—to outpatient care. With ICM Flow, more clients will transition safely to outpatient care, living more self-directed lives that support their wellness and connection to a community that has meaning for them.

ICM Flow will be driven by providers, consumers, and BHS leaders working together to bridge the wide gap between ICM and outpatient levels of care, and more effectively support clients in the transition. We expect to convene a series of discussion and planning meetings for stakeholder engagement, then identify priority areas of practice improvement to define and test. Woven throughout the project will be the integration of volunteers and peer employees. We will recruit these peers to help inform the planning, testing, data collection, interpretation, and implementation of any and all practice changes. The plan is for this initiative to be funded using Innovation (INN) dollars, following the approval of the MHSOAC.

MHSA Budget – FY17/18 through FY19/20 Three-Year Mental Health Services Act Expenditure Plan

	MHSA Funding						
	A	B	C	D	E	F	G
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve	Total
A. Estimated FY 2017/18 Funding							
1. Estimated Unspent Funds from Prior Fiscal Years	8,525,778	2,146,033	4,032,580	-	-		14,704,390
2. Estimated New FY2017/18 Funding	19,903,163	4,975,791	1,309,419				26,188,373
3. Transfer in FY2017/18a/	(5,477,519)			2,564,196	2,163,323	750,000	-
4. Access Local Prudent Reserve in FY2017/18						-	-
5. Estimated Available Funding for FY2017/18	22,951,422	7,121,823	5,341,999	2,564,196	2,163,323		40,142,763
B. Estimated FY2017/18 MHSA Expenditures	15,924,821	6,018,825	2,584,838	2,564,196	2,163,323		29,256,002
C. Estimated FY2018/19 Funding							-
1. Estimated Unspent Funds from Prior Fiscal Years	7,026,602	1,102,999	2,757,161	-	-		10,886,761
2. Estimated New FY2018/19 Funding	22,040,000	5,510,000	1,450,000				29,000,000
3. Transfer in FY2018/19a/	(5,344,428)			2,546,062	2,048,365	750,000	-
4. Access Local Prudent Reserve in FY2018/19						-	-
5. Estimated Available Funding for FY2018/19	23,722,174	6,612,999	4,207,161	2,546,062	2,048,365		39,136,761
D. Estimated FY2018/19 Expenditures	16,301,726	5,869,008	2,234,838	2,546,062	2,048,365		29,000,000
E. Estimated FY2019/20 Funding							-
1. Estimated Unspent Funds from Prior Fiscal Years	7,420,448	743,990	1,972,323	-	-		10,136,761
2. Estimated New FY2019/20 Funding	22,040,000	5,510,000	1,450,000				29,000,000
3. Transfer in FY2019/20a/	(5,586,643)			2,546,062	2,048,365	992,215	-
4. Access Local Prudent Reserve in FY2019/20						-	-
5. Estimated Available Funding for FY2019/20	23,873,805	6,253,990	3,422,323	2,546,062	2,048,365		38,144,546
F. Estimated FY2019/20 Expenditures	16,301,726	5,869,008	2,234,838	2,546,062	2,048,365		29,000,000
G. Estimated FY2019/20 Unspent Fund Balance	7,572,079	384,982	1,187,485	-	-		9,144,546

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2017	1,005,681
2. Contributions to the Local Prudent Reserve in FY 2017/18	750,000
3. Distributions from the Local Prudent Reserve in FY 2017/18	0
4. Estimated Local Prudent Reserve Balance on June 30, 2018	1,755,681
5. Contributions to the Local Prudent Reserve in FY 2018/19	750,000
6. Distributions from the Local Prudent Reserve in FY 2018/19	0
7. Estimated Local Prudent Reserve Balance on June 30, 2019	2,505,681
8. Contributions to the Local Prudent Reserve in FY 2019/20	992,215
9. Distributions from the Local Prudent Reserve in FY 2019/20	0
10. Estimated Local Prudent Reserve Balance on June 30, 2020	3,497,896

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS)

	Fiscal Year 2017/18					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. CSS Full Service Partnership 1. CYF (0-5)	342,392	220,570	-	-	-	121,822
2. CSS Full Service Partnership 2. CYF (6-18)	4,062,981	767,435	106,368	118,513	1,551,586	1,519,078
3. CSS Full Service Partnership 3. TAY (18-24)	1,051,342	750,566	231,126	998	67,150	1,502
4. CSS Full Service Partnership 4. Adults (18-59)	11,040,436	2,326,774	1,677,156	2,026,863	-	5,009,644
5. CSS Full Service Partnership 5. Older Adults (60+)	769,948	504,034	152,077	13,001	-	100,836
6. CSS Full Service Partnership 6. AOT	1,708,390	161,575	162,461	547,213	-	837,141
7. CSS FSP Permanent Housing (capital units and master lease)	612,923	612,923	-	-	-	-
8. Budget allocated to FSP clients served by CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	1,934,528	1,243,949	-	110,936	-	579,644
9. Budget allocated to FSP clients served by CSS Other Non-FSP 8. Vocational Services (45% FSP)	1,427,881	179,270	177,390	329,946	-	741,276
10. Budget allocated to FSP clients served by CSS Other Non-FSP 9. Emergency Stabilization Housing (50% FSP)	138,186	138,186	-	-	-	-
11. Budget allocated to FSP clients served by CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (20% F	91,543	89,012	2,532	-	-	-
12. Budget allocated to FSP clients served by CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (50% FSP)	557,898	557,898	-	-	-	-
Non-FSP Programs	-	-				
1. CSS Other Non-FSP 1. Behavioral Health Access Center	1,080,503	905,631	149,872	-	-	25,000
2. CSS Other Non-FSP 2. Prevention and Recovery in Early Psychosis (PREP)	1,292,356	1,026,116	86,353	5,175	64,829	109,883
3. CSS Other Non-FSP 3. Trauma Recovery	418,477	411,995	3,241	148	3,093	-
4. CSS Other Non-FSP 4. Integration of Behavioral Health and Primary Care	1,461,982	1,225,069	236,914	-	-	-
5. CSS Other Non-FSP 5. Integration of Behavioral Health Into the Juvenile Justice System	1,826,692	428,474	1,378	642	117,422	1,278,776
6. CSS Other Non-FSP 6. Dual Diagnosis Residential Treatment	83,285	83,285	-	-	-	-
7. CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	1,934,528	1,243,949	-	110,936	-	579,644
8. CSS Other Non-FSP 8. Vocational Services (45% FSP)	1,745,188	219,108	216,809	403,267	-	906,003
9. CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	92,124	92,124	-	-	-	-
10. CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)	213,601	207,694	5,907	-	-	-
11. CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	371,932	371,932	-	-	-	-
12. CSS Other Non-FSP 12. Expanding Outpatient MH Clinic Capacity	436,483	177,529	258,954	-	-	-
CSS Administration	1,562,250	1,562,168	81	-	-	-
CSS Evaluation	417,555	417,555	-	-	-	-
CSS MHSA Housing Program Assigned Funds	-					
Total CSS Program Estimated Expenditures	36,675,404	15,924,821	3,468,619	3,667,637	1,804,080	11,810,248
FSP Programs as Percent of Total	55%	estimated CSS funding over total CSS expenditures				

	Fiscal Year 2018/19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. CSS Full Service Partnership 1. CYF (0-5)	347,612	225,790	-	-	-	121,822
2. CSS Full Service Partnership 2. CYF (6-18)	4,081,144	785,599	106,368	118,513	1,551,586	1,519,078
3. CSS Full Service Partnership 3. TAY (18-24)	1,069,106	768,330	231,126	998	67,150	1,502
4. CSS Full Service Partnership 4. Adults (18-59)	11,095,506	2,381,843	1,677,156	2,026,863	-	5,009,644
5. CSS Full Service Partnership 5. Older Adults (60+)	781,877	515,963	152,077	13,001	-	100,836
6. CSS Full Service Partnership 6. AOT	1,712,214	165,399	162,461	547,213	-	837,141
7. CSS FSP Permanent Housing (capital units and master lease)	627,429	627,429	-	-	-	-
8. Budget allocated to FSP clients served by CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	1,963,969	1,273,390	-	110,936	-	579,644
9. Budget allocated to FSP clients served by CSS Other Non-FSP 8. Vocational Services (45% FSP)	1,432,124	183,513	177,390	329,946	-	741,276
10. Budget allocated to FSP clients served by CSS Other Non-FSP 9. Emergency Stabilization Housing (50% FSP)	141,456	141,456	-	-	-	-
11. Budget allocated to FSP clients served by CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (20% F	93,650	91,119	2,532	-	-	-
12. Budget allocated to FSP clients served by CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (50% FSP)	571,103	571,103	-	-	-	-
Non-FSP Programs		-		-	-	-
1. CSS Other Non-FSP 1. Behavioral Health Access Center	1,101,937	927,065	149,872	-	-	25,000
2. CSS Other Non-FSP 2. Prevention and Recovery in Early Psychosis (PREP)	1,316,642	1,050,402	86,353	5,175	64,829	109,883
3. CSS Other Non-FSP 3. Trauma Recovery	428,228	421,746	3,241	148	3,093	-
4. CSS Other Non-FSP 4. Integration of Behavioral Health and Primary Care	1,490,977	1,254,063	236,914	-	-	-
5. CSS Other Non-FSP 5. Integration of Behavioral Health Into the Juvenile Justice System	1,836,833	438,615	1,378	642	117,422	1,278,776
6. CSS Other Non-FSP 6. Dual Diagnosis Residential Treatment	85,256	85,256	-	-	-	-
7. CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	1,963,969	1,273,390	-	110,936	-	579,644
8. CSS Other Non-FSP 8. Vocational Services (45% FSP)	1,750,374	224,294	216,809	403,267	-	906,003
9. CSS Other Non-FSP 9. Emergency Stabilization Housing (50% FSP)	94,304	94,304	-	-	-	-
10. CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (20% FSP)	218,517	212,610	5,907	-	-	-
11. CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (50% FSP)	380,735	380,735	-	-	-	-
12. CSS Other Non-FSP 12. Expanding Outpatient MH Clinic Capacity	440,685	181,731	258,954	-	-	-
CSS Administration	1,599,223	1,599,141	81	-	-	-
CSS Evaluation	427,437	427,437	-	-	-	-
CSS MHSA Housing Program Assigned Funds	-	-		-	-	-
Total CSS Program Estimated Expenditures	37,052,310	16,301,726	3,468,619	3,667,637	1,804,080	11,810,248
FSP Programs as Percent of Total	54%	estimated CSS funding over total CSS expenditures				

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. CSS Full Service Partnership 1. CYF (0-5)	347,612	225,790	-	-	-	121,822
2. CSS Full Service Partnership 2. CYF (6-18)	4,081,144	785,599	106,368	118,513	1,551,586	1,519,078
3. CSS Full Service Partnership 3. TAY (18-24)	1,069,106	768,330	231,126	998	67,150	1,502
4. CSS Full Service Partnership 4. Adults (18-59)	11,095,506	2,381,843	1,677,156	2,026,863	-	5,009,644
5. CSS Full Service Partnership 5. Older Adults (60+)	781,877	515,963	152,077	13,001	-	100,836
6. CSS Full Service Partnership 6. AOT	1,712,214	165,399	162,461	547,213	-	837,141
7. CSS FSP Permanent Housing (capital units and master lease)	627,429	627,429	-	-	-	-
8. Budget allocated to FSP clients served by CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	1,963,969	1,273,390	-	110,936	-	579,644
9. Budget allocated to FSP clients served by CSS Other Non-FSP 8. Vocational Services (45% FSP)	1,432,124	183,513	177,390	329,946	-	741,276
10. Budget allocated to FSP clients served by CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	141,456	141,456	-	-	-	-
11. Budget allocated to FSP clients served by CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FS	93,650	91,119	2,532	-	-	-
12. Budget allocated to FSP clients served by CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	571,103	571,103	-	-	-	-
Non-FSP Programs		-		-	-	-
1. CSS Other Non-FSP 1. Behavioral Health Access Center	1,101,937	927,065	149,872	-	-	25,000
2. CSS Other Non-FSP 2. Prevention and Recovery in Early Psychosis (PREP)	1,316,642	1,050,402	86,353	5,175	64,829	109,883
3. CSS Other Non-FSP 3. Trauma Recovery	428,228	421,746	3,241	148	3,093	-
4. CSS Other Non-FSP 4. Integration of Behavioral Health and Primary Care	1,490,977	1,254,063	236,914	-	-	-
5. CSS Other Non-FSP 5. Integration of Behavioral Health Into the Juvenile Justice System	1,836,833	438,615	1,378	642	117,422	1,278,776
6. CSS Other Non-FSP 6. Dual Diagnosis Residential Treatment	85,256	85,256	-	-	-	-
7. CSS Other Non-FSP 7. Peer-to-Peer Supports: Clinic and Community-Based (50% FSP)	1,963,969	1,273,390	-	110,936	-	579,644
8. CSS Other Non-FSP 8. Vocational Services (45% FSP)	1,750,374	224,294	216,809	403,267	-	906,003
9. CSS Other Non-FSP 9. Emergency Stabilization Housing (60% FSP)	94,304	94,304	-	-	-	-
10. CSS Other Non-FSP 10. Housing Placement and Supportive Services (Direct Access to Housing) (30% FSP)	218,517	212,610	5,907	-	-	-
11. CSS Other Non-FSP 11. ROUTZ TAY Transitional Housing (60% FSP)	380,735	380,735	-	-	-	-
12. CSS Other Non-FSP 12. Expanding Outpatient MH Clinic Capacity	440,685	181,731	258,954	-	-	-
CSS Administration	1,599,223	1,599,141	81	-	-	-
CSS Evaluation	427,437	427,437	-	-	-	-
CSS MHSA Housing Program Assigned Funds	-	-		-	-	-
Total CSS Program Estimated Expenditures	37,052,310	16,301,726	3,468,619	3,667,637	1,804,080	11,810,248
FSP Programs as Percent of Total	54.2% estimated CSS funding over total CSS expenditures					

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI)

	Fiscal Year 2017/18					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. PEI 1. Stigma Reduction	186,752	186,752	-	-	-	-
2. PEI 2. School-Based Mental Health Pomotion (K-12) (50% Prevention)	658,412	538,707	211	146	37,556	81,792
3. PEI 3. School-Based Mental Health Pomotion (Higher Ed) (50% Prevention)	-	-	-	-	-	-
4. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	2,870,475	1,688,496	-	19,482	57,820	1,104,678
5. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	2,996,478	500,889	-	-	-	2,495,590
6. PEI 6. Comprehensive Crisis Services (10% Prevention)	58,660	53,983	4,677	-	-	-
7. PEI 7. CalMHSA Statewide Programs	100,000	100,000	-	-	-	-
PEI Programs - Early Intervention						
8. PEI 2. School-Based Mental Health Pomotion (K-12) (50% Prevention)	658,412	538,707	211	146	37,556	81,792
9. PEI 3. School-Based Mental Health Pomotion (Higher Ed) (50% Prevention)	-	-	-	-	-	-
10. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	2,870,475	1,688,496	-	19,482	57,820	1,104,678
11. PEI 5. Mental Health Consultation and Capacity Building (75% Prevention)	998,826	166,963	-	-	-	831,863
12. PEI 6. Comprehensive Crisis Services (10% Prevention)	527,939	485,846	42,093	-	-	-
PEI Administration	69,987	69,987	-	-	-	-
PEI Evaluation	-	-	-	-	-	-
PEI Assigned Funds	-					
Total PEI Program Estimated Expenditures	11,996,416	6,018,825	47,192	39,255	190,751	5,700,393

	Fiscal Year 2018/19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. PEI 1. Stigma Reduction	182,025	182,025	-	-	-	-
2. PEI 2. School-Based Mental Health Pomotion (K-12) (50% Prevention)	644,776	525,071	211	146	37,556	81,792
3. PEI 3. School-Based Mental Health Pomotion (Higher Ed) (50% Prevention)	-	-	-	-	-	-
4. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	2,827,736	1,645,757	-	19,482	57,820	1,104,678
5. PEI 5.Mental Health Consultation and Capacity Building (75% Prevention)	2,983,800	488,210	-	-	-	2,495,590
6. PEI 6. Comprehensive Crisis Services (10% Prevention)	57,293	52,616	4,677	-	-	-
7. PEI 7. CalMHSA Statewide Programs	100,000	100,000	-	-	-	-
PEI Programs - Early Intervention			-	-	-	-
8. PEI 2. School-Based Mental Health Pomotion (K-12) (50% Prevention)	644,776	525,071	211	146	37,556	81,792
9. PEI 3. School-Based Mental Health Pomotion (Higher Ed) (50% Prevention)	-	-	-	-	-	-
10. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	2,827,736	1645757.203	-	19,482	57,820	1,104,678
11. PEI 5.Mental Health Consultation and Capacity Building (75% Prevention)	994,600	162,737	-	-	-	831,863
12. PEI 6. Comprehensive Crisis Services (10% Prevention)	515,641	473,548	42,093	-	-	-
PEI Administration	68,215	68,215	-	-	-	-
PEI Evaluation	-	-	-	-	-	-
PEI Assigned Funds	-	-	-	-	-	-
Total PEI Program Estimated Expenditures	11,846,599	5,869,008	47,192	39,255	190,751	5,700,393

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. PEI 1. Stigma Reduction	182,025	182,025	-	-	-	-
2. PEI 2. School-Based Mental Health Pomotion (K-12) (50% Prevention)	644,776	525,071	211	146	37,556	81,792
3. PEI 3. School-Based Mental Health Pomotion (Higher Ed) (50% Prevention)	-	-	-	-	-	-
4. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	2,827,736	1,645,757	-	19,482	57,820	1,104,678
5. PEI 5.Mental Health Consultation and Capacity Building (75% Prevention)	2,983,800	488,210	-	-	-	2,495,590
6. PEI 6. Comprehensive Crisis Services (10% Prevention)	57,293	52,616	4,677	-	-	-
7. PEI 7. CalMHSA Statewide Programs	100,000	100,000	-	-	-	-
PEI Programs - Early Intervention			-	-	-	-
8. PEI 2. School-Based Mental Health Pomotion (K-12) (50% Prevention)	644,776	525,071	211	146	37,556	81,792
9. PEI 3. School-Based Mental Health Pomotion (Higher Ed) (50% Prevention)	-	-	-	-	-	-
10. PEI 4. Population Focused Mental Health Promotion and Early Intervention (50% Prevention)	2,827,736	1,645,757	-	19,482	57,820	1,104,678
11. PEI 5.Mental Health Consultation and Capacity Building (75% Prevention)	994,600	162,737	-	-	-	831,863
12. PEI 6. Comprehensive Crisis Services (10% Prevention)	515,641	473,548	42,093	-	-	-
PEI Administration	68,215	68,215	-	-	-	-
PEI Evaluation	-	-	-	-	-	-
PEI Assigned Funds	-	-	-	-	-	-
Total PEI Program Estimated Expenditures	11,846,599	5,869,008	47,192	39,255	190,751	5,700,393

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN)

	Fiscal Year 2017/18					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. INN 11. WAIST Nutrition Project	-	-	-	-	-	-
2. INN 14. First Impressions	350,000	350,000	-	-	-	-
3. INN 15. Building a Peer-to-Peer Support Network for Socially Isolated Older Adult	260,000	260,000	-	-	-	-
4. INN 16. Building a Peer-to-Peer Support Network for Transgender Individuals	265,000	265,000	-	-	-	-
5. INN 17. Hummingbird Place - Peer Respite	325,529	325,529	-	-	-	-
6. INN 18. Intensive Case Management Flow	750,000	750,000				
7. INN 19. Family-centered & Trauma-based Program	400,000	400,000				
INN Administration	86,000	86,000	-	-	-	-
INN Evaluation	148,309	148,309	-	-	-	-
Total INN Program Estimated Expenditures	2,584,838	2,584,838	-	-	-	-

	Fiscal Year 2018/19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. INN 11. WAIST Nutrition Project	-	-	-	-	-	-
2. INN 14. First Impressions	-	-	-	-	-	-
3. INN 15. Building a Peer-to-Peer Support Network for Socially Isolated Older Adult	260,000	260,000	-	-	-	-
4. INN 16. Building a Peer-to-Peer Support Network for Transgender Individuals	265,000	265,000	-	-	-	-
5. INN 17. Hummingbird Place - Peer Respite	325,529	325,529	-	-	-	-
6. INN 18. Intensive Case Management Flow	750,000	750,000				
7. INN 19. Family-centered & Trauma-based Program	400,000	400,000				
	-	-	-	-	-	-
INN Administration	86,000	86,000	-	-	-	-
INN Evaluation	148,309	148,309	-	-	-	-
Total INN Program Estimated Expenditures	2,234,838	2,234,838	-	-	-	-

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. INN 11. WAIST Nutrition Project	-	-	-	-	-	-
2. INN 14. First Impressions	-	-	-	-	-	-
3. INN 15. Building a Peer-to-Peer Support Network for Socially Isolated Older Adult	-	-	-	-	-	-
4. INN 16. Building a Peer-to-Peer Support Network for Transgender Individuals	-	-	-	-	-	-
5. INN 17. Hummingbird Place - Peer Respite	-	-	-	-	-	-
6. INN 18. Intensive Case Management Flow	750,000	750,000				
7. INN 19. Family-centered & Trauma-based Program	400,000	400,000				
8. TBD through CPP		850,529				
	-	-	-	-	-	-
INN Administration	86,000	86,000	-	-	-	-
INN Evaluation	148,309	148,309	-	-	-	-
Total INN Program Estimated Expenditures	1,384,309	2,234,838	-	-	-	-

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET)

	Fiscal Year 2017/18					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Training and TA	1,921,728	734,328	-	92,820	180,949	913,631
2. Career Pathways	1,143,950	1,143,950	-	-	-	-
3. Residency and Internships	499,721	499,721	-	-	-	-
WET Administration	167,134	167,134	-	-	-	-
WET Evaluation	19,062	19,062	-	-	-	-
Total WET Program Estimated Expenditures	3,751,596	2,564,196	-	92,820	180,949	913,631

	Fiscal Year 2018/19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Training and TA	1,916,535	729,135	-	92,820	180,949	913,631
2. Career Pathways	1,135,860	1,135,860	-	-	-	-
3. Residency and Internships	496,187	496,187	-	-	-	-
WET Administration	165,953	165,953	-	-	-	-
WET Evaluation	18,928	18,928	-	-	-	-
Total WET Program Estimated Expenditures	3,733,462	2,546,062	-	92,820	180,949	913,631

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Training and TA	1,916,535	729,135	-	92,820	180,949	913,631
2. Career Pathways	1,135,860	1,135,860	-	-	-	-
3. Residency and Internships	496,187	496,187	-	-	-	-
WET Administration	165,953	165,953	-	-	-	-
WET Evaluation	18,928	18,928	-	-	-	-
Total WET Program Estimated Expenditures	3,733,462	2,546,062	-	92,820	180,949	913,631

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN)

	Fiscal Year 2017/18					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Silver Avenue FHC/South East Child & Family Therapy Center						
2. Redwood Center Renovation						
3. Sunset Mental Health						
4. IHHC at Central YMCA (Tom Waddell)						
5. Southeast Health Center	750,000	750,000	-	-	-	-
6. South of Market Mental Health	-	-				
7. Behavioural Health Clinic Remodel	300,000	300,000	-	-	-	-
CFTN Programs - Technological Needs Projects						
8. Consumer Portal	59,034	59,034	-	-	-	-
9. Vocational IT	729,167	729,167	-	-	-	-
10. System Enhancements	174,756	174,756	-	-	-	-
CFTN Administration	150,365	150,365	-	-	-	-
Total CFTN Program Estimated Expenditures	2,163,323	2,163,323	-	-	-	-

	Fiscal Year 2018/19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Silver Avenue FHC/South East Child & Family Therapy Center						
2. Redwood Center Renovation						
3. Sunset Mental Health						
4. IHHC at Central YMCA (Tom Waddell)						
5. Southeast Health Center	750,000	750,000	-	-	-	-
6. South of Market Mental Health						
7. TBD through CPP	300,000	300,000	-	-	-	-
CFTN Programs - Technological Needs Projects						
8. Consumer Portal	52,938	52,938	-	-	-	-
9. Vocational IT	653,876	653,876	-	-	-	-
10. System Enhancements	156,711	156,711	-	-	-	-
CFTN Administration	134,839	134,839	-	-	-	-
Total CFTN Program Estimated Expenditures	2,048,365	2,048,365				

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Silver Avenue FHC/South East Child & Family Therapy Center						
2. Redwood Center Renovation						
3. Sunset Mental Health						
4. IHHC at Central YMCA (Tom Waddell)						
5. Southeast Health Center	750,000	750,000	-	-	-	-
6. South of Market Mental Health						
7. TBD through CPP	300,000	300,000	-	-	-	-
CFTN Programs - Technological Needs Projects						
8. Consumer Portal	52,938	52,938	-	-	-	-
9. Vocational IT	653,876	653,876	-	-	-	-
10. System Enhancements	156,711	156,711	-	-	-	-
CFTN Administration	134,839	134,839	-	-	-	-
Total CFTN Program Estimated Expenditures	2,048,365	2,048,365	-	-	-	-

Appendix A

ATTACHMENT A

MHSA HOUSING LOAN PROGRAM
ONGOING ANNUAL MHSA FUND RELEASE AUTHORIZATION FOR FUTURE UNEUNCUMBERED FUNDS

City/County: City and County of San Francisco

Until otherwise directed by City/County, and pursuant to Welfare and Institutions Code (W&I) Section 5892.5, City/County hereby request the annual release of MHSA funds in City/County's CalHFA MHSA account ("Account"). Said Account may include deposits of unencumbered MHSA Housing funds, MHSA residual receipt loan payments, and accrued interest (collectively referred to as "Funds"). As of May 1st of each calendar year, please:

- ☒ **Release and return all Funds to the City/County; OR**
- ☐ **Release and assign all Funds to the CalHFA administered Local Government Special Needs Housing Program.**

On behalf of the City/County listed above, I hereby certify the following:

The City/County will use any released MHSA Funds returned to the City/County to provide housing assistance to the target populations identified in W&I Section 5600.3. Housing assistance means rental assistance or capitalized operating subsidies; security deposits, utility deposits, or other move-in cost assistance; utility payments; moving cost assistance; and capital funding to build or rehabilitate housing for homeless, mentally ill persons or mentally ill persons who are at risk of being homeless; and

The City/County will administer released and returned MHSA Funds in compliance with the requirements of the MHSA including, but not limited to, the following:

- The City/County will follow the stakeholder process identified in (W&I Section 5848), when determining the use of the funds;
- The City/County will include the use of the funds in the County's Three-Year Program and Expenditure Plan or Annual Update, (W&I Section 5847);
- The City/County will account for the expenditure of those MHSA Funds in the City/County's Annual Revenue and Expenditure Report (W&I Section 5899) Reporting will begin in the fiscal year when the MHSA Housing Program funds are returned to the City/County by CalHFA; and
- The City/County will expend the returned funds within three years of receipt or the funds will be subject to reversion. (W&I Section 5892 (h)).

By: _____ Date: 4/18/17

Name: Kavoos Ghane Bassiri Title: Behavioral Health Director

ATTACHMENT A

MHSA HOUSING LOAN PROGRAM
ONGOING ANNUAL MHSA FUND RELEASE AUTHORIZATION FOR FUTURE UNEUNCUMBERED FUNDS

Make check payable to (if applicable): San Francisco Department of Public Health

Address: 101 Grove Street, Room 110
San Francisco, CA 94102

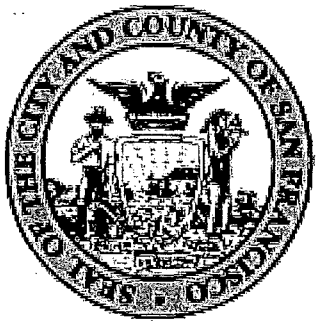
Must attach evidence of City/County Board of Supervisors Approval

---

State of California Use Only:

REVIEWED BY:

Department of Health Care Services Agency		**California Housing Finance**	
Signature	Date	Signature	Date
Name		Name	
Title		Title	



In San Francisco, MHSA-funded programs are administered by Behavioral Health Services, under the San Francisco Department of Public Health. We utilize existing networks within the Department of Public Health and in other civil services agencies, to provide high quality behavioral health services to children, transitional age youth, their families, adults and older adults. These services are provided in partnerships with clients, families, other agencies and community providers. **www.sfmhsa.org/about_us.html**

San Francisco Department of Public Health
Barbara A. Garcia, MPA
Director of Health

City and County of San Francisco
Edwin M. Lee
Mayor

September 1, 2017

Angela Calvillo, Clerk of the Board
Board of Supervisors
1 Dr. Carlton B Goodlett Place, Room 244
San Francisco, CA 94102

Dear Ms. Calvillo:

Attached, please find an original single-sided and two single-sided, black and white copies of a proposed resolution for Board of Supervisors approval that would adopt the San Francisco Mental Health Services Act (MHSA) Three-Year Program and Expenditure Plan FY17/18 – 19/20 (Integrated Plan).

The Mental Health Services Act was enacted in 2004 through a ballot initiative (Proposition 63) and provides funding to support new and expanded county mental health programs. San Francisco's MHSA Integrated Plan was developed with stakeholder input, posted for 30-day public comment, and heard at a Public Hearing at the San Francisco Mental Health Board, as required by the State to access MHSA funding. Recently enacted State legislation, AB 1467, also requires adoption of the MHSA Integrated Plan by the County Board of Supervisors prior to submission to the State Mental Health Overview and Accountability Commission.

The following is a list of accompanying documents:

- AB 1467
- The San Francisco Mental Health Services Act 2017-2020 Integrated Plan

Should you have any questions, please contact Imo Momoh, Director of Mental Health Services Act. Mr. Momoh can be reached at 415-255-3736 or Imo.Momoh@sfdph.org.

Sincerely,

Barbara A. Garcia, MPA
Director of Health

101 Grove Street San Francisco, CA 94102-4593

Wong, Linda (BOS)

ɔm: Board of Supervisors, (BOS)
ɹent: Wednesday, September 27, 2017 9:15 AM
To: Wong, Linda (BOS)
Subject: FW: Public Comment on File 170904
Attachments: StateAuditOfMHSA.pdf; LHCReportOnMHSA.pdf

From: Thomas Busse [mailto:tjbussesf@gmail.com]
Sent: Tuesday, September 26, 2017 5:15 PM
To: Board of Supervisors, (BOS) <board.of.supervisors@sfgov.org>
Subject: Public Comment on File 170904

[Please note attachments. I request the Clerk to place these in the file as I refer to these items in my comment and they provide context for the proposed action. Many thanks]

Public Comment To Members of the Budget and Finance Committee:

egret I will be unable to attend your meeting on 9/28; however, I have some comments on the MHST Expenditure plan. These summarize the remarks I had hoped to make regarding last year's Annual Report; however, the draft report was not actually available on the SFDPH's website last year, which is why there was no public comment and my complaints about this were not addressed. A particular concern was that Annual Report contained no benchmarking or comparative studies of efforts in other jurisdictions.

I have requested the Clerk of the Board to place a copy of reports from the Little Hoover Commission and the California State Auditor in the file detailing oversight and accountability deficiencies plaguing this program up and down the state. It is in this spirit the Legislature adopted AB 1467, and I ask the BOS not to treat its requirements as an inconvenient hurdle. Although SFDPH has paid lip-service to sunsetting ineffective programs and program evaluation in the Integration Plan, Proposition 63 was passed by the voters in 2004. It's been over a decade, and SFDPH has not delivered on what was promised to the voters. Even unreasonable people agree the City's strategy is not working.

In his 2016 Budget, Gov. Brown proposed redirecting MHST revenue to service a statewide affordable housing integrated care program in exchange for CEQA reforms. This effort failed, but it illustrates the need to insulate efforts from developing an entrenched constituency. On this point. the third generation atypical antipsychotics have enabled numerous individuals to live a functional life. Mental illness is such as stigma that the creation of tient seats on advisory boards requires public disclosure of very sensitive health information. With this in mind, how often have officials heard directly from success stories about what works?

SF's Senator Scott Wiener has made a noble bipartisan effort regarding safe use/injection centers. It's good policy. I urge the BOS to reserve MHSA funds for this purpose in the 2018/19 expenditure plan.

I urge a block-grant appropriations to BART, as that district assumes some county police function and would benefit from dedicated emergency psychiatric beds. Some individuals in crisis can fall through jurisdictional cracks.

Subsequent to San Francisco's implementation of Laura's Law, the legislature, in a bipartisan effort, allowed MHST revenues to be used for this purpose. The draft expenditure only funds evaluation, not implementation. In the context of the opioid epidemic, substance dependency is by definition not independent living, and how many Narcan revivals does it take for our ERs to close the discharge loop into conservatorships, or is that only a privilege for Brittany Spears? Knowingly discharging patients to the street is as morally wrong as willful neglect. Our society used to understand this due to syphills. Intervention is tragic – nobody wants to see it, and it has been horribly abused – but the current model deprives individuals of the very clarity of mind to know they need intervention and pushes the buck onto abusive and oppressive "family involvement" (culturally-competent care also involves frank recognition about certain cultural views on mental illness even when not politically correct - including professional elitism).

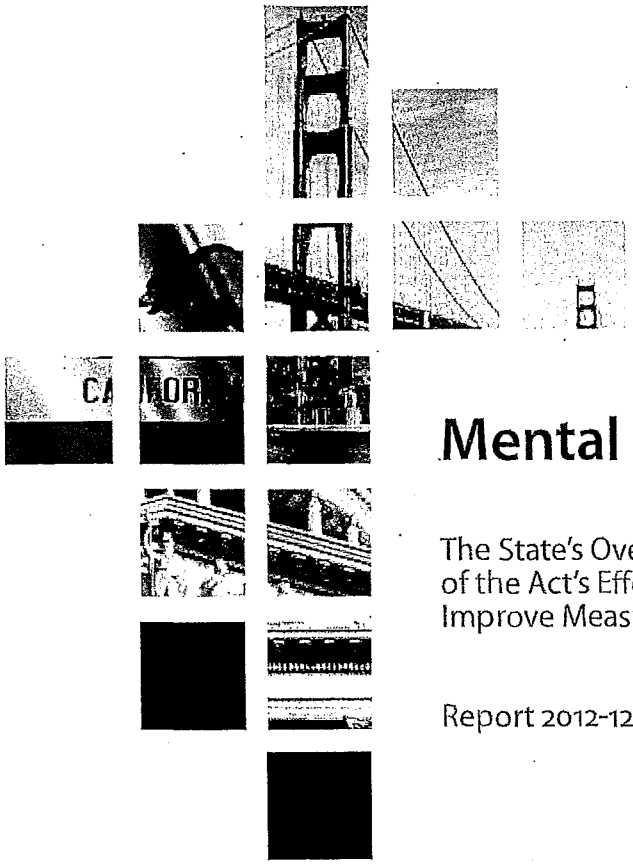
Better yet, I am of the belief it is better to catch individuals when they are falling down. It curtails otherwise inevitable entanglement with the ill-equipped criminal justice system. "Sit-Lie" is a public demand for intervention. In this, the Mental Health profession needs to be taken to task. 80% of psychiatrists won't even take private health insurance – let alone the walk-in service delivery favored by the Latino demographic. You can't even get to Integration with the current barriers to Intake.

Respectfully Submitted,

Thomas J. Busse
584 Castro Street #388
San Francisco, CA 94114

California State Auditor

August 2013



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

Report 2012-122

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California State Auditor

Elaine M. Howle State Auditor
Doug Cordiner Chief Deputy

August 15, 2013 2012-122

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As requested by the Joint Legislative Audit Committee, the California State Auditor (state auditor) presents this audit report concerning the Mental Health Services Act (MHSA). The MHSA was approved by voters in 2004 to expand existing mental health programs and services and to use innovative methods more likely to identify, mitigate, and treat mental illness. A focus of the MHSA is accountability and, initially, the MHSA assigned the responsibility of overseeing MHSA programs primarily to two state entities—the California Department of Mental Health (Mental Health) and the Mental Health Services Oversight and Accountability Commission (Accountability Commission).

This report concludes that Mental Health and the Accountability Commission have provided little oversight of counties' implementation of MHSA programs, particularly as it relates to evaluating whether these programs are effective. We expected that Mental Health and the Accountability Commission would have used a process to monitor, guide, and evaluate county implementation that built on their broad and specific MHSA oversight responsibilities and also incorporated best practices in doing so, but that is not what we found. However, looking to the future, the opportunity exists for the state entities responsible for oversight to better demonstrate the effectiveness of the MHSA. Because of the minimal oversight Mental Health and the Accountability Commission provided in the past, the State has little current assurance that the funds directed to counties—almost $7.4 billion from fiscal years 2006–07 through 2011–12—have been used effectively and appropriately. Effective late June 2012, legislation transferred most of Mental Health's oversight role to the California Department of Health Care Services (Health Care Services). Health Care Services is moving forward with these oversight responsibilities, which includes collaborating with the Accountability Commission on its evaluation efforts, but it is still in the early stages of planning and it is too soon to tell whether its efforts will address all of our concerns.

Further, we also expected that Mental Health would have taken steps to ensure counties received the guidance necessary to effectively evaluate and report on the performance of their MHSA programs, particularly given the MHSA's focus on accountability. However, Mental Health did not provide explicit direction to the counties on how to evaluate their programs effectively, including directions for setting reasonable goals, establishing specific objectives, and gathering the data necessary to meaningfully measure program performance. Thus, it is not surprising that our review of four county departments—Los Angeles County Department of Mental Health, County of Sacramento Department of Health and Human Services, County of San Bernardino Department of Behavioral Health Administration, and Santa Clara County Mental Health Department—found that these counties used differing and inconsistent approaches to assess and report on the performance of their MHSA programs. Some counties could not effectively demonstrate through their processes that their MHSA programs are achieving the stated intent. Counties were also inconsistent in collecting data related to program goals and how completely they analyzed and reported on those data to determine if stated program goals were achieved.

Respectfully submitted,

Elaine M. Howle

ELAINE M. HOWLE, CPA
State Auditor

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Contents

Summary

Results in Brief

Providing effective services and treatment for those who suffer from mental illness or who are at risk of mental illness is an issue of great statewide and national importance. Recent statistics by the U.S. Department of Health indicate that approximately 11 million U.S. adults, or 4.8 percent of the population, had serious mental illnesses in 2009. Critical incidents, such as the school shooting in Sandy Hook, point to the seriousness of these issues. Over time California has attempted to serve its mentally ill population through a variety of services and programs, and in 2004 the voters approved Proposition 63, the Mental Health Services Act (MHSA), to expand on these services and to use innovative methods more likely to identify, mitigate, and treat mental illness. The MHSA stresses that mental illnesses are extremely common, affecting almost every family in California, and that the failure to provide timely treatment can destroy individuals and families. It states, "No individual or family should have to suffer inadequate or insufficient treatment due to language or cultural barriers to care. Untreated mental illness is the leading cause of disability and suicide and imposes high costs on state and local government .... State and county governments are forced to pay billions of dollars each year in emergency medical care, long-term nursing home care, unemployment, housing, and law enforcement, including juvenile justice, jail and prison costs."

The MHSA imposes a 1 percent income tax on individuals earning over $1 million for counties[1] to use to provide mental health services to individuals severely affected by or at risk of serious mental illness. From fiscal years 2006–07 through 2011–12—the period of our review—almost $7.4 billion was directed to counties for their MHSA programs. The MHSA addresses a broad continuum of service needs, and its five components target different aspects of mental health services, including intensive services in the Community Services and Supports and Prevention and Early Intervention components, and exploring creative approaches to mental health services in the Innovation component. The remaining two MHSA components generally focus on expanding, educating, and training the local public mental health workforce and improving infrastructure; they are not designed to provide direct mental health services.

[1] *County* indicates a county mental health department, two or more county mental health departments acting jointly, and/or city-operated programs receiving funds per California Welfare and Institutions Code, Section 5701.5.

Audit Highlights...

Our performance review of the Mental Health Services Act (MHSA) highlighted the following:

» *The California Department of Mental Health (Mental Health) and the Mental Health Services Oversight and Accountability Commission (Accountability Commission) have provided little oversight of county implementation of MHSA programs and their effectiveness.*

- *We found no evidence that Mental Health performed on-site reviews to ensure that county assertions about their compliance with MHSA requirements and use of funds were accurate and proper.*
- *None of the entities charged with evaluating the effectiveness of MHSA programs—Mental Health, the Accountability Commission, or a third entity—have undertaken serious efforts to do so.*
- *Mental Health either did not always obtain certain data or did not ensure counties reported the required data.*
- *The Accountability Commission did not adopt a framework for evaluation until recently—more than eight years after the passage of the MHSA.*

» *It is too soon to tell whether the California Department of Health Care Services' efforts will address all of our concerns about the oversight of MHSA programs.*

» *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.*

A focus of the MHSA is accountability, and a significant stated purpose of the MHSA is "to ensure that all funds are expended in the most cost effective manner and services are provided in accordance with recommended best practices subject to local and state oversight to ensure accountability to taxpayers and to the public." Initially, the MHSA assigned the responsibility of overseeing MHSA programs primarily to two state entities—the California Department of Mental Health (Mental Health) and the Mental Health Services Oversight and Accountability Commission (Accountability Commission). However, these state entities have provided little oversight of county implementation of MHSA programs and their effectiveness. We expected that Mental Health and the Accountability Commission would have used a process to monitor, guide, and evaluate county implementation that built on their broad and specific MHSA oversight responsibilities and also incorporated best practices in doing so, but that is not what we found.

The opportunity exists for the state entities currently responsible for oversight to better demonstrate the effectiveness of the MHSA. Effective late June 2012, legislation transferred most of Mental Health's oversight role to the California Department of Health Care Services (Health Care Services). Health Care Services is moving forward with these oversight responsibilities, which include collaborating with the Accountability Commission on its evaluation efforts, but this is still in the early planning stages and it is too soon to tell whether its efforts will address all of our concerns. Nevertheless, because of the minimal oversight Mental Health and the Accountability Commission provided in the past, the State has little current assurance that the funds directed to counties for MHSA programs have been used effectively and appropriately.

We expected that Mental Health would base its monitoring of county MHSA programs on the provisions of the performance contract that the MHSA required Mental Health to enter into with each county. However, in fiscal year 2008–09, Mental Health stopped using the performance contract and began using an agreement that offered little specificity as to the steps a county should take to assure compliance with the MHSA. Functionally, it appears Mental Health treated the agreement as simply a means of providing MHSA funding to counties. Although the assurances within the agreement may have satisfied the minimal requirements set forth in state law, had Mental Health made better use of the agreement as a tool for holding counties accountable for their use of MHSA funds, it would have significantly bolstered the State's oversight role. We also identified shortcomings in certain counties' evaluation and reporting on the effectiveness of their MHSA programs. These shortcomings might have been mitigated had Mental Health chosen to use the performance contracts to improve the quality of county processes for measuring program performance. Going forward, Health Care

Services can use its performance contracts with counties to ensure that they specify program goals, identify data that are measurable and meaningfully associated with their goals, and use these data to evaluate the efficacy of their programs. The director indicated that Health Care Services intends to initiate efforts to monitor the adequacy of the counties' administration of MHSA programs. If consistently undertaken, these efforts could address some of the issues we noted about Mental Health's past monitoring.

We also found no evidence that Mental Health conducted systematic and comprehensive monitoring to ensure that counties did, in fact, implement their state-approved MHSA plans. The limited reviews we found failed to provide assurance that all counties consistently followed MHSA requirements and spent taxpayer funds appropriately. Further, Mental Health appears to have relied on county assertions or certifications as its main assurance that a county was complying with certain MHSA requirements. As a starting point, requiring assertions or certifications is useful in informing the county of what is expected and provided Mental Health with some assurance that the county intended to comply with MHSA requirements. However, without performing on-site reviews to ensure that the county had performed as asserted, Mental Health risked that the county may have misused state funds.

In addition, given that one focus of the MHSA is to ensure accountability to taxpayers and the public, we expected that the State would also evaluate the effectiveness of MHSA programs. However, the state entities given that responsibility—Mental Health, the Accountability Commission, and a third entity—have thus far not provided assurance that the MHSA is effective. Mental Health did not conduct a systematic evaluation of the effectiveness of MHSA programs during its tenure. Although it required counties to submit data concerning mental health services and the clients receiving those services, in most cases, Mental Health either failed to consistently obtain certain data or did not ensure that all counties reported the required data. Further, the Accountability Commission did not adopt a framework for evaluation until late March 2013—more than eight years after the passage of the MHSA. The Accountability Commission indicated that its efforts were initially focused on reviewing county plans for proposed MHSA programs because evaluation efforts needed to wait for the programs to mature. Although it seems reasonable that programs need time to mature before they are evaluated, the Accountability Commission began entering into ad hoc contracts related to evaluation in 2009; therefore, it seems to have judged those MHSA programs as mature enough for evaluation at that time.

Further, we expected that Mental Health would have taken steps to ensure that counties received the guidance necessary to effectively evaluate and report on the performance of their MHSA programs.

However, Mental Health did not provide explicit direction to the counties on how to evaluate their programs effectively, including directions for setting reasonable goals, establishing specific objectives, and gathering the data necessary to meaningfully measure program performance. When the responsible state entities do not provide guidance to counties for effective program evaluation, the public cannot be sure that MHSA programs are achieving their intended purposes.

Thus, it is not surprising that our review of four county departments—Los Angeles County Department of Mental Health (Los Angeles), County of Sacramento Department of Health and Human Services (Sacramento), County of San Bernardino Department of Behavioral Health Administration (San Bernardino), and Santa Clara County Mental Health Department (Santa Clara)—found that these counties used differing and inconsistent approaches to assess and report on their MHSA programs. For example, some counties could not effectively demonstrate through their processes that their MHSA programs are achieving the stated intent. Although the four reviewed counties generally included program goals in their MHSA plans, not all had communicated those goals to program providers, thereby not articulating expectations that providers demonstrate efforts to achieve those goals. Counties were also inconsistent in collecting data related to program goals and how completely they analyzed and reported on those data to determine if counties were achieving stated program goals.

Moreover, we found that the four counties rarely developed specific objectives to assess the effectiveness of program services. Setting specific goals and objectives and demonstrating that programs are achieving them seems particularly relevant for the Innovation component. Media reports have reflected skepticism about counties' Innovation programs, some of which include acupuncture and yoga. The media's perception of Innovation programs is likely because they may include novel or creative approaches to a mental health practice that may actually be very beneficial, but because the link between the program and the mental health benefit is not clear, these programs are sometimes questioned. Assessing and reporting on program effectiveness is therefore critical to ensure that only effective programs are continued and that the taxpayers and the public are assured that MHSA funds are put to the best use.

Finally, the MHSA requires counties to articulate plans for addressing the mental health needs of their communities, to include stakeholders in the community planning process, and to update the plans annually. The four counties reviewed complied with state regulations that specific groups of stakeholders and community representatives be included throughout the planning process and with community planning regulations that require staffing and training practices related to developing those plans.

However, counties did not always document in their MHSA plans and annual updates how they had circulated their draft plans to the community as required. In addition, Mental Health's guidance to counties on plan content has been inconsistent and this may have contributed to the issues we found with county documentation. Nevertheless, failure to properly document these important steps means counties cannot point to their plans to assure their stakeholders and the broader public that they have considered feedback on their plans and developed programs that address the communities' needs.

Recommendations

Health Care Services

To ensure that it monitors counties to the fullest extent, including conducting the monitoring MHSA specifies as well as implementing best practices, Health Care Services should do the following:

- Draft and enter into a performance contract with each county that allows for effective oversight and satisfies the intent of the MHSA, including requiring counties to demonstrate that each of their MHSA programs is meeting its respective intent.

- Conduct comprehensive on-site reviews of counties' MHSA programs, including verifying county compliance with MHSA requirements.

To improve the quality of county processes for measuring program performance, Health Care Services should use its performance contracts with counties to ensure that the counties do the following:

- Specify MHSA program goals in their plans and annual updates and include those same goals in contracts with program providers.

- Identify meaningful data that measure the achievement of all their goals, set specific objectives, require their program providers to capture those data, and use those data to verify and report on the effectiveness of their MHSA programs.

To ensure that counties have the needed guidance to implement MHSA programs, Health Care Services should collaborate with the Accountability Commission and develop and issue guidance or regulations, as appropriate, to counties on how to effectively evaluate and report on MHSA program performance.

To ensure that Health Care Services and other responsible state entities can evaluate MHSA programs and assist the Accountability Commission in its evaluation efforts, Health Care Services should collect complete and relevant MHSA data from the counties.

To help ensure county compliance with stakeholder regulations, Health Care Services should provide technical assistance to counties on the MHSA local planning process and ensure that its guidance to counties is clear and consistent with state regulations.

Accountability Commission

In order to fulfill its responsibilities to evaluate MHSA programs, the Accountability Commission should undertake the evaluations specified in its recently adopted framework for evaluation.

Sacramento, San Bernardino, and Santa Clara

Each county should review its existing MHSA contracts and by December 31, 2013, or as soon as is feasible, amend them as necessary to include plan goals.

Agency Comments

The three state entities and three counties to which we made recommendations—Health Care Services, the Accountability Commission, the California Mental Health Planning Council, and the counties of Sacramento, San Bernardino, and Santa Clara—agreed with our recommendations and generally agreed with the report's conclusions. We did not make any recommendations to Los Angeles.

Introduction

Background

Providing effective services and treatment for those who suffer from mental illness or who are at risk of mental illness is an issue of great statewide and national importance. Recent statistics by the U.S. Department of Health indicate that approximately 11 million U.S. adults, or 4.8 percent of the population, had serious mental illnesses in 2009. Critical incidents, such as the school shooting in Sandy Hook, point to the seriousness of these issues. Over time California has attempted to serve its mentally ill population through a variety of services and programs, and in 2004 the voters approved Proposition 63, the Mental Health Services Act (MHSA), in order to expand on these services and to use innovative methods more likely to identify, mitigate, and treat mental illness. The MHSA stresses that mental illnesses are extremely common, affecting almost every family in California. Further, it states that the failure to provide timely treatment can destroy individuals and families. "No individual or family should have to suffer inadequate or insufficient treatment due to language or cultural barriers to care. Untreated mental illness is the leading cause of disability and suicide and imposes high costs on state and local government . . . . State and county governments are forced to pay billions of dollars each year in emergency medical care, long-term nursing home care, unemployment, housing, and law enforcement, including juvenile justice, jail and prison costs." To respond to these concerns, the MHSA establishes five key purposes: "to define serious mental illness among children, adults, and seniors as a condition deserving attention; to reduce the long-term adverse impact of untreated serious mental illness on individuals, families, and state and local budgets; to expand the kinds of successful, innovative service programs for children, adults, and seniors already undertaken in California; to provide state and local funds for the purposes of the MHSA; and, finally, to ensure that all MHSA funds are expended in the most cost-effective manner and services are provided using recommended best practices subject to local and state oversight to ensure accountability to taxpayers and the public."

To support its purposes, the MHSA levies a 1 percent income tax on individuals earning more than $1 million, which is deposited into the Mental Health Services Fund (Fund) that the MHSA established. The funds must be spent to expand mental health services and cannot be used to replace existing state or county funding for mental health services. The funds primarily flow to counties[2] to provide

[2] *County* indicates a county mental health department, two or more county mental health departments acting jointly, and/or city-operated programs receiving funds per California Welfare and Institutions Code, Section 5701.5.

services to those individuals severely affected by or at risk for serious mental illness. The California Department of Mental Health (Mental Health) was the primary state entity responsible for overseeing the implementation of the MHSA until legislation effective June 2012 transferred the majority of the MHSA duties to the California Department of Health Care Services (Health Care Services). From fiscal years 2006–07 through 2011–12, Mental Health records indicate that the MHSA provided almost $7.4 billion to counties for the provision of mental health services.

Components of the Mental Health Services Act

Community Services and Supports: Provides direct mental health services to the severely and seriously mentally ill, such as mental health treatment, cost of health care treatment, and housing supports. Regulation requires counties to direct the majority of its Community Services and Supports funds to the Full-Service Partnership (Partnership) service category.

A Partnership is a service category under which the county, in collaboration with the client and the family, when appropriate, plans for and provides the full spectrum of community services. These services consist of mental health services and supports, such as peer support and crisis intervention services; and non-mental health services and supports, such as food, clothing, housing, and the cost of medical treatment.

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

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

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

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

Sources: Mental Health Services Act, Proposition 63 of 2004; California Code of Regulations, Title 19, sections 3310, 3610, 3615, 3620, 3810; certain California Department of Mental Health information notices; and other documentation.

MHSA Components

The MHSA provides funding for programs within five components, as defined in the text box. Community Services and Supports (Community Supports) provides services to individuals with serious mental illness. A significant portion of the MHSA funds allocated to counties is designated for Community Supports, and regulations require the counties to designate the biggest portion of their Community Supports funds to the Full-Service Partnership (Partnership) service category. Counties must use all other Community Supports funds to provide general development services, which are typically less extensive than those offered through a Partnership, for outreach and engagement in identifying unserved individuals who qualify for mental health services or to create housing for those with mental illness. Community Supports programs can be funded by a combination of funding sources, such as MHSA funds and Medi-Cal funds. Mental Health first requested that counties submit initial plans for Community Supports programs in 2005; state law requires that plans be updated at least annually.

The Prevention and Early Intervention (Prevention) component funds programs designed to prevent mental illnesses from becoming severe and disabling. The MHSA requires Prevention programs to emphasize improving timely access to services for underserved populations and specifies that the programs must include outreach to members of the community and others in order to increase recognition of the early signs of potentially severe and disabling mental illness. The programs must also offer access and links to medically necessary care to individuals with severe

mental illness and reduce the stigma or discrimination associated with mental illness diagnosis or with seeking mental health services. The Prevention component also calls for programs to emphasize strategies that reduce negative outcomes that may result from untreated mental illness, such as suicide, incarceration, homelessness, and prolonged suffering. Mental Health requested that counties submit their initial plans for Prevention programs in 2007.

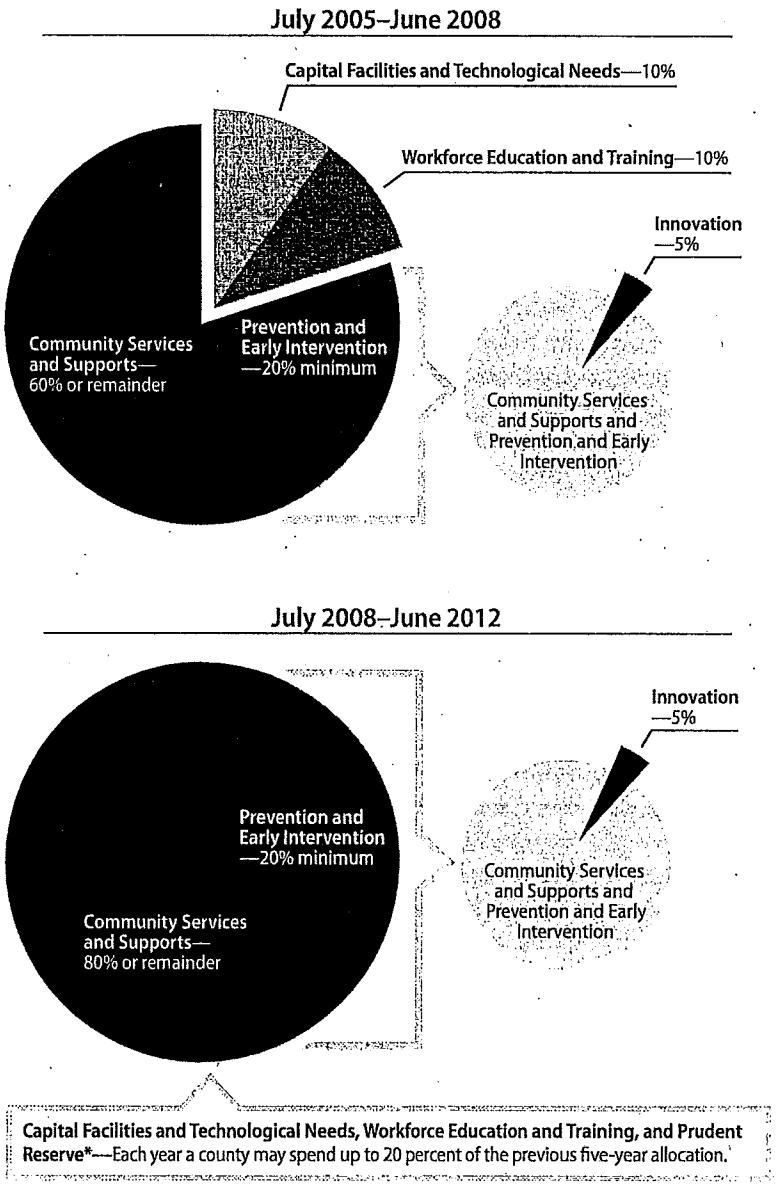
The MHSA calls for counties to spend a certain percentage of funds for Innovation programs that increase access to underserved groups, increase the quality of services, and promote interagency collaboration, among other things. In early 2009, when Mental Health issued guidelines on submitting plans for implementing the Innovation component, it acknowledged that the MHSA is less specific in its direction for this component than for the others. This component is intended to form an environment that develops new and effective practices and approaches in the field of mental health. In fact, the Mental Health guidance states that the scope of an Innovation program may include introducing a novel, creative, and/or ingenious approach to a mental health practice; as long as the program contributes to learning and maintains alignment with the MHSA, it may affect virtually any aspect of mental health practices, such as assessing a new application of a promising approach. In its guidance, Mental Health stated that Innovation programs are by nature similar to pilot or demonstration projects, are time limited, and should be assessed for effectiveness.

The final two MHSA components assist counties in adding infrastructure to accommodate the increase in clients resulting from MHSA funding. The Capital Facilities and Technological Needs (Facilities) component helps fund building and technology projects. The Workforce Education and Training (Training) component provides funds to train mental health professionals to meet the increased needs arising from MHSA services, among other purposes. Beginning in fiscal year 2008–09, the MHSA capped the amount of funds that counties can spend on the Facilities and Training components.

Figure 1 on the following page displays the proportions of a county's total MHSA allocation that must be spent for each of the five components. As noted above, the allocation requirements for the Facilities and Training components changed beginning in fiscal year 2008–09, so the figure reflects two time periods. For fiscal years 2005–06 through 2007–08, the MHSA required the allocation of 10 percent of the funds to Facilities and 10 percent to Training. From fiscal year 2008–09 onward, funding for these two MHSA components was at the counties' discretion; however, if a county chose to plan programs for the Facilities and Training components, each year Mental Health could apportion

up to a total of 20 percent of the county's average Community Supports allocation received over the previous five-year period to these components.

Figure 1
Apportionment of Mental Health Services Act Funds to Counties



Sources: Mental Health Services Act and Proposition 63 of 2004.

* State law requires counties to maintain a prudent reserve to ensure that service levels will continue in the event that revenues for the Mental Health Services Fund fall below recent averages.

Roles and Responsibilities

Initially Mental Health was the primary state entity overseeing the MHSA. Under Proposition 63, Mental Health had the responsibility to guide and monitor counties' implementation of the MHSA. However, beginning in March 2011, Mental Health's[3] role was reduced and subsequent changes in law effective June 2012 transferred nearly all remaining MHSA functions from Mental Health to other entities. Figure 2 on the following page shows Mental Health's responsibilities, beginning with Proposition 63, and demonstrates how legislation enacted in 2009, 2011, and 2012 modified them. Another entity within Mental Health—the Mental Health Planning Council—was also specifically tasked with evaluating MHSA programs.

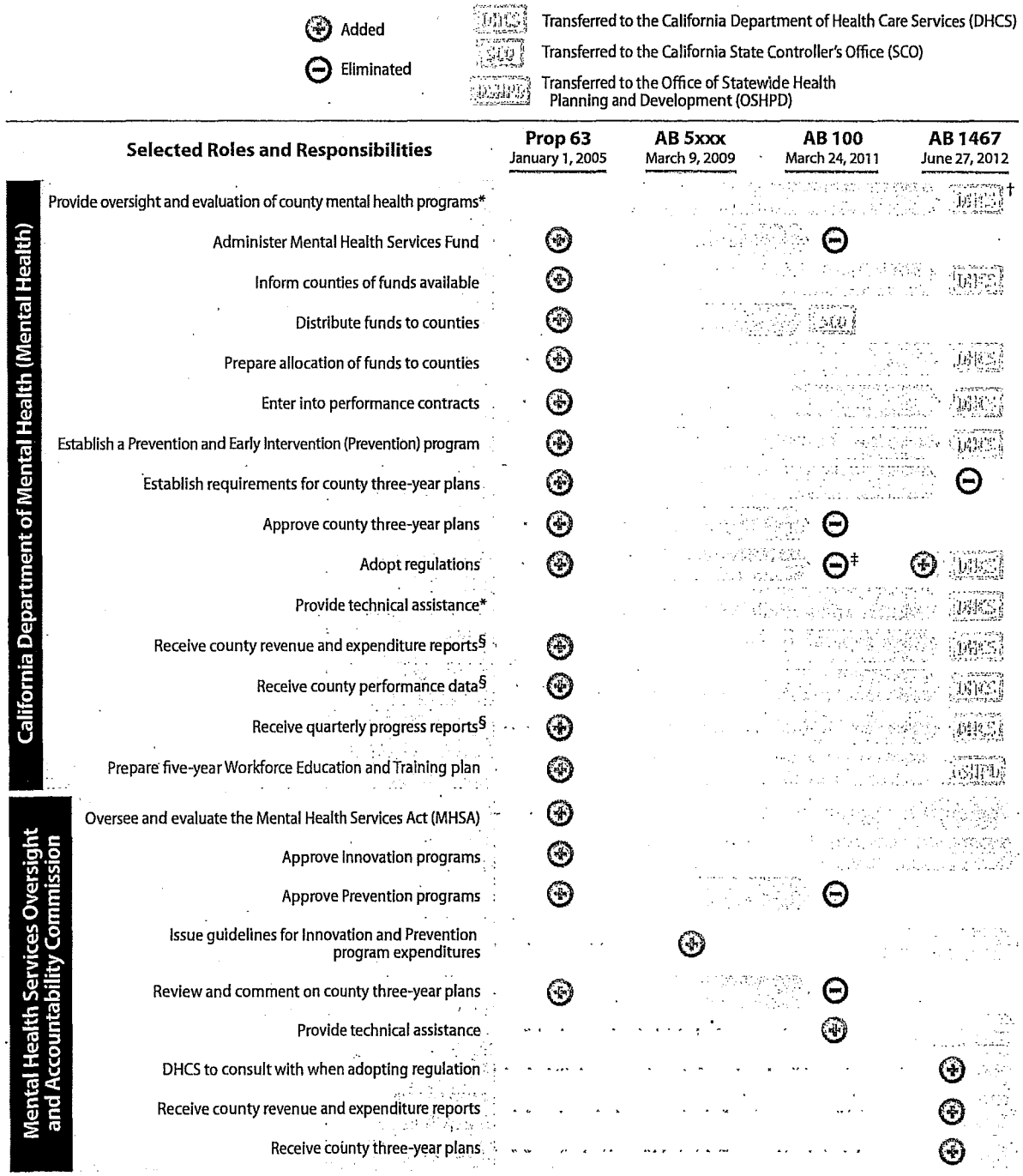
Proposition 63 established the Mental Health Services Oversight and Accountability Commission (Accountability Commission) to oversee certain components of the MHSA. The Accountability Commission consists of 16 voting members either appointed by the governor or granted membership by virtue of their position within state government, such as the superintendent of public instruction. At the time it was created, the Accountability Commission acted as a division within Mental Health; however, legislative changes effective March 2009 specified that the commission is to administer its operations separately and apart from Mental Health. As with Mental Health, the Accountability Commission's oversight authority changed over time. Legislation effective March 2011 removed the Accountability Commission's responsibility to review and comment on counties' plans; however, current statute requires counties to submit their plans to the Accountability Commission and for it to approve counties' plans for their Innovation programs before the counties may spend Innovation funds. The changes in the Accountability Commission's responsibilities over time are shown in Figure 2.

MHSA Funding and State Administration

The manner in which counties receive MHSA funds has also changed over the years. In the initial design, Mental Health approved funding before it went to the counties. Under Proposition 63, the State used the following process to distribute funds to counties: first, the California Department of Finance, in consultation with the Franchise Tax Board, determined the annual adjustment

[3] Beginning July 2012, Health Care Services assumed Mental Health's primary responsibilities for MHSA oversight, as Mental Health underwent a streamlining reorganization and became the California Department of State Hospitals.

Figure 2
Mental Health Services Act Selected Roles and Responsibilities for the California Department of Mental Health and the Mental Health Services Oversight and Accountability Commission



Sources: The MHSA, Proposition 63 of 2004 (Prop 63), Assembly Bill 5 (AB 5xxx) (Chapter 20, Statutes of 2009, Third Extraordinary Session), Assembly Bill 100 (AB 100) (Chapter 5, Statutes of 2011), and Assembly Bill 1467 (AB 1467) (Chapter 23, Statutes of 2012).

* This responsibility existed before passage of the MHSA, Proposition 63 of 2004.

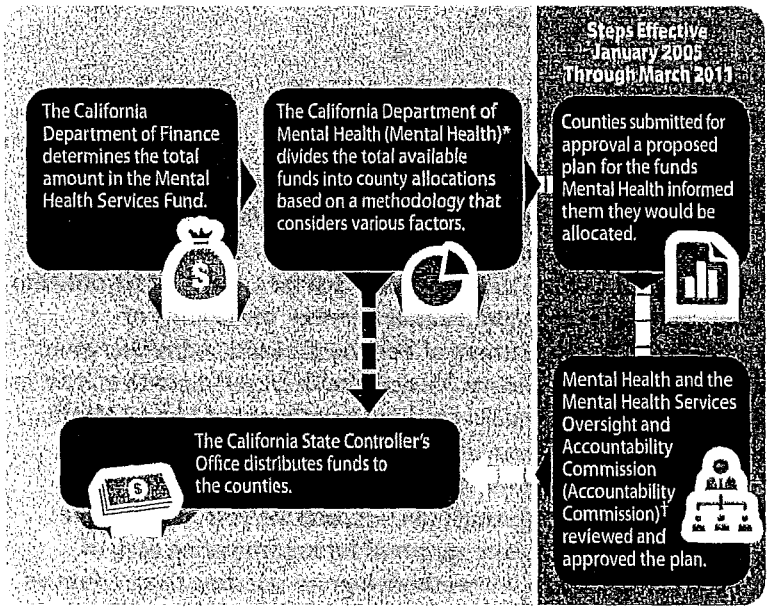
† Although not depicted in the figure, this requirement was transferred by Senate Bill 1009 (Chapter 34, Statutes of 2012), not Assembly Bill 1467.

‡ Legislation effective March 2011 removed Mental Health's exclusive authority to adopt regulations for MHSA and instead authorized "the State," and not just Mental Health, to adopt regulations related to the MHSA.

§ This responsibility was added by regulation on December 29, 2006.

amount in the Fund based on the projected amounts from the 1 percent tax. The California State Controller's Office (State Controller's Office) deposited the tax receipts monthly into the Fund. Next, Mental Health divided the total pool of funds among the counties, using a methodology based on factors such as the county's total population and the population most likely to apply for services, including those defined as *in poverty* and *uninsured*. Mental Health informed each county of the total funding amount it would receive, and each county submitted an annual plan detailing how it intended to use the funds. Depending on the component the plan addressed, Mental Health or the Accountability Commission evaluated the county's plan. Once the plan was approved, the State Controller's Office distributed funds to the county. Figure 3 displays the original flow of MHSA funds. However, legislation effective March 2011 separated state approval of plans from a county's receipt of MHSA funds.

Figure 3
Key Steps in State Allocation and Distribution Process for Mental Health Services Act Funds



Sources: The Mental Health Services Act, Proposition 63 of 2004, and Assembly Bill 100 (Chapter 5, Statutes of 2011).

* Mental Health's functions were transferred primarily to the California Department of Health Care Services beginning in fiscal year 2012–13.

† Until June 2012 state law required counties to receive approval from Mental Health with input from the Accountability Commission before receiving funds for Innovation programs. Current law allows counties to receive, but not spend, funds for Innovation programs before the Accountability Commission approves the programs.

The MHSA also provided the State with 5 percent of all MHSA annual revenues to cover its administrative costs, including but not limited to costs associated with evaluating the effectiveness of services the counties provide. The March 2011 legislation that reduced the State's oversight role also reduced the 5 percent to 3.5 percent.[4] Although for fiscal year 2011–12 the majority of this administrative funding was budgeted for state administration to support Mental Health and the Accountability Commission, many other state entities were budgeted funds from the 3.5 percent to support mental health functions. Table 1 lists the state entities that were budgeted MHSA administrative funds in fiscal year 2011–12 and the purposes of the funding.

Because of a shortage in the State's General Fund, legislation effective March 2011 shifted more than $850 million in MHSA funds to cover General Fund obligations for other mental health programs. Among those transfers, the Legislature shifted $183.6 million to Medi-Cal Specialty Mental Health Managed Care, $98.6 million for special education pupils, and $579 million for the Early Periodic Screening, Diagnosis, and Treatment program. The effect these transfers had in the allocations to the counties for fiscal year 2011–12, the year in which they occurred, can be seen in Appendix A.

Four Counties Selected for Audit

The Joint Legislative Audit Committee (audit committee) directed the California State Auditor (state auditor) to review Los Angeles County and one county each from the Inland Empire, Bay Area, and Central Valley. We selected the County of Sacramento Department of Health and Human Services, the County of San Bernardino Department of Behavioral Health Administration, and the Santa Clara County Mental Health Department to review, in addition to the Los Angeles County Department of Mental Health. Figure 4 on page 16 provides key information on the counties, including total population, total MHSA funds received during fiscal years 2006–07 through 2011–12, and the year in which the counties' initial plans were approved for implementing each of the five components. Our methodology for selecting these counties is described in Table 2 on page 17.

Further information on the selected counties is available in the appendixes. Appendix B summarizes the MHSA services that the four counties planned to provide during fiscal years 2006–07 through 2011–12. Appendix C provides county demographic

[4] Legislative change effective June 27, 2013, restored state administration to 5 percent.

and mental health diagnostic data by MHSA component, and Appendix D summarizes county MHSA revenues and expenditures by fiscal year and component.

Table 1
Mental Health Services Act Funding Budgeted for State Administration, by State Agency
Fiscal Year 2011–12

AGENCY RECEIVING FUNDS	BUDGET	PERCENTAGE OF TOTAL	PURPOSE OF FUNDING
California Department of Mental Health (Mental Health)* – Mental Health Planning Council (Planning Council)	$12,339,000 791,000†	43% 3	To fund key statewide mental health projects including housing, suicide prevention, mitigation of stigma projects, focused data analysis, and some community-based contracts.
Office of Statewide Health Planning and Development	5,895,000	20	To provide, among other things, educational loan repayments for mental health professionals to encourage work in the public mental health system in positions that have been deemed difficult to fill or hard to retain.
Mental Health Services Oversight and Accountability Commission	5,529,000	19	To oversee, review, and evaluate projects and programs funded by the Mental Health Services Act (MHSA), among other responsibilities.
California State Controller's Office (State Controller's Office)	1,733,000‡	6	To help support the development of a new Human Resource Management System, the 21st Century Project, a payroll system for use by state departments.
Judicial branch	1,063,000	4	To address the increased workload relating to mental health issues in the area of prevention and early intervention for juveniles with mental health illness in the juvenile court system or at risk for involvement in the system.
California Department of Health Care Services (Health Care Services)	865,000	3	To support a contract to develop and implement the interdepartmental California Mental Health Care Management Program, which serves to improve mental health care for Medi-Cal beneficiaries with a severe mental illness or a severe emotional disturbance.
California Military Department	552,000	2	To support a pilot behavioral health outreach program to improve coordination between the California National Guard, local veterans' services, and county mental health departments throughout the State.
California Department of Veterans Affairs	237,000	1	To support statewide administration to inform veterans and family members about federal benefits, local mental health departments, and other services.
Department of Developmental Services	393,000	1	To coordinate a statewide community-based system of mental health services for those with developmental disabilities.
California Department of Education	125,000	1	To support county mental health programs' work with local education agencies, county offices of education, and special education local plan areas to provide necessary services.
Financial Information Systems for California (FI$CAL)	137,000‡	1	To transform the State's systems and workforce to operate in an integrated financial management system environment. State agencies with accounting systems, including Mental Health, are required to provide funding to the project.
Board of Governors of the California Community Colleges	125,000	1	To assist in developing policies and practices that address the mental health needs of California community college students.
Totals	$28,993,000	100%	

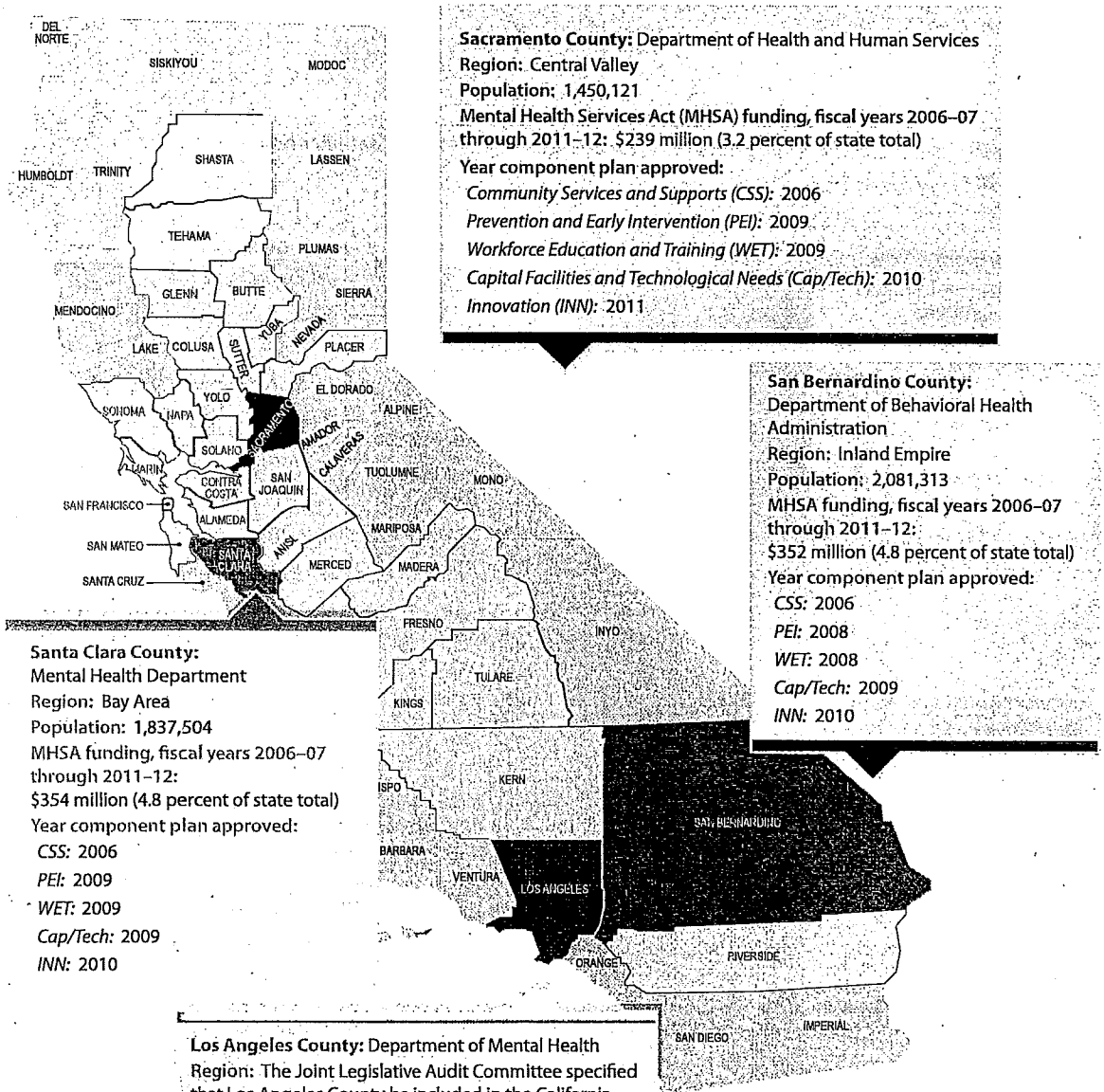
Sources: Fiscal year 2011–12 Budget Act and the *Mental Health Services Act Expenditure Report for Fiscal Year 2011–12.*

* Mental Health's functions were transferred primarily to Health Care Services beginning in fiscal year 2012–13.

† In fiscal year 2011–12, the Planning Council was a division of Mental Health, and the budget amount presented represents the portion of Mental Health's $12.3 million budget designated for the Planning Council.

‡ The State Controller's Office and FI$CAL receive apportionments based on amounts the California Department of Finance determines, and the amounts presented for these two entities are based on the *Mental Health Services Act Expenditure Report for Fiscal Year 2011–12.*

Figure 4
Regions and Counties Identified for Audit With Key Information



Sacramento County: Department of Health and Human Services
Region: Central Valley
Population: 1,450,121
Mental Health Services Act (MHSA) funding, fiscal years 2006–07 through 2011–12: $239 million (3.2 percent of state total)
Year component plan approved:
Community Services and Supports (CSS): 2006
Prevention and Early Intervention (PEI): 2009
Workforce Education and Training (WET): 2009
Capital Facilities and Technological Needs (Cap/Tech): 2010
Innovation (INN): 2011

San Bernardino County:
Department of Behavioral Health Administration
Region: Inland Empire
Population: 2,081,313
MHSA funding, fiscal years 2006–07 through 2011–12:
$352 million (4.8 percent of state total)
Year component plan approved:
CSS: 2006
PEI: 2008
WET: 2008
Cap/Tech: 2009
INN: 2010

Santa Clara County:
Mental Health Department
Region: Bay Area
Population: 1,837,504
MHSA funding, fiscal years 2006–07 through 2011–12:
$354 million (4.8 percent of state total)
Year component plan approved:
CSS: 2006
PEI: 2009
WET: 2009
Cap/Tech: 2009
INN: 2010

Los Angeles County: Department of Mental Health
Region: The Joint Legislative Audit Committee specified that Los Angeles County be included in the California State Auditor's review.
Population: 9,962,789
MHSA funding, fiscal years 2006–07 through 2011–12:
$2.2 billion (29.3 percent of state total)
Year component plan approved:
CSS: 2006
PEI: 2009
WET: 2009
Cap/Tech: 2009
INN: 2010

Sources: Counties' Web sites, allocation information obtained from the California Department of Mental Health's Web site and the California Department of State Hospitals; United States Census Bureau; state and county QuickFacts 2012; county population estimates; selected counties' MHSA plan approval documents; and information obtained from the Web sites of the Association of Bay Area Governments, DiscoverIE.com, and the California State Library.

Scope and Methodology

The audit committee directed the state auditor to conduct an audit of the MHSA, including a review of state oversight and county implementation and performance measurement of the MHSA. Table 2 outlines the audit committee's objectives and the methods we used to address them.

Table 2
Audit Objectives and the Methods Used to Address Them

	AUDIT OBJECTIVE	METHOD
1	Review and evaluate the laws, rules, and regulations significant to the audit objectives.	With the assistance of legal counsel, we reviewed relevant laws, regulations, and other background materials applicable to the Mental Health Services Act (MHSA).
2	Review and evaluate the roles and responsibilities of the California Department of Health Care Services (Health Care Services), the Mental Health Services Oversight and Accountability Commission (Accountability Commission), the Office of Statewide Health Planning and Development, the California State Controller's Office, and any other state agency regarding the MHSA and the programs and activities funded by the MHSA.	• Reviewed relevant state laws and regulations to determine the roles and responsibilities of each of the listed state entities as they relate to the MHSA. • Interviewed key officials from each state entity to identify and determine their roles and responsibilities as it relates to the MHSA. • Requested Health Care Services' response to various questions, contained within a representation letter, regarding its intentions and efforts going forward as it relates to its recently assumed MHSA responsibilities.
3	For the most recent six-year period, determine whether the respective state entities identified in Item 2 are allocating, spending, and monitoring MHSA funding related to Innovation programs for underserved communities, Prevention and Early Intervention (Prevention) services, and Community Services and Supports (Community Supports) (primarily Full-Service Partnership) in a reasonable manner consistent with applicable laws by performing the following:	At the time we began our audit work, we determined that our audit scope would focus on the most recent completed six-year period. Thus, we defined our audit period as fiscal years 2006–07 through 2011–12.
a.	Determine the amount of MHSA funds allocated by the State to counties for each component of the MHSA.	To identify MHSA funds allocated to counties* by component for fiscal years 2006–07 through 2011–12, we used two data sources. For fiscal years 2006–07 through 2009–10, we obtained counties' approved allocation amounts as listed on the California Department of Mental Health's (Mental Health) Web site. However, we found that this source did not appear to consistently present complete and updated allocation information for fiscal years 2010–11 and 2011–12, which may be due to legislative changes that eliminated Mental Health's role in reviewing counties' three-year plans and annual updates. As a result, to identify funds allocated to counties by component for fiscal years 2010–11 and 2011–12, we obtained California State Accounting and Reporting System data from the California Department of State Hospitals. We present this information, by county, in Appendix A.
b.	Identify the methodology the State uses to allocate funding to counties. Determine whether improvements in the methodology are necessary to ensure the most effective allocation of the funds.	• Reviewed relevant laws, regulations, and background materials to understand allocation requirements pertaining to the MHSA. • Interviewed key officials about the MHSA allocation process and methodology. • Reviewed and followed up as necessary on Health Care Services' response to a representation letter in which we requested it describe its plans to revise the allocation methodology, what the planned revisions will accomplish, and the timeline for completing the revision. Additionally, it is important to note that despite numerous attempts to obtain the methodology from Health Care Services throughout the course of our fieldwork, it did not provide the methodology until after our closing audit conference with them, which was held in mid-June, a circumstance we describe further in Chapter 1.

continued on next page...

	AUDIT OBJECTIVE	METHOD
	c. Determine the oversight protocols used by the respective entities to monitor the expenditure of funds and program compliance, performance, and outcomes. Determine whether any improvements should be made to these protocols.	• Reviewed relevant laws, regulations, and background materials to understand MHSA oversight requirements as they related to Mental Health, the Accountability Commission, and the Mental Health Planning Council (Planning Council). • Interviewed key officials about MHSA oversight processes. • Obtained and reviewed oversight tools used by Mental Health and the Accountability Commission to determine whether the tools satisfied the oversight requirements. • Assessed whether the oversight activities performed by Mental Health and the Accountability Commission met the requirements and intent of the MHSA. • Assessed whether the Planning Council fulfilled its statutory duties of evaluating mental health programs, including MHSA programs, by interviewing key staff and reviewing relevant documentation. • Obtained and reviewed Health Care Services' response to a representation letter in which we inquired about its plans to perform MHSA-related oversight activities, including a timeline of the activities and their frequency, as well as whether it plans to use review tools formerly used by Mental Health.
4	For Los Angeles County and a selection of one county each from the Inland Empire, Bay Area, and Central Valley, perform the following on each of the MHSA components—covering the most recent six-year period:	To select the three counties, in addition to Los Angeles, to include in our review, we obtained and assessed information to identify the common boundaries for the three regions: Inland Empire, Bay Area, and Central Valley. Using the MHSA allocation amounts that we derived following the process described in the method column for Objective 3 (a) for fiscal years 2006–07 through 2011–12, we selected the county within each of the three defined regions that received the highest amount of MHSA funds. The counties we selected for review are presented in the Introduction in Figure 4 on page 16.
	a. Review and assess the method each county uses to establish any performance measures and outcomes and determine if these measures and outcomes are meaningful and reasonable, including the methods used to establish any performance measures and outcomes for underserved and diverse communities. b. Evaluate the reasonableness of the methods used to obtain and analyze data to measure performance and outcomes.	• Interviewed key staff and reviewed available documentation to ascertain and assess the process each county uses to create performance measures and outcomes for the Community Supports, Prevention, and Innovation components. We excluded from our review the Workforce Education and Training and the Capital Facilities and Technological Needs components because these components do not directly provide mental health services to clients. • To evaluate the reasonableness of counties' measurement of their programs' performance, we selected six to nine service provider contracts at each county, generally based on each contract's total dollar amount, for fiscal years 2006–07 through 2011–12. For Los Angeles, San Bernardino, and Santa Clara, we selected three contracts each from the Community Supports, Prevention, and Innovation components, for a total of nine contracts to review at each county. For Sacramento, we selected three Community Supports and three Prevention contracts for a total of six contracts; we did not select any Innovation contracts because the county had no active Innovation services for the time period we reviewed. Mental Health issued guidance in 2009 instructing counties to choose one Prevention program to evaluate and report on in their plans. Although it is unclear whether Mental Health ever held counties accountable for this evaluation and reporting, where applicable we attempted to select this program. • We evaluated the counties' approach to measuring their MHSA programs' performance in four ways. First, we established whether the county defined program goals in its MHSA plans, thereby establishing objectives by which they could measure performance. Our second step determined whether counties included program goals in their provider contracts to ascertain whether counties clearly communicated program goals to providers and made providers accountable for achieving them. Third, we assessed whether counties had identified meaningful data with which to measure progress on achieving program goals (performance data). Fourth, we assessed whether counties collected and analyzed program performance data, and reported to county management and stakeholders about program performance.

AUDIT OBJECTIVE	METHOD
c. Identify key performance measures and outcomes achieved—including those achieved by traditionally underserved and diverse communities—such as reductions in homelessness and psychiatric hospitalizations. d. Review and assess the extent to which each county uses performance measures and outcomes to improve the local mental health systems.	Obtained a response from each county to a representation letter in which we asked counties various questions, and to provide supporting documentation as necessary, relating to key performance measures and outcomes achieved, as well as how the county used these data to improve its local mental health systems. Once received, we reviewed the responses, any supporting documentation, and followed up with the counties as necessary. To determine whether the responses were reasonable, we assessed whether they reflected the results of our testing explained in the Method column for Objectives 4a and 4b in this table.
e. Identify the type of services and support provided by each of the MHSA components and the demographics of the populations receiving those services.	To identify the services offered by each of the MHSA components for the four counties we reviewed, we obtained and reviewed the four selected counties' initial three-year plans for each of the five components as well as annual updates to those plans. Using these plans, for fiscal years 2006–07 through 2011–12, we developed a listing of programs and their descriptions, by component and county. Based on information we received from the counties, described in the step below, we also indicated for each program, when applicable, the age group the county specified the program would serve. This information is presented in Appendix B. To identify client demographic data for the four counties we reviewed for each of the three components that provide direct mental health services to clients—Community Supports, Prevention, and Innovation—we obtained from each county available demographics of the clients it has served including age, ethnicity, and primary language. Additionally, we obtained from each of the four counties available data related to the mental health diagnosis of the clients each has served. We classified the diagnosis data into categories based on the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV). We present this information for fiscal years 2006–07 through 2011–12 in Appendix C.
f. Determine the extent to which each county's plan reflects the content of the programs and services to be delivered and their planned expenditures. Further, compare each county's plan to the actual delivery of services and related expenditures.	• For the three MHSA components that provide direct mental health services to clients—Community Services and Supports, Prevention, and Innovation—for fiscal years 2006–07 through 2011–12, we selected the highest-dollar contract per component per fiscal year to review, for a total of 33 contracts. We compared the program as described in the plan to the contract Scope of Work to ascertain whether the county was delivering the programs in accordance with its plan. We found no exceptions. • For fiscal years 2006–07 through 2011–12, we obtained from each of the four counties their completed Revenue and Expenditure Reports (expenditure report). For fiscal years for which the county had not completed an expenditure report, we obtained, by MHSA component, the counties' expenditures and MHSA allocations. For each fiscal year and component, we compared counties' revenues and expenditures. For years where expenditure reports were available, we presented the counties' own calculations of the balance between revenues and expenditures. For years where expenditure reports were not available, we calculated this balance. We also used counties' expenditure reports to identify contributions they made to their local prudent reserve. We present this information in Appendix D.
g. Determine the degree to which each county employed a stakeholder process consistent with the law when developing its county plan.	• Reviewed relevant laws, regulations, and background materials to understand MHSA requirements as they relate to the local planning process and counties, including stakeholders in this process, when developing their plans and annual updates. • For each of the four counties we reviewed, we assessed the local planning process for development of its Community Supports plan; its most recent initial component plan, which was in every case Innovation; and its most recent annual update. To perform this assessment and to determine whether counties complied with applicable state requirements, we reviewed information about the local planning process contained within each of the plans, interviewed key county staff, and obtained and assessed various documents from the counties pertaining to their adherence to local planning process requirements, such as those related to training and stakeholder engagement.

continued on next page . . .

	AUDIT OBJECTIVE	METHOD
5	For Los Angeles County and the three additional counties selected under Item 4, select a sample of expenditures from each MHSA component covering the most recent six-year period to determine if the expenditures were allowable and reasonable.	• Interviewed key officials to understand each county's process for reviewing and approving invoices. • Documented the controls each county has in place to ensure provider invoices align with contracted services. • Because counties often contract with providers for the provision of MHSA services, for each county we selected expenditures for contracted services for Community Supports, Prevention, and Innovation for fiscal years 2006–07 through 2011–12. We reviewed a total of 43 expenditures. We determined whether each expenditure aligned with the services as stated in the contract and with the program as described in the county's plan. • To determine whether counties' payroll expenditures were reasonable and appropriate, we obtained from each county payroll data listing employees who provided MHSA client services during fiscal years 2006–07 through 2011–12. We selected one employee per year in which county personnel provided MHSA client services (a total of 21 employees) and obtained their job description to determine whether that employee's duties were reasonably related to MHSA. We found no exceptions.
6	Review and assess the method by which the State collects, compiles, and reports data from the counties to determine if there is a more efficient and comprehensive method to report these data in the aggregate at the state level for analyzing the performance and outcomes achieved by the services resulting from the MHSA.	• Reviewed relevant laws, regulations, and background materials to understand MHSA requirements as they relate to state and county reporting. • Identified the methods Mental Health used to collect MHSA data from the counties, including forms and databases used to store the data. Reviewed the forms to determine whether each was the most efficient and comprehensive approach. Additionally, we interviewed former Mental Health staff as well as Health Care Services staff to determine if any concerns with the quality of the data may exist. • Reviewed evaluations the Accountability Commission contracted for and interviewed staff to determine quality of data issues and utility of evaluations.
7	Review and assess any other issues that are significant to the MHSA.	We identified the transition of MHSA responsibilities from Mental Health to Health Care Services as a significant issue. We reviewed the transition plan and planning activities and interviewed staff to identify any areas of concern. We also asked Health Care Services in a representation letter to identify any outstanding issues relating to the transition. We found no reportable issues.

Sources: California State Auditor's analysis of Joint Legislative Audit Committee audit request number 2012-122, planning documents, and analysis of information and documentation identified in the column titled *Method*.

* *County* indicates a county mental health department, two or more county mental health departments acting jointly, and/or city-operated programs receiving funds per California Welfare and Institutions Code, Section 5701.5.

Chapter 1

DESPITE THE STATE'S INADEQUATE OVERSIGHT SO FAR, OPPORTUNITY EXISTS TO DEMONSTRATE THE EFFECTIVENESS OF THE MENTAL HEALTH SERVICES ACT

Chapter Summary

The state entities initially responsible for overseeing the Mental Health Services Act (MHSA) have historically provided ineffective oversight of the counties' implementation of MHSA programs. As a result, the State has little assurance that the counties have effectively and appropriately used the almost $7.4 billion directed to counties[5] for these programs from fiscal years 2006–07 through 2011–12. One focus of the MHSA is accountability, and during this period, the task of ensuring accountability was primarily the responsibility of the California Department of Mental Health (Mental Health) and the Mental Health Services Oversight and Accountability Commission (Accountability Commission). Although each entity minimally performed the duties the MHSA specifically required, they did not fully embrace the oversight necessary to demonstrate the effectiveness of the MHSA. In particular, we expected that the responsible entities would have used an effective process to monitor, guide, and evaluate counties' implementation of the MHSA, that they would build this process on their broad and specific MHSA oversight responsibilities, and that they would incorporate best practices; however, we found that they did not do so in the time period we reviewed.

Going forward, opportunity exists for the current responsible state entities to better demonstrate the effectiveness of the MHSA. Effective late June 2012, legislation transferred most of Mental Health's oversight role to the California Department of Health Care Services (Health Care Services). Health Care Services has reported its plans for fulfilling its MHSA responsibilities, which include providing assistance to the Accountability Commission on evaluating county MHSA programs. However, Health Care Services' planning efforts are in the beginning stages, and the Accountability Commission has just begun to implement its recently adopted evaluation implementation plan; thus, it is too early to tell whether these efforts will fully address our concerns.

[5] *County* indicates a county mental health department, two or more county mental health departments acting jointly, and/or city-operated programs receiving funds per California Welfare and Institutions Code, Section 5701.5.

The Responsible State Entities Have Historically Provided Minimal MHSA Oversight, Evaluation, and Guidance

As noted in the Introduction, one focus of the MHSA is accountability, and a significant stated purpose of the MHSA is "to ensure that all funds are expended in the most cost effective manner and services are provided in accordance with recommended best practices subject to local and state oversight to ensure accountability to taxpayers and to the public." Before voter approval of the MHSA, Mental Health was responsible for overseeing mental health programs, and the MHSA specifically stated that nothing in Proposition 63 modified or reduced the existing authority or responsibility of Mental Health. In addition, the MHSA created the Accountability Commission. Over time, the oversight roles and responsibilities related to the MHSA have shifted among these two oversight entities, as shown in Figure 5.[6] The period from January 2005 through March 2011 represents the initial oversight responsibilities resulting from voter approval of the MHSA. From April 2011 through June 2012, legislative changes to the roles of Mental Health and the Accountability Commission reduced the degree of state oversight. Beginning in July 2012, Health Care Services assumed primary responsibility for MHSA oversight as Mental Health underwent a streamlining reorganization to become the California Department of State Hospitals.

Although Mental Health and the Accountability Commission may have generally satisfied the MHSA's oversight requirements, they could have done more to ensure that counties were effectively implementing the MHSA.

Under the MHSA, Mental Health and the Accountability Commission were to provide oversight of MHSA programs to ensure that counties gave full consideration to concerns about quality, structure of service delivery, and access to services. Although these two entities may have generally satisfied the MHSA's oversight requirements, they could have done more to ensure that counties were effectively implementing the MHSA and that they were adequately evaluating the performance of their MHSA programs.

Mental Health's Minimalist Approach to Monitoring MHSA Programs Was Inadequate and Ineffective

Originally, Mental Health had both broad mental health and MHSA-specific monitoring, oversight, and implementation responsibilities to hold counties responsible for their use of mental health funds. Before enactment of the MHSA, Mental Health was required to "conduct, sponsor, coordinate and disseminate research and evaluation" on mental health resource utilization and

[6] The time frames in Figure 5 are approximate to the month to allow for ease of description.

Figure 5
The Three Phases of Oversight of the Mental Health Services Act

Sources: MHSA, Proposition 63 of 2004, and amendments.

Note: The time frames provided as beginning and ending periods are approximate to the month to allow for ease of description.

service delivery, make technical assistance available to counties, implement a system of required performance reporting by counties, and "perform any other activities useful to improving and maintaining the quality" of community mental health programs. As originally enacted, the MHSA specifically required Mental Health

to implement the Community Services and Supports (Community Supports) and Prevention and Early Intervention (Prevention) components of the MHSA through annual mental health services performance contracts (performance contracts) with counties. The MHSA required Mental Health to review and approve county plans and annual updates, which the text box describes. Mental Health could have used these performance contracts to ensure that the counties complied with their stated plans and annual updates by requiring the counties to track and report on performance measures that would demonstrate their effectiveness in meeting MHSA program goals and outcomes.

Summary of County Plans and Annual Updates

Upon initial implementation of each Mental Health Services Act (MHSA) component, counties were required to submit a three-year plan for MHSA programs that included descriptions of the proposed programs and the community planning process used to identify and develop the plan. Therefore, as required by law, counties were to submit an annual update generally describing their progress in implementing the existing component plan(s), proposals for new programs, and substantive alterations to existing programs.

Sources: California Welfare and Institutions Code and guidance issued by the California Department of Mental Health.

Based on its broad and specific responsibilities, we expected that Mental Health would have developed and implemented an effective monitoring process for its explicit oversight requirements and best practices related to effective monitoring. If periodic reviews revealed that counties were not in compliance with these requirements, the State's monitoring process would provide for enforcement action. A strong monitoring process and strong requirements help ensure that taxpayer funds are appropriately spent, that mental health services are effectively provided, and that issues of noncompliance are promptly discovered and corrected. However, we did not find a strong monitoring process in place.

Mental Health Made Poor Use of County Performance Contracts, and Recent Changes to State Law Have Complicated the State's Enforcement Mechanism

We believe Mental Health should have founded its monitoring of county MHSA programs on the required performance contract. These performance contracts with each county could well have served as a mechanism for holding the county accountable for the commitments it had made to the State. State law specifies that the performance contract must include several assurances that the county can and will comply with specific legal requirements, including complying with the data reporting requirements to fulfill the information needs of the State.

During fiscal year 2008–09, Mental Health switched from its original, more robust performance contract to an MHSA agreement that contained broad, general statements concerning how a county would comply with the law. The MHSA agreement offered few specifics as to what steps a county must take to assure compliance. Functionally, Mental Health appears to have treated the MHSA

agreement as a means of enabling counties to obtain MHSA funding. Although the assurance included in the MHSA agreement may have satisfied the minimal requirements set forth in state law, Mental Health could have drafted the performance contracts to require specific measurable commitments from the counties. Had Mental Health made better use of these performance contracts as a tool for holding counties accountable for their use of MHSA funds, it would have significantly bolstered the State's oversight role and might have mitigated the shortcomings we identified in selected counties' evaluation and reporting on the effectiveness of their MHSA programs. Going forward, Health Care Services can use its performance contracts with counties to ensure that they specify program goals, identify meaningful measurement of their goals, and use the resulting data to evaluate the efficacy of their programs.

Going forward, Health Care Services can use its performance contracts with counties to ensure that they specify program goals, identify meaningful measurement of their goals, and use the resulting data to evaluate the efficacy of their programs.

According to its director, Health Care Services is developing new performance contracts effective July 1, 2013. He stated that Health Care Services has included stakeholders and other state entities that have a role in the MHSA to obtain their input as to what the performance contracts should address. He also explained that once in place, the performance contracts will clearly delineate the roles and responsibilities of the counties in their local administration of the MHSA programs.

In addition to Mental Health's failure to use robust performance contracts, we are concerned because Health Care Services believes it does not have clear authority to ensure that counties comply with the terms of those performance contracts. Recent changes to state law have made the State's ability to withhold funds from counties that it deems out of compliance with those contracts difficult. Monitoring that reveals issues requiring correction typically triggers an enforcement process to ensure that corrective action is taken and the issues are resolved. Under state law, Mental Health possessed the authority to distribute funds from the Mental Health Services Fund (Fund) and to issue administrative sanctions against counties, including withholding funds if the county did not comply with state laws and regulations. Although Mental Health retained the authority to issue administrative sanctions against counties, legislation effective March 2011 made this particular enforcement process more difficult. The legislation gave the California State Controller's Office (State Controller's Office) the authority to distribute the money from the Fund. As a result, Mental Health's process to enforce MHSA requirements by withholding funds became less certain because it no longer administered the Fund. Health Care Services now faces the same challenge as it assumes MHSA oversight responsibilities. The director of Health Care Services believes that state law does not clearly define Health Care Services' authority to withhold MHSA funds from a county if it is noncompliant with its performance contract, state law, or regulations. Health Care Services

neither holds nor disburses funds for the MHSA to the counties; therefore, it cannot withhold MHSA funds and instead would likely have to coordinate, in terms of both authority and process, with the California Department of Finance, State Treasurer's Office, and/or the State Controller's Office. Although we believe that state law continues to give Health Care Services statutory authority to withhold funds from a noncompliant county, we agree that as a practical matter, its ability to exercise this authority with respect to a fund it no longer administers is unclear. Without a clear process—in this case the ability to withhold MHSA funds—the State has decreased ability to incentivize counties to quickly address and solve noncompliance that Health Care Services may identify through its monitoring activities.

Mental Health Failed to Perform Comprehensive On-Site Reviews of County MHSA Programs

On-site reviews are a powerful method of monitoring performance, but we found little evidence that Mental Health performed such reviews. On-site reviews would have allowed Mental Health to verify that counties had implemented MHSA programs effectively and appropriately, including meeting stated requirements. A former Mental Health manager stated that he was not aware of any on-site reviews conducted on the performance contracts. We noted one instance of Mental Health conducting a limited-scope desk review of a county and we found that Mental Health included a handful of questions in its triennial Medi-Cal reviews pertaining specifically to the MHSA. However, neither the desk audit nor the MHSA-related questions evaluated whether all counties had consistently followed MHSA requirements and spent taxpayer funds appropriately.

Reversion and Nonsupplant Requirements for County Mental Health Services Act Funding

Reversion requirement: State law specifies that any unspent Mental Health Services Act (MHSA) funds allocated to a county, other than those placed in a prudent reserve in accordance with the county's approved plan, must revert to the State within certain time frames and be made available for future distribution to other counties. Funds allocated for Community Services and Supports, Innovation, and Prevention and Early Intervention programs are subject to reversion after three years, whereas funds allocated for Capital Facilities and Technological Needs and Workforce Education and Training may be retained by the county for up to 10 years before reversion.

Nonsupplant requirement: State law requires counties to use MHSA funding to expand mental health services; these funds cannot be used to supplant existing state or county funds used by the county to provide mental health services.

Source: California Welfare and Institutions Code.

Mental Health appears to have relied on assertions or certifications as assurance that a county was complying with at least two of the MHSA requirements. Among other things, the MHSA requires unused funds to revert to the State for future distribution (reversion requirement) after specified periods of time and requires that funds be used to expand mental health services (nonsupplant requirement). The text box describes these requirements in more detail. To monitor the reversion requirement, Mental Health relied on each county to report on its annual Revenue and Expenditure Report and to certify the amount of unspent MHSA funds

that would revert to the State. Similarly, Mental Health's approach to monitoring the nonsupplant requirement generally consisted of having a county certify in a statement in its plans and annual updates that it had not used MHSA funds to supplant existing funding for mental health services. As a starting point, requiring assertions or certifications does inform the county of what is expected and provides Mental Health with some assurance that the county intends to comply with MHSA requirements. However, without performing on-site reviews to verify that the counties have in fact complied with the MHSA nonsupplant and reversion requirements, Mental Health's assurance was limited. Moreover, effective March 2011, the State is no longer responsible for approving county plans before the counties receive MHSA funding. Currently, county boards of supervisors are tasked with reviewing and approving these documents. Therefore, it is critical that Health Care Services take steps to monitor counties' use of MHSA funds to ensure that they are using the funds in accordance with applicable requirements and as the MHSA intended.

It is critical that Health Care Services take steps to monitor counties' use of MHSA funds to ensure that they are using the funds in accordance with applicable requirements and as the MHSA intended.

The director of Health Care Services indicated that it intends to initiate efforts to monitor the adequacy of county administration of MHSA programs. If consistently undertaken, these efforts may address some of the issues we noted about Mental Health's monitoring. However, as noted earlier, Health Care Services is in the early planning stages of these practices; thus, it is too early to tell whether its efforts will be effective. In addition, the director explained that Health Care Services has developed a preliminary list of specific county MHSA program and fiscal requirements that it will consider reviewing, which includes the nonsupplant requirement. Health Care Services' deputy director for Mental Health and Substance Use Disorder Services explained that Health Care Services intends to complete the program audit requirements before June 2013 so that the information may be included in the fiscal year 2013–14 protocol for its Medi-Cal Oversight Reviews, and the Audits and Investigations deputy director expects to complete the fiscal audit requirements by September 2013. However, the director noted that available staffing levels will dictate the breadth and depth of Health Care Services' review.

Mental Health Often Used Informal Guidance in Lieu of Regulations and Provided Little Guidance to Counties on How to Evaluate Program Performance

Although the MHSA expressly authorized Mental Health to promulgate regulations for implementation of its requirements and for a period of time gave Mental Health emergency rule-making authority, Mental Health did not fully exercise that authority. Mental Health did not issue regulations for three of the

five MHSA components—Prevention, Innovation, and Capital Facilities and Technological Needs (Facilities)—or for other statutory requirements. Instead, Mental Health published guidance letters it called *information notices*. However, to the extent some of the directives contained in these information notices were intended to be binding to the counties, these directives would not have been enforceable because they were not formally adopted as regulations. For example, state law requires counties to maintain a prudent reserve to ensure that service levels will continue if revenues for the Fund fall below recent averages. Mental Health issued an information notice "requiring" counties to establish a prudent reserve of 50 percent of their most recent allocation. Although at the time it had the authority to approve or reject county plans and annual updates based on, among other things, county establishment and maintenance of a prudent reserve, had Mental Health sought to separately enforce the 50 percent prudent reserve requirement, a court likely would have concluded that the requirement constituted an unenforceable underground regulation.

Until Health Care Services exercises all of the regulatory authority vested in it under state law by promulgating regulations to fully implement the MHSA, the State will have less ability to influence and enforce county administration of MHSA funds.

Until Health Care Services exercises all of the regulatory authority vested in it under state law by promulgating regulations to fully implement the MHSA, the State will have less ability to influence and enforce county administration of MHSA funds, particularly since the State no longer approves most elements of county plans. At the time that Mental Health issued its information notices, it played a role in approving county plans, giving the State an oversight mechanism to help ensure that counties appropriately implemented the MHSA. However, the State no longer has that same oversight mechanism, as only Innovation plans are now approved by the Accountability Commission, and each county's board of supervisors approves plans for the remaining components. According to the director of Health Care Services, it will first review and revise existing regulations that it has deemed invalid due to recent legislative changes. In August 2014 it plans to develop regulations, in consultation with the Accountability Commission, for the Prevention and Innovation components of the MHSA.[7] He stated that Health Care Services will continue to develop information notices as needed to provide guidance to counties on MHSA fiscal and reporting policies within its purview. He also explained that Health Care Services typically develops policies included in the information notices in consultation with the Accountability Commission and the County Mental Health Directors Association, and it considers stakeholder perspectives

[7] On June 27, 2013, state law was amended to require the Accountability Commission to adopt regulations for programs and expenditures related to the Prevention and Innovation components. In its response to our report on pages 128 and 129, Health Care Services acknowledged this recent change in law and assured us that it still intends to collaborate with the Accountability Commission beginning in July 2013 to review the current MHSA regulations and develop additional regulations.

in the development process. Nevertheless, as stated earlier, to the extent the directives in these information notices constitute rules of general application and are intended to be binding, they will not be enforceable unless they are properly adopted as regulations.

In addition, because one focus of the MHSA is to provide accountability to taxpayers and the public, we assumed that Mental Health would have taken steps to ensure that counties received the guidance necessary to effectively evaluate and report on the performance of their MHSA programs. However, we found scant evidence demonstrating that Mental Health had issued such guidance regarding the types of efforts counties should undertake to evaluate their MHSA programs. Mental Health issued an information notice in September 2007 directing counties to select one Prevention program for evaluation and sent another notice in January 2009 directing them to provide a final report that described, among other things, what was learned upon completion of an Innovation program. Neither of these notices provided explicit direction on how counties should evaluate their programs effectively, including how to set reasonable goals, establish specific objectives to attain those goals, identify and collect data relevant to the goals and objectives, and use those data to measure program performance. In the absence of such guidance, it is not surprising that we found inconsistent and, at times, inadequate approaches to performance assessment and reporting in the counties we reviewed. (We describe these issues in detail in Chapter 2.) Although the Accountability Commission has indicated that it will take steps to follow up on county efforts to carry out Mental Health's direction as previously described, without the responsible state entities providing guidance on how to evaluate program performance, the public will lack adequate assurance that MHSA programs are achieving their intended purposes.

Without state guidance on how counties should evaluate their programs effectively, we found inconsistent and, at times, inadequate approaches to performance assessment and reporting in the counties we reviewed.

The Responsible State Entities Have Not Undertaken Serious Efforts to Evaluate the Effectiveness of MHSA Programs That Counties Have Implemented

Although almost $7.4 billion in taxpayer funding was directed to mental health services and support for fiscal years 2006–07 through 2011–12, the Accountability Commission, Mental Health, and a third entity charged with evaluating MHSA programs have not provided adequate assurance to taxpayers and the public that these programs are effective. Recent efforts by the Accountability Commission have resulted in an evaluation plan, but the results remain to be seen as the implementation is not yet complete. Mental Health did not conduct a systematic evaluation of the effectiveness of MHSA programs, and although it did require counties to report extensive MHSA data, we have concerns with certain of these data, including

their completeness, which limits the value of evaluating the MHSA using these data. Beginning June 2012 Health Care Services largely assumed Mental Health's responsibilities to collect data and evaluate the efficacy of MHSA programs; however, its efforts to do so are in the early stages.

The MHSA has, since its inception, expressly required that funds allocated for state administration include amounts sufficient to ensure adequate research and evaluation of the effectiveness of services and achievement of the outcome measures related to Community Supports—specifically care for children, adults, and seniors—and Prevention programs. As of March 2009 the Accountability Commission has the authority to obtain data and other information from state and county entities to carry out its oversight and evaluation responsibilities. The third entity charged with evaluating MHSA program effectiveness is the California Mental Health Planning Council (Planning Council), which is tasked with annually reviewing the performance of mental health programs, including MHSA-funded programs, by using performance data and existing reports. Table 3 displays the MHSA expenditures each of these entities made to carry out their administrative duties, including any funds spent on evaluation activities for fiscal years 2011–12 and 2012–13.

Table 3
Expenditures of Mental Health Services Act Administrative Funds by the Three State Entities Required to Evaluate Mental Health Services Act-Funded Programs Fiscal Years 2011–12 Through 2012–13

	FISCAL YEAR	
STATE ENTITY	2011–12	2012–13*
Mental Health Services Oversight and Accountability Commission	$5,340,000	$6,925,000
California Department of Mental Health (Mental Health)†	12,210,000	9,841,000
California Mental Health Planning Council (Planning Council)	791,000‡	770,148

Sources: The Governor's Budget for fiscal year 2013–14 and information presented for the Planning Council based on documentation provided by the California Department of State Hospitals (State Hospitals) and the California Department of Health Care Services (Health Care Services) for fiscal years 2011–12 and 2012–13, respectively.

Note: The amounts displayed are representative of all Mental Health Services Act (MHSA)-related administrative expenditures for each entity, which includes any expenditures for evaluation efforts.

* The amounts presented for fiscal year 2012–13 are projected.

† Legislation effective June 27, 2012, transferred most of Mental Health's MHSA responsibilities to Health Care Services. Thus, the amount presented for fiscal year 2012–13 represents projected expenditures for Health Care Services. Further, because the Planning Council was a division within Mental Health until June 2012 and now resides as a division within Health Care Services, the amounts presented for Mental Health and Health Care Services include any expenditures made, or projected to be made, by the Planning Council.

‡ According to the Planning Council, due to its transition from Mental Health to Health Care Services, neither it nor State Hospitals could provide MHSA expenditure information for fiscal year 2011–12; thus, the amount presented is its budget for that year.

Despite Its Charge to Evaluate the MHSA, the Accountability Commission Has Been Slow to Establish a Necessary Framework

The Accountability Commission has been slow to develop a framework to evaluate MHSA programs. As a result, it cannot adequately demonstrate to taxpayers how implementing the MHSA has transformed county mental health systems. The Accountability Commission was established, in main part, to provide oversight. Therefore, we expected it to have created a framework for consistent evaluation. In 2008 and 2010, the Accountability Commission noted in policy papers the need for such evaluation. In fact, in the 2008 policy paper, the commission indicated that evaluation is critical for accurately depicting the extent to which counties have accomplished MHSA objectives, and it noted that large sums of taxpayer dollars have been earmarked for mental health transformation and accurate, non-biased results are required. However, it was not until late March 2013—more than eight years after the passage of the MHSA—that the Accountability Commission adopted an evaluation implementation plan[8] that sets out its evaluation activities for fiscal years 2013–14 through 2017–18. The specified evaluation activities include collecting, summarizing, and publicizing client-level outcomes from counties and refining the use of previously developed indicators—such as the number of arrests and average school attendance—that measure program performance.

Although the Accountability Commission's purpose in providing oversight has not changed since voter approval of the MHSA in 2004, it did not believe its responsibility to evaluate was made clear until 2009.

The Accountability Commission's executive director stated that the commission initially focused on a review of county plans for proposed MHSA programs, as evaluation efforts needed to wait for those programs to mature. In addition, the Accountability Commission did not believe its responsibility to evaluate was clear until the legislative changes made in 2009. However, the Accountability Commission's purpose in providing oversight has not changed since voter approval of the MHSA in 2004. Although it seems reasonable that programs need time to mature before they are evaluated, the Accountability Commission began entering into contracts related to evaluation in 2009 and we assume it had judged some MHSA programs mature enough for evaluation at that time. Further, the executive director noted that the implementation plan provides a framework for evaluating the MHSA as well as the broader community-based public mental health system. However, she acknowledged that the implementation of the framework has begun but it is not complete. We do not believe that developing an evaluation framework necessarily depends on those programs producing data. A framework is an approach to effectively and regularly review data that an entity collects. Ideally, an evaluation framework should be developed as programs are

[8] The Accountability Commission adopted the implementation plan to execute a master evaluation plan.

being implemented so program operators can collect and maintain information for use in evaluations. Even so, the Accountability Commission has had significant amounts of information about counties' programs and desired outcomes upon which to base its evaluations because it reviews the counties' plans.

The Accountability Commission's approach to funding its evaluation efforts also appears skewed. As shown in Table 4, since fiscal year 2009–10, its expenditures have grown significantly—reaching nearly $7 million in fiscal year 2012–13—yet, they are disproportionate to the amount the Accountability Commission reported spending on evaluation in the same year, almost $1.3 million. According to the executive director, the Accountability Commission began receiving funding earmarked for evaluation in fiscal year 2009–10 after requesting such funding. She explained that the commission funds evaluations either through such appropriations or by using funds remaining at fiscal year-end. However, given that one of the commission's primary purposes is to evaluate, we question whether it needs an additional specific appropriation for this purpose.

Table 4
Expenditures by the Mental Health Services Oversight and Accountability Commission and Amounts Dedicated to Evaluation
Fiscal Years 2005–06 Through 2012–13
(In Thousands)

FISCAL YEAR	EXPENDITURE	AMOUNT DEDICATED TO EVALUATION
2005–06	$707	$0
2006–07	1,480	0
2007–08	3,323	0
2008–09	4,089	0
2009–10	4,089	250
2010–11	4,538	1,894
2011–12	5,340	2,116
2012–13	6,925*	1,285
Totals	**$30,491**	**$5,545**

Sources: Governor's budgets for fiscal years 2012–13 and 2013–14, Budget Act amounts for authorized expenditures, and other information provided by the Mental Health Services Oversight and Accountability Commission (Accountability Commission), as well as the California State Auditor's review of Accountability Commission contract amounts related to Mental Health Services Act evaluation.

Note: According to the chief deputy of the Accountability Commission, before fiscal year 2011–12, the commission's budget preparation, management, and documents were handled by the California Department of Mental Health (Mental Health). The chief deputy explained that, in becoming independent, the Accountability Commission was unable to obtain or reconstruct expenditure information on prior-year budgets with any degree of reliability. He stated that the uncertainty is so great, the California Department of Finance accepts the Accountability Commission declaring its expenditure information before fiscal year 2010–11 as "not available;" nevertheless, the chief deputy provided Budget Act amounts for authorized expenditures and positions for fiscal years 2005–06 through 2009–10.

* The amount presented for fiscal year 2012–13 is projected.

We are even more concerned that in its implementation plan for fiscal year 2012–13, the Accountability Commission states that without an augmentation to its funding and staffing, it will only be able to complete roughly half of the evaluation activities called for in the plan. Such a statement is surprising for two reasons. First, legislation effective March 2011 removed from the Accountability Commission's duties the likely time-consuming review of county plans and approval of certain component plans, meaning that it could commit more of its existing resources to evaluation efforts. Second, as Table 4 indicates, the Accountability Commission's expenditures for fiscal year 2011–12 increased by more than $800,000 following the legislative reduction of its duties and it reported dedicating more than $220,000 to evaluation than in the previous fiscal year. The executive director informed us that the Accountability Commission intends to review all county plans although that is not explicit in state law, it will also approve counties' Innovation plans as state law requires. Nevertheless, evaluation of MHSA programs is a primary purpose of the Accountability Commission, and its belief that it needs additional specific funds to support its evaluation efforts causes us to question whether the commission is properly prioritizing its resources.

The Accountability Commission has contracted for certain evaluations related to the MHSA, but it has been slow to maximize use of the information from those evaluations. From July 2009 through June 2012, the Accountability Commission contracted for six studies;[9] as of May 2013, three were complete. The three contracted studies focused on disparities in access to care (access study), outcomes of Prevention programs (Prevention study), and Full-Service Partnership (Parternship) costs and the impact of the MHSA on client outcomes (Partnership study). The text box provides a summarized description of each contract.

Summary of the Mental Health Services Oversight and Accountability Commission's Completed Contracted Mental Health Services Act-Related Evaluations

Access study: The contractor was to analyze disparities in service access and delivery at the county level, including creation of detailed maps containing analyses of mental health services. The contractor was to work with three counties to implement procedures and methodologies to track mental health service delivery and utilization in order to reduce disparities in the delivery of services, improve access to care, and to deliver care in a more cost-effective manner. The contractor was to provide recommendations on how to develop a mental health tracking system in California. The Mental Health Services Oversight and Accountability Commission (Accountability Commission) stated that the final deliverable for this contract was provided in November 2011.

Prevention and Early Intervention (Prevention) study: The contractor was to review, summarize, and synthesize existing Prevention evaluations, reports, and studies with a particular focus on the impact of the component on respective outcomes. The contractor was also to determine Prevention program data elements that counties and their providers are tracking, and report on counties' intended outcomes and outcome measures based on the contractor's analysis of the Prevention plans. Study was final as of August 2011.

Full-Service Partnership study: The contractor was to determine the statewide and county-specific per person annual cost average, by specified age group, of Full-Service Partnership services; the impact specific Community Services and Supports programs have had on selected client outcomes; the impact of the Mental Health Services Act on client outcomes, using the input from clients, their families, and personal caregivers; and identify recommended data elements that are needed for comprehensive evaluation but that are not available in the data sets currently in use by the California Department of Mental Health or the counties. Study was final as of April 2013.

Sources: California State Auditor's review of the scope of work for the three Accountability Commission contracts.

[9] Mental Health entered into a contract in July 2009, but because the deliverable from that contract was due to the Accountability Commission, we consider it an Accountability Commission contract.

The Accountability Commission has had an Evaluation Committee since 2008, and since 2010, this committee has been charged with ensuring that information from evaluative efforts and reports is used and usable for continuous improvement relating to the MHSA. Given this responsibility, we expected that the Accountability Commission would have used the evaluation study findings to improve the MHSA. The final Partnership study was submitted in April 2013, and according to the Accountability Commission's chief legal counsel, because the report was only recently finished (May 2013), neither the Evaluation Committee nor the Accountability Commission has reviewed the report. We also found that the Evaluation Committee did not specifically review all the deliverables of either the access study or the final report for the Prevention study, based on interviews with the chief legal counsel and a review of Evaluation Committee agendas and minutes. Both of those studies have been final for more than 18 months.

The Evaluation Committee did not specifically review all the deliverables of either the access study or the final report for the Prevention study, yet both of those studies have been final for more than 18 months.

The chief legal counsel stated that until 2013, the focus of the Evaluation Committee has been prioritizing and recommending new evaluations to undertake, not reviewing or analyzing completed evaluations. We question this approach, however, because focusing on new evaluations de-emphasizes the Evaluation Committee's charge to ensure that information from completed evaluations is used and usable for continuous improvement to MHSA programs. Additionally, in a report dated March 2013, a contractor noted that the Accountability Commission needs to devote more attention to using evaluation information. According to the executive director of the Accountability Commission, the access study led the Accountability Commission to incorporate the use of several surveys, including a mental health survey administered by the University of California, Los Angeles, in its implementation plan. She also stated that the Prevention study's findings helped to guide and inform the scope of work for the larger-scale statewide Prevention evaluation that the Accountability Commission contracted for in June 2012. However, since the access study was completed in November 2011 and the Accountability Commission has not yet completed the steps outlined in the implementation plan, its actions do not adequately demonstrate a timely or effective use of the evaluation study findings. Furthermore, the Accountability Commission's use of the Prevention study's findings to help inform the scope of work for another evaluation contract does not indicate that the findings have been fully used to continuously improve the MHSA.

There Is No Indication That Mental Health Conducted Systematic MHSA Evaluations

Given its responsibilities and funding, we expected that Mental Health would have conducted regular evaluations of statewide performance of MHSA programs. However, beyond collecting

large amounts of data (see next section), we found no evidence that Mental Health conducted systematic evaluations. We did identify an evaluation that Mental Health had jointly funded with the California Health Care Foundation, of certain Community Supports programs, specifically Full-Service Partnership programs, through 2008 and 2009, but this type of review does not constitute a systematic evaluation.

The 2012 legislation that transferred most of Mental Health's remaining responsibilities to Health Care Services added requirements that Health Care Services and the Accountability Commission, in conjunction with other stakeholder groups, create a comprehensive plan for the coordinated evaluation of client outcomes. According to a branch chief within the Mental Health Services Division, beyond creating this required plan and working collaboratively with the Accountability Commission by providing data and information as necessary to support its current evaluation efforts, Health Care Services has no intention of conducting a separate statewide evaluation of MHSA programs. Further, the branch chief indicated that the master evaluation plan the Accountability Commission developed satisfies this requirement for a comprehensive joint plan. Nevertheless, until the master evaluation and implementation plans address the concerns we raise in this chapter, we believe efforts to evaluate the effectiveness of MHSA programs will fall short.

Until the Accountability Commission's master evaluation and implementation plans address the concerns we raise in this chapter, we believe efforts to evaluate the effectiveness of MHSA programs will fall short.

Mental Health Required Counties to Report Extensive MHSA Data, but the Data Are Incomplete and of Limited Value in Measuring MHSA Program Effectiveness

From December 2006 until its recent reorganization, Mental Health required counties to submit information related to the provision of mental health services and the clients receiving those services. However, in nearly all cases, Mental Health either failed to consistently obtain certain data or did not ensure that all counties reported required data. Mental Health's inaction likely hindered any meaningful evaluation of the data to identify the effectiveness of certain aspects of the MHSA. Table 5 on the following page details the type of data counties are required to submit, both during Mental Health's administration of the MHSA and currently; the frequency of counties' submission of the required data; and any concerns we noted in our review of the type and completeness of the data collected.

Table 5
Reporting Instruments and Data That Counties Are Required to Submit and Identified Concerns

REPORTING INSTRUMENTS AND DATA	SUMMARY OF INFORMATION CAPTURED	FREQUENCY	SUMMARY OF IDENTIFIED CONCERNS
Client and Service Information data	Includes client demographics, such as age and ethnicity, diagnosis, and description of services provided for all mental health clients. These data are captured in the Client and Service Information System.	No later than 60 days after the end of the month in which the services were provided.	Based on available information as of March 2013 provided by the California Department of Health Care Services (Health Care Services), the data are incomplete as not all counties have reported as required.
Consumer Perception Semi-Annual Survey	Includes clients and/or families' perceptions of quality and results of services provided.	Semiannually, 90 days after collection.	Based on available documentation, the survey was not consistently administered and the data are, therefore, incomplete and anecdotal.
Full-Service Partnership data	For clients that have a Full-Service Partnership (Partnership) agreement with the county, data collected includes residential status, employment status, financial support services, health status, substance abuse issues, and emergency interventions. This information is captured in the Full-Service Partnership Data Collection and Reporting System.	At the start of a Partnership agreement, quarterly, and when a key event occurs, such as loss of employment.	According to Health Care Services staff who formerly worked for the California Department of Mental Health (Mental Health), the data are incomplete as not all counties have reported as required.
Cost Report	As part of the annual cost and financial reporting, the county must submit information on revenue, distribution, and expenditures for Mental Health Services Act (MHSA) programs.	Annually.	According to documentation provided by Health Care Services, as of December 2012, 16 counties—including Los Angeles—had not yet filed their cost reports for fiscal year 2010–11, which were due in October 2012. Thus, the data may be incomplete as not all counties have reported as required.
MHSA Revenue and Expenditure Report	Includes a report of MHSA administration expenditures, MHSA program expenditures, and MHSA funds received during the fiscal year.	Annually.	None noted.
Quarterly Progress Report	Includes a count of clients planned to be served and actually served.	No later than 60 days following the end of the reporting quarter.	• Tracks clients participating in Community Services and Supports, but not Prevention and Early Intervention and Innovation. • Data are incomplete as not all counties have reported as required.

Sources: MHSA, Proposition 63 of 2004, associated regulations, Mental Health information notices, information provided by Health Care Services, and the California State Auditor's analysis of reporting instruments and data captured.

Perhaps the most problematic aspect of the information Mental Health collected from the counties is the significant gaps in the data that we and former Mental Health staff identified. These gaps likely would limit the value of any evaluation Mental Health, or others, performed or may perform using those data. As shown in Table 5, counties submit data including client demographics, diagnosis, residential status, and employment status, which are entered into two systems formerly administered by Mental Health and currently administered by Health Care Services: the Full-Service Partnership Data Collection and Reporting System (partnership system) and the Client and Service Information System (client service system).

According to the fiscal branch chief, seven counties have never submitted the required Partnership data. According to a research analyst formerly with Mental Health and now with Health Care Services, who is responsible for the systems, the counties experienced data processing issues that Mental Health never resolved. He explained that Mental Health never monitored whether counties submitted the required data or verified the data's accuracy. The research analyst's statements call into question the completeness and usefulness of the data. Similarly, the quality of the data maintained in the client service system is also flawed. As of March 2013, based on documentation Health Care Services provided, 43 counties were late in submitting their data and four of these were more than a year late.

Health Care Services stated that seven counties have never submitted the required Partnership data—the counties experienced data processing issues that Mental Health never resolved.

Additionally, based on information and documentation Health Care Services provided, data collected by way of the progress reports and consumer perception surveys were incomplete. These reporting instruments are described in Table 5. For instance, the progress report captured only data pertaining to Community Supports programs—the first MHSA component to be implemented—and omitted the Prevention and Innovation components. Mental Health failed to update the progress report to capture data related to these two components' programs, which were rolled out after Community Supports. Finally, Mental Health cancelled one of the semiannual surveys in 2009 citing numerous factors and logistical barriers, and former Mental Health staff could not demonstrate that survey data from one of the two surveys required in both 2010 and 2011 were submitted. Based on our review of the guidance issued to the counties, Mental Health also cancelled one of the two required surveys in 2012, citing similar reasons for doing so. Furthermore, these surveys are based on anecdotal information, not on data that could be measured or trended to evaluate program success. Lacking meaningful and complete data, the State is hindered in its ability to report on the success of MHSA programs and to assure taxpayers that their funds are not being wasted.

The director of Health Care Services stated that information technology (IT) staff are currently dedicated specifically to addressing technical issues with the partnership and client services systems, including problems with uploading data, error code translation, and other issues. In addition, Health Care Services has temporarily redirected an IT staff person to actively work with program staff and counties to resolve all known system issues. The director reported that Health Care Services will be working with the Accountability Commission over the next year to improve the system by addressing statewide system issues and data quality.

The Planning Council Has Not Fulfilled Its MHSA Responsibility

Finally, state law requires a third entity—the Planning Council—to annually "review the performance of mental health programs based on performance outcome data and other reports," and state law makes it clear that MHSA programs must be included. (The text box describes the Planning Council.) However, despite receiving MHSA funding to perform evaluations, the Planning Council has yet to fulfill its MHSA responsibilities. For its fiscal year 2011–12 operations—as depicted in Table 3 on page 30—the Planning Council reported a budget of $791,000, and MHSA funds made up roughly 60 percent of that. When asked how the Planning Council fulfilled its MHSA requirement, the executive officer pointed us to a report titled *California Mental Health Planning Council Accomplishments, 2008–2010* (accomplishments report). For the section applicable to the MHSA, the accomplishments report cites a Mental Health Board Workbook Project (workbook) and describes the workbook as a tool to facilitate uniform reporting to the Planning Council by local mental health boards on their analyses of their local performance data. However, the accomplishments report did not indicate whether any data collection or evaluations occurred.

California Mental Health Planning Council

The California Mental Health Planning Council (Planning Council) comprises 40 members whose purpose is to advocate for individuals with serious mental illness, to provide oversight and accountability for the public mental health system, to advise the governor and the Legislature on priority issues, and to participate in statewide planning. At the end of June 2012, state law transferred responsibilities relating to the Planning Council from the California Department of Mental Health to the California Department of Health Care Services (Health Care Services). The Planning Council, according to the Health Care Services Web site, holds quarterly meetings in different sections of California to allow maximum participation. Membership must include eight representatives from various state departments and appointees from various mental health constituency organizations. State law requires at least one-half of the members to be persons with mental disabilities, family members of persons with mental disabilities, and representatives of organizations advocating on behalf of persons with mental disabilities.

Sources: California Welfare and Institutions Code, meeting minutes provided by the Planning Council, and Health Care Services' Web site.

The Planning Council's executive officer attributed the workbook to her predecessor, stating that there are no associated records of what was done with the workbook or any county submissions based on the workbook, but that the Planning Council was in the process of designing a new workbook in consultation with county mental health boards. She also provided a draft revision of the accomplishments report extending through fiscal year 2012–13. However, the draft accomplishments report did not include actions satisfying the Planning Council's responsibilities related to the MHSA. Members of the Planning Council stated that the Planning Council reviewed the performance of certain MHSA programs by receiving information counties submitted and through presentations and other materials. However, because it did not document the results of its review of this information, we question whether the Planning Council met its statutory responsibility in this area. The executive officer stated that the Planning Council does not have resources to perform raw data analysis and until very recently there were almost no reports on MHSA programs, creating a lack of material with which to work. Reviewing the performance

of MHSA programs is critical to determining whether the MHSA is fulfilling its stated intents and purposes, yet the Planning Council, like the other entities charged with evaluating these programs, is not fulfilling its responsibility.

Counties' MHSA Funding Allocations May Not Be Appropriate

Another area of concern is the methodology used to determine the factors governing the MHSA funding to allocate to counties. A lack of substantive updates to the factors calls into question the propriety of the methodology. Mental Health was tasked with creating a method to divide among the counties annual tax revenues remitted to the Fund. Available documentation shows that Mental Health's methodology identified several factors and weighted them to derive each county's share (see text box). Mental Health outlined that methodology in a document issued to counties in June 2005. According to a Health Care Services memorandum, Mental Health last applied the methodology in fiscal year 2009–10. In subsequent years through fiscal year 2012–13, allocations were based on the ratio of the county's allocation to the total allocation for all counties for fiscal year 2009–10. However, it appears Mental Health has not updated the factors since 2008 and therefore has not accounted for counties' prevalence of mental illnesses, poverty rates, or populations. Thus, a county with a sharp rise in the prevalence of mental illnesses may still receive the same proportion of MHSA funds that it did for fiscal year 2009–10. Of further concern, based on available documentation, Mental Health developed its methodology in 2005, at the time that it implemented the Community Supports component, and does not appear to have altered that methodology when it implemented the remaining four components. Consequently, to the extent that changes such as in county population or the introduction of new MHSA components warrants modification of the allocation formula, MHSA allocations to counties may not be appropriate to meet changing county needs.

Summary of Factors the California Department of Mental Health Included in the Mental Health Services Act Allocation Methodology

State law required the California Department of Mental Health (Mental Health) to divide the available amount of Mental Health Services Act funds among the counties for any particular year and to give greater weight to significantly underserved counties or populations. Mental Health developed a formula, including the following weighted factors:

1. The need for mental health services in each county based on the following:
   a. The county's total population.
   b. Population most likely to apply for services, which represents the sum of:
      - The poverty population.
      - The uninsured population.
      - Population most likely to access services, which represents the prevalence of mental illness among different age groups and ethnic populations of poverty households.
2. Adjustments to the need for mental health services in each county based on the following:
   a. The cost of being self-sufficient.
   b. The available resources provided in fiscal year 2004–05, such as funding sources, including the State's General Fund managed care allocations.
3. An additional minimum planning estimate for each county, to provide small counties with a base level of funding.

Sources: Welfare and Institutions Code and Mental Health's Letter No. 05-02, issued June 1, 2005.

During the course of our audit, we made repeated requests of Health Care Services for documents and information regarding the allocation methodology, but its officials did not comply with our requests. At our audit closing conference in mid-June 2013,

Health Care Services officials in attendance again indicated that there was no such documentation. However, Health Care Services did provide a copy of a letter sent to the California Department of Finance dated June 2012 outlining how the factors comprising the methodology were weighted and applied to compute the counties' MHSA allocations for fiscal years 2009–10 through 2012–13.

Although the director has stated that Health Care Services will revise its methodology, currently no changes are planned until MHSA funding exceeds peak levels, i.e., the highest amount of taxes remitted to the fund in a single year, which occurred in fiscal year 2009–10, to ensure that adjustments to the methodology that might lower the amount a particular county receives will not result in a county being unable to fund existing MHSA obligations. The director stated that Health Care Services intends to review the existing factors to determine how updating them would affect MHSA allocations. Because responsibility for developing an allocation methodology now resides with Health Care Services, we believe it is imperative that it either update Mental Health's allocation methodology as necessary or create a new allocation methodology altogether to ensure that counties' MHSA allocations are appropriate and reasonable. Until Health Care Services can fully support the reasonableness of the allocation methodology, questions will remain as to whether the counties' allocations are commensurate with their need for mental health services.

Recommendations

Legislature

To ensure that Health Care Services can withhold MHSA funds from counties that fail to comply with MHSA requirements, the Legislature should enact legislation that clarifies Health Care Services' statutory authority to direct the State Controller's Office to withhold such funds from a noncompliant county.

Health Care Services

To ensure that it monitors counties to the fullest extent as the MHSA specifies and that it implements best practices, Health Care Services should do the following:

- Draft and enter into a performance contract with each county that contains sufficient assurances for effective oversight and furthers the intent of the MHSA, including demonstration that each of the county's MHSA programs are meeting the MHSA's intent.

- Conduct comprehensive on-site reviews of county MHSA programs, including verifying county compliance with MHSA requirements.

To ensure that counties have the needed guidance to implement and evaluate their MHSA programs, Health Care Services should do the following:

- Coordinate with the Accountability Commission and issue guidance or regulations, as appropriate, for Facilities programs and for other MHSA requirements, such as a prudent reserve.
- Commence this regulatory process no later than January 2014.
- Collaborate with the Accountability Commission to develop and issue guidance or regulations, as appropriate, to counties on how to effectively evaluate and report on the performance of their MHSA programs.

To ensure that Health Care Services and other state entities can evaluate MHSA programs and assist the Accountability Commission in its efforts, Health Care Services should do the following:

- Collect complete and relevant MHSA data from the counties.
- Resolve all known technical issues with the partnership and client services systems and provide adequate and expert resources to manage the systems going forward.

Health Care Services should, as soon as is feasible, revise or create a reasonable and justifiable allocation methodology to ensure that counties are appropriately funded based on their identified needs for mental health services. Health Care Services should ensure that it reviews the methodology regularly and updates it as necessary so that the factors and their weighting are appropriate.

Accountability Commission

To ensure that counties have needed guidance to implement and evaluate MHSA programs, the Accountability Commission should do the following:

- Issue regulations, as appropriate, for Prevention and Innovation programs.
- Commence the regulatory process no later than January 2014.

To fulfill its charge to evaluate MHSA programs, the Accountability Commission should undertake the evaluations specified in its implementation plan.

To ensure that it can fulfill its evaluation responsibilities, the Accountability Commission should examine its prioritization of resources as it pertains to performing all necessary evaluations.

To report on the progress of MHSA programs and support continuous improvement, the Accountability Commission should fully use the results of its evaluations to demonstrate to taxpayers and counties the successes and challenges of these programs.

Planning Council

The Planning Council should do the following:

- Take steps to ensure that it annually reviews the overall effectiveness of MHSA programs in accordance with state law.
- Document and make public the reviews that it performs of MHSA programs to demonstrate that it is performing all required reviews.

Chapter 2

COUNTIES SHOULD IMPROVE MENTAL HEALTH SERVICES ACT PERFORMANCE MEASUREMENT AND DOCUMENTATION OF STAKEHOLDER PLANNING EFFORTS

Chapter Summary

The four county departments we reviewed—Los Angeles County Department of Mental Health (Los Angeles), County of Sacramento Department of Health and Human Services (Sacramento), County of San Bernardino Department of Behavioral Health Administration (San Bernardino), and Santa Clara County Mental Health Department (Santa Clara)—differed in their approaches to assessing and reporting on their Mental Health Services Act (MHSA) programs. We noted that the counties varied in establishing meaningful goals for these programs and in implementing reasonable practices to evaluate their attainment of those goals.[10] For example, some counties did not consistently include program goals from their initial plans in their contracts with program providers. As a result, some counties could not demonstrate that they had communicated with providers the importance of pursuing and tracking performance in meeting goals. Counties also varied in collecting and analyzing data to determine the achievement of program goals and in how completely they reported program outcomes. In the absence of explicit evaluation requirements and specific state guidance as discussed in Chapter 1, these differences are not surprising.

All counties we reviewed complied with state regulations requiring the inclusion of specific stakeholders and community representatives throughout the MHSA planning process. However, we found instances in which counties did not comply with regulations requiring them to document or describe certain aspects of the public review process so they were unable to assure stakeholders or the public that their MHSA programs were prepared based on the broadest possible input from the communities and people those programs are intended to serve. Finally, we found that counties have generally taken steps to ensure that the payments they made to external contractors were for appropriate MHSA services.

Counties Develop Plans That Summarize MHSA Programs

The MHSA requires each county to lay out in a written plan the programs it will offer to address the mental health needs of its community. Figure 6 on page 45 illustrates the plan development

[10] County plans sometimes refer to goals as "outcomes," but we reserve the term *outcomes* for what programs have actually accomplished.

and approval cycle in effect from January 2005 through March 2011.[11] The figure shows that the process was iterative: once plans were approved, counties were to provide annual updates on those plans.

Mental Health Services Act Component Rollout Dates

2005: Community Services and Supports

2007: Workforce Education and Training

2007: Prevention and Early Intervention

2008: Capital Facilities and Technological Needs

2009: Innovation

Sources: California Department of Mental Health information notices dated August 2005, July 2007, September 2007, March 2008, and January 2009.

The counties generally developed their plans for each of the five MHSA components over time: Community Services and Supports (Community Supports), Workforce Education and Training (Training), Prevention and Early Intervention (Prevention), Capital Facilities and Technological Needs (Facilities), and Innovation. In a staggered rollout process from 2005 through 2009, Mental Health issued guidelines to the counties for each MHSA component (see text box).

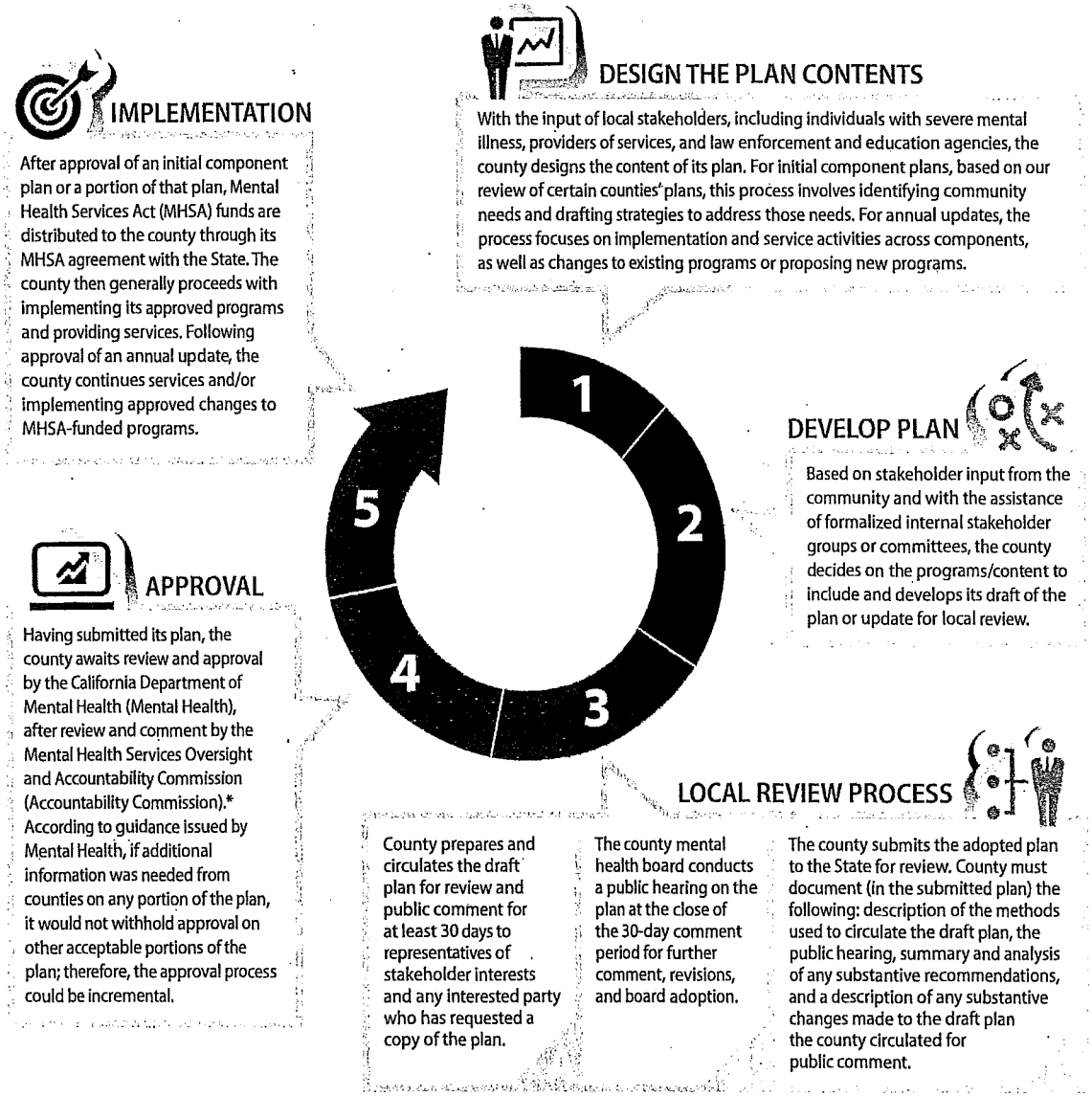
The counties' plans contain program descriptions and typically list program goals. For example, a program goal might be to reduce isolation in seniors or to assist homeless adults diagnosed with mental illness in accessing services. A county can generally include as many programs as it deems necessary, although realistically it can only fund so many programs with its annual MHSA allocation. Appendix B demonstrates the breadth and depth of the programs of the four reviewed counties. For example, Los Angeles' plans list 68 programs across the five MHSA components. Because program goals are generally included in the draft plan, stakeholders and county officials can review the goals as part of the local planning process. To understand whether a program is meeting its stated goals, a county should identify the data needed to make that determination. For example, to understand whether the county's senior population has reduced feelings of isolation as a result of its program, the county may develop and administer a survey of its program participants. However, the data to measure goals have generally not been stated in these plans. We found that counties often contract with service providers to deliver the programs outlined in their plans, and those contracts should specify providers' responsibilities in collecting data for county evaluation of their programs, but again they have not always done so.

Opportunity Exists for the Four Counties We Reviewed to Improve Their Performance Measurement Processes

The clear intent of the MHSA is to ensure that services are provided in accordance with best practices in programs that are subject to local and state oversight so as to ensure accountability to taxpayers and the public. However, we found little evidence demonstrating that Mental Health

[11] Effective March 2011 part of the process depicted in Figure 6 changed. Mental Health no longer reviewed and approved county plans, that role was transferred to each county's board of supervisors, except for Innovation programs, which are reviewed and approved by the Mental Health Services Oversight and Accountability Commission.

Figure 6
Summary of the Mental Health Services Act Annual Planning, Review, Approval, and Implementation Process Fiscal Year 2006–07 Through March 2011



Sources: California Welfare and Institutions Code and associated regulations, county MHSA plans and annual updates, and county provider contracts.

* Effective March 2011 Mental Health's review role ceased. Subsequent legislation requires counties' boards of supervisors to approve county plans. The Accountability Commission must review and approve Innovation programs.

had issued guidance to counties regarding the specific steps they should take to evaluate the performance of their MHSA programs, and our review of the four counties' evaluation efforts revealed differing and inconsistent approaches to assessing and reporting on that performance, potentially hindering statewide efforts to

It is imperative for counties to use performance data as they make decisions about which programs to approve.

evaluate the effectiveness of MHSA programs. Further, effective March 2011, the State is no longer statutorily required to review and approve county plans, with the exception of those relating to Innovation. Currently, county boards of supervisors are tasked with reviewing and approving these documents. Thus, moving forward, it will become imperative for counties to use performance data as they make decisions about which programs to approve.

Effective measurement of program performance depends on setting program goals, communicating them to program providers, and effectively collecting, measuring, and analyzing meaningful data. We evaluated the reviewed counties' approaches to measuring their MHSA programs' performance in four ways. First, we established whether they defined program goals in their MHSA plans, thereby establishing objectives by which they could measure performance. Because counties commonly contracted with providers to deliver mental health services, we next determined whether they included program goals in those contracts and made providers accountable for achieving them. Third, we assessed whether counties had identified meaningful data for measuring progress on achieving the program goals. Finally, we assessed whether counties collected and analyzed those data and reported the results.

To identify programs to review, we selected six to nine provider contracts, largely based on their total dollar amounts, from fiscal years 2006–07 through 2011–12 for each county we reviewed. For Los Angeles, San Bernardino, and Santa Clara, we selected three contracts each from the Community Supports, Prevention, and Innovation components for a total of nine contracts per county. For Sacramento, we selected three Community Supports and three Prevention contracts, for a total of six contracts; we did not select Innovation contracts because Sacramento stated it had no active Innovation services for the period under review.[12] The MHSA components for Training and Facilities are not designed to provide mental health services, so we did not include them.

By Not Consistently Including MHSA Plan Goals in Contracts With Their Providers, Counties Cannot Ensure That the Providers Are Aware of Those Goals or Are Held Accountable for Achieving Them

The counties we reviewed generally stated goals for their MHSA programs in their plans and annual updates. Because the plans are the county's official description of the manner in which its

[12] For fiscal year 2010–11, Sacramento included an Innovation program in its plan; the program is described in Appendix B. In fiscal years 2010–11 and 2011–12, Appendix D reflects that Sacramento made expenditures for Innovation. The fiscal year 2010–11 expenditures were for planning and the fiscal year 2011–12 expenditures were for a contracted entity that administered the Innovation program. However, as noted above, the county stated it was not providing Innovation services to mental health consumers in either fiscal year 2010–11 or 2011–12.

programs will fulfill the intent of the MHSA, it is important that the plans contain goals for each MHSA program the county designs. The plans of Los Angeles and Sacramento listed goals for each program we reviewed. For example, the description of a Los Angeles Community Supports program stated that the county embraces reducing incarceration in jails and juvenile halls as well as institutionalization. However, our review of plans from San Bernardino and Santa Clara found an instance in each plan in which the county did not clearly identify the goals for a program; thus, these counties have not made clear what those programs are intended to achieve, calling into question whether the programs will fulfill the intent of the MHSA. Moreover, although the counties' plans contained program goals, they rarely developed specific objectives that would allow them to assess the effectiveness of the program in achieving the stated goals.

We also found that three of the four counties failed to include the plan's goals in their contracts with program providers. Los Angeles effectively used its contracting process with program providers to communicate all program goals for which they were responsible. However, the other three counties did not.

- San Bernardino did not include all program goals in six of the nine provider contracts we reviewed. For example, the contract establishing the county's Coalition Against Sexual Exploitation program did not contain all the program goals identified in the county plan, such as increasing the understanding of the impact of sexual exploitation, the risk factors, and the means to develop rapport and initiate effective identification and collaborative intervention and treatment.

- Santa Clara included the services it planned to provide in the three contracts we reviewed for its Community Supports programs but did not include the actual program goals listed in its plan.

- Although Sacramento included goals in the six contracts we reviewed, the content of three of those contracts was not always consistent with the goals stated in the county plans. For a Community Supports program, the county plan stated a goal of using bilingual, culturally competent staff, with a minimum of 20 percent of those staff being mental health services clients, family members, and caregivers. However, the program provider's contract did not state this goal.

Without ensuring that the contracts include all the applicable programs' goals, counties cannot be certain that providers are aware of the programs' objectives, that they are achieving the programs' intent, or that providers can be held accountable for attaining the programs' goals.

Without Meaningful Data, Some Counties Are Hindered in Measuring Whether Their Programs' Goals Were Achieved

Counties and their contract providers often identified meaningful data and ways to measure goal achievement. However, the counties we reviewed varied in how effectively they identified such data. Some counties reported strong practices for using specific goals and identifying the needed data. Los Angeles and Sacramento both reported taking steps to identify the appropriate data to measure and to ensure that providers were aware of the need to collect those data. However, San Bernardino and Santa Clara typically used ad hoc approaches that were not always sufficient in identifying meaningful data. Because these counties cannot reasonably measure whether their MHSA programs accomplished their identified goals, they are less able to ensure that they are providing effective mental health services to their communities.

Generally, Los Angeles and Sacramento effectively identified meaningful data that would allow them to measure their programs' effectiveness. For its Full-Service Partnership (Partnership) programs, Los Angeles expanded upon existing data collection instruments that it required providers to use. These expanded data elements include detailed information about clients' living arrangements, such as whether clients and provider staff believe the change in the living arrangement was positive or negative. A Sacramento Prevention program that aims to reduce bullying in local schools identified improved student perceptions of school safety as a program goal. To capture data on that goal, the program used detailed pre- and post-survey instruments administered to students at school sites where the program was conducted.

More than half of the contracts we reviewed for San Bernardino and Santa Clara did not identify meaningful data for measuring their programs' effectiveness.

However, more than half of the contracts we reviewed for San Bernardino and Santa Clara did not identify meaningful data for measuring their programs' effectiveness. Eight of the nine contracts San Bernardino executed lacked requirements for collecting and providing information suitable for measuring goal achievement. Further, San Bernardino lacked a process to identify meaningful data to measure its progress in achieving goals. For example, the county gave the providers of all three Innovation programs we reviewed templates to summarize program performance, but the templates did not specify what data the providers should capture. One way in which the county could better ensure that it identifies meaningful data is to strengthen the inclusion of desired goals in its contracts; San Bernardino's chief of research and analytics indicated that the county was reviewing its Community Supports provider contracts for this purpose. In addition, the managers of its Prevention and Innovation programs indicated that the county was continuing to improve its evaluation efforts of those programs and that, beginning July 2013, it will be implementing some standard evaluation tools.

In five of the nine program provider contracts we reviewed, Santa Clara did not always identify the data to collect to determine goal achievement, and it did not have processes in place for its Community Supports and Prevention programs for that purpose. For example, in one Prevention program we reviewed, the county developed a program that includes making books available for young children in doctors' offices as a screening tool for identifying early indications of developmental delays and providing key linkages to certain county mental health services. However, based on the required reporting, the county could not determine whether the program met the goal of increasing early detection of developmental delays. The director of Santa Clara's family and children's services division indicated that as of April 2013 the county was in the contract renewal process and was reviewing all of its contracts and making modifications to ensure that the contracts include data and outcome requirements.

The counties also rarely developed specific, well-defined, and measurable objectives that would allow them to assess the effectiveness of program services. Without such specific objectives, counties are not able to demonstrate their programs' actual success. We assessed both plans and contracts prepared by each county to determine whether those documents contained specific measurable objectives. Although Sacramento's Community Supports plan included one such objective, all other plans we reviewed across all four counties did not. Of the 33 contracts we reviewed, only three Sacramento contracts and one Los Angeles contract contained specific objectives. A Sacramento Community Supports program contract to develop permanent housing units contained the specific objective that 80 percent of clients would obtain housing within 120 days of enrolling in the program. However, neither the Santa Clara nor San Bernardino contracts we reviewed contained specific objectives. Although one of San Bernardino's providers stated its progress in meeting objectives in an annual report, all the goals these objectives were derived from except one differed from those in the county's plan; however, in one instance the specific objectives the provider reported on did address a program goal listed in the county's plan.

Without specific, well-defined and measurable objectives, counties are not able to demonstrate their programs' actual success.

Setting specific objectives, assessing programs for meeting those objectives, and reporting on the results seems especially relevant to the Innovation component. Media reports reflect skepticism about counties' Innovation programs, some of which include acupuncture and yoga, perhaps because Innovation programs may include novel, creative, and/or ingenious approaches to a mental health practice and at times the link between the program and mental health is not obvious. Counties have been advised that Innovation programs are efforts to learn about promising approaches to treating and preventing mental illness and that the programs are similar to pilot or demonstration projects, are time limited, and should be assessed for effectiveness. Assessing and reporting on the effectiveness of

Innovation programs are critical to ensuring that only effective programs are continued and to assuring taxpayers and the public that MHSA funds are put to the best use.

Not All Counties Analyzed and Reported on Data, Hindering Their Ability to Assess and Communicate Whether They Were Meeting Program Goals

Quality data collection, analysis, and reporting processes related to program goals are central to effective performance measurement.

The quality of data collection, analysis, and reporting related to program goals differed among counties and across their MHSA components. Such processes are central to effective performance measurement because they allow counties to demonstrate their programs' effectiveness. When the processes are flawed or incomplete, the counties and their respective communities cannot measure the difference that MHSA programs are making in the lives of community members with mental health illnesses.

Los Angeles was generally effective in its collection and analysis of data related to program goals. For example, for its Community Supports programs, the county formulated reports using data that providers entered directly into an online database created by the county and referred to as the Outcomes Measures Application. It then shared these reports, including detailed data on living arrangements and mental health, with internal and external stakeholders. Los Angeles also provided analysis of its Community Supports and Prevention programs' outcomes in its fiscal year 2012–13 annual update. For example, the county reported on its Community Supports program goal of reduced incarceration by stating that it achieved a 26 percent decrease in the number of older adult clients who were incarcerated in fiscal year 2010–11, along with a 36 percent decrease in the number of days those clients were incarcerated. Nevertheless, Los Angeles, like the other counties reviewed, generally lacked specific targeted objectives that were well defined and measurable and that quantified what program success is. Therefore, even though its report of these decreases for two measures related to incarceration may indicate successful achievement, if its targeted objectives had been decreases of 50 percent and 75 percent, respectively, it would not indicate a successful attainment of the stated goal.

Although Sacramento consistently collected, analyzed, and often reported on data related to the three Community Supports programs we reviewed, it did not always do so for its Prevention programs. In two of the three Prevention programs we reviewed, the county failed to collect data that its contracts required providers to submit. For example, one Prevention contract required the provider to measure clients' awareness of suicide risk before and after participating in the program, but the county did not request the data in the report template it distributed to the provider. As a result, the provider never submitted the data to the county. The county's division of behavioral health's program planner confirmed the oversight and stated that the county is amending the template to collect the data in the future.

San Bernardino also often failed to collect meaningful data, which affected its ability to adequately analyze and report on program goals. Specifically, it did not collect data on goals identified for contracts we reviewed for its Innovation programs, for one of the contracts we reviewed for a Prevention program, and for some of the goals identified for each of the three contracts we reviewed for its Community Supports programs. This failure to collect data may be due to San Bernardino's insufficient identification of meaningful data, as described earlier.

Santa Clara also did not collect relevant data on some goals identified for its Prevention and Community Supports programs we reviewed, although it did appear to have processes in place to properly analyze and report on its Innovation programs. Specifically, Santa Clara did not collect sufficient data for three Community Supports and two Prevention program contracts, preventing it from sufficiently analyzing and reporting on any of these programs' accomplishments. In contrast, for the three Innovation program contracts we reviewed, Santa Clara did collect meaningful data on the goals and prepared reports on the performance. For its Innovation program, Adults with Autism and Co-occurring Mental Health Disorders, one goal is to understand the effectiveness of a new diagnosis tool; Santa Clara has an evaluation plan for the program that resulted in detailed monthly reports that noted a higher rate of diagnosing autism using the tool. In addition, for its Innovation programs and based on information provided by the county, it established learning advisory committees that are charged with refining project design, assessing progress, and evaluating results. Consequently, Santa Clara appears to have processes in place to analyze and report on the performance of its Innovation programs.

Counties Described Program Outcomes and Efforts to Use Data to Improve MHSA Services, but Our Review Suggests That These Outcomes and Efforts Are Incomplete

For the four counties we reviewed, the Joint Legislative Audit Committee (audit committee) asked us to identify key outcomes achieved, including those achieved for traditionally underserved and diverse communities, such as reductions in homelessness and psychiatric hospitalizations.[13] Further, the audit committee asked us to review and assess the extent to which each county uses outcomes to improve the local mental health systems. To address these objectives, we asked the four counties to respond with documentation to

[13] The audit committee asked us to identify key performance measures—as well as outcomes achieved—as part of its audit request. However, during the course of our field work and based on counties' responses to our inquiries, we learned that the terms *performance measures* and *outcomes* were generally used interchangeably. Thus, for the purposes of our report, we have chosen to use the term *outcomes* to describe what programs actually achieved with respect to their goals.

questions relating to data they view as key to evaluating their MHSA programs, any key outcomes achieved, and ways they have used those outcomes to improve services. Although the state entities charged with oversight and evaluation of MHSA programs have not provided specific performance measurement directions, counties' use of data to measure a program's achievement of goals and whether they produced specified outcomes would allow counties and the public to assess the success of MHSA programs. However, based on some of the counties' responses to our questions, we concluded that the counties' efforts to evaluate and improve their MHSA programs are incomplete.

Based on some of the counties' responses to our questions, we concluded that the counties' efforts to evaluate and improve their MHSA programs are incomplete.

The level of detail present in Los Angeles' response and our conclusions regarding its generally strong efforts to measure program performance document that county's efforts to use outcome data to improve services. The detailed Los Angeles report addressed data collection and outcomes across all of its MHSA components, and the director of the Los Angeles Department of Mental Health called out specific outcomes the county achieved, such as a 71 percent reduction in days spent homeless for adult Partnership clients. This outcome works toward satisfying the county's Partnership program goal that clients experience positive housing outcomes. According to the director, Los Angeles frequently uses performance measures and outcomes for improving MHSA programs and services. In one instance, the director explained a county review found that older adult Partnership clients with certain disorders were the most costly to treat; in response, the county is bringing in an expert on these specific disorders to train provider staff on best treatment practices. The review provided other specific past and planned efforts to use outcomes for program improvement, including efforts aimed at further improving practices for measuring outcomes.

Sacramento's response was less detailed than our review of its program performance measurement processes led us to expect. The former acting director of Sacramento County's Department of Health and Human Services provided limited data on outcomes achieved and was not specific in reporting on the ways the county used outcomes to improve programs. Among the outcomes she reported was a 58 percent decrease in mental health-related emergency room visits by Partnership clients. She also listed only one outcome for one of the county's Prevention programs and noted that the shortage of reportable outcomes data stemmed from both the nature of the programs and limited resources. However, she acknowledged that as resources become available in the future, measures and outcomes will be reported. In addition, the outcomes she did report were generally taken from documents focusing on fiscal years 2007–08 through 2009–10. Our review established that the county has no more recent Community Supports outcomes

of this kind. However, the former acting director stated that the county is developing additional reports on Partnership program outcomes for fiscal years 2010–11 and 2011–12. Finally, in contrast to the other three counties' responses, she reported that Sacramento only intermittently used performance outcomes and measures to improve the county's services. As an example, the county increased the capacity of its Partnership programs because of the positive outcomes in those programs. Although the former acting director acknowledged limitations on the county's collection of outcome data, we believe its ability in this area was likely also hampered by the county not always including goals in its program provider contracts or collecting all data the contracts specified—issues described previously.

San Bernardino's director of the Department of Behavioral Health Administration (Behavioral Health director) identified performance measures that the county states are key for evaluating MHSA programs or services and described the ways in which it used the performance measures and outcomes to improve its programs. As an example of the county's success, she pointed to an outcome from a Community Supports program that targeted older adults, stating that 82 percent of clients maintained or improved their mental health functions based on a tool the county used to assess overall psychological, social, and occupational functions for people 18 and older. She also identified a Community Supports program for which data showed a population of underserved juvenile justice clients whose demographics included bilingual clients, and clients with incidences of substance abuse and problems with truancy. As a result of these data, San Bernardino hired an additional bilingual staff member to provide services to bilingual clients, rolled out new services relating to substance abuse treatment, and expanded supportive services to assist youth with transportation to and from school, among other things.

The director of Santa Clara's Mental Health Department (Mental Health director) noted that 88 percent of individuals to whom the county provided care come from underserved and diverse populations as one example of its success in increasing access to care for these populations. The Mental Health director also indicated that the county began providing childcare resources as a result of data it collected indicating that parents were cancelling or not appearing at scheduled appointments; outcome data subsequently indicated a significant increase in parent participation. Although both San Bernardino's Behavioral Health director and Santa Clara's Mental Health director stated that their counties frequently made use of collected data to measure program performance and resulting outcomes to improve their programs, our review found issues with the performance measurement processes these counties used. Therefore, even though the counties reported specific program

outcomes and the use of those outcomes to improve their mental health delivery systems, our review shows that this level of reporting may not be representative of their MHSA programs.

Issues May Exist With County Collection and Reporting of Data That Affect Statewide Evaluation

In a July 2010 report, one of the Accountability Commission's contractors noted disparate evaluation efforts of MHSA activities and in two other reports published in May and December 2011, the same contractor noted limitations of the data.

As described in Chapter 1, evaluating the effectiveness of MHSA programs is a state-level responsibility, and the State's evaluation should reasonably be able to rely on the counties' data on program outcomes and goal achievement. However, the Accountability Commission has reported issues with county data collection and reporting. In a July 2010 report, one of its contractors noted disparate evaluation efforts of MHSA activities, pointing out that although nearly all counties the contractor had interviewed or surveyed were evaluating one or more MHSA components, each evaluation effort represented a unique method for understanding what was working and what was not. The report also pointed out that several universities and other research partners were engaged in independent research related to MHSA-funded activities. The report concluded that although each evaluation effort provides some benefit, it also increases the complexity of a statewide evaluation effort that seeks to build on existing efforts, avoid duplicative data collection requests, and ensure that data collection is consistent.

In two other reports published in May and December 2011, the same contractor noted limitations of the data. Generally, both reports reviewed, summarized, and synthesized existing evaluations. The May report focused on Community Supports programs and reported that fully understanding the impact of Community Supports on client outcomes—such as living situations or employment—across counties was hampered by inconsistent collection and reporting of data. Specifically, the May report indicated that counties did not always report client outcomes by age group or other important demographics, including ethnicity and gender; they did not reveal their data sources, such as self-reported or clinician rating; and they did not consistently report on the same measures for assessing client outcomes. The December report provided a summary and synthesis of existing evaluations and studies on the impact of MHSA on nine MHSA values—including client and family involvement and engagement, and integration of mental health services with substance abuse services and primary care—and the report found that sufficient information or evidence was not available to assess the impact that the MHSA has had on those nine values. The report attributed its findings, in part, to the tendency of counties to focus their evaluation efforts on client-level outcomes rather than a broader set of outcomes that include the family, program, and community. As a result, both the limited

quantity and quality of information hampered the contractor's ability to summarize and come to definitive conclusions about the impact of the MHSA on MHSA values across counties. These reports, as well as the July 2010 report, underscore the inconsistent quality of data or information collected and reported that we found in our review of four counties. Further, they suggest the need for broader, standardized collection and measurement practices, even as individual counties pursue the specific goals of their programs.

These reports suggest the need for broader, standardized collection and measurement practices, even as individual counties pursue the specific goals of their programs.

Counties Generally Complied With Regulations Governing the MHSA Planning Process, Including Stakeholder Involvement, but They Can Improve Some Documentation Practices

To determine whether the four counties complied with regulations governing stakeholder involvement in the MHSA planning process, we reviewed their processes for developing, reviewing, and submitting their plans and updates. We chose for review the counties' planning processes for the first MHSA component they rolled out—Community Supports—as well as the component they had most recently rolled out—Innovation—and we reviewed their most recent annual updates.

Counties complied with regulations that require including specific types of stakeholders and representatives throughout the planning process. The plans generally indicated they had used similar structures to govern the stakeholder process and that stakeholder work groups provided program ideas and concepts to central groups or committees that included the stakeholders and county representatives responsible for overseeing the planning process and development of the draft plan. For example, in its Community Supports plan, Sacramento used a steering committee, four task forces, and several work groups. The four task forces each formed stakeholder work groups to complete assessments of the priority needs of targeted populations and to suggest programs and strategies to meet those needs. Each task force also reviewed program components and prioritized recommendations before sending the recommendations to the steering committee, which oversaw the MHSA planning process and included clients and family members. Further, counties documented that they included the required stakeholders in the planning processes we reviewed. The membership of both stakeholder workgroups and central groups or committees generally included not only clients and their family members but also representatives from community advocacy groups, public service agencies, and organizations. For example, during its Innovation planning process, Los Angeles stakeholder delegates included representatives from client networks and coalitions, faith-based organizations, law enforcement and education agencies, and specific ethnic and cultural communities.

The counties we reviewed also implemented staffing and training practices consistent with community planning regulations. To support MHSA planning, the four counties designated positions responsible for overall administration of planning—typically an MHSA coordinator—and for engaging specific communities such as unserved and underserved populations. In addition, based on interviews with county staff and available examples of training-related materials, including attendance rosters, we found that all four counties offered training to staff and stakeholders.

We found that the county plans we reviewed reflected certain inconsistencies between the counties' documentation of their planning processes and the documentation requirements contained in the regulations.

However, we found that the county plans we reviewed reflected certain inconsistencies between the counties' documentation of their planning processes and the documentation requirements contained in the regulations. Since December 2006 regulations have required that a county's plans and annual updates must explain how the county complied with requirements related to the community planning process, including stakeholder participation. Figure 6 on page 45 describes the general process involved in a county's community planning process, including the local review process. All four counties we reviewed included a standardized form that attested to their compliance, but they did not describe how they complied. The requirement to describe stakeholder involvement in plan review is important because it helps ensure that a county's MHSA services were vetted by the community, including individuals the MHSA programs are meant to serve, and that the county was responsive to the community's feedback.

Those same December 2006 regulations require the county to document certain aspects of its local review process as part of its plans and annual updates. For example, the county must describe the methods it used to circulate its draft component plan or annual update for public comment, yet the counties we reviewed did not always submit a complete description of these methods with their component plan or update. The four counties' Innovation component plans stated only the dates during which the draft plan had been posted for public review and provided no further detail of how the counties circulated the drafts. This was also the case with Sacramento's fiscal year 2012–13 annual update. These descriptions seemed particularly incomplete since we noted detailed descriptions in other plans we reviewed, such as translating plan summaries into multiple languages, distributing draft plans to local libraries, and responding to phone and e-mail requests for copies of the drafts. Los Angeles, Sacramento, and Santa Clara responded to our questions by stating they undertook methods to circulate the plans that were not outlined in their plans. San Bernardino did not state that it had undertaken additional methods, but it acknowledged that the plan needed clarification to be fully in line with the requirement.

The reasons underlying the inconsistencies vary. Between fiscal years 2005–06 and 2010–11, Mental Health issued guidelines to counties for preparing component plans and annual updates. These guidelines, however, did not always fully align with the regulations pertaining to the planning process. Specifically, Mental Health's Community Supports component plan guidelines—issued in August 2005 and before these regulations were in effect—explicitly required counties to provide information or documentation of the local review process, such as how the county circulated the draft plan for public review. However, Mental Health's Innovation component plan guidelines do not mention this requirement. Similarly, Mental Health omitted a requirement related to obtaining stakeholder input from the standardized form counties use to certify their compliance with requirements. As a result, the form did not specifically ask counties to explain how they complied with the given regulation. Despite the inadequate guidance from Mental Health in these instances, counties were still required to comply with the applicable regulations.

Despite the inadequate guidance from Mental Health, counties were still required to comply with the applicable regulations.

The four counties we reviewed generally maintained that although they are confident their planning processes are complete, they could have done more to document these processes in their plans and thus comply with the regulations. Santa Clara's MHSA coordinator confirmed that the county's plans did not include the specific language that regulations required but stated that the county followed the guidance from Mental Health. The deputy director of San Bernardino's program support services stated that although the county maintains that it met the requirements of the process and that its MHSA plans document that process, the language in the plan should have been clearer to fully align with regulations. Similarly, Sacramento's MHSA program manager indicated that although their plans lacked the explicit content that regulations require, the county strives to circulate its plans, documents the feedback it receives, and complies with other planning requirements. The MHSA program manager also stated that the county plans to review the draft content of its fiscal year 2013–14 annual update to ensure that the final version includes specifics on how the county met these requirements. The deputy director of Los Angeles' program support bureau stated that the standardized form Los Angeles used to assert compliance with certain planning requirements for its fiscal year 2012–13 annual update—which makes the same statements about compliance as the form Mental Health required counties to complete—was used by all counties and vetted by certain state entities involved in overseeing the MHSA. As evidence of Los Angeles' compliance with regulations, the deputy director also provided a flyer about the Innovation review process. However, Los Angeles did not describe the flyer, including how it was distributed to the public, in its submitted plan, and thus it does not fulfill the regulation's requirement. Although each

county expressed confidence that its planning process is strong, failure to comply with required documentation of the planning process means counties cannot always point to their official plans to assure their stakeholders or the public that their plans for MHSA programs are prepared with the broadest possible input.

Counties' Review of Provider Invoices and Contract Oversight Helps to Ensure That Payments to Providers Are for Contracted Services

The four counties have a common control in place that helps ensure payments to providers are for contracted programs.

Our review showed that the four counties have a common control in place that helps ensure that payments to providers are for programs that the county contracts for and that are specified in their plans. Counties often contract with providers to deliver mental health programs in lieu of using county-operated clinics. Based on interviews with county staff and our review of available documentation, we noted that each county has an invoice review and approval process in place for ensuring that providers' requests for payment are appropriate. For example, in Sacramento the fiscal services division receives a provider's monthly invoice and forwards it to program staff to review each expenditure and compare it to the provider's contract. If the expenditure aligns with the contract, staff approve the invoice for payment. For the Community Supports, Prevention, and Innovation components, we reviewed a total of 43 invoices selected from the four counties covering fiscal years 2006–07 through 2011–12, and we found that the respective county had reviewed and approved each invoice.

Contract oversight provides the counties with valuable insights about their providers' performance, including the types of services rendered and whether the programs reflect the county's plan. Based on interviews and our review of available documentation, the four counties appear to perform oversight activities that help ensure that providers are requesting payment only for those services they deliver in accordance with their contracts and the counties' plans. For example, three of the four counties we reviewed use contract monitors. Generally, these staff function as liaisons between the counties and the providers and perform site visits, among other responsibilities. All four counties also had quality assurance review programs in place. For example, Los Angeles has two levels of quality assurance reviews that, according to the compliance officer of the Compliance Program and Audit Services division, are scheduled to include all providers of mental health programs the county offers, including providers of MHSA programs. These quality assurance reviews typically include examining a provider's expenditures, client charts, services delivered, and the provider's internal controls to ensure compliance with the county's program requirements.

Generally, program provider contracts and program descriptions in the county plans supported county expenditures. However, we questioned two invoices Santa Clara paid. For the period covering May 2007 through June 2008, Santa Clara entered into a contract with a provider who offered transitional housing unit beds—i.e., sleeping arrangements—for clients on a daily basis; the services were part of Santa Clara's Community Supports plan. The invoice totaled over $7,600 but provided no support for the services the contractor claimed. The invoice listed the total number of beds the contractor claimed were occupied during the month multiplied by the daily rate charged per bed. Although the county's contract with the provider required the provider to maintain detailed records about services provided, including admissions lists, it did not specifically require detailed invoice support. Without support, such as an admissions list, to demonstrate the number of clients requiring beds on any given day, the county has little assurance that it is paying for MHSA services that were actually provided. In addition, we reviewed an invoice for over $58,000 from a program provider that was contracted to deliver early detection, prevention, and intervention services to adolescents and transition-age youth as part of Santa Clara's Prevention plan. However, the invoice included more than $19,000 for services that were not a part of the provider's contract. According to the director of the family and children's services division, the invoiced services were mistakenly left out of the provider's contract. In May 2013 the county executed a contract amendment allowing for the previously paid services. Although the contract has been corrected, the county modified it only because we brought the discrepancy to the county's attention, almost a year after the county paid its provider for services the provider was not authorized to supply.

Recommendations

California Department of Health Care Services

To improve the quality of county processes for measuring program performance, the California Department of Health Care Services (Health Care Services) should use its performance contracts with counties to ensure that they do the following:

- Specify MHSA program goals in their plans and annual updates and include those same goals in their contracts with program providers.

- Identify meaningful data to measure the achievement of all their goals, set specific objectives, and require their program providers to capture those data so they can use the data to verify and report the effectiveness of their MHSA programs.

Health Care Services should develop standardized data collection guidelines or regulations, as appropriate, that will address inconsistencies in the data that counties report to the State. In developing these guidelines or regulations, Health Care Services should consult with the Accountability Commission to ensure that data collected reasonably fulfill statewide evaluation purposes.

To help ensure county compliance with stakeholder regulations, Health Care Services should provide technical assistance to counties on the MHSA local planning review process and ensure that its guidance to counties is clear and consistent with state regulations.

Santa Clara

Santa Clara should do the following:

- Review its existing MHSA contracts and by December 31, 2013, or as soon as is feasible, amend them as necessary to include plan goals.
- Ensure that all MHSA invoices are adequately supported with information that demonstrates that MHSA services were provided.

Sacramento

Sacramento should review its existing MHSA contracts and by December 31, 2013, or as soon as is feasible, amend them as necessary to include plan goals.

San Bernardino

San Bernardino should review its existing MHSA contracts and by December 31, 2013, or as soon as is feasible, amend them as necessary to include plan goals.

We conducted this audit under the authority vested in the California State Auditor by Section 8543 et seq. of the California Government Code and according to generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives specified in the scope section of the report. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Respectfully submitted,

Elaine M. Howle

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Appendix A

Mental Health Services Act Funds by County and Component Fiscal Years 2006–07 Through 2011–12

The Joint Legislative Audit Committee directed the California State Auditor to determine the amount of Mental Health Services Act (MHSA) funds that the State allocated to the counties for each MHSA component for the past six fiscal years. Table A shows county allocation amounts from the California Department of Mental Health's (Mental Health) Web site for fiscal years 2006–07 through 2009–10 and California State Accounting and Reporting System (CALSTARS) expenditure data obtained from the California Department of State Hospitals (State Hospitals) for fiscal years 2010–11 and 2011–12. Effective June 27, 2012, the State streamlined and reorganized Mental Health, which became State Hospitals. The California Department of Health Care Services, State Hospitals, and the California Department of Social Services now perform duties that Mental Health once performed.

As Table A shows, the amount of funds allocated or spent varied widely among counties and fiscal years. Funding in fiscal year 2011–12 was the lowest in the past five fiscal years corresponding with the Legislature directing more than $850 million to other mental health programs. Because Mental Health implemented the five MHSA components over time, it did not allocate funds for each component in every fiscal year. We did not determine the accuracy or completeness of the amounts listed in the table.

Table A
Unaudited Mental Health Services Act Funds by County and by Component Fiscal Years 2006–07 Through 2011–12

COUNTY/ COMPONENT	FISCAL YEAR 2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	TOTAL
Alameda							
CSS	$11,145,798	$33,067,500	$22,863,600	$51,914,400	$56,956,441	$26,276,200	$182,223,939
PEI	–	9,301,000	10,366,400	13,902,800	15,557,864	7,081,300	51,209,364
INN	–	–	2,543,800	2,543,800	6,825,900	1,742,400	13,655,900
CAPTECH	–	12,327,100	3,873,200	–	16,200,300	–	32,400,600
WET	3,645,000	3,911,700	1,800,000	–	–	1,800,000	11,156,700
Totals	**$14,790,798**	**$53,607,300**	**$41,447,000**	**$48,361,000**	**$95,540,505**	**$36,899,900**	**$290,646,503**

CSS = Community Services and Supports
PEI = Prevention and Early Intervention
INN = Innovation
CAPTECH = Capital Facilities and Technological Needs
WET = Workforce Education and Training

continued on next page...

COUNTY/ COMPONENT	FISCAL YEAR 2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	TOTAL
Alpine							
CSS	$254,927	$358,300	$622,600	$872,600	$751,314	$718,400	$3,578,141
PEI	–	100,000	150,200	250,200	319,500	26,500	946,400
INN	–	–	62,000	62,000	232,600	44,500	401,100
CAPTECH	–	600,000	188,500	–	788,500	–	1,577,000
WET	225,000	225,000	–	–	450,000	–	900,000
Totals	**$479,927**	**$1,283,300**	**$1,023,300**	**$1,184,800**	**$2,541,914**	**$889,400**	**$7,402,641**
Amador							
CSS	$531,570	$1,355,900	$1,298,300	$1,648,300	$2,074,619	$1,357,100	$8,265,789
PEI	–	100,000	227,600*	327,600*	732,300*	99,700	1,587,200
INN	–	–	115,200	115,200	367,400	80,000	677,800
CAPTECH	–	600,000	188,500	–	788,500	–	1,577,000
WET	225,000	225,000	–	–	416,200	–	866,200
Totals	**$756,570**	**$2,280,900**	**$1,829,600**	**$2,091,100**	**$4,379,019**	**$1,636,800**	**$12,973,989**
Berkeley City†							
CSS	$896,084	$3,466,100	$1,893,500	$2,687,100	$4,131,965	$2,212,400	$15,287,149
PEI	–	370,300	897,600	1,207,700	1,605,605	614,500	4,695,705
INN	–	–	214,800	214,800	685,200	147,700	1,262,500
CAPTECH	–	1,089,700	342,400	–	1,432,100	–	2,864,200
WET	313,800	343,100	–	–	656,900	–	1,313,800
Totals	**$1,209,884**	**$5,269,200**	**$3,348,300**	**$4,109,600**	**$8,511,770**	**$2,974,600**	**$25,423,354**
Butte							
CSS	$1,999,624	$5,818,700	$3,984,300	$5,540,000	$4,649,400	$4,196,600	$26,188,624
PEI	–	639,300	1,545,000*	2,074,800*	1,883,600*	274,700	7,417,400
INN	–	–	418,100	418,100	1,326,200	285,000	2,447,400
CAPTECH	–	849,700	581,200	–	742,061	–	3,172,961
WET	541,800	587,100	–	–	–	–	1,128,900
Totals	**$2,541,424**	**$8,894,800**	**$6,528,600**	**$7,832,900**	**$8,601,261**	**$5,956,300**	**$40,355,285**
Calaveras							
CSS	$609,442	$1,614,800	$1,404,300	$1,754,300	$1,960,526	$1,444,400	$8,787,768
PEI	–	12,100	292,300*	409,300*	417,100*	247,200	1,481,000
INN	–	–	126,400	126,400	400,300	86,500	739,600
CAPTECH	–	600,000	188,500	–	408,500	–	1,197,000
WET	225,000	225,000	–	–	–	–	450,000
Totals	**$834,442**	**$2,560,900**	**$2,011,500**	**$2,284,000**	**$3,186,426**	**$1,778,100**	**$12,655,368**

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COUNTY/ COMPONENT	FISCAL YEAR 2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	TOTAL
Colusa							
CSS	$430,973	$1,008,200	$1,159,500	$1,509,800	$1,314,300	$1,242,900	$6,663,373
PEI	–	100,000	153,100*	258,100	225,500*	154,400*	886,100
INN	–	–	101,500	101,500	327,100	72,000	602,100
CAPTECH	–	600,000	188,500	–	325,559	–	1,114,059
WET	225,000	225,000	–	–	–	–	450,000
Totals	**$655,973**	**$1,931,200**	**$1,602,600**	**$1,864,100**	**$2,192,459**	**$1,469,300**	**$9,715,632**
Contra Costa							
CSS	$7,192,809	$20,989,700	$14,657,600	$20,347,800	$17,715,700	$16,752,600	$97,655,709
PEI	–	2,686,300	6,489,100*	8,712,300*	5,154,800	8,104,400*	31,146,900
INN	–	–	1,616,400	1,616,400	3,689,672	1,106,800*	8,029,272
CAPTECH	–	778,300	2,443,900	–	6,022,200	–	16,244,400
WET	2,276,500	2,461,500	–	–	–	–	4,738,000
Totals	**$9,469,309**	**$33,915,800**	**$25,207,000**	**$30,676,000**	**$32,582,372**	**$25,963,800**	**$157,814,281**
Del Norte							
CSS	$475,514	$1,187,400	$1,224,500	$1,574,500	$1,370,935	$1,296,400	$7,129,249
PEI	–	100,000	187,000	287,000	596,200	148,600*	1,318,800
INN	–	–	108,100	108,100	400,500	75,800	692,500
CAPTECH	–	400,000	188,500	–	788,500	–	1,577,000
WET	225,000	225,000	–	–	416,200	–	866,200
Totals	**$700,514**	**$2,112,400**	**$1,708,100**	**$1,969,600**	**$3,572,335**	**$1,520,800**	**$11,583,749**
El Dorado							
CSS	$1,437,533	$5,180,200	$2,853,700	$3,744,800	$4,476,340	$3,083,200	$20,775,773
PEI	–	1,177,000	1,036,700*	1,385,000*	2,636,699*	850,500*	6,240,669
INN	–	–	292,000	292,000	923,500	198,100	1,705,600
CAPTECH	–	1,235,800	388,300	–	1,624,100	–	3,248,200
WET	365,300	389,700	–	–	389,700	–	1,144,700
Totals	**$1,802,833**	**$7,137,470**	**$4,570,700**	**$5,421,800**	**$10,050,339**	**$4,131,800**	**$33,114,942**
Fresno							
CSS	$8,042,129	$22,462,500	$15,958,200	$22,217,000	$19,343,600	$18,292,000	$106,215,429
PEI	–	2,721,000	6,722,800*	9,168,400*	8,400,200*	5,649,900*	32,662,300
INN	–	–	1,739,800	1,739,800	5,552,100	1,198,500	10,230,200
CAPTECH	–	2,068,000	2,641,200	–	8,022,449	–	19,069,749
WET	2,306,000	2,679,800	–	–	–	–	4,985,800
Totals	**$10,348,129**	**$36,169,400**	**$27,062,000**	**$33,125,200**	**$41,318,349**	**$25,140,400**	**$173,163,478**

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COUNTY/ COMPONENT	FISCAL YEAR 2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	TOTAL
Glenn							
CSS	$486,119	$1,189,200	$1,234,500	$1,584,500	$1,379,600	$1,304,600	$7,178,519
PEI	–	100,000	188,500*	288,500*	261,900*	175,500*	1,014,400
INN	–	–	108,700	108,700	348,300	76,200	641,900
CAPTECH	–	600,000	188,500	–	–	–	788,500
WET	225,000	225,000	1,800,000	–	–	800,000	4,050,000
Totals	**$711,119**	**$2,114,200**	**$3,520,200**	**$1,981,700**	**$1,989,800**	**$3,356,300**	**$13,673,319**
Humboldt							
CSS	$1,294,231	$4,495,400	$2,553,400	$3,340,600	$2,908,500	$3,349,460	$17,941,591
PEI	–	370,200	892,700*	700,200*	1,087,600*	547,940*	3,598,640
INN	–	–	258,700	268,700	430,700	165,800	1,123,900
CAPTECH	–	1,068,100	335,600	–	–	–	1,403,700
WET	313,700	337,200	–	–	–	–	650,900
Totals	**$1,607,931**	**$6,180,900**	**$4,040,400**	**$4,799,500**	**$4,426,800**	**$3,663,200**	**$24,718,731**
Imperial							
CSS	$1,716,012	$5,475,500	$3,408,200	$4,576,900	$3,985,000	$3,768,400	$22,930,012
PEI	–	503,600	1,249,900*	706,600*	2,607,876*	1,052,500*	7,120,476
INN	–	–	353,200	393,200	1,123,400	749,200	2,072,000
CAPTECH	–	668,900	492,900	–	2,061,800	–	4,123,600
WET	426,800	503,000	–	–	929,800	–	1,859,600
Totals	**$2,142,812**	**$8,051,000**	**$5,504,200**	**$6,636,700**	**$10,707,876**	**$5,063,100**	**$38,105,688**
Inyo							
CSS	$373,705	$730,600	$783,600	$1,038,100	$1,380,500	$885,000	$5,153,005
PEI	–	100,000	152,100	152,100	153,700	128,400	786,300
INN	–	–	72,800	72,800	234,500	51,400	431,500
CAPTECH	–	600,000	188,500	–	788,500	–	1,577,000
WET	225,000	225,000	–	–	416,200	–	866,200
Totals	**$598,705**	**$1,655,600**	**$1,197,000**	**$1,358,500**	**$2,973,400**	**$1,030,800**	**$8,814,005**
Kern							
CSS	$7,048,579	$19,040,100	$13,868,500	$19,210,900	$16,726,300	$15,817,000	$91,711,379
PEI	–	2,333,700	5,764,300*	7,785,800*	14,982,431*	4,938,700*	35,770,931
INN	–	–	1,503,100	1,503,100	2,539,100	1,094,300	6,579,600
CAPTECH	–	7,165,600	2,251,400	–	6,006,056	–	15,423,056
WET	1,977,700	2,297,000	–	–	50	–	4,274,750
Totals	**$9,026,279**	**$30,836,400**	**$23,387,300**	**$28,565,800**	**$40,253,937**	**$21,690,000**	**$153,759,716**

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COUNTY/ COMPONENT	FISCAL YEAR 2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	TOTAL
Kings							
CSS	$1,511,485	[illegible]	$2,936,100	[illegible]	$7,763,463	[illegible]	$23,943,248
PEI		[illegible]	1,024,200	[illegible]	2,933,300	[illegible]	6,420,224
INN			298,300	[illegible]	945,900	[illegible]	1,746,000
CAPTECH		[illegible]	394,100		1,648,400		3,296,800
WET	353,600	[illegible]			403,000		1,159,000
Totals	**$1,865,085**	**$6,699,224**	**$4,652,700**	**$5,558,300**	**$13,694,063**	**$4,095,900**	**$36,565,272**
Lake							
CSS	$760,035	[illegible]	$1,615,300	[illegible]	$2,300,502	[illegible]	$10,457,537
PEI		[illegible]	427,300*	[illegible]	927,548*	[illegible]	2,456,048
INN			150,000	[illegible]	546,300	[illegible]	947,200
CAPTECH		[illegible]	188,500		613,500		1,402,000
WET	225,000	[illegible]			416,250		866,250
Totals	**$985,035**	**$3,165,800**	**$2,381,100**	**$2,706,900**	**$4,804,100**	**$2,086,100**	**$16,129,035**
Lassen							
CSS	$479,453	[illegible]	$1,228,100	[illegible]	$1,430,600	[illegible]	$7,203,053
PEI		[illegible]	186,000	[illegible]	148,400	[illegible]	868,400
INN			108,200	[illegible]	400,900	[illegible]	693,200
CAPTECH		[illegible]	188,500		788,500		1,577,000
WET	225,000	[illegible]			450,000		900,000
Totals	**$704,453**	**$2,112,500**	**$1,710,800**	**$1,972,300**	**$3,218,400**	**$1,523,200**	**$11,241,653**
Los Angeles							
CSS	$90,691,911	[illegible]	$180,588,300	[illegible]	$319,091,506	[illegible]	$1,315,824,717
PEI		[illegible]	82,273,100*	[illegible]	122,608,254*	[illegible]	417,396,654
INN			20,294,900	[illegible]	50,730,032	[illegible]	105,229,532
CAPTECH		[illegible]	33,479,200		88,232,464		219,764,703
WET	34,667,140	[illegible]	1,800,000		37,868,778	[illegible]	107,506,718
Totals	**$125,359,051**	**$423,645,939**	**$318,435,500**	**$386,017,900**	**$618,531,034**	**$293,732,900**	**$2,165,722,324**
Madera							
CSS	$1,514,515	[illegible]	$3,020,000	[illegible]	$3,515,500	[illegible]	$20,585,315
PEI		[illegible]	1,087,300*	[illegible]	1,411,400*	[illegible]	5,338,100
INN			311,100	[illegible]	522,300	[illegible]	1,357,700
CAPTECH		[illegible]	429,600		1,796,800		3,593,600
WET	371,900	[illegible]					807,600
Totals	**$1,886,415**	**$7,415,000**	**$4,848,000**	**$5,833,800**	**$7,246,000**	**$4,453,100**	**$31,682,315**

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Marin							
CSS	$1,727,527	$6,189,900	$3,711,600	$5,124,500	$5,067,750	$4,219,100	$26,040,377
PEI	–	632,800	1,543,200*	2,095,200*	1,906,100*	1,288,600	7,465,900
INN	–	–	402,000	402,000	1,481,800	276,100	2,561,900
CAPTECH	–	1,893,900	595,100	–	1,085,740	–	3,574,740
WET	536,300	596,900	–	–	130,200	–	1,263,400
Totals	**$2,263,827**	**$9,313,500**	**$6,251,900**	**$7,621,700**	**$9,671,590**	**$5,783,800**	**$40,906,317**
Mariposa							
CSS	$380,977	$748,200	$792,600	$1,042,600	$1,166,284	$858,500	$4,989,161
PEI	–	100,000	152,200	262,200	379,000	118,500	1,011,900
INN	–	–	73,400	73,400	236,400	51,800	435,000
CAPTECH	–	600,000	188,500	–	–	–	788,500
WET	225,000	225,000	–	–	–	–	450,000
Totals	**$605,977**	**$1,673,200**	**$1,206,700**	**$1,368,200**	**$1,781,684**	**$1,038,800**	**$7,674,561**
Mendocino							
CSS	$926,687	$3,137,200	$1,851,400	$2,361,000	$2,645,881	$1,943,800	$12,865,968
PEI	–	150,000	587,600*	786,700*	1,713,266*	482,900	3,720,466
INN	–	–	181,400	181,400	663,000	122,700	1,148,500
CAPTECH	–	704,500	221,400	–	925,900	–	1,851,800
WET	225,000	225,000	–	–	–	–	450,000
Totals	**$1,151,687**	**$4,216,700**	**$2,841,800**	**$3,329,100**	**$5,984,047**	**$2,549,400**	**$20,036,734**
Merced							
CSS	$2,534,123	$6,692,200	$4,971,600	$6,737,600	$3,833,833	$5,547,300	$30,316,656
PEI	–	769,500	1,902,600*	2,592,700*	2,377,400*	598,100	9,240,300
INN	–	–	522,700	522,700	1,663,400	358,600	3,067,400
CAPTECH	–	2,385,600	749,600	–	394,620	–	3,529,820
WET	652,000	760,000	–	–	–	–	1,412,000
Totals	**$3,186,123**	**$10,607,300**	**$8,146,500**	**$9,853,000**	**$8,269,253**	**$7,504,000**	**$47,566,176**
Modoc							
CSS	$321,891	$656,400	$712,000	$983,000	$1,114,405	$792,100	$4,458,796
PEI	–	100,000	151,200*	251,200*	245,945*	152,500	900,845
INN	–	–	68,000	68,000	253,900	48,300	438,200
CAPTECH	–	600,000	188,500	–	788,500	–	1,577,000
WET	225,000	225,000	–	–	–	–	450,000
Totals	**$546,891**	**$1,481,400**	**$1,119,700**	**$1,281,200**	**$2,402,750**	**$992,900**	**$7,824,841**

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Mono							
CSS	$356,737	$669,800	$759,900	$690,900	$1,081,775	$831,500	$4,609,612
PEI		100,000	151,700*	251,700	208,750	128,000*	840,150
INN			71,200	71,200	204,800	50,400	397,600
CAPTECH		600,000	188,500	100,000	53,772		942,272
WET	225,000	225,000					450,000
Totals	**$581,737**	**$1,594,800**	**$1,171,300**	**$1,332,800**	**$1,549,097**	**$1,009,900**	**$7,239,634**
Monterey							
CSS	$3,885,218	$10,519,500	$7,765,900	$10,576,700	$9,208,800	$8,708,200	$50,660,318
PEI		1,357,700	3,264,100*	4,362,400	3,952,300*	2,678,600*	15,615,100
INN			837,400	837,400	1,402,400	571,200	3,648,400
CAPTECH		3,982,200	1,219,800				5,102,000
WET	1,150,600	1,225,200					2,375,800
Totals	**$5,035,818**	**$16,980,600**	**$13,087,200**	**$15,776,500**	**$14,563,500**	**$11,958,000**	**$77,401,618**
Napa							
CSS	$1,136,972	$3,840,200	$2,343,900	$2,107,500	$2,901,700	$2,558,500	$15,888,772
PEI		1,346,100	842,600*	1,140,000*	2,378,800*	1,064,900*	5,773,400
INN			240,500	240,800	762,900	164,100	1,408,000
CAPTECH		1,003,000	323,900		1,100,856		2,455,756
WET	293,300	324,900			574,200		1,192,400
Totals	**$1,430,272**	**$5,542,200**	**$3,750,900**	**$4,489,000**	**$7,718,456**	**$3,787,500**	**$26,718,328**
Nevada							
CSS	$1,012,437	$3,367,287	$2,058,300	$2,598,300	$3,011,875	$2,199,300	$14,187,499
PEI		262,600	627,700	838,600	693,450	427,900	2,850,250
INN			199,100	199,100	359,213	134,900	891,713
CAPTECH		745,000	234,100		30		979,230
WET	225,000	232,000					457,000
Totals	**$1,237,437**	**$4,606,987**	**$3,119,200**	**$3,636,000**	**$4,064,568**	**$2,701,500**	**$19,365,692**
Orange							
CSS	$25,757,558	$70,799,600	$52,212,700	$71,573,400	$63,187,200	$59,752,100	$344,282,558
PEI		9,755,200	23,561,700*	31,517,400	28,637,000*	9,367,400*	112,838,700
INN			5,787,600	5,787,600	18,410,300	3,958,900	33,944,400
CAPTECH		28,308,000	8,894,500		15,559,675		52,762,475
WET	8,267,200	8,948,100					17,215,300
Totals	**$34,024,758**	**$117,811,200**	**$90,456,500**	**$109,878,400**	**$125,794,175**	**$83,078,400**	**$561,043,433**

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Placer							
CSS	$2,284,145	$6,479,900	$4,593,100	$6,249,400	$6,776,853	$4,888,035	$31,271,433
PEI	–	1,701,400	1,769,300*	2,416,500*	3,505,525*	494,900*	9,887,625
INN	–	–	483,800	483,800	1,541,300	589,865	3,098,765
CAPTECH	–	2,276,500	715,300	–	1,943,002	–	4,934,802
WET	594,400	1,795,700	1,800,000	–	710,005	1,800,000	5,640,105
Totals	**$2,878,545**	**$10,193,500**	**$9,361,500**	**$9,149,700**	**$14,476,685**	**$8,772,800**	**$54,832,730**
Plumas							
CSS	$392,188	$886,900	$1,039,000	$1,458,000	$1,197,900	$1,200,400	$6,174,388
PEI	–	100,000	152,100	252,100	149,500	28,400	782,100
INN	–	–	98,000	98,000	365,500	69,800	631,300
CAPTECH	–	600,000	188,500	–	788,500	–	1,577,000
WET	225,000	225,000	69,000	–	71,500	–	590,500
Totals	**$617,188**	**$1,811,900**	**$1,546,600**	**$1,808,100**	**$2,572,900**	**$1,398,600**	**$9,755,288**
Riverside							
CSS	$16,878,027	$43,990,700	$33,610,600	$47,117,200	$51,294,200	$38,793,200	$231,683,927
PEI	–	5,612,500	14,190,600*	19,468,208*	26,816,452*	12,040,800*	78,128,552
INN	–	–	3,673,500	3,673,500	11,519,251	2,539,300	21,405,551
CAPTECH	–	18,358,100	5,768,100	–	17,826,200	–	41,952,400
WET	4,756,400	5,941,900	–	–	30	–	10,698,330
Totals	**$21,634,427**	**$73,903,200**	**$57,242,800**	**$70,258,900**	**$107,456,133**	**$53,373,300**	**$383,868,760**
Sacramento							
CSS	$10,021,351	$31,272,200	$19,822,329	$37,976,100	$33,141,107	$23,754,100	$145,987,187
PEI	–	3,630,500	8,969,700*	12,467,000*	21,657,600*	7,546,300*	54,050,800
INN	–	–	2,267,300	2,267,300	8,379,100	1,565,200	14,478,900
CAPTECH	–	11,242,700	4,174,871	2,671,000	1,797,290	–	18,089,861
WET	3,076,700	3,574,100	–	–	–	–	6,650,800
Totals	**$13,098,051**	**$49,719,500**	**$35,234,200**	**$43,365,100**	**$64,975,097**	**$32,865,600**	**$239,257,548**
San Benito							
CSS	$737,007	$2,066,100	$1,580,000	$1,930,000	$2,329,200	$1,589,000	$10,221,307
PEI	–	166,300	398,700	93,600	282,075	270,800	1,649,475
INN	–	–	145,000	145,000	455,200	97,400	842,600
CAPTECH	–	600,000	188,500	–	788,500	–	1,577,000
WET	225,000	225,000	–	–	–	–	450,000
Totals	**$962,007**	**$3,047,400**	**$2,312,200**	**$2,606,600**	**$3,854,975**	**$1,957,200**	**$14,740,382**

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COUNTY/ COMPONENT	FISCAL YEAR 2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	TOTAL
San Bernardino							
CSS	$17,340,108	$45,907,600	$34,194,700	$47,400,100	$41,393,300	$38,143,000	$224,778,808
PEI	–	7,986,400	14,610,400*	18,325,800*	18,150,610*	11,713,200*	70,736,410
INNN	–	–	3,737,900	3,737,900	6,311,400	2,570,200	16,357,400
CAPTECH	–	19,162,500	5,706,700	–	1,819,498	–	25,688,698
WET	5,030,900	1,780,200	1,800,000	1,742,000	–	1,800,000	14,553,100
Totals	**$22,371,008**	**$75,186,700**	**$60,049,700**	**$71,105,800**	**$67,674,808**	**$55,726,400**	**$352,114,416**
San Diego							
CSS	$25,671,808	$72,981,300	$52,232,700	$73,166,800	$68,058,657	$60,240,700	$352,321,965
PEI	–	27,439,600	23,625,400*	31,805,200*	31,185,555*	19,643,300*	115,903,855
INNN	–	–	5,816,200	5,816,200	12,260,950	3,991,400	27,884,750
CAPTECH	–	28,417,800	8,928,900	–	34,358,758	–	71,705,458
WET	8,248,700	9,962,100	–	–	40	–	17,310,840
Totals	**$33,920,508**	**$120,164,600**	**$90,603,200**	**$110,788,200**	**$145,863,960**	**$83,786,400**	**$585,126,868**
San Francisco							
CSS	$5,386,299	$17,873,000	$11,570,900	$16,467,000	$16,454,050	$13,557,900	$81,309,449
PEI	–	7,269,600	5,445,300*	7,958,500*	11,585,019*	3,758,400*	30,416,819
INNN	–	–	1,313,800	1,313,800	4,200,900	904,300	7,732,800
CAPTECH	–	1,931,100	1,983,600	–	6,148,350	–	14,445,050
WET	1,923,400	1,206,600	–	–	1,172,159	–	5,122,159
Totals	**$7,309,699**	**$28,482,600**	**$20,313,600**	**$25,139,300**	**$39,560,478**	**$18,220,600**	**$139,026,277**
San Joaquin							
CSS	$5,645,671	$15,207,900	$11,097,800	$15,292,600	$15,347,167	$12,591,000	$75,182,138
PEI	–	1,365,100	4,575,900	4,611,900	4,337,500	3,156,600	20,150,000
INNN	–	–	1,197,800	1,197,800	3,816,200	822,700	7,034,500
CAPTECH	–	5,673,500	1,782,600	–	7,456,100	–	14,912,200
WET	1,580,600	1,796,700	–	–	–	–	3,377,300
Totals	**$7,226,271**	**$24,543,200**	**$18,654,100**	**$22,705,300**	**$30,956,967**	**$16,570,300**	**$120,656,138**
San Luis Obispo							
CSS	$2,317,778	$6,906,700	$4,167,425	$6,901,550	$5,100,150	$4,101,800	$29,495,403
PEI	–	760,000	1,832,100*	2,451,000*	2,224,000*	1,505,600*	8,772,700
INNN	–	–	487,300	487,300	1,545,200	331,900	2,851,700
CAPTECH	–	2,168,000	1,126,675	294,950	294,950	–	3,884,575
WET	644,100	692,400	–	–	–	–	1,336,500
Totals	**$2,961,878**	**$10,527,100**	**$7,613,500**	**$9,134,800**	**$9,164,300**	**$6,939,300**	**$46,340,878**

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COUNTY/ COMPONENT	FISCAL YEAR 2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	TOTAL
San Mateo							
CSS	$5,022,392	$15,083,100	$10,472,300	$14,546,900	$12,665,000	$11,976,500	$69,765,592
PEI	–	989,800	4,749,800*	6,241,500*	10,494,687*	5,847,400*	29,422,787
INNN	–	–	1,163,000	1,068,000	4,279,100	794,700	7,399,800
CAPTECH	–	5,539,300	1,740,400	–	1,992,724	–	9,272,424
WET	1,685,900	751,700	–	–	1,717,340	–	5,154,940
Totals	**$6,708,292**	**$24,363,400**	**$18,125,500**	**$22,050,900**	**$31,148,851**	**$18,618,600**	**$121,015,543**
Santa Barbara							
CSS	$3,853,402	$11,527,900	$7,582,206	$10,474,700	$9,120,002	$8,624,200	$51,182,410
PEI	–	1,346,800	3,236,300*	4,321,500*	6,813,610*	2,653,400*	18,371,610
INNN	–	–	829,800	829,800	2,948,600	565,700	5,173,900
CAPTECH	–	3,830,200	1,203,400	–	–	–	5,033,600
WET	1,141,400	1,213,700	115,294	–	1,328,994	–	3,799,388
Totals	**$4,994,802**	**$17,918,600**	**$12,967,000**	**$15,626,000**	**$20,211,206**	**$11,843,300**	**$83,560,908**
Santa Clara							
CSS	$13,521,652	$39,490,800	$28,814,300	$38,732,100	$48,528,816	$33,536,100	$202,623,768
PEI	–	5,663,100	13,664,300*	18,321,000*	37,640,067*	11,254,700*	86,543,167
INNN	–	–	3,263,200	3,263,200	11,720,900	2,238,600	20,485,900
CAPTECH	–	16,205,900	5,091,700	–	9,459,000	–	30,756,000
WET	4,799,400	5,171,300	–	2,000,000	2,000,000	–	13,970,700
Totals	**$18,321,052**	**$66,530,500**	**$50,833,500**	**$62,316,300**	**$109,348,783**	**$47,029,400**	**$354,379,535**
Santa Cruz							
CSS	$2,393,226	$6,876,300	$4,902,500	$6,660,600	$7,414,350	$5,483,900	$33,730,876
PEI	–	1,867,400	2,049,400*	2,404,300*	3,902,394*	1,678,400	11,223,894
INNN	–	–	527,600	527,600	1,674,100	359,500	3,088,800
CAPTECH	–	1,394,000	752,200	–	3,146,200	–	6,292,400
WET	726,600	758,000	–	–	–	–	1,484,600
Totals	**$3,119,826**	**$10,885,700**	**$8,231,700**	**$9,924,500**	**$16,137,044**	**$7,521,800**	**$55,820,570**
Shasta							
CSS	$1,712,376	$5,988,200	$3,362,700	$4,764,700	$3,887,301	$3,476,000	$23,101,277
PEI	–	508,500	1,233,800	1,664,400	1,160,400	847,000	5,414,100
INNN	–	–	346,800	346,800	1,099,800	236,500	2,029,900
CAPTECH	–	1,501,000	471,600	–	1,972,600	–	3,945,200
WET	431,000	472,600	–	–	–	–	903,600
Totals	**$2,143,376**	**$8,480,300**	**$5,414,900**	**$6,475,900**	**$8,120,101**	**$4,759,500**	**$35,394,077**

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COUNTY/ COMPONENT	FISCAL YEAR 2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	TOTAL
Sierra							
CSS	$271,896	$1,400,200	$644,800	$894,800	$1,155,424	$736,700	$4,108,820
PEI		100,000	150,400	150,400	326,633	126,700	954,133
INN			63,500	63,500	237,900	45,400	410,300
CAPTECH		600,000	188,500		788,500		1,577,000
WET	225,000	225,000			31,590		481,590
Totals	**$496,896**	**$1,330,200**	**$1,047,200**	**$1,208,700**	**$2,540,047**	**$908,800**	**$7,531,843**
Siskiyou							
CSS	$588,535	$1,583,500	$1,374,300	$1,724,300	$1,957,175	$1,371,700	$8,597,510
PEI		112,300	265,900*	369,900	891,900*	225,600	1,865,300
INN			122,800	122,800	451,000	84,400	781,000
CAPTECH		600,000	188,500		788,500		1,577,000
WET	225,000	225,000			416,200		866,200
Totals	**$813,535**	**$2,470,800**	**$1,951,500**	**$2,216,700**	**$4,504,775**	**$1,729,700**	**$13,687,010**
Solano							
CSS	$3,258,606	$9,382,600	$6,642,100	$9,143,000	$7,960,501	$7,527,700	$43,914,507
PEI		1,381,000	2,776,700*	3,753,900*	2,618,800*	2,869,400*	13,399,300
INN			718,900	718,900	1,390,050	493,000	3,320,850
CAPTECH		1,651,123	1,073,800		3,681,923		7,920,846
WET	1,216,877	1,347,500			(252,377)		2,041,000
Totals	**$4,475,483**	**$14,762,323**	**$11,211,500**	**$13,615,800**	**$15,398,897**	**$11,132,500**	**$70,596,503**
Sonoma							
CSS	$3,741,594	$11,152,000	$7,518,500	$10,234,200	$11,812,783	$8,426,900	$52,886,977
PEI		1,940,200	3,198,500*	4,260,000*	9,306,300*	2,012,600	20,717,600
INN			813,300	813,300	2,986,900	553,900	5,167,400
CAPTECH		741,500	1,175,700		4,120,361		9,037,961
WET	1,135,800	1,180,000			2,145,400		4,461,200
Totals	**$4,877,394**	**$17,414,100**	**$12,706,000**	**$15,308,500**	**$30,371,744**	**$11,593,400**	**$92,271,138**
Stanislaus							
CSS	$4,293,970	$14,335,000	$8,502,900	$11,684,900	$10,173,700	$9,620,600	$58,611,070
PEI		1,414,500	3,475,800*	4,719,800*	4,314,900*	2,906,400*	16,830,900
INN			914,400	914,400	2,912,500	627,800	5,369,100
CAPTECH		2,497,700	1,359,600		5,686,800		11,373,600
WET	1,198,800	1,369,300					2,568,100
Totals	**$5,492,770**	**$21,446,000**	**$14,252,700**	**$17,318,600**	**$23,087,900**	**$13,154,800**	**$94,752,770**

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COUNTY/ COMPONENT	FISCAL YEAR 2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	TOTAL
Sutter-Yuba							
CSS	$1,761,564	$5,196,400	$3,568,300	$4,510,900	$5,043,253	$3,714,000	$23,794,417
PEI	–	427,900	1,076,200*	444,500	2,434,400*	1,036,800	6,439,800
INN	–	–	344,500	342,500	1,258,600	1,232,900	2,180,500
CAPTECH	–	1,343,200	422,100	–	1,765,300	–	3,530,600
WET	450,000	450,000	–	–	900,000	–	1,800,000
Totals	**$2,211,564**	**$7,437,500**	**$5,411,100**	**$6,299,900**	**$11,401,553**	**$4,983,700**	**$37,745,317**
Tehama							
CSS	$716,402	$2,652,700	$1,555,100	$1,929,800	$1,679,800	$1,588,500	$10,121,802
PEI	–	162,900	404,400	560,600	823,100	278,900	2,219,900
INN	–	–	144,500	144,500	527,700	97,800	914,500
CAPTECH	–	1,600,000	188,500	–	788,500	–	1,577,000
WET	225,000	225,000	–	–	450,000	–	900,000
Totals	**$941,402**	**$3,640,600**	**$2,292,500**	**$2,624,400**	**$4,269,100**	**$1,965,200**	**$15,733,202**
Tri City†							
CSS	$1,907,890	$5,976,200	$3,721,400	$4,989,000	$2,362,389	$4,107,700	$23,064,579
PEI	–	702,900	1,621,200	2,116,400	2,975,582	1,086,600	8,502,682
INN	–	–	402,600	402,600	1,472,300	271,500	2,549,000
CAPTECH	–	2,059,600	647,100	–	2,706,700	–	5,413,400
WET	595,800	548,200	–	–	1,144,000	–	2,288,000
Totals	**$2,503,690**	**$9,286,900**	**$6,392,300**	**$7,508,000**	**$10,660,971**	**$5,465,800**	**$41,817,661**
Trinity							
CSS	$355,222	$648,900	$755,600	$1,005,600	$127,725	$827,900	$3,720,947
PEI	–	300,000	151,600	225,600	1,091,975*	179,900	1,748,075
INN	–	–	70,900	70,900	194,200	50,200	386,200
CAPTECH	–	600,000	188,500	–	500	–	789,000
WET	225,000	225,000	–	–	140,000	–	590,000
Totals	**$580,222**	**$1,573,900**	**$1,166,600**	**$1,328,100**	**$1,554,400**	**$1,031,000**	**$7,234,222**
Tulare							
CSS	$4,105,199	$11,056,200	$7,577,700	$11,088,900	$10,399,375	$9,126,900	$53,350,674
PEI	–	1,552,300	3,259,800	4,435,000	2,012,425	2,019,800	13,279,825
INN	–	–	865,300	865,300	3,189,300	594,400	5,514,300
CAPTECH	–	4,066,500	1,775,700	–	5,336,000	–	11,172,000
WET	1,120,600	1,793,900	–	–	2,246,400	–	4,660,900
Totals	**$5,225,799**	**$17,732,700**	**$13,478,500**	**$16,385,600**	**$23,183,500**	**$11,971,600**	**$87,977,699**

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COUNTY/ COMPONENT	FISCAL YEAR 2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	TOTAL
Tuolumne							
CSS	$693,980	$1,959,500	$1,520,700	$1,870,700	$2,122,475	$1,540,300	$9,707,655
PEI	–	151,000	357,800	475,300*	313,050	242,900	1,540,050
INN	–	–	138,200	138,200	469,650	93,400	839,450
CAPTECH	–	600,000	188,500	–	372,047	–	1,160,547
WET	225,000	225,000	–	–	–	–	450,000
Totals	**$918,980**	**$2,935,500**	**$2,205,200**	**$2,484,200**	**$3,277,222**	**$1,876,600**	**$13,697,702**
Ventura							
CSS	$6,810,115	$1,581,700	$11,671,400	$18,726,100	$26,904,863	$12,417,800	$98,345,978
PEI	–	2,414,300	5,853,700*	7,849,800*	13,676,217*	4,826,700*	34,620,717
INN	–	–	1,483,000	1,483,000	5,085,650	1,014,000	9,065,650
CAPTECH	–	7,091,300	4,174,700	–	4,213,527	–	15,479,527
WET	2,046,000	2,240,500	–	–	2,575,830	–	6,862,330
Totals	**$8,856,115**	**$30,561,800**	**$23,182,800**	**$28,058,900**	**$52,456,087**	**$21,258,500**	**$164,374,202**
Yolo							
CSS	$1,838,123	$6,225,800	$3,692,900	$4,975,000	$9,786,617	$4,096,100	$30,614,540
PEI	–	570,700	1,407,100*	1,908,100*	3,180,183*	1,175,900*	8,241,983
INN	–	–	386,700	386,700	1,422,400	264,700	2,460,500
CAPTECH	–	1,730,800	543,800	–	1,696,975	–	3,971,575
WET	483,700	558,800	–	–	577,625	–	1,620,125
Totals	**$2,321,823**	**$9,086,100**	**$6,030,500**	**$7,269,800**	**$16,663,800**	**$5,536,700**	**$46,908,723**
Statewide							
CSS	$320,453,101	$918,430,987	$644,124,260	$896,588,050	$982,640,247	$741,431,795	$4,503,668,440
PEI	–	147,756,594	278,600,000	378,000,000*	469,648,647	232,062,340*	1,471,067,581
INN	–	–	71,000,000	71,000,000	197,705,668	48,957,265	388,662,933
CAPTECH	–	343,115,862	114,091,446	269,950	280,725,187	–	739,202,445
WET	106,070,717	110,000,300	9,184,294	2,142,000	60,892,214	9,000,000	297,064,525
Totals	**$426,523,818**	**$1,486,303,743**	**$1,117,000,000**	**$1,347,000,000**	**$1,991,611,963**	**$1,031,451,400‡**	**$7,381,256,524**

Sources: Unaudited county allocations published by the California Department of Mental Health on its Web site for fiscal years 2006–07 through 2009–10 and California State Accounting and Reporting System expenditure data for fiscal years 2010–11 through 2011–12.

* For fiscal years 2008–09 through 2011–12, Prevention and Early Intervention (Prevention) funds include amounts the State used to conduct statewide Prevention programs.

† *County* indicates a county mental health department, two or more county mental health departments acting jointly, and/or city-operated programs receiving funds per California Welfare and Institutions Code, Section 5701.5.

‡ Legislation was passed in March 2011 directing more than $850 million in Mental Health Services Act funds to other mental health programs in fiscal year 2011–12. The reduction in funds in fiscal year 2011–12 appears to correspond with this change in legislation.

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Appendix B

Mental Health Services Act Programs for the Four Counties Reviewed Fiscal Years 2006–07 Through 2011–12

The Joint Legislative Audit Committee directed the California State Auditor to identify the type of services and supports that counties provided through each of their Mental Health Services Act (MHSA) components, covering the most recent six-year period. We reviewed four county departments: Los Angeles County Department of Mental Health, County of Sacramento Department of Health and Human Services, County of San Bernardino Department of Behavioral Health Administration, and Santa Clara County Mental Health Department. Tables B.1 through B.4 on the following pages list by component the names of the counties' planned MHSA programs with a brief description of each. The programs listed are those that appeared in the counties' plans for fiscal years 2006–07 through 2011–12. Each table also indicates the age group the county targeted with its planned programs for the Community Services and Supports, Prevention and Early Intervention, and Innovation programs. Because the MHSA components of Workforce Education and Training and Capital Facilities and Technological Needs are not designed to provide mental health services directly to clients, counties typically did not specify target age groups for these components.

Table B.1
Los Angeles County Department of Mental Health: Mental Health Services Act Planned Programs/Actions by Component Fiscal Years 2006–07 Through 2011–12

		FISCAL YEAR						AGE GROUP TARGETED			
PROGRAM/ACTION TITLE	DESCRIPTION	2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Community Services and Supports											
Children's Full-Service Partnership (Partnership)	County works with individuals and families to provide all necessary and appropriate services and supports to assist the individual/family in achieving the goals identified.	✓	✓	✓	✓	✓	✓	●			
Family Support Services	Provides access to mental health services such as individual psychotherapy, couples/group therapy, and crisis intervention for parents/families of seriously emotionally disturbed children who are enrolled in Partnership services.	✓	✓	✓	✓	✓	✓	●			

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PROGRAM/ACTION TITLE	DESCRIPTION	FISCAL YEAR						AGE GROUP TARGETED			
		2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Community Services and Supports											
Children's Integrated Mental Health/ Co-Occurring Disorders	Provides training to enhance the ability of mental health professionals to identify, assess, and engage individuals experiencing substance abuse and/or co-occurring disorders.	✓	✓	✓				●			
Children's Respite Care	Provides support services to relieve eligible parents and/or caregivers from ongoing stress that results from providing constant care to a seriously emotionally disturbed child.	✓	✓	✓	✓			●			
Children's Field-Capable Clinical Services	Performs evidence-based direct interventions to address the needs of children who are seriously emotionally disturbed and/or severely and persistently mentally ill.			✓	✓	✓	✓	●			
Transition-Age Youth Full-Service Partnership	Provides intensive mental health services and supports to high-need and high-risk severely emotionally disturbed transition-age youth who are transitioning out of the child welfare system or are at risk of becoming homeless or leaving long-term institutional care.	✓	✓	✓	✓	✓	✓		●		
Transition-Age Youth Drop-In Centers	Provides entry points to the mental health system for homeless youth or youth in unstable living conditions. Provides "low-demand, high-tolerance" environments offering temporary safety and basic services.	✓	✓	✓	✓	✓	✓		●		
Transition-Age Youth Housing Services	Includes three activities: housing specialists to assist in securing housing, enhanced emergency shelter program to provide temporary shelter, and project-based operating subsidies to provide subsidies to transition-age youth for securing permanent housing.	✓	✓	✓	✓	✓	✓		●		
Transition-Age Youth Probation Camp Services	Teams of parent/peer advocates, clinicians, health staff, and others provide on-site treatment and support services at probation camps.	✓	✓	✓	✓	✓	✓		●		

PROGRAM/ACTION TITLE	DESCRIPTION	FISCAL YEAR						AGE GROUP TARGETED			
		2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Community Services and Supports											
Transition-Age Youth Field-Capable Clinical Services	Provides field-capable services for seriously emotionally disturbed and/or severely and persistently mentally ill transition-age youth. The services are evidence-based direct interventions and may serve to transition youth from Partnership programs to lower levels of service.			✓	✓	✓	✓		●		
Adult Full-Service Partnerships	Provides "whatever it takes" to assist individuals with housing, employment, education, and integrated treatment for those with co-occurring mental health and substance abuse disorders.	✓	✓	✓	✓	✓	✓			●	
Wellness/ Client-Run Centers	Funds centers that provide self-help services and an opportunity for clients in advanced stages of recovery to address both physical and mental health needs and to focus on increasing self-reliance and community integration.	✓	✓	✓	✓	✓	✓			●	
Adult Institutions for Mental Disease Step-Down Facility	Helps clients from acute inpatient and institutional settings be safely maintained in the community with mental health services.	✓	✓	✓	✓	✓	✓			●	
Adult Housing Services	Provides housing services for homeless individuals and families and those living in institutional settings. Housing specialists provide housing placement services for a safe and nonthreatening environment for chronically homeless individuals with mental health issues.	✓	✓	✓	✓	✓	✓			●	
Adult Services—Jail Transition and Linkage Services	Addresses the needs of individuals in collaboration with the judicial system by providing identification, outreach, support, advocacy, linkage, and interagency collaboration in the courtroom.	✓	✓	✓	✓	✓	✓			●	
Adult Field-Capable Clinical Services	Enables providers to reach unserved, underserved, or inappropriately served individuals who will not or cannot access mental health services in traditional settings.			✓	✓	✓	✓			●	

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PROGRAM/ACTION TITLE	DESCRIPTION	FISCAL YEAR						AGE GROUP TARGETED			
		2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Community Services and Supports											
Older Adult Full-Service Partnership	Provides services for older adults with a serious mental illness who are in need of intensive mental health services and who have experienced a reduction in personal or community functioning.	✓	✓	✓	✓	✓	✓				●
Older Adult Transformation Design Team	Develops an infrastructure of older adult services through work on data collection, outcome measures, performance-based contracting, and more.	✓	✓	✓	✓	✓	✓				●
Older Adult Field-Capable Clinical Services	Directly responds to and addresses the needs of unserved and underserved older adults by providing screening, assessment, linkage, medication support, and case management. Assists older adults who are severely mentally ill, isolated, self-neglecting, abused, and/or homeless.	✓	✓	✓	✓	✓	✓				●
Older Adult Service Extender Program	Provides training to service extenders who are peers in recovery, family members, or other individuals interested in providing field-capable clinical services to older adults.	✓	✓	✓	✓	✓	✓				●
Older Adult Training Program	Addresses training needs of existing mental health professionals, service extenders, and community partners, including specialized training for staff.	✓	✓	✓	✓	✓	✓				●
Alternative Crisis Services	Includes the following five areas of services: urgent care centers designed to reduce unnecessary and lengthy involuntary inpatient treatment; countywide resource management, including centralized administrative and clinical management functions; residential and bridging services; enriched residential services providing on-site mental health services; and services to reduce homelessness.	✓	✓	✓	✓	✓	✓	●	●	●	●

PROGRAM/ACTION TITLE	DESCRIPTION	FISCAL YEAR						AGE GROUP TARGETED			
		2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Community Services and Supports											
Planning, Outreach, and Engagement	Implements strategies to increase awareness of the Mental Health Services Act (MHSA) among unserved, underserved, and inappropriately served populations, including outreach to the homeless and development of the County Department of Mental Health's Division of Empowerment and Advocacy.	✓	✓	✓	✓	✓	✓	●*	●	●*	●
Service Area Navigators	Funds persons who work to link needed services to members of the community. Teams are age-group specific.	✓	✓	✓	✓	✓	✓	●*	●	●*	●
Prevention and Early Intervention											
Early Start Suicide Prevention	Contains several suicide prevention components, including increasing the capacity and quality of the suicide prevention hotline; increasing public awareness efforts; providing training; providing support groups; and offering activities targeted toward diverse and at-risk populations.			✓	✓	✓	✓	●	●	●	●
Early Start School Mental Health Initiative	Implements a school threat assessment response team to identify at-risk students, and provides services in all Los Angeles service areas.			✓	✓	✓	✓	●	●	●	●
Early Start Anti-Stigma and Discrimination	Implements client-focused strategies, family support and education, and broader community advocacy strategies to reduce stigma and discrimination in communities.			✓	✓	✓	✓	●	●	●	●
School-Based Services	Provides several interventions to build resiliency in children, identify as early as possible children and youth who have risk factors, and provide on-site services to address nonacademic problems.				✓	✓	✓	●	●		
Family Education and Support Services	Provides interventions to build competencies, capacity, and resilience in parents, family members, and other caregivers. Concentrates on parental skill building in a variety of settings.				✓	✓	✓	●	●	●	●
At-Risk Family Services	Provides training and assistance to families of children at risk for out-of-home placements, builds skills for families with difficult children, and provides support to families with histories that place them at risk.				✓	✓	✓	●	●	●	●

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PROGRAM/ACTION TITLE	DESCRIPTION	FISCAL YEAR						AGE GROUP TARGETED			
		2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Prevention and Early Intervention											
Trauma Recovery Services	Provides short-term crisis counseling to clients, family, and staff affected by a traumatic event, and provides intensive services to trauma-exposed youth.				✓	✓	✓	●	●	●	●
Primary Care and Behavioral Health Services	Develops mental health services within primary care clinics, and helps prevent patients at clinics from developing severe behavioral health issues.				✓	✓	✓	●	●	●	●
Early Care and Support for Transition-Age Youth	Includes three components for transition-age youth: building resiliency and increasing protective factors, addressing depressive disorders, and minimizing impact for youth who may be in the early stages of mental illness.				✓	✓	✓	●	●	●	
Juvenile Justice Services	Builds resiliency and protective factors among youth and children exposed to risk factors, promotes coping and life skills, and identifies mental health issues among youth in the juvenile justice system as early as possible.				✓	✓	✓	●	●	●	
Early Care and Support for Older Adults	Establishes the means to identify and link older adults who need treatment but are reluctant, are hidden, or are unknown; to prevent and alleviate depressive disorders; and to provide brief mental health treatment for older adults.				✓	✓	✓		●	●	●
Improving Access for Underserved Populations	Builds resiliency and increases protective factors among non-English-speaking or limited-English-speaking and other underserved populations, identifies at-risk individuals, and provides culturally and linguistically appropriate mental health services.				✓	✓	✓	●	●	●	●
American Indian Project	Builds resiliency and increases protective factors among children, youth, and their families; addresses stressful forces in children's and youth's lives; and identifies as early as possible children and youth who have risk factors.				✓	✓	✓	●	●	●	●

PROGRAM/ACTION TITLE	DESCRIPTION	FISCAL YEAR						AGE GROUP TARGETED			
		2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Innovation											
Integrated Clinic Model	Provides integrated care in a large, complex urban environment specifically targeting the most vulnerable populations and integrating primary care sites with mental health services. The program focuses on individuals eligible for specialty mental health services who could benefit from primary health and/or substance abuse services.				✓	✓	✓	†		†	
Integrated Mobile Health Team Model	Provides integrated care in a geographically widespread, complex urban environment, managing it under one agency and increasing access to services by leveraging multiple funding sources.				✓	✓	✓	†		†	
Community-Designed Integrated Service Management Model	Provides integrated care in a diverse urban environment by differentiating specific needs and approaches for five underrepresented ethnic communities, focusing on community self-direction for integrated service delivery. Peers are integrated into the mix of formal and nontraditional providers.				✓	✓	✓	†		†	
Integrated Peer-Run Model	Provides peer-run integrated services and peer-run crisis houses to expand the potential of peer-run services. Peer-run integrated services management addresses physical health, mental health, and substance abuse issues.				✓	✓	✓	†		†	
Workforce Education and Training											
Workforce Education and Training Coordination	Funds staffing for the planning and development of the county workforce plan.			✓	✓	✓	✓	NA	NA	NA	NA
County of Los Angeles Oversight Committee	Funds a committee to guide and support the implementation of the county plan.			✓	✓			NA	NA	NA	NA
Transformation Academy Without Walls	Provides a training program aimed at improving the skills of the mental health workforce. Includes standard curricula and incorporates coaching and mentoring.			✓	✓	✓	✓	NA	NA	NA	NA

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PROGRAM/ACTION TITLE	DESCRIPTION	FISCAL YEAR						AGE GROUP TARGETED			
		2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Workforce Education and Training											
Recovery-Oriented Supervision Trainings	Immerses supervisors in the basic tenets of the MHSA, provides them with updated information on issues related to recovery and wellness, and teaches them how to integrate clients and family members into the mental health workforce.				✓	✓	✓	NA	NA	NA	NA
Interpreter Training Program	Offers training in phases: trains interpreters for mental health settings, trains mental health providers in how best to use interpreters, and offers technical assistance and follow-up support.			✓	✓	✓	✓	NA	NA	NA	NA
Training for Community Partners	Offers training on symptomatology and on how to access health services to community partners, including law enforcement, probation departments, and child protective services.			✓	✓	✓	✓	NA	NA	NA	NA
Intensive Mental Health Recovery Specialist Training Program	Offers training for entry-level professionals who represent the linguistic and cultural diversity of those receiving services. Efforts are also made to recruit and match trainees with ideal field placement.			✓	✓	✓	✓	NA	NA	NA	NA
Expand Employment and Professional Advancement Opportunities for Consumers in the Public Mental Health System	Increases training and employment of clients in the public mental health system and decreases barriers to employment. Specifically targets older adults and transition-age youth.			✓	✓	✓	✓	NA	NA	NA	NA
Expand Employment and Professional Advancement Opportunities for Parent Advocates, Child Advocates, and Caregivers in the Public Mental Health System	Helps develop skills needed to perform community outreach, advocacy, and leadership duties, with a focus on teaching participants how to navigate systems including mental health, schools, regional centers, and child protective services. Targets parents, child advocates, and caregivers of children.				✓	✓	✓	NA	NA	NA	NA
Expand Employment and Professional Advancement Opportunities for Family Member Advocates in the Public Mental Health System	Trains family members of clients to develop or augment skills related to community outreach, advocacy, and leadership, and decreases barriers to employment.				✓	✓	✓	NA	NA	NA	NA

PROGRAM/ACTION TITLE	DESCRIPTION	FISCAL YEAR						AGE GROUP TARGETED			
		2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Workforce Education and Training											
Mental Health Career Advisors	Develops a group of advisors who will work with newly entering and/or existing mental health staff to help them as they enter and remain in the mental health workforce.				✓	✓	✓	NA	NA	NA	NA
High School Through University Mental Health Pathways	Expands academic programs to promote mental health careers to high school, community college, and university students, especially in communities or areas of the county where ethnically diverse populations reside.				✓	✓	✓	NA	NA	NA	NA
Market Research and Advertising Strategy for Recruitment of Professionals in the Public Mental Health System	Establishes a collaboration with an academic institution, research institute, or think tank to conduct market research and formulate advertising strategies to identify ways of attracting and targeting new professionals into the public mental health field.			✓	✓	✓	✓	NA	NA	NA	NA
Partnership with Educational Institutions to Increase the Number of Mental Health Professionals in the Public Mental Health System	Works with educational institutions currently producing, or that may in the future produce, mental health professionals in key high-need disciplines to expand capacity for developing additional mental health professionals.			✓	✓	✓	✓	NA	NA	NA	NA
Recovery-Oriented Internship Development	Works with degree-granting institutions providing recovery-oriented classroom instruction to develop relationships with nontraditional providers, and works with existing providers to increase the number of internships available.				✓	✓	✓	NA	NA	NA	NA
Tuition Reimbursement Program	Provides up to $5,000 per year for tuition expenses for individuals interested in entering or enhancing skills for the mental health field who meet certain criteria.				✓	✓	✓	NA	NA	NA	NA
Associate and Bachelor Degree 20/20 and/or 10/30 Program	Targets individuals currently working in public mental health who are interested in advancing in their career by obtaining an associate- or a bachelor-level degree. Program pays for a portion of their salaries to allow students to meet academic responsibilities.					✓	✓	NA	NA	NA	NA

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PROGRAM/ACTION TITLE	DESCRIPTION	FISCAL YEAR						AGE GROUP TARGETED			
		2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Workforce Education and Training											
Stipend Programs for Psychologists, Masters of Social Work, Masters of Family Therapy, Psychiatric Nurse Practitioners, and Psychiatric Technicians	Seeks to expand the number of psychologists, masters in social work, marriage and family therapists, psychiatric nurse practitioners, and psychiatric technicians in the county by offering stipends in the programs that will represent underserved ethnic groups.			✓	✓	✓	✓	NA	NA	NA	NA
Loan Forgiveness Program	Explores loan forgiveness to programs that complement existing programs and meet the need for a linguistically and culturally competent workforce based on geographic, cultural, and linguistic needs.				✓	✓	✓	NA	NA	NA	NA
Capital Facilities and Technological Needs											
Integrated Behavioral Health Information System	Provides clinicians direct access to current client clinical records regardless of where each client was seen previously in the network, including medication history, recent assessments, treatment plans, and clinical notes. It also provides an improved means of measuring and reporting MHSA outcomes.				✓	✓	✓	NA	NA	NA	NA
Contract Provider Technology Project	Provides contract providers with a means to pursue technology improvements in support of MHSA activities. Distributes MHSA information technology funds to more than 125 contract providers to pursue predetermined technological projects.				✓	✓		NA	NA	NA	NA
Consumer/Family Access to Computer Resources Project	Promotes client/family growth and autonomy, provides basic computer skills training to clients allowing them to effectively use computer resources available to them and provides appropriate access to technical assistance resources.				✓	✓		NA	NA	NA	NA
Personal Health Record Awareness and Education	Develops written and online awareness and educational materials with the target audiences of client/family and mental health services provider.				✓	✓		NA	NA	NA	NA
Data Warehouse Redesign Project	Based on the implementation of electronic health records, prepares the county to store new clinical, administrative, and financial data sources as well as establishes resources for warehousing legacy data.				✓	✓		NA	NA	NA	NA

PROGRAM/ACTION TITLE	DESCRIPTION	FISCAL YEAR						AGE GROUP TARGETED			
		2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Capital Facilities and Technological Needs											
Telepsychiatry Feasibility Study and Recommendation Project	Hires a consultant to identify opportunities for a variety of telepsychiatry projects, research the possible benefits of widespread and systematic adoption of telepsychiatry, and make recommendations regarding the value of implementing telepsychiatry.				✓			NA	NA	NA	NA
Telepsychiatry Implementation Project	Extends functionality of the existing telepsychiatry pilot to meet the MHSA information technology goal of modernizing and transforming clinical and administrative information systems.					✓		NA	NA	NA	NA

Sources: MHSA component plans and annual updates prepared by the Los Angeles County Department of Mental Health.

NA = Not applicable. Workforce Education and Training and Capital Facilities and Technological Needs generally include efforts that focus on expanding, educating, and training the local public mental health workforce and improving infrastructure. Because programs within these components are not designed to provide direct mental health services, no age group is targeted.

✓ = Program appears in a plan applicable for the fiscal year.

● = County plan indicated that program targeted this age group.

* The county's plans did not specify an age group this program served; based on the program description, it reasonably serves all age groups.

† The county's Innovation component plan did not identify specific age groups for this program. We, therefore, could not determine which discrete age groups the program targeted.

Table B.2
County of Sacramento Department of Health and Human Services: Mental Health Services Act Services Planned Programs/Actions by Component
Fiscal Years 2006–07 Through 2011–12

PROGRAM/ ACTION TITLE	DESCRIPTION	FISCAL YEAR						AGE GROUP TARGETED			
		2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Community Services and Supports											
Transitional Community Opportunities for Recovery and Engagement (TCORE)	Provides community-based services for those leaving or at risk of entering acute care settings and who are not linked to ongoing mental health services.	✓	✓	✓	✓	✓	✓		●	●	●
Sierra Elder Wellness*	Provides specialized geriatric psychiatric support, multidisciplinary mental health assessments, treatment, and intensive case management services for individuals with multiple co-occurring mental health, physical health, and/or substance abuse and social service needs requiring intensive case management services.	✓	✓	✓	✓	✓	✓			●	●
Permanent Supportive Housing Program	Consists of three components: (1) offers same-day access to services such as mental health assessments and medication, and limited temporary housing; (2) provides short-term housing and focuses on rapid access to permanent housing and Full-Service Partnership (Partnership) level of services for moderate and episodic intensive-level service needs; and (3) provides permanent supportive housing and a Partnership level of mental health services.	✓	✓	✓	✓	✓	✓	●	●	●	●
Transcultural Wellness Center	Addresses the mental health needs of the Asian/Pacific Islander community, taking into account the cultural and religious beliefs and values, traditional and natural healing practices, and ceremonies this community recognizes.	✓	✓	✓	✓	✓	✓	●	●	●	●
Wellness and Recovery Center	Consists of three components: (1) two community-based, multi-service centers that provide a supportive environment offering choice and self-directed guidance for recovery and transition into community life; (2) peer support services for individuals linked to the TCORE clinics serving adults; and (3) program promoting and advocating for client involvement in the mental health system through a wide array of services and supports including advocacy, system navigation, training, support groups, and psycho-educational groups.	✓	✓	✓	✓	✓	✓	●	●	●	●

PROGRAM/ ACTION TITLE	DESCRIPTION	FISCAL YEAR						AGE GROUP TARGETED			
		2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Community Services and Supports											
Adult Full-Service Partnership	Contains two components serving adults with persistent and significant mental illness. Services include case management, benefits acquisition, crisis response, intervention and stabilization, medication evaluation and support, and effective ongoing specialty mental health services. Supports include housing, employment, education, and transportation.				✓	✓	✓		●	●	●
Juvenile Justice Diversion and Treatment Program	Provides screenings, assessments, and intensive mental health services and Partnership supports to eligible youth and their families involved in the juvenile justice system.				✓	✓	✓	●	●		
Prevention and Early Intervention											
Suicide Prevention Program	Consists of five components focusing on suicide prevention and education: (1) a 24-hour telephone crisis line, (2) brief individual and group bereavement counseling services, (3) support groups and services designed to encourage healing for those coping with a loss by suicide, (4) services designed to reduce isolation and decrease the risk of suicide, and (5) field-based flexible services to community members experiencing a crisis. Services include assessment, support services, and linkage to ongoing services and supports.				✓	✓	✓	●	●	●	●
Strengthening Families Program	Contains five components: (1) provides behavioral consultations to preschools and early care learning environments designed to increase teacher awareness about the meaning of behavior; (2) provides health exams, assessments, referrals, and treatment services for children from birth to 5 years old who are placed into protective custody; (3) trains school staff to educate others on anti-bullying strategies; (4) implements prevention approaches for youth age 6 to 18 and families to improve social skills, increase protective factors, prevent youth violence, and reduce or eliminate family conflict; and (5) independent living program expanded to non-foster, homeless, and lesbian, gay, bisexual, transgender, and questioning youth age 16 to 25 to gain life skills.					✓	✓	●	●	●	●

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PROGRAM/ ACTION TITLE	DESCRIPTION	FISCAL YEAR						AGE GROUP TARGETED			
		2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Prevention and Early Intervention											
Integrated Health and Wellness Program	Consists of two components: (1) provides assessment, early identification, and treatment of the onset of psychosis and (2) serves adults demonstrating early signs of isolation and depression through socialization opportunities, skill-building groups, transportation services, and collaboration with health care providers.					✓	✓	●	●	●	●
Mental Health Promotion Project	Increases awareness about mental health issues and reduces stigma and discrimination toward individuals and families living with mental illness.					✓	✓	●	●	●	●
Innovation											
Respite Partnership Collaborative	Establishes a collaborative to learn whether a partnership with a community-based organization can, among other things, lead to new partnerships that can help address crisis and other mental health issues in Sacramento.					✓	✓	●	●	●	●
Workforce Education and Training											
Workforce Staffing Support	Facilitate the implementation of Workforce Education and Training efforts across the county.			✓	✓	✓	✓	NA	NA	NA	NA
System Training Continuum	Expands training capacity of mental health staff, system partners, consumers, and family members.			✓	✓	✓	✓	NA	NA	NA	NA
Office of Consumer and Family Member Employment	Seeks to develop entry and employment opportunities to address occupational shortages.			✓	✓	✓	✓	NA	NA	NA	NA
High School Training	Introduces mental health career information to high school students.			✓	✓	✓	✓	NA	NA	NA	NA
Psychiatric Residents and Fellowships	Places medical residents and fellows in mental health settings with dedicated supervision.			✓	✓	✓	✓	NA	NA	NA	NA
Multidisciplinary Seminar	Seeks to increase the number of psychiatrists and other practitioners working in community mental health that are trained in specific service models.			✓	✓	✓	✓	NA	NA	NA	NA
Consumer Leadership Stipends	Provides clients and family members the opportunity to receive stipends for leadership or educational opportunities that increase knowledge, build skills, and further advocacy for clients on mental health issues.			✓	✓	✓	✓	NA	NA	NA	NA

PROGRAM/ ACTION TITLE	DESCRIPTION	FISCAL YEAR						AGE GROUP TARGETED			
		2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Workforce Education and Training											
Stipends for Individuals, Especially Consumers and Family Members, for Education Programs to Enter the Mental Health Field	Establishes a fund to allow individuals to apply for stipends to participate in educational opportunities that will lead to employment in Sacramento County's mental health system.			✓	✓	✓	✓	NA	NA	NA	NA
Capital Facilities and Technological Needs											
Technological Needs Project	Consists of five phases to build infrastructure to meet Sacramento County's goals in its Community Services and Supports plan and to achieve the federal objectives of meaningful use of electronic health records to improve client care.				✓	✓	✓	NA	NA	NA	NA

Sources: Mental Health Services Act component plans and annual updates prepared by the County of Sacramento Department of Health and Human Services.

NA = Not applicable. Workforce Education and Training and Capital Facilities and Technological Needs generally include efforts that focus on expanding, educating, and training the local public mental health workforce and improving infrastructure. Because programs within these components are not designed to provide direct mental health services, no age group is targeted.

✓ = Program appears in a plan applicable for the fiscal year.

● = County plan indicated that program targeted this age group.

* In fiscal year 2006–07, this program was titled Older Adult Intensive Services Program.

Table B.3
County of San Bernardino Department of Behavioral Health Administration: Mental Health Services Act Planned Programs by Component
Fiscal Years 2006–07 Through 2011–12

		FISCAL YEAR						AGE GROUP TARGETED			
PROGRAM TITLE	DESCRIPTION	2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Community Services and Supports											
Comprehensive Child and Family Support System	Coordinate and access an array of county services for children who are challenged with emotional disturbances. Uses evidence-based practices and includes case management, flexible funding, family focus treatment, service coordination, child care, co-occurring treatment, psychiatric services, family advocacy, and parent partnerships.	✓	✓	✓	✓	✓	✓	●	●		
Integrated New Family Opportunities	Provides mental health services to children age 13 to 17 in custody and post-custody juvenile detention. Services seek to reduce out-of-home placements.			✓	✓	✓	✓	●			
One Stop Transition-Age Youth Center	Provides integrated mental health services to individuals age 16 to 25 at a drop-in center. Clients receive mental health services as well as short-term residential and educational/vocational services to help transition-age youth become independent, stay out of the hospital or a higher level of care, reduce involvement in the criminal justice system, and reduce homelessness.	✓	✓	✓	✓	✓	✓		●		
Consumer-Operated Peer Support System	Includes an independent program using clients hired as mental health specialists. Services include peer education and advocacy, employment support, and life skills development classes. Also expands existing clubhouse services to underserved adults.	✓	✓	✓	✓	✓	✓			●	
Forensic Integrated Mental Health Services	Consists of three programs that all target severely and persistently mentally ill individuals involved with the criminal justice system. The programs are the forensic assertive community treatment program, the supervised treatment after release program, and the crisis intervention training program.	✓	✓	✓	✓	✓	✓			●	

PROGRAM TITLE	DESCRIPTION	FISCAL YEAR						AGE GROUP TARGETED			
		2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Community Services and Supports											
Assertive Community Treatment Team for High Users of Arrowhead Regional Center Behavioral Health Hospital	Provides support services 24 hours a day to clients who are frequent users of acute psychiatric hospitalization or are caught in the arrest cycle for minor crimes. The program includes peer support, clinical interventions, housing, and employment services.	✓	✓	✓	✓	✓	✓		●	●	●
Crisis Walk-In Center	Redesigns and expands current walk-in clinics to provide urgent mental health services. Provides integrated substance abuse treatment services for dually diagnosed clients.	✓	✓	✓	✓	✓	✓	●	●	●	●
Psychiatric Triage Diversion Team at Arrowhead Regional Medical Center	Creates a preliminary psychiatric screening program to better use mental health resources and reduce unnecessary hospitalizations.	✓	✓	✓	✓	✓	✓	●		●	●
Community Crisis Response Team	Combines the previously approved child's crisis response team and adult crisis response team, creating a community crisis response team, a seamless program that melds crisis intervention with outreach and education.			✓	✓	✓	✓	●	●	●	●
Homeless Intensive Case Management and Outreach	Provides case management services and linkage to community and county resources for mentally ill adults who are homeless or at risk of homelessness, incarceration, or hospitalization.			✓	✓	✓	✓		●	●	●
Alliance for Behavioral and Emotional Treatment	An alliance of organizations, private practitioners, and county departments that provide a variety of services to the mentally ill in the Big Bear Lake area.			✓	✓	✓	✓	●	●	●	●
System Transformation for Engaging Partners in Uplifting People	Develops Full-Service Partnership (Partnership) teams providing outpatient mental health and medication support services, community crisis intervention and case management services, and integrated treatment support.				✓					●	
Circle of Care: System Development	Provides mental health treatment and case management services to older adults age 60 and over to assist them in remaining independent and active in their communities.	✓	✓	✓	✓	✓	✓				●

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PROGRAM TITLE	DESCRIPTION	FISCAL YEAR						AGE GROUP TARGETED			
		2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Community Services and Supports											
Circle of Care: Mobile Outreach and Intensive Case Management	Provides a mobile crisis team that provides services to older adults who are isolated in their homes, homeless, or in crisis. Also establishes a Partnership system of care initially in the High Desert.	✓	✓	✓	✓	✓	✓			●	●
Improving Information Systems	Purchases multiple software applications, such as electronic health records and geographic information system applications, designed to better track the success of the Mental Health Services Act (MHSA) implementation.	✓	✓					●	●	●	●
Department Training Program	Provides a comprehensive staff development program to train all staff and clients who are hired or participate in client activities in leadership roles.	✓	✓					●	●	●	●
Cultural Competence Program	Provides a comprehensive cultural competence program to better serve an ethnically and linguistically diverse population and eliminate disparities in access to services.	✓	✓					●	●	●	●
Housing and Employment Program	Provides housing and employment support services according to the appropriate level of care.	✓	✓						●	●	●
Capital Purchases	San Bernardino County is requesting $4,033,800 to be used for capital purchases for all 10 programs to be funded and implemented under the MHSA. Capital purchases include purchases such as cars, copiers, computers, furniture, and office rents that are required tools to operate the programs requested in the county's three-year Community Services and Supports plan.	✓						•	•	•	•
Prevention and Early Intervention											
Student Assistance Program	Minimizes the barriers to learning and supports students in developing academic and personal success by training educators to identify students in need of additional interventions. Additionally, provides early intervention and counseling services.			✓	✓	✓	✓	●	●	●	
Resilience Promotion in African-American Children	Promotes resilience in African-American children in order to mediate the development of post-traumatic stress disorders, mood disorders, anxiety disorders, substance abuse, and psychotic disorders. The program consists of a 12-week intensive program followed by weekly counseling and mentoring.			✓	✓	✓	✓	●	●		

PROGRAM TITLE	DESCRIPTION	FISCAL YEAR						AGE GROUP TARGETED			
		2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Prevention and Early Intervention											
Preschool Project	Targets children (and their families) in Head Start programs who are displaying aggressive behavior or who have suffered traumatic loss. Includes programs to identify children needing referrals for more intensive mental health services, and provides direct services to children and their caregivers.			✓	✓	✓	✓	●	●	●	●
Family Resource Center	Attempts to reduce stigma and discrimination by providing a variety of prevention and early intervention services in a natural community setting. Each center implements programs that are culturally specific and community relevant.			✓	✓	✓	✓	●	●	●	●
Native American Resource Center	Provides culturally specific prevention and early intervention services to Native Americans.			✓	✓	✓	✓	●	●	●	●
National Curriculum and Training Institutes Crossroads Education Classes	Provides classes throughout the county in order to provide early intervention for children at risk of school failure and/or juvenile justice involvement. In addition, the program promotes communication between youth and family members.			✓	✓	✓	✓	●	●	●	
Promotores de Salud	Trains identified community leaders to become personal contacts or liaisons to mental health services and programs within the community. The goal of the program is to reduce stigma and make information regarding mental health resources more accessible.			✓	✓	✓	✓	●	●	●	●
Older Adult Community Services Program	Addresses needs of older adults by providing a mobile resource unit, wellness services, home safety programs, and suicide prevention through peer-to-peer counseling.			✓	✓	✓	✓			●	●
Child and Youth Connection	A collaborative effort with the San Bernardino County Department of Children's Services to screen children placed in foster care for mental health issues. Also provides funds for a mentoring specialist and a mental health liaison to the public defender's office.			✓	✓	✓	✓	●	●	●	●
Nurse Family Partnership/ LIFT	An evidence-based home visitation program in which nurses link families with needed health, mental health, and human social services.			✓	✓	✓	✓	●	●		

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PROGRAM TITLE	DESCRIPTION	FISCAL YEAR						AGE GROUP TARGETED			
		2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Prevention and Early Intervention											
Active Duty and Family Support	Provides in-home psychosocial assessments for returning military personnel and their families and provides prevention activities for children and families while a family member is deployed.			✓	✓	✓	✓	●	●	●	
Community Wholeness and Enrichment Project	Targets transition-age youth and adults and their families suffering early onset of mild mental health issues and identifies residents suffering from mild to moderate mental issues that can be addressed before hospitalization or incarceration.			✓	✓	✓	✓	●	●	●	●
Innovation											
On-Line Diverse Community Experiences	Creates pages on social networking sites such as Facebook and Twitter to disseminate news and information about mental health resources and increase connectivity. Also provides computer training to transition-age youth at community centers to aid access to online resources.					✓	✓	●	●	●	●
Coalition Against Sexual Exploitation	An interagency approach that includes government agencies, community organizations, parents, and other caretakers to develop a comprehensive model of interventions and services to address the issue of sexual exploitation of diverse children and youth.					✓	✓	●	●		
Community Resiliency Model	Adapts existing trauma training to a community-based model, offering training to diverse community members who in turn offer education and skills presentations to at-risk and underserved groups in their communities.					✓	✓	●	●	●	●
Holistic Campus	Creates a center that offers culturally appropriate and community-based mental health services for diverse and underserved populations outside of a clinical setting. Potential offerings include acupuncture, sweat lodges, pet therapy, yoga, and healing circles. Actual offerings are determined by a community advisory board.					✓	✓	●	●	●	●

PROGRAM TITLE	DESCRIPTION	FISCAL YEAR						AGE GROUP TARGETED			
		2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Innovation											
Interagency Youth Resiliency Team	Creates an interagency team to explore and test the implementation of innovative approaches that empower youth and their resource providers in the process of enhancing connections by resolving issues of grief and loss, resolving issues relating to exposure to violence, building coping skills, and assisting resource providers in navigating systems and services.					✓	✓	*		*	
Transition-Age Youth Behavioral Health Hostel	Creates a youth hostel to allow transition-age youth to access peer-run services and linkages to the mental health system. Focuses on two groups of underserved transition-age youth: former foster youth/wards; and lesbian, gay, bisexual, transgender, and questioning youth.						✓		●		
Workforce Education and Training											
Expand Existing Training Program	Provides clients and family members, all levels of the diverse workforce, and contract agencies with education and training needed to advance the vision and business strategy adopted by the county, as well as fundamental MHSA concepts.		✓	✓	✓	✓	✓	NA	NA	NA	NA
Training to Support the Fundamental Concepts of the MHSA	Provides access for county staff, contract agencies, and clients and family members to training on wellness, recovery, and discovery models as well as evidence-based practices.		✓	✓	✓	✓	✓	NA	NA	NA	NA
Development of Core Competencies	Develops processes to ensure that staff receive training in topics central to their duties, and that the content of those trainings has been vetted.		✓	✓	✓	✓	✓	NA	NA	NA	NA
Outreach to High School, Adult Education, Community College, and Regional Occupational Program Students	In collaboration with California State University, San Bernardino, develop a career pathway from high school through graduation from university for careers in the mental health system. Also, develops agreements with adult schools throughout the county to provide federally mandated vocational training at county facilities and collaborate with other community colleges to develop certificate programs for careers in mental health.		✓	✓	✓	✓	✓	NA	NA	NA	NA
Leadership Development Program	Develops leaders from existing staff, begins succession planning for future county leadership, and builds leadership into supervisory training.		✓	✓	✓	✓	✓	NA	NA	NA	NA

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PROGRAM TITLE	DESCRIPTION	FISCAL YEAR						AGE GROUP TARGETED			
		2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Workforce Education and Training											
Peer and Family Advocate Workforce Support Initiatives	Expand the number and locations of trainings for the Peer and Family Advocate Certificate program from the city to the county.		✓	✓	✓	✓	✓	NA	NA	NA	NA
Expand Existing Internship Program	Increases internships within the Department of Behavioral Health as well as coordinates intern programs with contract agencies, thereby increasing the pool of potential future employees.		✓	✓	✓	✓	✓	NA	NA	NA	NA
Psychiatric Residency Program	Establishes a psychiatric residency program through the Arrowhead Regional Medical Center with specializations in child or geriatric psychiatry, public mental health, or multidisciplinary psychiatry.		✓	✓	✓	✓	✓	NA	NA	NA	NA
Scholarship Program	Creates a scholarship program that helps current county employees continue their education in the mental health field.		✓	✓	✓	✓	✓	NA	NA	NA	NA
Increase Eligibility for Federal Workforce Funding	Works to obtain federal designation for four additional county areas as areas with a shortage of mental health professionals, which would then open up additional federal funding opportunities.		✓	✓	✓	✓	✓	NA	NA	NA	NA
Capital Facilities and Technological Needs											
One-Stop Center/Crisis Residential Program	Converts a former medical facility into a one-stop center for transition-age youth. The center provides access to care and houses a crisis residential program.				✓			NA	NA	NA	NA
Integrated Information Systems Infrastructure	Incorporates multiple technology projects, such as a Charon-Vax server upgrade and improvements to data warehouse and electronic record keeping, with the intent of creating an integrated information systems infrastructure.				✓	✓		NA	NA	NA	NA
Integrated Healthcare Project	Develops, in conjunction with other county agencies, an integrated health care facility that combines medical and behavioral health services to address the whole person.					✓		NA	NA	NA	NA

Sources: MHSA plans and annual updates prepared by the County of San Bernardino Department of Behavioral Health Administration.

NA = Not applicable. Workforce Education and Training and Capital Facilities and Technological Needs generally include efforts that focus on expanding, educating, and training the local public mental health workforce and improving infrastructure. Because programs within these components are not designed to provide direct mental health services, no age group is targeted.

✓ = Program appears in a plan applicable for the fiscal year.

● = County plan indicated that program targeted this age group.

* Program description in county's plan did not contain specific age groups. We, therefore, could not determine which discrete age groups the program targeted.

Table B.4
Santa Clara County Mental Health Department: Mental Health Services Act Planned Programs by Component
Fiscal Years 2006–07 Through 2011–12

		FISCAL YEAR						AGE GROUP TARGETED			
PROGRAM TITLE	DESCRIPTION	2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Community Services and Supports											
Child and Family System Improvement/ Full-Service Partnerships*	Provides a comprehensive program for youth age 0 to 15 that combines critical core services within a wraparound model that incorporates age-appropriate elements.	✓	✓	✓	✓	✓	✓	●			
Young Child System of Care Development	Creates a program, in cooperation with First Five Santa Clara and the Infant and Toddler Mental Health Collaborative, that addresses the full-service needs of children under the age of 6 in Santa Clara County who are experiencing significant mental health challenges.	✓	✓	✓	✓	✓	✓	●			
Child and Family System Improvement/ Behavioral Health Recovery Services*	Creates a strategic effort to improve the current Child and Family Behavioral Health outpatient system through the research, design, and implementation of systemwide level-of-care screening, assessment, and practice guidelines that incorporate core transformation principles and support selected evidence-based practices.	✓	✓	✓	✓	✓	✓	●			
Transition-Age Youth System of Care Development/ Full-Service Partnerships (Partnership)†	Combines critical core services and wraparound services designed for transition-age youth using a model called the Transition to Independence Process System.	✓	✓	✓	✓	✓	✓		●		
Transition-Age Youth Behavioral Health Services Outpatient System Redesign†	Creates a strategic effort to improve the current outpatient transition-age youth system through the research, design, and implementation of systemwide level-of-care screening, assessment, and practice guidelines that incorporate core transformation principles and support selected evidenced-based practices.	✓	✓	✓	✓	✓	✓		●		
Transition-Age Youth System of Care/Crisis and Drop-In Services and Supports†	Establishes a 24-hour drop-in center for transition-age youth that provides a safe place in a nonstigmatizing environment with access to mental health, other basic services, and crisis intervention during the day.	✓	✓	✓	✓	✓	✓		●		

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PROGRAM TITLE	DESCRIPTION	FISCAL YEAR						AGE GROUP TARGETED			
		2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Community Services and Supports											
Transition-Age Youth System of Care Development/ Education Partnership†	Establishes a specialized recovery-through-education program through a partnership with a local community college, the California Department of Mental Health, the California Department of Rehabilitation and potential employers.	✓	✓	✓	✓	✓	✓		●		
Adult System Development/ Full-Service Partnerships‡	Establishes a Partnership program that provides all necessary services and supports that assist the client in achieving his or her personal recovery goals.	✓	✓	✓	✓	✓	✓			●	
Adult System Development/ Behavioral Health Recovery Services— Outpatient System Redesign‡	Establishes a strategic effort to shift the current mental health outpatient system to a behavioral health model, including stakeholder involvement and embracing a wellness and recovery model.	✓	✓	✓	✓	✓	✓			●	
Adult Criminal Justice System Development	Addresses the mental health needs of individuals with concurrent mental health and substance abuse problems who are also involved in the criminal justice system.	✓	✓	✓	✓	✓	✓			●	
Adult System Development /Urgent Care and Crisis Support‡	Establishes urgent care and mobile crisis support services near the Santa Clara County Valley Medical Center Emergency Psychiatric Service. These will respond to individuals who are in immediate need of medication management, crisis intervention, and linkage to community-based outpatient services.	✓	✓	✓	✓	✓	✓			●	
Adult System Development/ Consumer and Family Self Help‡	Hires program managers for Consumer Affairs and Family Support and Education to increase the engagement of family, significant others, and peers in supporting the individualized wellness and recovery plan for each client.	✓	✓	✓	✓	✓	✓			●	
Older Adult System of Care Development/ Full-Service Partnerships§	Establishes a Partnership program for individuals over the age of 60 who are seriously mentally ill. Clients receive necessary services and supports that assist them in achieving their personal recovery goals.	✓	✓	✓	✓	✓	✓				●

PROGRAM TITLE	DESCRIPTION	FISCAL YEAR						AGE GROUP TARGETED			
		2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Community Services and Supports											
Older Adult System of Care Development/ Behavioral Health Recovery Services[§]	Represents a strategic effort to shift the current mental health outpatient system to a behavioral health model, including stakeholder involvement and embracing a wellness and recovery model.	✓	✓	✓	✓	✓	✓				●
Older Adult System of Care Development/ Mobile Assessment and Outreach[§]	Creates a mobile assessment and outreach team to provide for the mental health needs of older adults who are physically, linguistically, or culturally isolated.	✓	✓	✓	✓	✓	✓				●
Older Adult System of Care Development/ Family and Caregiver Support[§]	Provides counseling support and education to older adults, their families, and care providers on aging and mental health issues.	✓	✓	✓	✓	✓	✓				●
Housing Options Initiative	Provides permanent supportive and transitional housing.	✓	✓	✓	✓	✓	✓			●	
Community Family Outreach[‖]	Hires program managers for Consumer Affairs and Family Relations who will help the county move toward a more consumer-centered model of mental health recovery services.	✓	✓	✓	✓	✓	✓			●	
Behavioral and Primary Health Care Partnership	Creates a partnership with a local primary care provider to address a need for better access to basic health care for mental health clients.	✓	✓	✓	✓	✓	✓			●	
Behavioral Health Learning Partnership/ Education Employment, Self-Sufficiency Recovery Services[‖]	Creates a partnership with local community colleges to provide support for mental health clients to obtain their high school diploma and continue their education in community colleges or universities.	✓	✓	✓	✓	✓	✓			●	
Behavioral Health Learning Partnership	Creates a training center for stakeholders that include technical support, training, and consultation to ensure ongoing education in various healing practices.	✓	✓	✓	✓	✓	✓			●	
Adult System of Care Development/ Regional Survivors of Torture Treatment	Develops specialized services to assist refugees in Santa Clara County. Services will include psychiatric and psycho-social assessment and treatment, linkage to medical services, family support and education, and linkage to self-help through the Refugee and Immigrant Forum Ethnic Community Advisory Committee.	✓	✓	✓	✓	✓	✓			●	

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PROGRAM TITLE	DESCRIPTION	FISCAL YEAR						AGE GROUP TARGETED			
		2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Prevention and Early Intervention											
Community Engagement and Capacity Building for Reducing Stigma and Discrimination	Reduces disparities in access to mental health interventions among underserved cultural populations due to sigma, discrimination, and lack of knowledge about mental health services. This goal is accomplished through four strategies: expanding outreach and engagement, enhancing mental health literacy, identifying programs to reduce stigma and discrimination, and building community capacity.				✓	✓	✓	●	●	●	●
Strengthening Families and Children	Prevents or intervenes early in the development of emotional and behavioral problems in young children by providing parents with outcome-based parenting strategies, support services, and access to screenings to identify developmental delays. In conjunction with other agencies, these strategies establish a foundational network of prevention and early intervention services to underserved cultural populations.				✓	✓	✓	●	●		
Prevention and Early Interventions for Individuals Experiencing Onset of Serious Psychiatric Illness with Psychotic Features	Implements a continuum of services targeting individuals experiencing an at-risk mental state or first onset. The services attempt to detect and treat serious mental illness early through community education, targeted multicultural outreach, community-based interventions, multifamily support groups, peer-support services, supported employment, and education and social services navigation.				✓	✓	✓	●	●	●	●
Primary Care/ Behavioral Health Integration for Adults and Older Adults	Provides a continuum of services targeting adults and older adults experiencing the onset of psychiatric illness. Some key strategies for this project will focus on improved coordination between primary care services and mental health services; improved capacity of primary care providers to identify, prevent, and treat mental health problems; improved mental health and social functioning of those with serious mental illness; and creating programs to prevent suicide.					✓			●	●	●

PROGRAM TITLE	DESCRIPTION	FISCAL YEAR						AGE GROUP TARGETED			
		2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Prevention and Early Intervention											
Suicide Prevention	Implements the five strategies of the county's suicide plan including coordinated suicide intervention programs and services, a community education and information campaign, improved media coverage and public dialogue, policy and governance advocacy to promote change, and it establishes robust data collection and monitoring to evaluate prevention efforts.						✓	●	●	●	●
Innovation											
Early Childhood Universal Screening Project	Creates online screening tools in primary health care settings in order to better detect mental illness in children, especially those speaking only Spanish.					✓	✓	●		●	
Peer-Run Transition-Age Youth Innovation	Develops a model to expand the leadership capacity of transition-age youth partners in the delivery of services in 24-hour care setting to improve access and outcomes for high-risk residents.					✓	✓		●		
Adults with Autism and Co-Occurring Mental Health Disorders	Determines whether a specialized assessment instrument will help clinicians more accurately diagnose co-occurring mental health disorders in adults with autism.						✓			●	●
Older Adults	Increases quality of services for isolated older adults from underserved cultural and ethnic groups through a 12-week interactive activity in which the older adult is elicited to reminisce, capture, and express his or her life story.					✓	✓				●
Multi-Cultural Center	Increases access to underserved and inappropriately served ethnic communities by creating a multicultural center where members of all ethnic communities can find a sense of cultural resonance, belonging, and support. Services are designed and delivered by peer and family partners.					✓	✓	#		#	
Transitional Mental Health Services for Newly Released County Inmates	Creates a collaborative support group between the mental health department, faith-based organizations, and service providers for newly released inmates with mental health issues.					✓	✓	#		#	

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PROGRAM TITLE	DESCRIPTION	FISCAL YEAR						AGE GROUP TARGETED			
		2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Innovation											
Mental Health/Law Enforcement Post-Crisis Intervention	Collects data on all suicide or mental health-related calls in the city of San Jose and creates a response team that will follow up on all incidents within 24 hours.					✓	✓	#	#	#	
Interactive Video Simulator Training	Establishes a process whereby clients and family members, especially those from ethnic communities, can directly impart their perspectives and needs as they collaborate as equal partners in the creation of a training delivery system for law enforcement. The program also seeks to create a series of interactive video scenarios and lesson plans that impact the way law enforcement responds to mental health crisis situations.					✓	✓	**	**	**	
Workforce Education and Training											
Workforce Education and Training Coordination	Hires staff to implement the county's Workforce Education and Training plan.				✓	✓	✓	NA	NA	NA	NA
Promising Practice-Based Training in Adult Recovery Principles and Child, Adolescent and Family Service Models	Expands a training program for staff, contract staff, and stakeholders that addresses child, adolescent, and family treatment models.				✓	✓	✓	NA	NA	NA	NA
Improved Services & Outreach to Unserved and Underserved Populations	Expands training for all staff to improve services to ethnic and cultural populations including marginalized populations.				✓	✓	✓	NA	NA	NA	NA
Welcoming Consumers and Family Members	Develops and implements training, workshops, and consultations that create an environment that welcomes consumers and family members as contributing members of the public health system, thereby reducing barriers to accepting and welcoming consumers into the workforce.				✓	✓	✓	NA	NA	NA	NA
Workforce Education and Training Collaboration With Key System Partners	Builds on the collaboration between the Mental Health Department and key system partners to develop and share training and education programs so consumers and family members receive more effective integrated services.				✓	✓	✓	NA	NA	NA	NA

PROGRAM TITLE	DESCRIPTION	FISCAL YEAR						AGE GROUP TARGETED			
		2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Workforce Education and Training											
Comprehensive Mental Health Career Pathway Model	Develops a career pathway model for consumers and family members that leads to participants becoming eligible for part- and full-time permanent positions with the county or community-based organizations.				✓	✓	✓	NA	NA	NA	NA
Stipends and Incentives to Support Mental Health Career Pathway	Provides financial support to attract and enable clients, family, and community partners to enroll in a full range of educational programs that are prerequisites for employment and advancement in public mental health.				✓	✓	✓	NA	NA	NA	NA
Capital Facilities and Technological Needs											
Electronic Health Record	Provides a comprehensive electronic medical record for consumers that can be shared in a secure and integrated environment across service providers.				✓	✓	✓	NA	NA	NA	NA
Enterprise Wide Data Warehouse	Creates a single data repository for all Mental Health Department service, administrative, financial, and provider information.				✓	✓		NA	NA	NA	NA
Consumer Portal and Web site Redesign Initiative	Provides additional services for consumers and their families by enhancing the current Mental Health Department Web site and developing a secure client portal.				✓	✓		NA	NA	NA	NA
Consumer Learning Centers	Sets up supervised computer labs and provides basic personal computer skills training to clients in Mental Health Services Act recovery programs and living in the community.				✓	✓		NA	NA	NA	NA
Bed and Housing Database Exchange	Creates a database that allows operators of inpatient/residential mental health facilities to post their open beds whenever they become available so that case managers, clinicians, and others authorized to act on behalf of Mental Health Department clients can quickly see what is available in housing and/or beds.				✓	✓		NA	NA	NA	NA
County Health Record Integration	Creates a system that provides secure, real-time combined countywide client health records that can be accessed across various service-providing agencies and provide a collaborative, cross-agency view of registered clients' demographic, services and care, medications, physical health services, insurance, employment, housing, and other information.						✓	NA	NA	NA	NA

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PROGRAM TITLE	DESCRIPTION	FISCAL YEAR						AGE GROUP TARGETED			
		2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Capital Facilities and Technological Needs											
Medi-Plex Health Center (Facility Renovation)	Redesigns and reconstructs space for children and transition-age youth that is large enough to accommodate both and offer privacy and space for each group.						✓	NA	NA	NA	NA
Downtown Mental Health Renovation	Renovates a portion of a building that will be used for a self-help center providing outpatient services and training.						✓	NA	NA	NA	NA

Sources: Mental Health Services Act plans and annual updates prepared by the Santa Clara County Mental Health Department.

NA = Not applicable. Workforce Education and Training and Capital Facilities and Technological Needs generally include efforts that focus on expanding, educating, and training the local public mental health workforce and improving infrastructure. Because programs within these components are not designed to provide direct mental health services, no age group is targeted.

✓ = Program appears in a plan applicable for the fiscal year.

● = County plan indicated that program targeted this age group.

* Program combined into Child and Family System Improvement in fiscal year 2008–09.

† Program combined into Transition-Age Youth System of Care Development in fiscal year 2008–09.

‡ Program combined into Adult System Development in fiscal year 2008–09.

§ Program combined into Older Adult System of Care Development in fiscal year 2008–09.

‖ Program combined into Behavioral Health Learning Partnership/Education Employment, Self-Sufficiency Recovery Services in fiscal year 2008–09.

\# The county's Innovation component plan did not identify specific age groups for the program. We, therefore, could not determine which discrete age groups the program targeted.

** This program is not designed to provide mental health services; rather, the purpose of the program is to create and present an effective mental health training delivery system for field law enforcement officers by adapting an existing technology in a new and innovative manner.

Appendix C

Mental Health Services Act Client Demographics and Diagnoses for the Four Counties Reviewed Fiscal Years 2006–07 Through 2011–12

The Joint Legislative Audit Committee directed the California State Auditor to identify the demographics of the populations receiving services funded by the Mental Health Services Act (MHSA) in each of the four counties we reviewed. To provide additional information about the population receiving MHSA services, where available we obtained from each of the four counties mental health diagnoses of their clients. We did not confirm the accuracy or completeness of the demographic or diagnostic data the counties provided.

County Client Demographics

We reviewed four county departments: Los Angeles County Department of Mental Health (Los Angeles), County of Sacramento Department of Health and Human Services (Sacramento), County of San Bernardino Department of Behavioral Health Administration (San Bernardino), and Santa Clara County Mental Health Department (Santa Clara). Tables C.1 through C.4 beginning on page 109 summarize client demographic data for those departments for the Community Services and Supports (Community Supports), Prevention and Early Intervention (Prevention), and Innovation (Innovation) components by fiscal year. If a county could not provide data for a given component for the audit period, which we established as fiscal years 2006–07 through 2011–12, we did not display data for that component. For example, Table C.2 does not include demographic data for clients receiving Innovation services because Sacramento had not provided Innovation services as of fiscal year 2011–12.[14] The tables do not include the Workforce Education and Training and Capital Facilities and Technological Needs components because these components do not provide direct services to clients.

We identified three state-defined demographic categories to use for this review: age, ethnicity, and primary language. The tables include the age group demographic because age group is a main focus of MHSA program design. Regulations define four age groups: children and youth, from birth, or age 0,

[14] For fiscal year 2010–11, Sacramento included an Innovation program in its plan; the program is described in Appendix B. In fiscal years 2010–11 and 2011–12, Appendix D reflects that Sacramento made expenditures for Innovation. The fiscal year 2010–11 expenditures were for planning and the fiscal year 2011–12 expenditures were for a contract entity administering the Innovation program. However, as noted above, the county stated it was not providing Innovation services to mental health consumers in either fiscal year 2010–11 or 2011–12.

through age 17 and certain disabled individuals age 18 and over; transition-age youth, age 16 to 25; adults, age 18 through 59; and older adults, age 60 and older. To prevent unnecessary duplication of client counts, we requested that the counties provide information in non-overlapping age categories: children and youth, age 0-15; transition-age youth, age 16-25; adults, age 26-59; and older adults, age 60 and over. Also included are the ethnicity and primary language demographics because state regulations name both as contributing to a determination of being underserved, and the underserved are a focus of the MHSA. We limited the display of the primary language data that counties provided to the five most commonly reported primary languages for each county. For each county at least 95 percent of all clients who identified with a primary language, excluding those identified with "Other" or "Unknown," identified with one of the five most commonly reported languages.

Counties vary in the relative ethnic and linguistic makeup of their MHSA clients. For instance, tables C.1 and C.4 show that Hispanics and Latinos make up a significant number of MHSA clients in both Los Angeles and Santa Clara counties, respectively. Spanish and Vietnamese were common non-English primary languages among all counties' MHSA clients, although Los Angeles, Sacramento, San Bernardino, and Santa Clara counties reported Armenian, Russian, Farsi, and Chinese, respectively, as other major primary languages.

County Client Diagnoses

Tables C.5, C.6, and C.7 beginning on page 114 provide client diagnoses by fiscal year and county for the Community Supports, Prevention, and Innovation components, respectively. Not all counties tracked client diagnoses across these three components or for each year in our audit period. In some cases, this was because the counties had not yet implemented programs for a specific component, such as Innovation. To allow for comparison among counties, we summarized county-provided diagnoses into broader classifications as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV). According to the American Psychiatric Association, the DSM-IV is the standard classification of mental disorders used by mental health professionals in the United States. Each classification includes examples of the disorders that make up the classification.

Table C.1

Los Angeles County Department of Mental Health Client Counts for Age Group, Ethnicity, and Primary Language by Mental Health Services Act Component Fiscal Years 2006–07 Through 2011–12

		COMMUNITY SERVICES AND SUPPORTS						PREVENTION AND EARLY INTERVENTION			INNOVATION
		FISCAL YEAR 2006–07	FISCAL YEAR 2007–08	FISCAL YEAR 2008–09	FISCAL YEAR 2009–10	FISCAL YEAR 2010–11	FISCAL YEAR 2011–12	FISCAL YEAR 2009–10	FISCAL YEAR 2010–11	FISCAL YEAR 2011–12	FISCAL YEAR 2011–12
Age Group*	Children and Youth (0-15)	929	7,499	3,215	11,604	13,256	12,789	2,334	25,952	32,789	71
	Transition-Age Youth (16-25)	1,369	9,669	5,416	10,473	13,451	14,047	1,976	10,898	13,767	17
	Adult (26-59)	7,993	17,572	25,896	53,141	60,370	61,897	3,907	36,875	15,216	222
	Older Adult (60+)	1,105	3,184	4,745	9,051	10,134	10,695	340	2,251	1,565	34
Ethnicity	African-American	4,286	9,281	13,246	23,647	26,156	26,604	2,533	10,647	13,587	92
	American Native	35	187	199	540	580	555	61	203	279	19
	Asian/Pacific Islander	1,551	2,576	2,917	5,163	5,985	5,761	309	1,051	1,635	10
	Hispanic	3,026	7,927	11,990	29,994	35,461	36,770	3,627	26,167	35,780	60
	Other	527	1,095	1,370	3,247	3,687	3,741	283	1,335	2,078	13
	White	1,879	5,742	8,819	20,984	23,333	23,352	1,704	11,808	8,484	801
Primary Language†	Armenian	23	84	144	889	882	1,079	73	180	306	11
	Cambodian	731	1,792	768	970	964	1,050	7	64	97	2
	English	7,834	19,736	29,408	62,907	71,659	73,141	6,527	32,951	44,550	204
	Other	526	1,083	1,401	3,225	3,431	3,406	267	1,248	872	15
	Spanish	1,646	3,849	5,621	13,830	15,749	16,339	1,507	10,892	15,330	361
	Unknown/Not Reported	227	507	760	1,509	1,801	1,717	114	454	603	16
	Vietnamese	317	1,065	442	701	716	638	22	47	85	

Source: Unaudited information provided by the Los Angeles County Department of Mental Health (Los Angeles).

* California Code of Regulations relating to the Mental Health Services Act defines the age groups as children and youth age 0 through 17 and certain disabled individuals age 18 and over, transition-age youth age 16 to 25, adult age 18 to 59, and older adult age 60 and over.

† Primary Language lists the five most commonly reported languages in data provided by Los Angeles for fiscal years 2006–07 through 2011–12. We combined all other languages in the category "Other."

Table C.2

County of Sacramento Department of Health and Human Services Client Counts for Age Group, Ethnicity, and Primary Language by Mental Health Services Act Component
Fiscal Years 2007–08 Through 2011–12

		COMMUNITY SERVICES AND SUPPORTS					PREVENTION AND EARLY INTERVENTION		
		FISCAL YEAR 2007–08	FISCAL YEAR 2008–09	FISCAL YEAR 2009–10	FISCAL YEAR 2010–11	FISCAL YEAR 2011–12	FISCAL YEAR 2009–10	FISCAL YEAR 2010–11	FISCAL YEAR 2011–12
Age Group*	Children and Youth (0-15)	65	167	153	238	280	1,083	2,470	2,919
	Transition-Age Youth (16-25)	148	334	579	1,028	1,155	2,596	1,587	3,692
	Adult (26-59)	556	964	4,591	6,764	7,592	9,574	8,172	6,194
	Older Adult (60+)	118	110	534	828	830	1,363	447	921
	Unknown	11	4	1,729	583	582	50	6,334	26,926
Ethnicity	African-American	166	408	1,058	1,695	1,984	2,405	320	1,021
	Asian	149	99	723	1,020	966	1,501	167	477
	Hispanic	110	270	546	962	1,178	1,297	462	1,501
	Multi	63	48	46	92	91	1,058	182	510
	Native	5	51	60	163	196	122	89	256
	Other	19	16	269	321	348	1,899	7	110
	Pacific Islander	11	42	47	66	76	0	92	118
	Unknown	28	77	2,113	1,062	1,040	1,554	4,138	23,506
	White	347	1,338	2,724	4,179	4,560	5,946	13,553	18,731
Primary Language†	English	763	2,312	4,743	7,257	8,640	14,764	18,805	42,457
	Hmong	27	78	215	286	284	1	2	32
	Other	36	61	456	1,483	421	0	45	178
	Russian	3	2	79	77	75	0	6	27
	Spanish	12	77	195	270	191	0	86	1,001
	Unknown	30	80	1,766	762	701	4	64	1,086
	Vietnamese	27	5	132	136	127	0	2	11

Source: Unaudited information provided by the County of Sacramento Department of Health and Human Services (Sacramento).

* California Code of Regulations relating to the Mental Health Services Act defines the age groups as children and youth age 0 through 17 and certain disabled individuals age 18 and over, transition-age youth age 16 to 25, adult age 18 to 59, and older adult age 60 and over.

† Primary Language lists the five most commonly reported languages in data provided by Sacramento for fiscal years 2007–08 through 2011–12. We combined all other languages in the category "Other."

Table C.3

County of San Bernardino Department of Behavioral Health Administration Client Counts for Age Group, Ethnicity, and Primary Language by Mental Health Services Act Component
Fiscal Years 2006–07 Through 2011–12

		COMMUNITY SERVICES AND SUPPORTS						PREVENTION AND EARLY INTERVENTION				INNOVATION	
		FISCAL YEAR 2006–07	FISCAL YEAR 2007–08	FISCAL YEAR 2008–09	FISCAL YEAR 2009–10	FISCAL YEAR 2010–11	FISCAL YEAR 2011–12	FISCAL YEAR 2008–09	FISCAL YEAR 2009–10	FISCAL YEAR 2010–11	FISCAL YEAR 2011–12	FISCAL YEAR 2010–11	FISCAL YEAR 2011–12
Age Group*	Children and Youth (0-15)	82	561	1,983	2,197	2,005	1,870	466	16,757	19,199	10,886	5	1,151
	Transition-Age Youth (16-25)	581	1,070	2,497	3,920	3,563	3,117	217	2,473	14,223	9,973	12	1,207
	Adult (26-59)	1,771	2,224	4,324	6,904	7,225	6,706	27	5,626	12,614	40,207	–	3,634
	Older Adult (60+)	78	216	387	572	577	593	1	5,571	4,942	12,578	–	953
	Unknown	–	–	–	4	–	–	–	–	–	–	–	1,062
Ethnicity†	African-American	452	612	1,456	2,257	2,175	2,082	114	4,128	5,611	17,385	12	709
	Asian/Pacific Islander	55	89	126	231	233	236	8	1,056	1,045	9,588	–	998
	Hispanic/Latino	779‡	1,214‡	2,914‡	4,253‡	4,138‡	3,678‡	385	12,008‡	16,049	73,640‡	3	3,632
	Native American	25	50	93	128	132	124	2	1,156	821	7,982	–	253
	Other	762	1,108	2,590	4,009	3,707	3,159	43	1,876	9,634	18,987	–	893
	White/Caucasian	1,218	2,242	4,926	6,972	7,123	6,688	159	11,201	15,249	42,380	2	1,522
Primary Language§	English	2,190	3,665	8,440	12,392	12,326	11,587			20,797	131,151	17	4,453
	Farsi	–	–	2	–	–	1			–	270	–	3
	Mandarin	–	4	–	–	–	–			–	29	–	1
	Other	92	164	144	294	249	230	NA‖	NA‖	2,140	15,142	–	43
	Spanish	126	136	332	555	455	416			1,720	17,104	–	1,415
	Unknown	103	203	268	379	329	248			3,400	5,239	–	2,408
	Vietnamese	1	3	5	11	11	10			13	80	–	1

Source: Unaudited information provided by the County of San Bernardino Department of Behavioral Health Administration (San Bernardino).

* California Code of Regulations relating to the Mental Health Services Act defines the age groups as children and youth age 0 through 17 and certain disabled individuals age 18 and over, transition-age youth age 16 to 25, adult age 18 to 59, and older adult age 60 and over.

† San Bernardino provided detailed ethnicity data. We combined the data into six categories. Asian/Pacific Islander is composed of Amerasian, Asian/Pacific Islander, Asian Indian, Cambodian, Chinese, Filipino, Guamanian, Hmong, Japanese, Korean, Laotian, Samoan, Vietnamese, and Hawaiian Native. Hispanic is composed of Caribbean, Central American, Cuban, Dominican, Costa Rican, and Hispanic. Native American is composed of Native Alaskan and Native American. White includes White, Italian, and Armenian. Other is composed of Arab, Other Non-White, Unknown/Other, and Multiple.

‡ This includes persons of Hispanic origin, although those clients are also included in the category "Other."

§ Primary Language lists the five most commonly reported languages in data provided by San Bernardino for fiscal years 2006–07 through 2011–12. We combined all other languages in the category "Other."

‖ NA = Not available as San Bernardino did not provide Prevention and Early Intervention primary language information for this year.

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Table C.4

Santa Clara County Mental Health Department Client Counts for Age Group, Ethnicity, and Primary Language by Mental Health Services Act Component
Fiscal Years 2006–07 Through 2011–12

		COMMUNITY SERVICES AND SUPPORTS						PREVENTION AND EARLY INTERVENTION		INNOVATION
		FISCAL YEAR 2006–07	FISCAL YEAR 2007–08	FISCAL YEAR 2008–09	FISCAL YEAR 2009–10	FISCAL YEAR 2010–11	FISCAL YEAR 2011–12	FISCAL YEAR 2010–11	FISCAL YEAR 2011–12	FISCAL YEAR 2011–12
Age Group*	Children and Youth (0-15)	3,804	3,956	4,695	5,143	6,151	7,059	6	–	42
	Transition-Age Youth (16-25)	1,219	1,237	1,751	2,021	2,193	2,135	8	26	164
	Adult (26-59)	4,949	5,037	5,499	5,791	5,735	6,107	3	–	449
	Older Adult (60+)	880	907	979	968	1,027	1,045	–	–	17
	Unknown	–	–	–	–	–	–	–	–	127
Ethnicity	African-American	912	964	1,123	1,205	1,250	1,342	–	8	248
	American Indian	137	150	202	216	213	225	–	–	133
	Asian/Pacific Islander	1,892	1,829	1,884	1,918	2,007	1,979	–	10	347
	Latino	3,271	3,799	4,604	4,998	5,963	7,022	9	10	495
	Mixed	13	16	19	25	34	42	2	–	5
	Other	429	437	461	470	514	529	1	–	64
	Unknown	417	372	451	495	555	745	–	–	168
	White	3,781	3,779	4,180	4,381	4,570	4,681	5	17	262
Primary Language†	Cambodian	275	257	245	233	236	180	–	–	14
	Chinese	67	63	63	67	63	57	–	23	970
	English	8,684	8,983	10,341	11,040	12,036	12,998	10	–	23
	Other	407	408	427	443	465	447	5	–	472
	Spanish	743	987	1,186	1,215	1,630	2,140	2	–	1
	Vietnamese	519	530	556	558	551	550	–	–	31
	Unknown	157	112	106	105	125	187	–	–	8

Source: Unaudited information provided by the Santa Clara County Mental Health Department (Santa Clara).

* California Code of Regulations relating to the Mental Health Services Act defines the age groups as children and youth age 0 through 17 and certain disabled individuals age 18 and over, transition-age youth age 16 to 25, adult age 18 to 59, and older adult age 60 and over.

† Primary Language lists the five most commonly reported languages in data provided by Santa Clara for fiscal years 2006–07 through 2011–12. We combined all other languages in the category "Other."

Table C.5

Community Services and Supports Client Counts by Mental Health Diagnosis and County Fiscal Years 2006–07 Through 2011–12

MENTAL HEALTH DIAGNOSIS*	DESCRIPTION	FISCAL YEAR 2006–07				FISCAL YEAR 2007–08			
		LOS ANGELES	SACRAMENTO	SAN BERNARDINO	SANTA CLARA	LOS ANGELES	SACRAMENTO	SAN BERNARDINO	SANTA CLARA
Adjustment disorders	Includes adjustment disorders with depression and with anxiety.	143	NA†	28	699	404	19	143	764
Anxiety disorders	Includes disorders such as panic disorders, obsessive-compulsive disorder, and agoraphobia.	807	NA†	57	988	1,662	12	246	1,122
Delirium, dementia, and amnestic and other cognitive disorders	Includes delirium, dementia, and disorders such as amnestic disorders.	NA‡	NA†	NA‡	5	NA‡	2	NA‡	12
Disorders usually first diagnosed in infancy, childhood, or adolescence	Includes disorders such as mental retardation, attention-deficit, and disruptive behavior disorders.	647	NA†	172	1,712	1,555	30	233	1,927
Mood disorders	Includes depressive and bipolar disorders.	5,668	NA†	1,499	3,841	14,013	257	2,544	3,773
Personality disorders	Includes disorders such as borderline personality disorder, narcissistic personality disorder, and paranoid personality disorder.	2	NA†	[illegible]	[illegible]	5	[illegible]	[illegible]	12
Schizophrenia and other psychotic disorders	Includes disorders such as schizophrenia, delusional disorder, and psychotic disorders.	3,812	NA†	810	3,185	8,198	145	826	3,261
Somatoform disorders	Includes somatoform disorder and disorders such as pain disorder and hypochondriasis.	2	NA†	[illegible]	36	5	NA‡	[illegible]	5
Substance-related disorders	Includes disorders such as alcohol-related, amphetamine-related, and cocaine-related disorders.	107	NA†	36	NA‡	265	3	60	NA‡
Other	Includes disorders counties diagnose irregularly such as dissociative disorders, sexual and gender identity disorders, eating disorders, and sleep disorders.	87	NA†	10	18	247	4	18	124
None/unknown	Includes clients who left services before being diagnosed, those whom counties determined not to have a Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) disorder, and clients reported as having an unknown diagnosis.	29	NA†	NA‡	287	153	18	NA‡	333

continued . . .

Sources: Unaudited diagnosis data provided by the Los Angeles County Department of Mental Health (Los Angeles), the County of Sacramento Department of Health and Human Services (Sacramento), the County of San Bernardino Department of Behavioral Health Administration (San Bernardino), and the Santa Clara County Mental Health Department (Santa Clara).

NA = Not applicable.

* Mental health diagnosis based on classifications from the DSM-IV.

† Sacramento did not provide client counts for Community Services and Supports programs; the county stated it implemented those programs in fiscal year 2007–08.

‡ The county did not provide client counts for this mental health diagnosis.

FISCAL YEAR 2008–09				FISCAL YEAR 2009–10				FISCAL YEAR 2010–11				FISCAL YEAR 2011–12			
LOS ANGELES	SACRAMENTO	SAN BERNARDINO	SANTA CLARA	LOS ANGELES	SACRAMENTO	SAN BERNARDINO	SANTA CLARA	LOS ANGELES	SACRAMENTO	SAN BERNARDINO	SANTA CLARA	LOS ANGELES	SACRAMENTO	SAN BERNARDINO	SANTA CLARA
507	40	399	936	1,580	46	415	1,079	2,212	58	407	1,380	2,304	78	396	1,689
2,125	57	991	1,693	5,200	75	966	1,445	6,254	95	790	1,728	6,985	102	785	1,906
NA‡	–	NA‡	8	NA‡	2	NA‡	13	NA‡	1	NA‡	11	NA‡	1	NA‡	19
2,006	40	914	2,886	7,156	83	1,088	2,840	7,846	84	1,105	3,450	7,856	134	1,071	3,947
20,878	334	5,294	4,292	45,520	691	8,291	4,357	51,612	687	7,868	4,504	53,140	695	7,145	4,665
18	7	1	47	64	24	6	38	54	27	2	18	46	30	1	21
12,011	190	1,882	3,335	22,758	623	2,750	3,425	25,111	591	2,903	3,536	24,981	596	2,675	3,823
8	NA‡	1	30	37	NA‡	2	25	71	NA‡	1	24	71	NA‡	1	25
415	6	46	NA‡	617	1	32	NA‡	647	18	30	NA‡	640	20	26	NA‡
422	7	163	131	714	8	221	172	818	15	262	163	764	13	192	146
150	3	NA‡	445	392	9	NA‡	307	588	1	NA‡	322	532	10	NA‡	345

. . . continued

Table C.6

Prevention and Early Intervention Client Counts by Mental Health Diagnosis and County
Fiscal Years 2008–09 Through 2011–12

MENTAL HEALTH DIAGNOSIS*	DESCRIPTION	FISCAL YEAR 2008–09				FISCAL YEAR 2009–10				FISCAL YEAR 2010–11				FISCAL YEAR 2011–12			
		LOS ANGELES	SACRAMENTO	SAN BERNARDINO	SANTA CLARA	LOS ANGELES	SACRAMENTO	SAN BERNARDINO	SANTA CLARA	LOS ANGELES	SACRAMENTO	SAN BERNARDINO	SANTA CLARA	LOS ANGELES	SACRAMENTO	SAN BERNARDINO	SANTA CLARA
Adjustment disorders	Includes adjustment disorders with depression and with anxiety.	NA†	NA‡	16	NA§	291	NA‡	33	NA§	2,762	NA‡	71	2	4,601	1	196	107
Anxiety disorders	Includes disorders such as panic disorders, obsessive-compulsive disorder, and agoraphobia.	NA†	NA‡	17	NA§	563	NA‡	72	NA§	5,772	NA‡	49	4	8,512	3	96	57
Delirium, dementia, and amnestic and other cognitive disorders	Includes delirium, dementia, and disorders such as amnestic disorders.	NA†	NA‡	NA‖	NA§	NA‖	NA‡	NA‖	NA§	NA‖	NA‡	NA‖	–	NA‖	–	NA‖	–
Disorders usually first diagnosed in infancy, childhood, or adolescence	Includes disorders such as mental retardation, attention-deficit, and disruptive behavior disorders.	NA†	NA‡	11	NA§	[illegible]	NA‡	29	NA§	12,005	NA‡	34	2	15,295	3	110	[illegible]
Mood disorders	Includes depressive and bipolar disorders.	NA†	NA‡	33	NA§	4,949	NA‡	173	NA§	19,317	NA‡	68	3	26,831	7	86	322
Personality disorders	Includes disorders such as borderline personality disorder, narcissistic personality disorder, and paranoid personality disorder.	NA†	NA‡	[illegible]	NA§	[illegible]	NA‡	[illegible]	NA§	[illegible]	NA‡	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Schizophrenia and other psychotic disorders	Includes disorders such as schizophrenia, delusional disorder, and psychotic disorders.	NA†	NA‡	8	NA§	1,531	NA‡	17	NA§	3,535	NA‡	–	4	4,364	71	2	25
Somatoform disorders	Includes somatoform disorder and disorders such as pain disorder and hypochondriasis.	NA†	NA‡	[illegible]	NA§	[illegible]	NA‡	[illegible]	NA§	[illegible]	NA‡	[illegible]	[illegible]	1,224	[illegible]	2	[illegible]
Substance-related disorders	Includes disorders such as alcohol-related, amphetamine-related, and cocaine-related disorders.	NA†	NA‡	2	NA§	44	NA‡	1	NA§	112	NA‡	3	NA‖	169	1	7	NA‖
Other	Includes disorders counties diagnose irregularly such as dissociative disorders, sexual and gender identity disorders, eating disorders, and sleep disorders.	NA†	NA‡	[illegible]	NA§	94	NA‡	28	NA§	313	NA‡	81	2	391	–	506	16
None/unknown	Includes clients who left services before being diagnosed, those whom counties determined not to have a Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) disorder and clients reported as having an unknown diagnosis.	NA†	NA‡	NA‖	NA§	87	NA‡	NA‖	NA§	1,422	NA‡	NA‖	–	1,653	–	NA‖	41

Sources: Unaudited diagnosis data provided by the Los Angeles County Department of Mental Health (Los Angeles), the County of Sacramento Department of Health and Human Services (Sacramento), the County of San Bernardino Department of Behavioral Health Administration (San Bernardino), and the Santa Clara County Mental Health Department (Santa Clara).

NA = Not applicable.

* Mental health diagnosis based on classifications from the DSM-IV.

† Los Angeles did not provide client counts for Prevention and Early Intervention (Prevention) programs; the county stated it began those programs in fiscal year 2009–10.

‡ Sacramento did not provide client counts for Prevention programs; the county stated it tracked one program beginning in fiscal year 2011–12.

§ Santa Clara did not provide client counts for Prevention programs; the county stated it implemented those programs in fiscal year 2010–11.

‖ The county did not provide client counts for this mental health diagnosis.

Table C.7
Innovation Client Counts by Mental Health Diagnosis and County
Fiscal Year 2011–12

		FISCAL YEAR 2011–12			
MENTAL HEALTH DIAGNOSIS*	DESCRIPTION	LOS ANGELES	SACRAMENTO	SAN BERNARDINO	SANTA CLARA
Adjustment disorders	Includes adjustment disorders with depression and with anxiety.	13	NA†	NA§	1
Anxiety disorders	Includes disorders such as panic disorders, obsessive-compulsive disorder, and agoraphobia.	21	NA†	NA§	18
Delirium, dementia, and amnestic and other cognitive disorders	Includes delirium, dementia, and disorders such as amnestic disorders.	NA†	NA†	NA§	–
Disorders usually first diagnosed in infancy, childhood, or adolescence	Includes disorders such as mental retardation, attention-deficit and disruptive behavior disorders.	2	NA†	NA§	1
Mood disorders	Includes depressive and bipolar disorders.	194	NA†	NA§	12
Personality disorders	Includes disorders such as borderline personality disorder, narcissistic personality disorder, and paranoid personality disorder.	–	NA†	NA§	–
Schizophrenia and other psychotic disorders	Includes disorders such as schizophrenia, delusional disorder, and psychotic disorders.	41	NA†	NA§	2
Somatoform disorders	Includes somatoform disorders and disorders such as pain disorder and hypochondriasis.	–	NA†	NA§	–
Substance-related disorders	Includes disorders such as alcohol-related, amphetamine-related, and cocaine-related disorders.	1	NA†	NA§	NA‡
Other	Includes disorders counties diagnose irregularly.‖	1	NA†	NA§	–
None/unknown	Includes clients who left services before being diagnosed, those whom counties determined not to have a Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) disorder, and clients reported as having an unknown diagnosis.	–	NA†	NA§	2

Sources: Unaudited diagnosis data provided by the Los Angeles County Department of Mental Health (Los Angeles), the County of Sacramento Department of Health and Human Services (Sacramento), the County of San Bernardino Department of Behavioral Health Administration (San Bernardino), and the Santa Clara County Mental Health Department (Santa Clara).

NA = Not applicable.

* Mental health diagnosis based on classifications from the DSM-IV.

† Sacramento did not provide client counts for Innovation programs; the county stated it did not offer services through Innovation programs until fiscal year 2012–13.

‡ The county did not provide client counts for this mental health diagnosis.

§ San Bernardino did not provide client counts for Innovation programs; the county stated it does not collect data in a usable format pending a software implementation.

‖ Los Angeles reported one client with an unspecified disorder affecting a medical condition.

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Appendix D

Mental Health Services Act Revenues, Expenditures, and Prudent Reserves for the Four Counties Reviewed Fiscal Years 2006–07 Through 2011–12

The Joint Legislative Audit Committee directed the California State Auditor to compare counties' Mental Health Services Act (MHSA) planned expenditures to their actual expenditures for the last six fiscal years, which we established as 2006–07 through 2011–12. We reviewed four county departments: Los Angeles County Department of Mental Health, County of Sacramento Department of Health and Human Services, County of San Bernardino Department of Behavioral Health Administration, and Santa Clara County Mental Health Department. Tables D.1 through D.4 on the following pages summarize their revenues and expenditures using data obtained from the annual Revenue and Expenditure Report (RER) each county submitted to Mental Health. The RER ranged from fiscal years 2006–07 through 2010–11. In order to present MHSA revenues for years for which a county had not yet prepared an RER, we used the allocation amounts presented in Appendix A; for county expenditures, we obtained county accounting information. We did not confirm the accuracy or completeness of the counties' RERs or the accounting information they provided. Tables D.1, D.2, D.3, and D.4 generally show that, in total, the counties had growing positive ending balances in the earlier years of the time frame and that these peaked in fiscal year 2010–11.

To ensure that program service levels continue in the event of an MHSA revenue shortfall, counties are required to establish and maintain a prudent reserve. Tables D.1 through D.4 show the MHSA funds each county contributed to its prudent reserve as expenditures; the tables also summarize these funds in a stand-alone section. Because we obtained county contributions to the prudent reserve from the counties' RERs, we could not identify the amounts counties may have dedicated to their prudent reserves in fiscal years for which RERs were not available. Also, the stand-alone tables summarizing prudent reserve do not reflect funds the counties may have spent from these reserves. All expenditures are reflected in tables D.1 through D.4.

Table D.1

Los Angeles County Department of Mental Health: Mental Health Services Act Revenues and Expenditures by Component Fiscal Years 2006–07 Through 2011–12

Revenues and Expenditures by Component

COMPONENT	FISCAL YEAR 2006–07*	2007–08*	2008–09*	2009–10*	2010–11†	2011–12†
Community Services and Supports						
Unspent funds available	$69,580,600	$119,546,820	$128,669,270	$5,806,002	$34,791,908	$113,731,605
Revenues	107,787,977	158,076,638	182,714,073	260,798,561	319,091,506‡	210,077,200
Expenditures	57,821,757	148,954,188	177,999,591	230,812,655	240,151,809	249,898,868
Contributions to prudent reserve‖	–	–	127,577,750	–	–	–
Ending balance	119,546,820	128,669,270	5,806,002	34,791,908	113,731,605	73,909,937
Prevention and Early Intervention						
Unspent funds available	$–	$–	$6,220,352	$100,461,486	$143,979,291	$216,594,237
Revenues	–	7,074,500	97,522,000	87,648,558	122,608,254	67,946,000
Expenditures	–	854,148	3,280,866	10,983,101	49,993,308	81,599,995
Contributions to prudent reserve‖	–	–	–	33,147,652	–	–
Ending balance	–	6,220,352	100,461,486	143,979,291	216,594,237	202,940,242
Innovation						
Unspent funds available	$–	$–	$–	$20,294,900	$40,006,830	$89,687,855
Revenues	–	–	20,294,900	20,294,900	50,730,032	13,909,700
Expenditures	–	–	–	582,970	1,049,007	4,983,293
Ending balance	–	–	20,294,900	40,006,830	89,687,855	98,614,262
Workforce Education and Training						
Unspent funds available	$–	$–	$814,730	$2,098,038	$54,014,046	$87,956,208
Revenues	–	2,450,146	27,519,016	37,268,778	37,868,778	11,800,000
Expenditures	–	1,585,416	7,352,608	4,735,770	3,926,616	3,472,844
Ending balance	–	864,730	20,981,138	54,014,046	87,956,208	96,283,364
Capital Facilities and Technological Needs						
Unspent funds available	$–	$–	$–	$43,359,775	$70,204,026	$152,913,733
Revenues	–	–	43,359,775	28,570,858	88,232,464	–
Expenditures	–	–	–	1,727,107	5,522,757	2,322,814
Ending balance	–	–	43,359,775	70,204,026	152,913,733	98,590,919
Total ending balances	**$119,546,820**	**$135,704,352**	**$190,903,301**	**$342,996,101**	**$660,883,638**	**$600,338,726**

Mental Health Services Act Funds Dedicated to Local Prudent Reserve

COMPONENT	2006–07	2007–08	2008–09	2009–10	2010–11‖	2011–12‖	TOTAL
Community Services and Supports	$–	–	$127,577,750	–	$–	$–	$127,577,750
Prevention and Early Intervention	–	–	–	$33,147,652	–	–	33,147,652
Totals	**$–**	**$–**	**$127,577,750**	**$33,147,652**	**$–**	**$–**	**$160,725,402**

Sources: Unaudited county Revenue and Expenditure Reports (RERs), unaudited internal county accounting data, and Appendix A allocation data.

* For fiscal years 2006–07 through 2009–10, revenues and expenditures are from the county's unaudited RERs. According to the director of finance for the county's Mental Health Department, revenues reflect cash received for the respective fiscal year and interest earned on those amounts.

† For fiscal years 2010–11 and 2011–12, revenues are based on state-allocated amounts the California Department of Mental Health reported and include some funds the county assigned to a Joint Powers Authority and, therefore, were not administered locally (see Appendix A). Expenditures are based on unaudited county accounting reports.

‡ According to the director of finance for the county's Mental Health Department, Community Services and Supports revenue for fiscal year 2010–11 was $210 million. Revenues are based on state-allocated amounts the California Department of Mental Health reported and are unaudited.

‖ The Mental Health Services Act requires a prudent reserve to ensure that the county can continue to provide Community Services and Supports and Prevention and Early Intervention programs to its current clients. The amounts shown are from the county's RERs and these documents were limited to fiscal years 2006–07 through 2009–10; thus, there may be contributions to the prudent reserve the table does not reflect.

Table D.2
County of Sacramento Department of Health and Human Services: Mental Health Services Act Revenues and Expenditures by Component
Fiscal Years 2006–07 Through 2011–12

Revenues and Expenditures by Component

COMPONENT	FISCAL YEAR 2006–07*	2007–08*	2008–09*	2009–10†	2010–11†	2011–12†
Community Services and Supports‡						
Unspent funds available	$1,231,301	$7,052,900	$11,285,593	$17,521,544	$15,366,689	$16,945,386
Revenues	13,769,665	16,507,375	30,857,863	27,976,100	33,141,107	23,754,100
Expenditures	7,948,066	9,622,947	15,501,500	30,130,955	31,562,410	24,661,208
Contributions to prudent reserve§	–	2,651,735	9,120,412	–	–	–
Ending balance	7,052,900	11,285,593	17,521,544	15,366,689	16,945,386	16,038,278
Prevention and Early Intervention						
Unspent funds available	$–	$–	$–	$1,232,942	$12,536,187	$30,703,357
Revenues	–	–	1,529,164	12,246,700	21,657,600	7,546,300
Expenditures	–	–	296,222	943,455	3,490,430	8,565,608
Contributions to prudent reserve§	–	–	–	–	–	–
Ending balance	–	–	1,232,942	12,536,187	30,703,357	29,684,049
Innovation‖						
Unspent funds available	$–	$–	$–	$–	$2,267,300	$10,504,242
Revenues	–	–	–	2,267,300	8,379,100	1,565,200
Expenditures	–	–	–	–	142,158	4,152,581
Ending balance	–	–	–	2,267,300	10,504,242	7,916,861
Workforce Education and Training						
Unspent funds available	$–	$–	$–	$402,178	$203,096	$(130,108)
Revenues	–	–	439,649	–	–	–
Expenditures	–	–	37,471	199,082	333,204	517,939
Ending balance	–	–	402,178	203,096	(130,108)	(648,047)
Capital Facilities and Technological Needs						
Unspent funds available	$–	$–	$–	$9,431	$884,431	$390,718
Revenues	–	–	642,371	875,000	1,797,290	–
Expenditures	–	–	632,940	1,299,713	2,291,003	2,110,071
Ending balance	–	–	9,431	884,431	390,718	(1,719,353)
Total ending balances	**$7,052,900**	**$11,285,593**	**$19,166,095**	**$31,257,703**	**$58,413,595**	**$51,271,788**

continued on next page...

Mental Health Services Act Funds Dedicated to Local Prudent Reserve

COMPONENT	FISCAL YEAR 2006–07	2007–08	2008–09	2009–10§	2010–11§	2011–12§	TOTAL
Community Services and Supports	$–	$2,651,735	$9,120,412	$–	$–	$–	$11,772,147
Prevention and Early Intervention	–	–	–	–	–	–	–
Totals	**$–**	**$2,651,735**	**$9,120,412**	**$–**	**$–**	**$–**	**$11,772,147**

Sources: Unaudited county Revenue and Expenditure Reports (RERs), unaudited internal county accounting data, and Appendix A allocation data.

* For fiscal years 2006–07 through 2008–09, revenues and expenditures are from the county's unaudited RERs. Revenues reflect deposits from state-allocated amounts and interest earned on those amounts.

† For fiscal years 2009–10 through 2011–12, revenues are based on state-allocated amounts the California Department of Mental Health reported and include some funds the county assigned to a Joint Powers Authority and, therefore, were not administered locally (see Appendix A). Expenditures are based on unaudited county accounting reports.

‡ Because of the nature of its accounting systems, Sacramento's Community Services and Supports expenditure totals for fiscal years 2009–10 and 2010–11 include amounts that may later be reimbursed by non-MHSA funds. As a result, Community Services and Supports total expenditures for those years may be overstated.

§ The Mental Health Services Act requires a prudent reserve to ensure that the county can continue to provide Community Services and Supports and Prevention and Early Intervention programs to its current clients. The amounts shown are from the county's RERs and these documents were limited to fiscal years 2006–07 through 2008–09; thus, there may be contributions to the prudent reserve the table does not reflect.

‖ For fiscal year 2010–11, Sacramento included an Innovation program in its plan; the program is described in Appendix B. In fiscal years 2010–11 and 2011–12, Appendix D reflects that Sacramento made expenditures for Innovation. The fiscal year 2010–11 expenditures are for planning and the fiscal year 2011–12 expenditures are for a contracted entity administering the Innovation program. However, the county stated it was not providing Innovation services to mental health consumers in either fiscal year 2010–11 or 2011–12.

Table D.3
County of San Bernardino Department of Behavioral Health Administration: Mental Health Services Act Revenues and Expenditures by Component
Fiscal Years 2006–07 Through 2011–12

Revenues and Expenditures by Component

	FISCAL YEAR					
COMPONENT	2006–07*	2007–08*	2008–09*	2009–10*	2010–11*	2011–12†
Community Services and Supports						
Unspent funds available	$4,826,566	$22,658,065	$16,898,180‡	$14,213,315	$5,375,467	$14,528,329
Revenues	23,182,869	32,231,426	36,781,333	27,864,269	52,343,415	39,143,000
Expenditures	5,351,370	27,899,042	39,466,198	40,394,678	43,190,553	52,268,360
Contributions to prudent reserve§	–	(11,989,911)	–	(5,107,439)	–	–
Ending balance	22,658,065	15,900,538	14,213,315	5,375,467	14,528,329	1,402,969
Prevention and Early Intervention						
Unspent funds available	$–	$–	$676,619	$15,324,917	$14,521,032	$20,666,822
Revenues	–	881,387	17,511,603	7,628,096	16,407,441	12,213,200
Expenditures	–	204,768	2,863,305	9,276,968	10,261,651	13,199,134
Contributions to prudent reserve§	–	676,619	–	5,055,013	–	–
Ending balance	–	15,324,917	14,213,032	20,666,822	19,680,888	
Innovation						
Unspent funds available	$–	$–	$–	$(6,167)	$6,467,016	$12,837,468
Revenues	–	–	–	6,794,246	7,110,599	2,570,200
Expenditures	–	–	6,167	321,063	740,147	5,979,698
Ending balance	–	–	(6,167)	6,467,016	12,837,468	9,427,970
Workforce Education and Training						
Unspent funds available	$–	$–	$130,654	$10,893,797	$9,730,507	$8,548,314
Revenues	–	754,600	11,856,500	1,204,765	120,145	1,800,000
Expenditures	–	623,946	1,093,357	2,368,055	1,302,338	1,993,020
Ending balance	–	130,654	10,893,797	9,730,507	8,548,314	8,355,294
Capital Facilities and Technological Needs						
Unspent funds available	$–	$–	$–	$–	$21,554,836	$19,589,365
Revenues	–	–	–	21,779,502	1,953,323	1,124,439
Expenditures	–	–	–	2,224,666	3,918,794	1,474,804
Ending balance	–	–	–	19,554,836	19,589,365	19,114,561
Total ending balances	**$22,658,065**	**$17,749,821**	**$40,425,862**	**$57,648,858**	**$76,170,298**	**$56,981,682**

Mental Health Services Act Funds Dedicated to Local Prudent Reserve

COMPONENT	2006–07	2007–08	2008–09	2009–10	2010–11	2011–12§	TOTAL
Community Services and Supports	$–	$11,989,911	$–	$5,107,439	$–	$–	$17,097,350
Prevention and Early Intervention	–	–	–	5,055,013	–	–	5,055,013
Totals	**$–**	**$11,989,911**	**$–**	**$10,162,452**	**$–**	**$–**	**$22,152,363**

Sources: Unaudited county Revenue and Expenditure Reports (RERs), unaudited internal county accounting data, and Appendix A allocation data.

* For fiscal years 2006–07 through 2010–11, revenues and expenditures are from the county's unaudited RERs. Revenues reflect deposits from state-allocated amounts and interest earned on those amounts.

† For fiscal year 2011–12, revenues are based on state-allocated amounts the California Department of Mental Health reported and include some funds the county assigned to a Joint Powers Authority and therefore were not administered locally (see Appendix A). Expenditures are based on unaudited county accounting reports.

‡ The unspent funds available as noted on the county's RER for fiscal year 2008–09 differed from the reported ending balance for fiscal year 2007–08 by over $44,000. The table reflects the difference.

§ The MHSA requires a prudent reserve to ensure that the county can continue to provide Community Services and Supports and Prevention and Early Intervention programs to its current clients. The amounts shown are from the county's RERs and these documents were limited to fiscal years 2006–07 through 2010–11; thus, there may be contributions to the prudent reserve the table does not reflect.

Table D.4

Santa Clara County Mental Health Department: Mental Health Services Act Revenues and Expenditures by Component
Fiscal Years 2006–07 Through 2011–12

Revenues and Expenditures by Component

COMPONENT	2006–07*	2007–08*	2008–09*	2009–10*	2010–11†	2011–12†
Community Services and Supports						
Unspent funds available	$541,443	$17,502,332	$22,209,300	$21,513,979	$21,213,304	$35,842,965
Revenues	20,253,043	29,209,374	29,578,237	37,295,274	48,528,816	33,536,100
Expenditures	3,292,154	16,362,683	30,273,558	31,139,949	33,899,155	31,590,232
Contributions to prudent reserve‡	–	8,139,723	–	6,456,000	–	–
Ending balance	17,502,332	22,209,300	21,513,979	21,213,304	35,842,965	37,788,833
Prevention and Early Intervention						
Unspent funds available	$–	$–	$1,122,314	$790,434	$3,793,491	$35,344,648
Revenues	–	1,216,607	24,604	11,677,300	37,640,067	11,254,700
Expenditures	–	94,293	356,484	3,974,243	6,088,910	11,127,713
Contributions to prudent reserve‡	–	–	–	4,700,000	–	–
Ending balance	–	1,122,314	790,434	3,793,491	35,344,648	35,471,635
Innovation						
Unspent funds available	$–	$–	$–	$–	$240,772	$11,543,088
Revenues	–	–	–	310,919	11,720,900	2,238,600
Expenditures	–	–	–	70,147	418,584	2,553,459
Ending balance	–	–	–	240,772	11,543,088	11,228,229
Workforce Education and Training						
Unspent funds available	$–	$–	$695,073	$245,310	$7,921,404	$7,232,081
Revenues	–	743,304	18,419	9,294,049	2,000,000	–
Expenditures	–	48,231	468,182	1,617,955	2,689,323	1,851,704
Ending balance	–	695,073	245,310	7,921,404	7,232,081	5,380,377
Capital Facilities and Technological Needs						
Unspent funds available	$–	$–	$–	$–	$11,772,188	$19,488,405
Revenues	–	–	–	11,888,212	9,459,000	–
Expenditures	–	–	–	116,024	1,742,783	2,517,915
Ending balance	–	–	–	11,772,188	19,488,405	16,970,490
Total ending balances	**$17,502,332**	**$24,026,687**	**$22,549,723**	**$44,941,159**	**$109,451,187**	**$106,839,564**

Mental Health Services Act Funds Dedicated to Local Prudent Reserve

COMPONENT	2006–07	2007–08	2008–09	2009–10	2010–11‡	2011–12‡	TOTAL
Community Services and Supports	$–	$8,139,723	$–	$6,456,000	$–	$–	$14,595,723
Prevention and Early Intervention	–	–	–	4,700,000	–	–	4,700,000
Totals	**$–**	**$8,139,723**	**$–**	**$11,156,000**	**$–**	**$–**	**$19,295,723**

Sources: Unaudited county Revenue and Expenditure Reports (RERs), unaudited internal county accounting data, and Appendix A allocation data.

* For fiscal years 2006–07 through 2009–10, revenues and expenditures are from the county's unaudited RERs. Revenues reflect deposits from state-allocated amounts and interest earned on those amounts.

† For fiscal years 2010–11 and 2011–12, revenues are based on state-allocated amounts the California Department of Mental Health reported and include some funds the county assigned to a Joint Powers Authority and therefore were not administered locally (see Appendix A). Expenditures are based on unaudited county accounting reports.

‡ The Mental Health Services Act requires a prudent reserve to ensure that the county can continue to provide Community Services and Supports and Prevention and Early Intervention programs to its current clients. The amounts shown are from the county's RERs and these documents were limited to fiscal years 2006–07 through 2009–10; thus, there may be contributions to the prudent reserve the table does not reflect.

DHCS
TOBY DOUGLAS
DIRECTOR

State of California—Health and Human Services Agency
Department of Health Care Services

EDMUND G. BROWN JR.
GOVERNOR

JUL 17 2013

Ms. Elaine M. Howle, CPA*
State Auditor
California Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, CA 95814

Dear Ms. Howle:

The California Department of Health Care Services has prepared its response to the California State Auditor, Bureau of State Audits' (BSA) draft report, "Mental Health Services Act: The State's Oversight has Provided Little Assurance of the Act's Effectiveness [redacted]," report number 2012-122.

DHCS appreciates the work performed by BSA and the opportunity to respond to the draft report. Please contact Ms. Melanie Pascua, Audit Coordinator, at (916) 445-2410 if you have any questions.

Sincerely,

for Toby Douglas, Director

Enclosure

cc: See Next Page

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* California State Auditor's comment appears on page 133.

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**Department of Health Care Services'
Response to the Bureau of State Audits Draft Report Entitled
"Mental Health Services Act: The State's Oversight has Provided Little Assurance
of the Act's Effectiveness [redacted]," Report Number 2012-122**

Chapter 1: Despite the State's Historically Inadequate Oversight, Opportunity Exists to Demonstrate the Effectiveness of the Mental Health Services Act (MHSA)

Recommendation: To ensure that it monitors counties to the fullest extent including conducting the monitoring MHSA specifies as well as implementing best practices, the Department of Health Care Services (DHCS or Department) should draft and enter into a performance contract with each county that contains assurances that allow for effective oversight and further the intent of the MHSA, including counties demonstrating that each of their MHSA-funded programs are meeting its intent.

Response: DHCS agrees with the recommendation.

The current draft of the performance contract contains language that allows DHCS to monitor a county's performance according to the provisions of the Mental Health Services Act and related regulations. The draft performance contract also provides that a county may be required to develop a plan of correction regarding any findings. The draft performance contract also requires each county to annually certify that it is in compliance with all MHSA related laws and regulations.

To assist in demonstrating that counties meet the intent of the MHSA, the draft performance contract requires MHSA data reporting on full service partnerships, the achievement of performance outcomes, and revenues and expenditures. The Department will use this information for audits and reporting to the public and the Accountability Commission will be able to use it to support their evaluation activities according to the Oversight Commission Evaluation Master Plan.

DHCS will release the performance contract to counties in August 2013. It should be noted that DHCS must negotiate the terms of the performance contract with counties, and the release of this contract was delayed due to contract negotiations.

Recommendation: To ensure that it monitors counties to the fullest extent including conducting the monitoring MHSA specifies as well as implementing best practices, DHCS should conduct comprehensive onsite

reviews of counties' MHSA-funded programs including verifying county compliance with MHSA requirements.

Response: DHCS agrees with the recommendation.

Program Compliance Reviews:
DHCS performs a Medi-Cal Specialty Mental Health Services system review of each County Mental Health Plan on a triennial basis. Within the current limitation of program review resources, the Department has added questions specific to MHSA program requirements to the FY 2013-14 Annual Review Protocol for Consolidated Specialty Mental Health Services and Other Funded Services. The FY 2013-14 reviews will begin in October 2013.

The Department will require a county to submit a plan of correction for any items found to be out of compliance. The Department will follow up with the county to ensure it has implemented a plan of correction that is effective. For any significant compliance issues, the Department may conduct focused reviews and/or more frequent site reviews to assure corrective actions are clearly identified and implemented.

To the extent that it is able to do so with available staff resources, the Department will continue to develop MHSA programmatic review criteria to add to its compliance protocol with input from the Accountability Commission.

Fiscal Audits:

DHCS has three audit positions dedicated to completing comprehensive onsite reviews of counties' MHSA funded programs including verifying county compliance with MHSA requirements. DHCS will start the onsite reviews in the current production cycle.

Recommendation: To ensure that counties have needed guidance to implement and evaluate MHSA-funded programs, DHCS should issue regulations, as appropriate, for Prevention, Innovation, and Facilities programs and for other MHSA requirements such as a prudent reserve.

Response: DHCS agrees with the recommendation.

Due to the recent enactment of Assembly Bill 82 (Chapter 23, Statutes of 2013), the Accountability Commission is now responsible for developing regulations for Prevention and Early Intervention (PEI) and Innovation (INN) components while DHCS ①

continues to be responsible for developing regulations for the Community Services and Supports (CSS), Workforce Education and Training (WET), and Capital Facilities/Technological Needs (CF/TN) components.

DHCS will work in collaboration with the Accountability Commission beginning in July 2013 to review the current MHSA regulations and develop additional regulations. Work will begin with a review of the general MHSA requirements, including the local stakeholder process. The Department will review and revise CSS regulations followed by the development of CF/TN regulations. The Office of Statewide Health Planning and Development (OSHPD) is currently reviewing the WET regulations.

Recommendation: To ensure that counties have needed guidance to implement and evaluate MHSA-funded programs, DHCS should commence the regulatory process no later than January 2014.

Response: DHCS agrees with the recommendation.

DHCS will work in collaboration with the Accountability Commission beginning in July 2013 to review the current MHSA regulations and develop additional regulations. DHCS expects to have draft regulations available for public comment during Spring 2014. Assuming the standard regulations timeline, MHSA regulations will be adopted during Fall 2014.

Recommendation: To ensure that counties have needed guidance to implement and evaluate MHSA-funded programs, DHCS should collaborate with the Accountability Commission to develop and issue guidance to counties on how to effectively evaluate and report on the performance of their MHSA-funded programs.

Response: DHCS agrees with the recommendation.

DHCS will work collaboratively with the Accountability Commission to develop and issue guidance to counties on how to effectively evaluate and report on the performance of their MHSA-funded programs. This includes coordinated efforts on the performance outcomes indicators and measures, ongoing data reporting, and county training. DHCS will also continue to support and further the activities of the Accountability Commission's Evaluation Master Plan where appropriate.

Recommendation: To ensure that DHCS and other state entities can evaluate MHSA-funded programs and assist the Accountability Commission in its

efforts, DHCS should collect complete and relevant MHSA data from the counties.

Response: DHCS agrees with the recommendation.

Beginning in March 2013, the Department began a review of data submission completeness and accuracy. The Department has contacted all counties that are late in submitting Client and Service Information (CSI) and Data Collection and Reporting (DCR) data to assess their plans for submitting complete data and to assist where needed. The Department has also established a helpdesk to address county data reporting system questions and to escalate data reporting issues. DHCS will continue to assist counties to assure complete, accurate, and current data reporting; post monthly county submission status reports on the DHCS website; and coordinate with the California Mental Health Directors Association (CMHDA) and the counties for any needed system improvements and updates to data reporting requirements.

Recommendation: To ensure that DHCS and other state entities can evaluate MHSA-funded programs and assist the Accountability Commission in its efforts, DHCS should resolve all known technical issues with the partnership and client services databases and provide adequate resources with the necessary expertise to manage the databases going forward.

Response: DHCS agrees with the recommendation.

The Department has redirected Information Technology (IT) staff to manage and support the CSI and DCR reporting and database systems. These technical staff work directly with county staff and their system vendors to resolve county data submission issues. .

Through collaboration with the Accountability Commission, DHCS has recently received additional resources to assist with implementing system updates to the DCR data system. To further improve data reporting, the Department and the Accountability Commission have created a schedule of system updates to address priority system improvements to make the system more efficient for county use.

Recommendation: DHCS should, as soon as is feasible, revise or create a reasonable and justifiable allocation methodology to ensure that counties are appropriately funded based on their identified needs for mental health services. DHCS should ensure that it reviews the

methodology on a regular basis and updates it as necessary to ensure the factors and the weighting of the factors are appropriate.

Response: DHCS agrees with the recommendation.

Currently DHCS is using an allocation methodology agreed upon by the Department and CMHDA. During FY 2013-14, DHCS will review the current allocation methodology in consultation with the Accountability Commission and CMHDA to determine the most appropriate criteria for funding mental health service needs. Annually in June, the Department may update county allocation ratios for the next fiscal year based on the funding criteria and any updated factors or weightings.

Chapter 2: Counties Should Improve Mental Health Services Act Performance Measurements and Documentation of Stakeholders Planning Efforts

Recommendation: To improve the quality of county processes related to measuring program performance, DHCS should use its performance contracts with counties to ensure they specify MHSA-funded program goals in their plans and annual updates and include those same goals in contracts with program providers

Response: DHCS agrees with the recommendation.

The current draft of the performance contract contains language specifying that counties must include MHSA-funded program goals in their three-year program and expenditure plans and annual updates and to include these same goals in their county contracts with program providers. The Department will also develop regulations to ensure MHSA-funded contract providers have contractual goals that are consistent with the approved three-year program and expenditure plans and annual updates.

Recommendation: To improve the quality of county processes related to measuring program performance, DHCS should use its performance contracts with counties to ensure they identify meaningful data to measure the achievement of all their goals, set specific objectives and require their program providers to capture those data and use that data to report on the effectiveness of each of the MHSA-funded programs in attaining their respective goals.

Response: DHCS agrees with the recommendation.

The current draft performance contract contains language specifying that counties must report required data for the purpose

of evaluating mental health outcomes. The counties must collect and report this data for services provided by county owned and operated providers and contract providers. The specific outcomes are established jointly by DHCS and the Accountability Commission, in collaboration with the CMHDA and in consultation with the California Mental Health Planning Council. The Department will also strive to develop consistent outcomes definitions and uniform, statewide data reporting requirements by leading and/or consulting with various performance outcomes committees and workgroups.

Recommendation: DHCS should develop standardized data collection guidelines or regulations, as appropriate that will address inconsistencies in the data counties report to the State. In developing the standardized data collection guidelines, DHCS should consult with the Accountability Commission to ensure data collected reasonably meets its needs for purposes of statewide evaluation.

Response: DHCS agrees with the recommendation.

DHCS will consult with the Accountability Commission to develop regulations necessary to ensure data are collected consistently for the purposes of statewide evaluation.

Recommendation: To help ensure county compliance with stakeholder regulations, DHCS should provide technical assistance to counties on the MHSA local planning review process and ensure that its guidance to counties is clear and consistent with state regulations.

Response: DHCS agrees with the recommendation.

DHCS oversees the MHSA training and technical assistance contract that provides a variety of training options and technical assistance to county mental health plans and service providers. Utilizing this resource and available funding, the Department will work with the contractor and the Accountability Commission to develop training for counties on the MHSA local planning review process. This contract also provides training to Local Mental Health Boards on their role in implementing the MHSA. DHCS will address training and technical assistance contract changes needed for local planning review process as part of its next contract update, which is expected to be fully executed by August 2013.

Comment

CALIFORNIA STATE AUDITOR'S COMMENT ON THE RESPONSE FROM THE CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

To provide clarity and perspective, we are commenting on the California Department of Health Care Services' (Health Care Services) response to our audit. The number below corresponds to the number we have placed in the margin of Health Care Services' response.

Health Care Services correctly indicated in its response that the Mental Health Services Oversight and Accountability Commission (Accountability Commission) is now responsible for developing regulations for Prevention and Early Intervention and Innovation programs and that Health Care Services continues to have responsibility for developing regulations for Capital Facilities and Technological Needs (Facilities) programs. As a result, we modified the recommendation on page 41 to clarify that Health Care Services should coordinate with the Accountability Commission and issue regulations, as appropriate, for Facilities programs and other Mental Health Services Act requirements. ①

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STATE OF CALIFORNIA
EDMUND G. BROWN JR., Governor

MHSOAC
Mental Health Services
Oversight & Accountability Commission

July 19, 2013

Elaine M. Howle, State Auditor*
Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, CA 95814

Re: Response to State Audit Report 2012-122

Dear Ms. Howle:

Please find enclosed the response of the Mental Health Services Oversight and Accountability Commission to the confidential redacted draft of the State Audit Report 2012-122.

Consistent with your request, we have submitted this written response in the envelope provided and the entire response, including this cover letter, on the enclosed CD using a PDF file.

On behalf of the Commission, we wish to express our appreciation for your audit team's hard work and professionalism.

Sincerely,

Sherri Gauger

SHERRI GAUGER
Executive Director
Mental Health Services Oversight & Accountability Commission

* California State Auditor's comments begin on page 139.

Overall Response

The Mental Health Services Oversight and Accountability Commission (MHSOAC) appreciates the Bureau of State Audit's (BSA) fundamental finding that the MHSOAC has generally satisfied the Mental Health Services Act's (MHSA) oversight requirements and joins the BSA in acknowledging that more can be, and is being, done. As the BSA report states, the MHSOAC's oversight authority changed overtime. During the first five years of its existence the initial focus of the MHSOAC's oversight was on the responsible implementation of expanded services and appropriate expenditure of MHSA funds. On November 8, 2010, the MHSOAC broadened its focus from "inputs" to "outputs" when it adopted "Accountability through Evaluative Efforts." Evaluation remains one of seven oversight strategies and the MHSOAC joins the BSA in its recommendations that, generally, the MHSOAC continue its current evaluation efforts.

BSA Recommendation

To fulfill its responsibilities to evaluate MHSA-funded programs, the Accountability Commission should undertake the evaluations specified in its implementation plan.

Response

The MHSOAC agrees with this recommendation.

The MHSOAC entered into its first evaluation of the Mental Health Services Act (MHSA) in 2009, the same year it was first statutorily authorized to evaluate the MHSA. Soon after in 2010, the Commission adopted an initial framework for evaluation. The Evaluation Master Plan continues and builds upon these past efforts and current MHSOAC evaluations to complete a comprehensive, cohesive look at community mental health. In the May Revision to the Fiscal Year (FY) 2013-14 budget, the Governor proposed and the Legislature supported beginning implementing the Evaluation Master Plan. For FY 2013-14 some highlights include continuing measuring priority indicators and transferring this function to the MHSOAC, developing a system to track outcomes for persons receiving services that are less intensive than a full service partnership, and determining the effectiveness of methods for engaging and serving transitional age youth clients. Highlights of future years include determining the effectiveness of selected programs for older adults, consumer run services, and services for children. ①

The MHSOC appreciates the BSA's endorsement of the MHSOAC continuing these efforts.

Elaine M. Howle
Response to State Audit Report 2012-122
July 19, 2013
Page 3

BSA Recommendation

To ensure it can fulfill its responsibilities to evaluate MHSA-funded programs, the Accountability Commission should examine its prioritization of resources to ensure it is performing necessary evaluations.

Response

The MHSOAC agrees and will continue to examine its budget for potentially available resources to support evaluation efforts.

The Governor and Legislature provide the MHSOAC with specific resources to accomplish identified tasks in fulfilling statutory functions. The MHSOAC has followed standard state best management practices by utilizing resources given to it for those purposes, including evaluation. Evaluation is one of the MHSOAC's many statutory responsibilities and one of seven strategies for oversight adopted by the Commission in its Logic Model. While evaluation is a priority, it is not the sole priority, and the MHSOAC has balanced the resources it receives with its statutory responsibilities and strategies to oversee the community mental health system. ②

While the MHSOAC's budget has increased over the past years, it has been for a specified purpose. For example, in FY 2012-13, the MHSOAC budget increased by approximately $1.6 million. That change was the result of contracts being reassigned from the former California Department of Mental Health to the MHSOAC to support specific organizations. These contracts and amounts are part of fulfilling the statutory responsibility that resources "assist consumers and family members to ensure the appropriate state and county agencies give full consideration to concerns about quality, structure of service delivery, or access to services." To redirect these resources to evaluation would be improper. ② ②

Even while managing within state practices, the MHSOAC spent more than the budgeted amounts on evaluation for the past three fiscal years due to year-end savings. Occasionally, a department can identify year-end, one-time savings in its budget. The MHSOAC was able to commit an additional $394,000 in FY 2010-11, $616,000 in FY 2011-12, and $285,000 in FY 2012-13 for a total of an additional $1.295 million that was prioritized for evaluation. ②

Additionally, the MHSOAC leveraged an opportunity to redirect personnel to evaluation. When Assembly Bill 100 (Chapter 5, Statutes of 2011) eliminated plan review at the state level, the MHSOAC identified three vacant positions that were used for plan review and reclassified them to further support evaluation.

The MHSOAC agrees with the priority the BSA places on evaluation, appreciates the value the Governor and Legislature have placed on funding implementing the Evaluation Master Plan, and will continue to look for opportunities to identify additional resources from year-end, one-time funds for additional evaluations.

BSA Recommendation

To report on the progress of MHSA-funded programs and support continuous improvement, the Accountability Commission should use the results of its evaluations to demonstrate to taxpayers and counties the successes and challenges of MHSA-funded programs.

Response

The MHSOAC agrees with this recommendation and one of the strategies the MHSOAC formally adopted in its Logic Model to oversee the community mental health system is to "utilize evaluation results for quality improvement."

The results of MHSOAC evaluations are already being used in this way. In January 2013, California Senate President Pro Tempore Darrell Steinberg advanced a National Framework for Investment in Mental Health to the Vice President of the United States Joseph Biden. This framework offered seven different MHSOAC evaluation results to support the national model.

These evaluations laid a foundation for supporting Senator Steinberg's "A Call for State Action: Invest in Mental Health Services for Community Wellness," a $206 million increase for items, including crisis residential treatment capacity, mobile crisis support teams, and triage personnel, which became the Investment in Mental Health Wellness Act of 2013.

Evaluation results have been used locally too. For example, the results of mapping disparities to access in services was then brought to select counties so this information could be used when developing service plans.

Each of the MHSOAC's Committees' charters include as a task to "receive regular updates on MHSOAC evaluation efforts, consider implications of pertinent results, and make plans to act on those that are relevant to Committee purpose and objectives." MHSOAC Committees are actively engaged in this task.

The MHSOAC will continue to use evaluation results to accomplish this recommendation.

BSA Recommendation

To ensure that counties have needed guidance to implement and evaluate MHSA-funded programs, the Accountability Commission should do the following:

- Issue regulations, as appropriate, for Prevention and Innovation programs.
- Commence the regulatory process no later than January 2014.

Response

The Commission agrees with this recommendation. The Commission first received regulatory authority in June 2013 and has begun the regulatory process for Prevention and Early Intervention and Innovation programs.

Comments

CALIFORNIA STATE AUDITOR'S COMMENTS ON THE RESPONSE FROM THE MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

To provide clarity and perspective, we are commenting on the Mental Health Services Oversight and Accountability Commission's (Accountability Commission) response to our audit. The numbers below correspond to the numbers we have placed in the margin of the Accountability Commission's response.

We disagree with the Accountability Commission's assertion that it was first statutorily authorized to evaluate the Mental Health Services Act (MHSA) in 2009. Although the Legislature expressly added evaluation to the list of the Accountability Commission's enumerated authorized activities in 2009, the Accountability Commission was established in 2004 by Proposition 63 to "oversee" the MHSA. Moreover, the California Department of Mental Health was required to allocate administrative funds, including funds specifically for the purpose of evaluation, to the Accountability Commission, among others. Accordingly, we believe that the Accountability Commission was charged with evaluating MHSA programs before 2009, and we located an Accountability Commission document dated April 2008 that supports that contention. Specifically, before the 2009 amendment expressly authorizing it to evaluate MHSA programs, the commission adopted a proposal that stated the Accountability Commission had an overarching responsibility for oversight and accountability and should be a lead entity for evaluating the extent to which the MHSA's objectives have been accomplished. ①

The Accountability Commission states that evaluation is one of many of its statutory functions and, though it is one of seven strategies adopted to oversee the MHSA programs, it is not its sole priority. We never recommended that evaluations be its sole priority. Rather, as we state on page 42, we recommended that the Accountability Commission examine its prioritization of resources as it pertains to ensuring it is performing all necessary evaluations. We do believe, however, that for an entity established to oversee the accountability of MHSA programs, that evaluations to ensure those programs are achieving their intended outcomes and goals should be a top priority. ②

We believe the recommendation to the Accountability Commission to prioritize its resources for evaluation is warranted and supported by the report's conclusions. The recommendation is based on our discussion and information in Table 4 on pages 32 and 33 where we summarize the Accountability Commission's expenditures and

amounts dedicated to evaluation. Table 4 includes the additional funds totaling $1.295 million that the Accountability Commission highlights in its response that it prioritized for evaluations in fiscal years 2010–11 through 2012–13. As we describe on page 33 in the report, with its reduction in duties following legislative change in March 2011, it seems reasonable that the Accountability Commission would have more of its existing resources to commit to evaluation efforts. The Accountability Commission maintains that its budget for fiscal year 2012–13 increased by $1.6 million to support specific organizations and that using these resources for evaluation would be improper. While we do not disagree, this does not explain why the amount it dedicated to evaluation in fiscal year 2012–13 decreased from the previous fiscal year as shown in Table 4. Specifically, when we reduce its fiscal year 2012–13 expenditures by the $1.6 million, the resulting amount is roughly equal to the Accountability Commission's expenditures for fiscal year 2011–12. Yet, as shown in Table 4, the amount it dedicated to evaluation decreased by roughly $800,000, from approximately $2.1 million in fiscal year 2011–12 to nearly $1.3 million in fiscal year 2012–13.

California Mental Health Planning Council

CHAIRPERSON
John Ryan
EXECUTIVE OFFICER
Jane Adcock

July 17, 2013

Elaine M. Howle, CPA
California State Auditor
555 Capitol Mall, Suite 300
Sacramento, CA 95814

Dear Ms. Howle,

➢ Advocacy
➢ Evaluation
➢ Inclusion

The California Mental Health Planning Council respectfully submits the following comment in response to the draft report for the audit of the Mental Health Services Act.

> The Council agrees with and is taking steps to address the recommendations. As the report has acknowledged, there are insufficient sources of performance outcomes or other data available for the Council's evaluation. Until they become available, the Council will seek alternative, innovative ways to fulfill its statutory responsibility while maintaining its advocacy efforts and identification of successful practices.
>
> Also, it should be noted that while the Council has not recently produced reports on performance outcomes related to the MHSA, the Council did develop and release the Performance Indicators in 2010 which have been subsequently adopted by the MHSOAC and are currently being used in their data analysis and evaluation activities.

Thank you for the opportunity to review and respond to the draft report. Please do not hesitate to contact our Executive Officer, Jane Adcock, at (916) 319-9343 or jane.adcock@cmhpc.ca.gov should you have any questions.

Sincerely,

John Ryan, Chairperson

MS 2706
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916.651.3839
fax 916.319.8030

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LAC DMH
LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
550 S. VERMONT AVE., LOS ANGELES, CA 90020 HTTP://DMH.LACOUNTY.GOV

MARVIN J. SOUTHARD, D.S.W.
Director
ROBIN KAY, Ph.D.
Chief Deputy Director
RODERICK SHANER, M.D.
Medical Director

July 17, 2013

Elaine M. Howle, CPA*
State Auditor
California State Auditor, Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, CA 95814

Dear Ms. Howle:

I am in receipt of the results of the Mental Health Services Act (MHSA) audit for Los Angeles County. Our Department has placed considerable resources into collecting, reporting, and using clinical outcomes, with an emphasis on improving services and client quality of life. We are pleased that the audit acknowledged our efforts in this area and no recommendations were issued for our County.

There are two sections we wish to provide clarification for your consideration. On page 24, your report states "Currently county boards of supervisors are tasked with reviewing and approving these documents." Our County Counsel has stipulated that the Board of Supervisors "adopts" MHSA Annual Updates and 3-Year Integrated Plans and that our Mental Health Commission is charged with "approving" those plans. ①

Per our discussion with Sharon Fullner from your office, the second sentence of the first footnote from Appendix Table D.1 should be revised to state "Revenues reflect cash received for the respective fiscal year and interest earned on these amounts." ②

Finally, we believe that Appendix Table D.1 has mis-stated Fiscal Year 2010-11 Community Services and Supports (CSS) planning estimates. Our CSS revenue was $210 million and not $319 million as stated in Table D.1. ③

* California State Auditor's comments appear on page 145.

Elaine M. Howle, CPA
July 17, 2013
Page 2

Our Department plans to use your results to continue to improve the quality of our local planning processes and to enhance the scope and depth of our MHSA evaluation efforts.

Sincerely,

Marvin J. Southard, D.S.W.
Director

MJS:RK:DM:dig

c: Robin Kay, Ph.D.
Dennis Murata, M.S.W.
Debbie Innes-Gomberg, Ph.D.

Comments

CALIFORNIA STATE AUDITOR'S COMMENTS ON THE RESPONSE FROM THE LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

To provide clarity and perspective, we are commenting on the Los Angeles County Department of Mental Health's (Los Angeles) response to our audit. The numbers below correspond to the numbers we have placed in the margin of Los Angeles' response.

Los Angeles is concerned with our use of the word "approve" rather than "adopt." Under state law, county boards of supervisors are required to adopt county plans. However, because the plans are developed as a result of an ongoing stakeholder process and then acted upon by boards of supervisors, we used the word "approve" so that our readers would understand that those boards only act on what is presented to them after counties engage in the stakeholder process. The word "adopt" means "to accept formally and put into effect." Since "accept" is defined as, among other things "to give admittance or approval," we believe using the word "approve" accurately reflects the adoption of county plans as required by law. ①

We have included Los Angeles' perspective in a footnote to Table D.1 on page 120. ②

Audit evidence obtained from the California Department of State Hospitals supports the fiscal year 2010–11 Community Services and Supports revenue figure reflected in Table D.1. Nevertheless, we added a footnote to the table to present Los Angeles' perspective on the revenue amounts. Also, as we state in Appendix D on page 119 and again in Table D.1 on page 120 the figures are unaudited. ③

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Health and Human Services
Sherri Z. Heller, Ed.D., Director

County of Sacramento

Divisions
Behavioral Health Services
Child Protective Services
Departmental Administration
Primary Health Services
Public Health
Senior and Adult Services

July 17, 2013

Ms. Elaine M. Howle, CPA
California State Auditor
555 Capitol Mall, Suite 300
Sacramento, CA 95814

RE: Response to Draft Audit Report – "Mental Health Services Act: [Redacted], and Select Counties Can Improve Measurement of Their Program Performance" (2012-122)

Dear Ms. Howle:

Enclosed please find Sacramento County's response to the draft audit report, titled "Mental Health Services Act: [redacted], and Select Counties Can Improve Measurement of Their Program Performance."

As instructed, we have included a hard copy of our response and also included this cover letter and our response on the CD provided.

Please contact Mary Ann Carrasco, Deputy Director, Division of Behavioral Health Services, at (916) 875-9904 if you have any questions or would like to discuss our response.

Sincerely,

Sherri Z. Heller

Enclosures (2)

c: Mary Ann Carrasco

Sacramento County – Response to Draft Audit Report 2012-122, titled "Mental Health Services Act: [redacted], and Select Counties Can Improve Measurement of Their Program Performance"

Sacramento County Recommendation: Sacramento County should review its existing MHSA contracts and by December 31, 2013, ***or as soon as feasible***, amend them as necessary to include plan goals.

The Sacramento County Division of Behavioral Health Services (Division) is committed to addressing the recommendations contained in the audit report. To this end, the Division will conduct a complete review of the goals stated in the Mental Health Services Act (MHSA) plans as compared with the goals captured in the contracts for MHSA-funded programming. The Division will begin the internal review process immediately. Necessary revisions to contract scopes identified through the review process will be addressed with contracted service providers. These revisions will require review and approval by counsel/administration for both County and the provider agencies. Contracting authority is granted by the local Board of Supervisors. Due to the volume of contracts potentially impacted, the Division anticipates completion of this entire process with updated scopes capturing the plan goals prepared for inclusion in MHSA-funded contracts by June 30, 2014.

The Division looks forward to reading the audit report in its entirety upon release.

County of San Bernardino

Department of Behavioral Health Administration
268 W. Hospitality Lane, Suite 400, San Bernardino, CA 92415 • (909) 382-3133 • Fax (909) 382-3105

CaSONYA THOMAS, MPA, CHC
Director

July 17, 2013

Elaine M. Howle, CPA*
State Auditor
California State Auditor
555 Capitol Mall, Suite 300
Sacramento, CA 95814

Dear Ms. Howle:

Thank you for this opportunity to respond to the draft copy of the "Mental Health Services Act: Select Counties Can Improve Measurement of Their Program Performance" report. The County of San Bernardino Department of Behavioral Health (DBH) supports the use of performance audits as a tool to improve local mental health systems.

The behavioral health programs implemented by DBH strive to be recognized as a progressive system of seamless, accessible and effective services that promote prevention, intervention, recovery and resiliency for individuals, families and communities. The department values the inclusion of stakeholders in the community planning process and agrees that it is important to identify key performance measures and outcomes achieved and to assess the extent to which counties use performance measures and outcomes to improve their system of care.

The positive results of this audit demonstrate the commitment of DBH to the principles of openness and accountability. DBH is pleased that the audit report reflects no findings for DBH and appreciates the Auditor's acknowledgement that the department was in the process of improving its performance evaluation methods before the audit was undertaken. Specifically, the audit recognized DBH: ①

- Complied with state regulations requiring that specific groups of stakeholders and community representatives be included throughout the Mental Health Services Act (MHSA) planning process and with community planning regulations that require staffing and training practices related to developing our plans.
- Demonstrated specific program outcomes and that outcomes were used to improve its mental health delivery system.
- Reviewed its Community Support provider contracts to strengthen the inclusion of desired goals.
- County expenditures were supported by program provider contracts and program descriptions in the county plans.

As requested, we have enclosed a written response to the report in the specified format.

DBH is invested in continuous improvement and will use this audit experience to further enhance our efforts to work with stakeholders to create a progressive, culturally competent system that promotes wellness and recovery for adults and older adults with serious mental illness and resiliency for children with serious emotional disorders and their families.

Sincerely,

CaSonya Thomas, MPA
Director

CT:rr

Enclosure
(Copies noted on the next page)

* California State Auditor's comment appears on page 153.

State Auditor Elaine M. Howle
July 17, 2013
Page 2

cc: Gregory C. Devereaux, County Chief Executive Officer
Linda Haugan, Assistant Executive Officer, Human Services
Frank Salazar, Deputy County Counsel
Sharon Fuller, Senior Auditor, California State Auditor

COUNTY OF SAN BERNARDINO RESPONSE TO MENTAL HEALTH SERVICES ACT: [REDACTED], AND SELECT COUNTIES CAN IMPROVE MEASUREMENT OF THEIR PROGRAM PERFORMANCE REPORT

July 17, 2013

This management response to the audit report received on July 11, 2013, is provided by the Department of Behavioral Health on behalf of the County of San Bernardino.

RECOMMENDATION: San Bernardino County should review its existing MHSA contracts and by December 31, 2013, amend them as necessary to include plan goals.

RESPONSE

The Department of Behavioral Health (DBH) includes plan goals in its Mental Health Services Act (MHSA) contract language, and goals are monitored on an ongoing basis. ①

DBH has more than 60 MHSA contracts, and in the possible absence of specific contract language or collection of certain data favored by the audit, it should be not assumed or inferred that program goals are not being set, monitored, and accomplished, or that meaningful services are not being provided to the community. ①

The department uses various performance measures to evaluate MHSA-funded programs and services. Continued monitoring provides the information necessary to make modifications, as needed, to ensure the efficiency and effectiveness of mental health services. ①

The County of San Bernardino remains committed to continuous improvement, including developing/refining its approaches for evaluation of performance outcomes. DBH understands the value of this audit and the opportunity it offers to further enhance its programs and services to community members impacted by mental illness, and to continue to adhere to the spirit of MHSA.

Action Steps and Time Frame

DBH will review its existing MHSA contracts and amend as necessary.

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Comment

CALIFORNIA STATE AUDITOR'S COMMENT ON THE RESPONSE FROM THE COUNTY OF SAN BERNARDINO DEPARTMENT OF BEHAVIORAL HEALTH ADMINISTRATION

To provide clarity and perspective, we are commenting on the County of San Bernardino Department of Behavioral Health Administration's (San Bernardino) response to our audit. The number below corresponds to the number we have placed in the margin of San Bernardino's response.

San Bernardino has mischaracterized the information in the audit report. On pages 47 through 53 we discuss what we found in our review of county plans and nine San Bernardino provider contracts and our concerns with the plans and contracts including program goals, etc. In summary, we identified the following concerns regarding San Bernardino's plans and the nine contracts: ①

- San Bernardino did not always state goals for its programs in its county plans. *(See page 47.)*
- For six contracts, San Bernardino did not include all program goals as stated in the county plans. *(See page 47.)*
- Eight contracts lacked requirements for collecting and providing information suitable for measuring the attainment of program goals. *(See page 48.)*
- None of the nine contracts contained specific objectives—meaning objectives that were well defined and measurable. *(See page 49.)*
- San Bernardino typically used ad-hoc approaches that were not always sufficient in identifying meaningful data to measure progress in meeting its programs' goals. Moreover, it often failed to collect meaningful data, which affected San Bernardino's ability to adequately analyze and report on whether program goals are being achieved. *(See pages 48 and 51.)*
- Even though San Bernardino reported to us specific program outcomes and the use of those outcomes to improve its mental health delivery systems, our review shows that this reporting may not be representative of the county's MHSA programs. *(See page 53.)*

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Dedicated to the Health of the Whole Community

SANTA CLARA VALLEY HEALTH & HOSPITAL SYSTEM
DEPARTMENT OF MENTAL HEALTH

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July 17, 2013

Elaine Howle, CPA
State Auditor
California State Auditor's Office
555 Capitol Mall, Suite 300
Sacramento, CA 95814

RE: 2012-122 Mental Health Services Act

Dear Ms. Howle:

Santa Clara County Mental Health Department ("County") is providing you with our written response to the redacted draft report, titled "Mental Health Services Act: [redacted], and Select Counties Can Improve Measurement of Their Program Performance," which we received on July 11, 2013 (the "Draft Report"). The following is the County's response to the State Auditor's two recommendations in the report for the County:

- **Recommendation #1**: The County should review its existing MHSA contracts and by December 31, 2013, or as soon as feasible, amend them as necessary to include plan goals.

  Response: The County will review its existing MHSA contracts with each mental health program division, Family and Children Services, Adult and Older Adult Services, Integrated Behavioral Health Services, and Learning Partnership. Each division will evaluate their specific MHSA contracts and will ensure plan goals are included for each program. Once the County has completed their evaluation of the contracts and defined the goals that need to be included, a timeline will be established to implement the contract amendments. This will be a multi-step process to be initiated immediately.

- **Recommendation #2**: The County should ensure that all MHSA invoices are adequately supported with information that demonstrates MHSA services were provided.

  Response: As part of the MHSA contract review process described above, the County will conduct a review of billing and invoicing procedures of each of the MHSA contracts. This process will include identifying documentation requirements for each category of invoices, i.e., direct services, flex funds, etc, and will establish invoicing requirements for each invoice category. Those requirements will be standardized and included in contract amendments.

Overall, the County agrees that a standardized system of performance measurement across all counties for MHSA and non-MHSA public mental health services is desired. We believe this can be accomplished by developing a broader performance measurement system that draws upon the findings and recommendations provided in various state and county evaluation reports that have been funded with MHSA resources over the past several years. To that end, the Full Service Partnership (FSP) data collected and reported to the State utilizes a common outcomes measurement methodology that provides important information on the outcomes yielded by MHSA funded programs for consumers across age-specific domains of functioning. Given that the MHSA funded FSP model of service is employed widely across the state, and the data collection system utilized to measure FSP outcomes has been developed with input from local and state stakeholders, we believe that this is an excellent foundation to build upon to establish a common set of measures that can be used across a variety of mental health service programs.

MHSA programs are critical to the provision of mental health services throughout the State. Thank you for your important review of the County's MHSA program, and for the opportunity to review and comment on the Draft Report.

Sincerely,

Nancy Peña, PhD

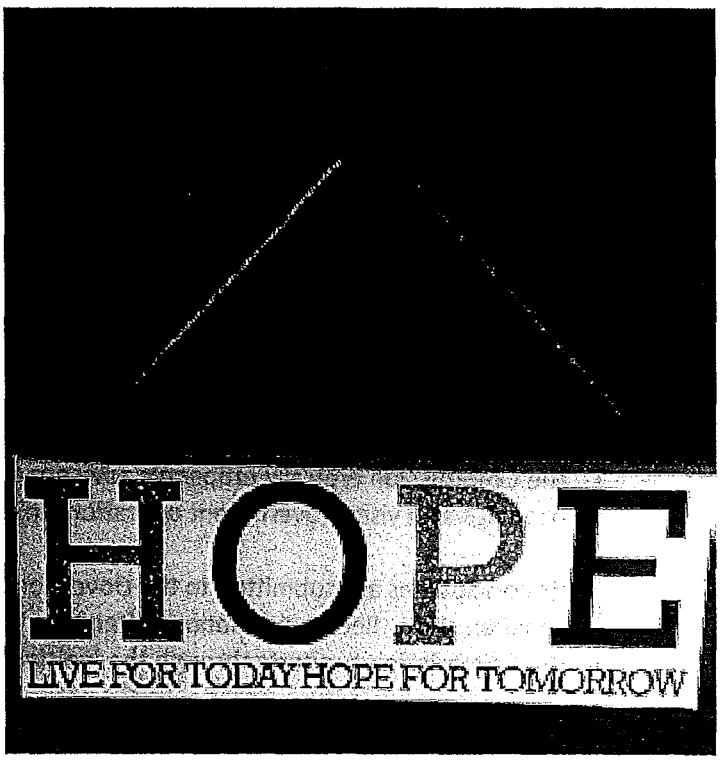
Nancy Peña, Ph.D., Director
Mental Health Department

cc: Laura Kearney, Project Manager
Sharon Fuller, Project Lead
Theresa Fuentes, Lead Deputy County Counsel
Jeanne Moral, MHSA Coordinator

cc: Members of the Legislature
Office of the Lieutenant Governor
Little Hoover Commission
Department of Finance
Attorney General
State Controller
State Treasurer
Legislative Analyst
Senate Office of Research
California Research Bureau
Capitol Press

PROMISES STILL TO KEEP: A SECOND LOOK AT THE MENTAL HEALTH SERVICES ACT

REPORT #233, SEPTEMBER 2016



A LITTLE HOOVER COMMISSION LETTER REPORT TO
THE GOVERNOR AND LEGISLATURE OF CALIFORNIA

To Promote Economy and Efficiency

The Little Hoover Commission, formally known as the Milton Marks "Little Hoover" Commission on California State Government Organization and Economy, is an independent state oversight agency.

By statute, the Commission is a bipartisan board composed of five public members appointed by the governor, four public members appointed by the Legislature, two senators and two assemblymembers.

In creating the Commission in 1962, the Legislature declared its purpose:

...to secure assistance for the Governor and itself in promoting economy, efficiency and improved services in the transaction of the public business in the various departments, agencies and instrumentalities of the executive branch of the state government, and in making the operation of all state departments, agencies and instrumentalities, and all expenditures of public funds, more directly responsive to the wishes of the people as expressed by their elected representatives...

The Commission fulfills this charge by listening to the public, consulting with the experts and conferring with the wise. In the course of its investigations, the Commission typically empanels advisory committees, conducts public hearings and visits government operations in action.

Its conclusions are submitted to the Governor and the Legislature for their consideration. Recommendations often take the form of legislation, which the Commission supports through the legislative process.

Cover photo by Little Hoover Commission staff at Hacienda of Hope – Project Return Peer Support Network, Long Beach, California.

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This report is available from the Commission's website at www.lhc.ca.gov.

LETTER FROM THE CHAIR

September 8, 2016

The Honorable Edmund G. Brown, Jr.
Governor of California

The Honorable Kevin de León
President pro Tempore of the Senate
and members of the Senate

The Honorable Jean Fuller
Senate Minority Leader

The Honorable Anthony Rendon
Speaker of the Assembly
and members of the Assembly

The Honorable Chad Mayes
Assembly Minority Leader

Dear Governor and Members of the Legislature:

More than a decade ago, California voters passed a landmark tax initiative that promised to expand access to mental health services and transform how people get help by providing services, when and where needed, at any stage of an illness.

For some Californians, the Mental Health Services Act (MHSA) has fulfilled this promise. Proposition 63-funded programs have helped individuals with mental illness recover and thrive. For some, the funding created programs that offer housing, healthcare, medication and help to become self-sufficient. For others at risk of developing mental illness, the funding provides safe, supportive local centers to stay and work through episodes of crisis. These are but two examples of the types of programs in which counties invest money from the Act. Throughout this report we offer a glimpse into nine programs the Commission visited this year and give voice to some who have benefited from these programs.

But these inspiring stories of success are shadowed by a continuing failure of the state to demonstrate what is collectively being accomplished. The state still can't provide conclusive data to show how it is keeping promises made to voters in 2004, or to wealthy taxpayers who fund Proposition 63 programs with a 1 percent surtax, and most importantly, to the individual Californians and their families who rely on these services for much-needed help. Others have shown this can be done. The County Behavioral Health Directors Association partnered with a non-profit public policy institute to release two reports showing successful outcome measures for county full-service partnership program participants.

In its January 2015 report, *Promises Still to Keep: A Decade of the Mental Health Services Act*, the Commission called on the state to better validate how money generated by the Act is used. The report cited a dispersed governance system with no definitive center of leadership. It also found a lack of meaningful data to account for expenditures or demonstrate outcomes to paint a picture of who is being served. In May 2016, the Commission revisited the topic, inviting relevant agencies, as well as stakeholders, to discuss progress in addressing shortcomings raised in the Commission's 2015 review.

Despite some encouraging developments, many of the same concerns remain. The Commission heard repeatedly from stakeholders desperate for more oversight of the Act and concerned about the lack of

consequences for bad behavior. Many said the processes to oversee the distribution and use of MHSA funds at the local and state levels are still woefully inadequate and leave those with questions or concerns confused about where to get answers. Others said that without more detailed demographic data, policymakers won't know whether more can or should be done to reach underserved communities.

The Commission admits to remaining somewhat baffled by the extreme complexity of interlaced agencies and data reporting systems that collectively still can't handily tell taxpayers how their money is being spent, who is being helped and what impact it is making. Though Proposition 63 created a new entity to oversee programs funded by the Act, the Little Hoover Commission has questioned why an oversight commission exists if it cannot deliver meaningful oversight. Additionally, though the Department of Health Care Services is empowered and funded to enforce the Act, this responsibility appears to be lost among others. Without strong leadership at the top, it is uncertain who is responsible to look out across the system to see what is working and make sure those lessons are being shared statewide. The state itself spends more than $100 million from the MHSA and there is little oversight of that spending, beyond the regular budget process.

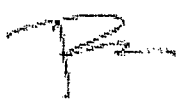
It is clearer than ever in the wake of the Commission's second review that the state must identify a well-defined leader to administer, oversee and enforce the MHSA or it will remain difficult to articulate a cohesive vision for the Act and ensure accountability to alleviate many of the visible statewide impacts of mental illness. This leader also should take charge to ensure counties are appropriately engaging stakeholders and that success stories are shared statewide.

Consequences of a long-standing inability to demonstrate the value of statewide Proposition 63-funded programs are already apparent. Lawmakers have begun chipping away at this lucrative funding source. Recently enacted legislation championed by the Steinberg Institute steers $130 million in annual proceeds to finance a $2 billion bond for supportive housing for homeless individuals with mental illness. This is one way to inject state priorities and accountability into how MHSA funds are used. Some, however, expressed concerns to the Commission that this may open a floodgate for setting additional priorities beyond those specified in the voter-approved ballot measure.

As lawmakers debate other possible diversions, the state's plans to finally provide data are tied up in a massive, multi-year technology project. Counties and others, at least in a partial way, are moving more quickly toward fiscal accountability and transparency of MHSA funds. The Commission believes the state must more rapidly develop its own data system to monitor and measure outcomes being delivered by MHSA funding. Proposition 63 backers in 2004 assured voters a high level of statewide oversight for this new revenue stream. Twelve years without definitive data to meet these assurances is hardly what voters expected, and if known, may well have provided a different outcome at the ballot box.

Despite some of these misgivings, the Commission remains hopeful that the many proposals it heard to improve fiscal transparency and accountability for outcomes will lead to necessary improvements. The Commission was most inspired by the stories shared during the site visits by those whose lives have been improved. With better accountability, the Commission also remains hopeful that many more Californians, rather than just some, will receive the help that they need. The Commission respectfully submits recommendations to strengthen the oversight of the Mental Health Services Act and stands ready to assist in this important initiative to improve the health of Californians.

Sincerely,



Pedro Nava
Chair, Little Hoover Commission

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SIDEBARS

INTRODUCTION

More than a year after the Little Hoover Commission's first look at the Mental Health Services Act, it decided to conduct a follow-up review and found that many concerns remain unheeded. The Commission launched its initial study of the Act in June 2014 to better understand what happens after voters say yes to a spending plan at the ballot box. Introduced to voters in 2004 as Proposition 63, the Act imposed a 1 percent surtax on the wealthiest Californians to directly fund specific types of mental health programs and services across the state and invigorate a faltering statewide mental health system. Since 2004, the Act has generated approximately $17 billion for mental health programs and services throughout the state – currently at a rate of $2 billion annually. These funds now comprise approximately 24 percent of the state's entire public mental health budget.[1]

Proposition 63 allowed the Legislature to modify the Act without seeking voter approval for each reform. In the years since, the Legislature has exercised its authority to make significant amendments five times. Early reforms expedited distribution of money to on-the-ground service providers, eliminated the state's upfront review of spending plans and reoriented accountability for expenditures to the counties. Other reforms have expanded the variety of allowable programs or diverted funds for specific, one-time expenditures.

In its last review, the Commission heard many accounts of success, including programs and services for the state's mentally ill that likely would have been unaffordable without Proposition 63 funding. Often these anecdotal successes, however, lacked verifiable data. In its January 2015 report, *Promises Still to Keep: A Decade of the Mental Health Services Act*, the Commission voiced concern that as money comes through the MHSA pipeline each year, the state lacks an accountability mechanism to assure taxpayers, voters, and most importantly, mental health care consumers and advocates, that the money is being spent in ways voters intended.

The Commission also found overlapping and sometimes unaccountable bureaucracies and an oversight body lacking "teeth" for enforcement. Stakeholders, and ultimately the Commission, were concerned that the state lacks an organization that can effectively oversee the Mental Health Services Act. The mental health program within Department of Health Care Services is overshadowed by the state's massive Medi-Cal program and, without authority, the Mental Health Services Oversight and Accountability Commission (oversight commission) cannot help counties correct deficiencies in their plans or enforce changes to comply with the law. Recommendations from the Commission's January 2015 report are in Appendix B.

Oversight Hearing and Site Visits

The Commission initiated this follow-up review in May 2016 to gauge progress in addressing the serious concerns raised in its 2015 report. The Commission heard from state agencies responsible for overseeing the act, representatives from county mental health directors and local boards, as well as the Act's authors and numerous stakeholders, including clients, family members and advocates. Hearing participants are listed in Appendix A.

In May and June 2016, Commissioners also visited nine programs funded in part or entirely by the Mental Health Services Act in three counties: San Bernardino, Sacramento and Los Angeles. During these visits, the Commission saw how programs funded by the Act help Californians before they need intensive care, and others recover and reclaim their lives. These visits introduced the Commission to programs that give individuals short respites while getting needed help and others that help people transition from unstable living situations to permanent, supportive housing. Most significantly, the Commission heard directly from Californians whose lives and health are improving as a result of these programs.

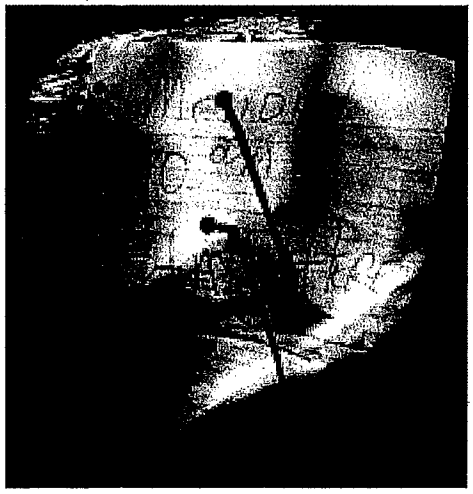
Descriptions of programs visited, as well as the voices of some participants, are included throughout this report.

Based on its 2015 report, the information provided at its May 2016 hearing and visits to programs funded by the Mental Health Services Act, the Commission has identified several challenges that persist. Important questions remain unanswered: Who oversees MHSA spending, where does the money go and is the Act achieving its goals? Furthermore, though the Act built-in a stakeholder process for spending plans, Californians do not yet have a clear path for participating in, or question, spending decisions. And though the Act promised opportunities to transform the way mental health services are delivered in California by funding new and innovative programs, the state does not offer counties meaningful ways to share lessons learned. The Commission offers recommendations on pages to come to help the state keep its 2004 promise to Californians.

The Integrated Mobile Health Team, Los Angeles County

The Integrated Mobile Health Team helps clients transition from homelessness into permanent supportive housing, improving their mental health and substance use disorders. Mental health, physical health and substance abuse services are provided by multi-disciplinary staff working as one team, under one point of supervision and operating under one set of administrative and operational policies and procedures, using an integrated medical record/chart. Through a "street medicine" approach, the program staff bring care to its clients wherever they are – whether living in an encampment, a car or on the street. In July 2016, the team received the National Association of County's Achievement Award. (CSS-funded, formerly INN)

One client explained he joined the program and came off the streets because "I didn't like the feeling of being worthless."



Photos by Little Hoover Commission staff and the Integrated Mobile Health Team, Mental Health America of Los Angeles in Long Beach, California.

A CONTINUING CHALLENGE: "MUDDLED" LEADERSHIP OVERSEES MHSA FUNDING

When voters approved Proposition 63 in 2004, they also approved a statewide governance system to administer and oversee new mental health programs funded by the Act. The Department of Mental Health was to take the lead state role in implementing most of the new programs created in the measure, as well as allocate funds for those programs through contracts with counties (The Department of Health Care Services picked up oversight responsibilities for the Act after the Governor and the Legislature dismantled the Department of Mental Health in 2012). A new Mental Health Services Oversight and Accountability Commission also would review county plans for mental health services and approve expenditures for certain programs. The measure layered these additional responsibilities within the existing mental health system and throughout the state's Welfare and Institutions Code. As such, the Act left intact the responsibilities of other existing agencies, including the Mental Health Planning Council to review, to oversee and review the state's mental health system.[2] (Examples of statutory roles and responsibilities for these agencies are included in Appendix C.)

In the years since, the Legislature has amended this system several times, but three state agencies continue to share responsibility for administering and overseeing aspects of the Act. At times, these three entities are required to work together to fulfill their roles – providing technical assistance, designing a comprehensive joint plan for a coordinated evaluation of client outcomes and developing regulations and other instructions to administer or implement the Act.[3] State law also assigns specific oversight functions to each:

The Department of Health Care Services (DHCS). The department alone has the authority to enter into performance contracts with counties, enforce compliance and issue administrative sanctions if necessary.[4] In fiscal year 2016-17, the department received funding from the Mental Health Services Act for 19 full-time equivalent staff for these and other functions related to the Act.[5]

State mental health leaders say the DHCS' role in overseeing the Act is focused on monitoring and auditing for compliance and providing fiscal and program oversight. In practice, the department's oversight of the Act appears minimal.

The annual performance contracts the department establishes with each county mental health program are its main tool for program oversight. Department leaders conduct onsite reviews of these contracts every three years, at a rate of about 15-18 counties per year – to ensure compliance with state and federal laws and the terms of the contract between the department and county mental health programs.[6] The executive director of the oversight commission told Commissioners in May, "the DHCS has profound capacity through its performance contracts to shape these programs."[7] However, these performance contracts encompass a broad range of mental health programs and services,

El Hogar Guest House Homeless Clinic, Sacramento County

"The Home" is an entry point for mental health and homeless services in Sacramento County. The facility provides a clinic for homeless individuals and temporary housing for adults 18 and older. Services include comprehensive mental health assessments and evaluations, medications, links to housing and applications for benefits and services. The program used MHSA funds to expand services for client care, such as offering subsidies for housing and dental work. (CSS-funded)

One client, thankful for the help she received through El Hogar explained, "California has so many programs compared to [my experiences in] other states. I wish they could have even 10 percent of what California has. Being able to have housing, dental work and services has been awesome for me."

of which those funded by the Mental Health Services Act are but one part – and a relatively new one. After the absorbing responsibilities from the Department of Mental Health in 2012, DHCS in fiscal year 2013-14 added questions specific to the Act in its reviews. Currently, the department's review protocol includes only 17 questions related to the Mental Health Services Act – these take up just eight out of the protocol's 121 pages.[8] The department's deputy director admitted to the Commission that these reviews of the Act are "not very robust."[9]

To provide fiscal oversight, the department also performs "a desk review" of each county's annual revenue and expenditure report to ensure accuracy and consistency from year to year. Counties are required to submit these annual reports, identifying MHSA revenues, expenditures and unexpended funds and providing information to evaluate programs funded.[10] However, as of August 2016, 37 counties had submitted reports for fiscal year 2013-14 and just 26 counties had submitted reports for fiscal year 2014-15.[11] (A list of each county's reporting status is included in Appendix D.) For those reports received, the department reviews the balance of unspent funds, reportable interest, revenue received and program expenditure levels, and compares the balance of unspent funds reported in the prior year's report to ensure they match. The department also reviews the amount of revenue counties report receiving with what the State Controller's Office says it distributed.[12] However, it does not analyze the data reported in these reports to determine whether counties spent the funds as they proposed.

The department alone holds power to address local shortcomings in implementation of the Act by imposing administrative sanctions such as withholding part or all of state mental health funds from the county and requiring the county to enter into negotiations to comply with state laws and regulations. The department also can refer issues to the courts. The Commission heard testimony from some stakeholders that it is appropriate for the department to serve as the enforcer of the Act. However, when Commissioners asked department officials how they might ensure that bad actors are not continuously getting funding, the deputy director said "there isn't a requirement on the department that we can point to that says this is our role and responsibility." Additionally, in a subsequent conversation with Commission staff, the deputy director said that if a county is found out of compliance with the Act, rather than initiating administrative sanctions she prefers to phone the county's mental health director and prompt them for corrective action.[13]

The Mental Health Services Oversight and Accountability Commission. The Mental Health Services Act established the oversight commission to oversee programs funded by the Act, as well as the state's systems of care for adults, older adults and children. As such, leaders from the oversight commission view its oversight responsibility broadly, to encompass the whole public mental health system, not just the Mental Health Services Act. "Because [the oversight commission] was created by Proposition 63, people think its role is just

KEY COMPONENTS OF THE MENTAL HEALTH SERVICES ACT

Community Services and Supports (CSS). 80 percent of county funding from the Mental Health Services Act treats severely mentally ill Californians through CSS. Within this component counties fund a variety of programs and services to help people recover and thrive, including full-service partnerships and outreach and engagement activities aimed at reaching unserved populations. Full-service partnerships provide "whatever it takes" services to support those with the most severe mental health challenges.

Prevention and Early Intervention (PEI). Counties may use up to 20 percent of their MHSA funds for PEI programs, which are designed to identify early mental illness before it becomes severe and disabling. PEI programs are intended to improve timely access to services for underserved populations and reduce negative outcomes from untreated mental illness.

Innovation. Counties may use up to 5 percent of the funding they receive for CSS and PEI to pay for new and innovative programs that develop, test and implement promising practices that have not yet demonstrated their effectiveness.

to oversee the Act. But it's broader," one senior official at the oversight commission explained.[14] In addition, state law also assigns the oversight commission specific functions and responsibilities related to the Act, such as receiving all county plans for review, and for approving Innovation programs. In fiscal year 2016-17, the oversight commission received funding from the Mental Health Services Act for 30 full-time equivalent staff to carry out its responsibilities.[15]

In its 2015 report, concerned that the DHCS did not consistently exercise its enforcement authority over the Act in a timely fashion, the Commission recommended expanding the oversight commission's authority to review and approve county MHSA Prevention and Early Intervention (PEI) plans, as it does with Innovation plans. The Commission also recommended the oversight commission be granted authority to respond to critical issues identified in county spending plans and clarify the process by which problems get solved. The intent of that recommendation was not punitive, but to expedite a review process that was, at times, taking DHCS up to two years. Some advocates and stakeholders still believe that the state should reinstate authority of the oversight commission to review and approve county spending plans, as well as statewide projects funded by the Act.[16]

In response to the Little Hoover Commission's recommendation, the oversight commission executive director told Commissioners that he was working to "strengthen the local process, strengthen the boards of supervisors, and [the oversight commission's] ability to do oversight based on the outcomes." He said that giving the oversight commission "teeth" could potentially distract his commissioners and staff from other functions and would require them to "to really think differently about how we do our job."[17] The lack of progress of the oversight commission over the last year even to develop a response to the Commission's previous recommendation indicates that something else must be done to improve accountability and facilitate achievement toward the Act's goals.

The Mental Health Planning Council. Among other functions, the planning council reviews program performance of the overall mental health system, including programs funded by the Mental Health Services Act. Also, it annually reviews program performance outcome data to identify successful programs and make recommendations for replication in other areas.[18] State law articulates a role for the planning council in developing plans to address the state's mental health workforce needs and shortages.[19] In fiscal year 2016-17, the planning council received funding from the Mental Health Services Act for five full-time equivalent staff.[20] Mental Health Planning Council officials say it lacks the data it says it needs to assess the strengths of the mental health system overall.

Hacienda of Hope, Los Angeles County

Hacienda of Hope is a short-term respite home run by "peers" – adults who are living with mental illness themselves. The respite program, operated by Project Return, The Peer Support Network, offers support and tools to foster wellness and manage crisis and recovery for up to eight guests in the program's two-story home. Guests create individualized wellness and recovery plans and connect with local resources for employment, housing and mental and physical health care. Adults 18 and older who are experiencing distress or a life crisis, but who are not in immediate danger or in need of on-site medical treatment are eligible to stay. Typically, guests stay between one and three days. They may stay up to 14 days if additional help is needed. (CSS-funded, formerly INN)

A former client, now peer-advisor said of the program, "This is a hopeful place to go when you don't have hope, when you are broken."

Without Direction, Some Oversight Functions Haven't Happened

The state has laws requiring counties to provide a substantial amount of information about the Mental Health Services Act that could be used for evaluation. Counties, for example, submit three-year MHSA program and expenditure plans and annual updates to the oversight commission and the DHCS.[21] These plans include descriptions of MHSA programs, that if compared with expenditure reports, could be used to ensure counties spent their MHSA dollars as they proposed. Yet, no state agency performs this type of review.

DHCS, when it implements recent legislative reforms, will post online county plans as well as revenue and expenditure reports.[22] This reform should improve fiscal transparency, but falls short of ensuring accountability.

The oversight commission does not broadly review information contained in counties' program and expenditure plans to identify compliance issues or compile a statewide picture of implementation of the Act. Currently, oversight commission staff only read counties' plans within the context of reviewing Innovation programs. However, according to its deputy director, the oversight commission plans to build technology to make it easier to analyze the county-submitted reports and compare and contrast information across plans.[23]

Palmer Apartments, Sacramento County

Run by Transforming Lives, Cultivating Success (TLCS), the Palmer Apartments offer short-term housing for up to 48 adults experiencing homelessness and psychiatric disability. The program provides a safe, hospitable alternative to shelters and access to permanent housing within 30 days once income is secured. Longer-term temporary housing also is available for those awaiting openings in MHSA-financed housing developments. Clients and staff work collaboratively to break the cycle of homelessness during average stays of six to eight months. (CSS-funded)

Reflecting on his experience, one client said "This is the first step for me being who I am. These people give us hope and from here, I'm learning how to live again."

State law does not require any state agency to review, analyze and summarize information contained in all of the county MHSA program plans and ensure the counties are spending the MHSA funds as they said they would. Perhaps it should.

Multiple Agencies, But Who is Accountable?

"Individually, each of the entities – the oversight commission and department of health care services – is very clear about their own responsibilities as set in law," Josephine Black, Chairperson, and Jane Adcock, Executive Officer, of the California Mental Health Planning Council wrote in testimony to the Commission. "However, when taking a global look, the roles are muddled resulting in divided (and weakened) leadership for key aspects of the public mental health system and no clear designation of authority. Who is to hold the system accountable? Who is to hold the oversight entities accountable?"[24]

Advocates, stakeholders and others told the Commission they remain confused and dissatisfied with the diffusion and overlap of responsibilities at the state. They are still concerned that no one is accountable for overseeing the Act and systematically and comprehensively evaluating its outcomes. Questions remain about which agencies are ultimately responsible for ensuring the promises made to voters are kept:

- Is it the responsibility of the oversight commission to focus its oversight and evaluation efforts specifically on programs funded by the Mental Health Services Act, or on the broader public mental health system? And if the oversight commission's role is broad, how does that differ with the planning council?
- Is it the responsibility of the department to investigate whether county spending plans align with actual expenditures or is this a function of the oversight commission?
- Which agency is responsible for ensuring the state's progress toward achieving the transformational vision of mental health services proposed to and approved by voters in 2004?
- Which agency is ultimately responsible for determining how to evaluate the programs funded by the Act – is it the oversight commission, the department, counties or the Health and Human Services Agency?

- Which agency is best situated to enforce compliance with the Act and to hear and address concerns raised by consumers, family members, stakeholders and advocates if and when issues arise at the local level?
- When problems are identified by the oversight commission or the planning council, how do either of these entities ensure corrective action is taken by the department which has authority to act?

When looking for accountability to the Mental Health Services Act, it's difficult to see clearly because a tangled web of organizations with conflicting and overlapping oversight responsibilities is tasked with the job. Some argue that this diffusion makes sense: the Act is but one funding stream for a diverse and complex mental health system. But who is truly accountable? When asked by Commissioners, former State Senator Darrell Steinberg and co-author of the Mental Health Services Act, said ultimately, it's elected leaders – the Governor and the Legislature.[25] At some juncture, policymakers may question this division of responsibilities and consider whether California needs all three organizations. In the meantime, despite past clarifications, more must be done to further articulate the roles and responsibilities of the various state agencies that administer, oversee and enforce the Act. Voters enacted the measure with the expectation of oversight, putting a strong onus on the state to ensure that these dollars – specifically – are spent as voters intended and produce the outcomes promised. The state should notify any non-compliant county behavioral health department and board of supervisors with a written notice including a deadline and specific remedy to achieve compliance and these written notices should be prominently published on a state website. To ensure compliance, the state should withhold money from non-compliant counties – as current law allows – and redistribute this money to other counties that are complying with the Act. The Legislature should enhance current law to make this withholding mandatory after one or more formal written notices regarding non-compliance are sent to the county.

Recommendation 1: The Legislature should further clarify the roles and responsibilities of the state agencies responsible for administering, overseeing and enforcing the Mental Health Services Act. Specifically it should:

- ***Clarify expectations for the scope of responsibilities of the department, oversight commission and planning council and define the separate roles of each in ensuring the Mental Health Services Act funds are used as voters intended.***
- ***Call on the entity charged with enforcement, currently the Department of Health Care Services, to identify the mechanism by which it will enforce the Act. The entity should identify metrics it will apply to evaluate county performance with potential consequences. Repeated poor performance should result in mandatory redistribution of money to compliant counties.***

THE QUESTION REMAINS: WHERE IS THE MONEY GOING?

To better answer basic questions about the statewide allocation and use of Mental Health Services Act funds, the Commission in 2015 recommended the Mental Health Services Oversight and Accountability Commission post meaningful financial information on its website. At a minimum, the Commission suggested, this should include a fiscal snapshot of overall and current year revenues and allocations by program component areas. It also should include information on how the state spends MHSA state administration funds.

Since the Commission's last review, the oversight commission launched an updated website which includes some financial elements recommended by the Commission. Among them: a breakdown of the cumulative MHSA revenue reported since the Act passed in 2004.[26] The website also includes a placeholder page for county-submitted reports and financial evaluation reports. When posted, the public will find important information about the Act in one centralized location.[27] These, and planned improvements described below, are steps in the right direction. But, more can be done to help voters, taxpayers and mental health advocates, consumers and their families understand how money from the Act is used locally and statewide.

Though some counties make financial information about their MHSA expenditures readily available, the Commission heard from stakeholders and other members of the public that in some communities it is still difficult to track how MHSA funds are spent. (Counties receive about 95 percent of the dollars generated by the Act each year in amounts based on a formula established by the Department of Health Care Services. In fiscal year 2016-17, counties received approximately $1.9 billion.[28])

"Mental health advocates, providers, and stakeholders alike, all want to know where the money is going. Most counties are not transparent with MHSA growth revenue and additional resources are not trickling down to the providers who offer mental health services," Matthew Gallagher, program director for the California Youth Empowerment Network, told the Commission. "So where is all the money going?"[29]

New Tools Promise Easier Access to Local Financial Information

Some suggested a state entity should be made responsible for dispersing the information in a user-friendly format online. Also needed: a reporting process that quickly makes the information public.[30]

A new fiscal transparency tool could show local MHSA expenditures online. According to its executive director, the oversight commission built the tool using data that counties must submit to the state in annual revenue and expenditure reports. The tool, he said, can show the distribution of MHSA funds to each county by component, identify how much has been spent and how much remains unspent, and show cumulative balances for each component of the MHSA. Plans to showcase the tool on the oversight commission's website have stalled while addressing county

One Stop Transitional Age Youth Center, San Bernardino County

The one stop center – one of four in the county – provides a range of drop-in services for youth ages 16-25 with, or at risk of, mental and emotional issues. The goal of treatment: to offer employment assistance, educational opportunities, shelter housing, counseling and group activities to help clients become independent, stay out of the hospital or higher levels of care, reduce involvement in the criminal justice system and reduce homelessness. Because of disproportionate over-representation in the justice system and foster care system, the program specifically targets Latino and African-American youth. The county's Probation and Children and Family Services, and other community groups, act as program partners. (CSS-funded)

concerns about the validity and reliability of the fiscal data on which it is built.[31] Despite setbacks, plans are in place to launch the tool by October 2016.[32]

The No Place Like Home initiative, a legislation package signed by Governor Brown in July 2016, established a new program for addressing homelessness and also included accountability measures. The legislation requires counties to certify the accuracy of their revenue and expenditure reports – and reiterates that the Department of Health Care Services may withhold Mental Health Services Funds for counties that fail to submit timely reports. Additionally, the legislation requires the department and the oversight commission to post county revenue and expenditure reports online.[33] When implemented, this will help fulfill one of the Commission's previous recommendations.

The Department of Health Care Services intends to begin posting these reports online no later than mid-September 2016, beginning with reports from fiscal year 2014-15.[34] It is clear to the Commission that making reports publicly available will create additional pressure on noncompliant counties to submit their reports, as would, at a minimum, posting each county's submission status.

"State level reporting does not allow for review of where the funding is going besides the full services partnerships, and also does not provide meaningful comparison of the relative costs and results of each FSP program. We don't know who or what produces the best results and how the answers might vary based on age, sex or ethnicity."
Rusty Selix, Executive Director of Policy and Advocacy, Mental Health America of California[35]

Additionally, proposed legislation, if signed by the Governor, would make it easier for Californians to understand how counties, alone and collectively, use MHSA funds. With this information, local decision-makers, advocates and stakeholders may be able to identify best practices in other counties and better inform their own spending decisions. Specifically, the measure, AB 2279 (Cooley), would require the DHCS, by July 1, 2018, to analyze data submitted by counties in their revenue and expenditure reports and annually produce a summary of revenues, expenditures and funds held in reserve. By requiring the department to make readily-available data about revenues and expenditures by component, by county, the legislation also would implement Commission recommendations.

Accomplishments of State Administrative Funds are Still Difficult to Track

Though the bulk of Mental Health Services Act funds go directly to counties to spend on programs and services, 5 percent goes each year to state administration of the Act. As the tax base grows, so, too, does the state's share. In fiscal year 2016-17, the Act is expected to generate approximately $102 million for state administration, about $15 million more than during the Commission's last review.[36]

State law guides how this portion of funds is spent. The Mental Health Services Act, as presented to voters in 2004, directed the California Mental Health Planning Council and the Mental Health Services Oversight and Accountability Commission to use the state administration funds "to implement all duties pursuant to the [MHSA] programs." The Act further specified that the state administration funds be used for two purposes:

- "assist consumers and family members to ensure the appropriate state and county agencies give full consideration to concerns about quality, structure of service delivery or access to services" and
- "ensure adequate research and evaluation regarding the effectiveness of services being provided and achievement of the outcome measures set forth [in the Act]."[37]

Current law gives these funds to five state agencies – the Department of Health Care Services, the California Mental Health Planning Council, the Mental Health Services Oversight and Accountability Commission, the Office of Statewide Health Planning and Development and the Department of Public Health – as well as any other state agency that implements MHSA programs. In fiscal year 2016-17, these five agencies received approximately $22 million to support 72.5 positions and provide oversight of the Act. (Of this, the DHCS, planning council and oversight commission together received about $15 million and 54 positions). Additionally, eight other agencies received funding for 23.5 positions and a myriad of programs ranging from supporting student mental health, conducting outreach to service members,

funding regional centers that develop innovative PEI projects and administering various grants.[38]

The Commission, concerned that there is insufficient oversight of this large and growing pot of money, recommended in 2015 the oversight commission bolster its oversight of the state administration funds and provide policymakers with analysis, beyond the straightforward fiscal accounting provided by the Department of Health Care Services. The annual MHSA Expenditure Report, produced by the DHCS, provides a high-level overview of overall MHSA revenues and expenditures, as well as a brief description of how and where the state administration funds are disbursed. It does not offer an analysis, however, of how the various state entities use the funds to achieve MHSA goals.

Currently, decisions about the allocation of state administration funds are made through the regular budget process. The Department of Finance issues policies and procedures for departments to propose budget changes – including proposals for departments to access MHSA funds. Rules prevent the oversight commission from consulting on MHSA-related budget change proposals. However, the oversight commission does consult with the Department of Finance, the Legislative Analyst's Office and legislative committees on specific budget proposals.[39] For example, the oversight commission currently is working with the Department of Finance and the Legislature to make it easier to understand how much is available in unspent state administrative funds.

The state needs to ensure that its 5 percent share of MHSA funds are spent appropriately. Someone must be responsible for asking: is it spent on purposes defined by the Act and what is it achieving?

During the Commission's last review, the Mental Health Services Oversight and Accountability Commission's financial oversight committee had begun inviting entities that receive part of the MHSA state administrative funds to report how the money is used. These presentations were helpful for decision-makers and stakeholders to better understand how these funds were being used and what they were accomplishing. However, the last time the committee heard a presentation from one of the state departments receiving funds was in November 2014.[40]

The former Department of Mental Health coordinated interagency partnerships among the various entities that received MHSA state administration funds. It also established memorandums of understanding with receiving entities that clarified expectations and responsibilities for use of the MHSA funds.[41] This type of oversight is needed again. To strengthen oversight of the ever-growing amount of state administrative funds and make it easier to analyze and evaluate their uses, the oversight commission should regularly analyze how state administrative funds are spent and what they achieve. Findings could help legislators and policy leaders better determine the successes of state programs funded with MHSA dollars, and make more informed decisions about spending increases or cuts as the fiscal climate demands.

Recommendation 2: The Governor should approve legislation, AB 2279 (Cooley), to make it easier for Californians to see how and where their Proposition 63 tax dollars are being spent.

Recommendation 3: The Department of Health Care Services should immediately begin posting online the MHSA Revenue and Expenditure reports it has available, instead of waiting for all counties to submit all reports.

Recommendation 4: The state must ensure MHSA state administrative funds are spent properly.

- ***The Mental Health Services Oversight and Accountability Commission's financial oversight committee should reinstate presentations from departments receiving a portion of the state administrative funds, analyze expenditures and compile an annual report for consideration of the full oversight commission.***
- ***The oversight commission should share its findings with the Department of Finance, Legislators and the public.***

STILL UNKNOWN: IS THE ACT ACHIEVING ITS GOALS?

Despite compelling claims that the Mental Health Services Act has transformed mental health services in communities across California, the Commission noted in its 2015 report that the state cannot yet demonstrate meaningful, statewide outcomes across the range of programs and services supported by Proposition 63 dollars. In large part, this is due to the lack of robust data that can show policymakers and mental health leaders what interventions are working in specific populations.

"Data is not just esoteric. It provides necessary information to share with policymakers who may not believe that there is any real solution to the state's homelessness crisis, or to help people stop cycling out of emergency rooms when they need immediate mental health assistance," former state Senator Darrell Steinberg, co-author of the Act, told the Commission.[42]

Josephine Black, Chairperson, and Jane Adcock, Executive Officer of the Mental Health Planning Council echoed a similar sentiment about the importance of mental health data: "We have many individual stories of success and they are extremely important and put a human face on the progress. However, data is the fundamental and universally-accepted evidence of progress."[43]

MHSA Data Effort Lost in Broader Mental Health Data System Fix

To tell a successful Proposition 63 story, the Commission in 2015 urged state mental health leaders to improve online access to existing MHSA information, plans and reports and showcase more model programs and best practices. The executive director of the oversight commission said he plans additional upgrades to the organization's website over the next three to five years to map programs by type, geography and outcomes.[44] This is a promising vision.

The Commission also recommended the state develop a comprehensive, statewide mental health data collection system. As a first step, the Commission called on the oversight commission and the Department of Health Care Services to develop a plan and timeline for a data collection system capable of blending information for MHSA programs and other state behavioral and mental health programs.

Since the Commission's 2015 review, the state has continued with long-term plans to modernize legacy data systems for its mental health and alcohol and drug abuse programs. The proposal: a seven-year, multi-phase, multi-million dollar project to upgrade the state's existing mental health data systems and streamline data collection. The oversight commission in 2015 funded the Department of Health Care Services to prepare a preliminary plan for this upgrade. As of July 2016, the department is awaiting approval from the Department of Technology to submit the preliminary plan to the federal

QUALITY DATA COULD THWART RAIDS ON MHSA FUNDING

At its May 2016 hearing, the Commission heard testimony from advocates and members of the public that recent legislative proposals to steer MHSA funds to new uses, while well-intended, may weaken the ability of counties to care for the mentally ill. Some said these proposals simply target the Mental Health Services Act as a "go to" funding source for ever-expanding programs and will lead to "theft" from the Act in future budget years.[56] During the 2015-16 legislative session, members proposed several bills to redirect Mental Health Service Act funds, including approximately $130 million annually in bond interest payments and more than $7 million dollars in one-time expenditures. These funds were proposed to construct permanent, supportive housing for chronically homeless people with mental illness, expand on-campus mental health services at colleges and provide funds for administration and technical assistance for specific programs.[57]

Centers for Medicare and Medicaid Services.[45] Next steps include another plan to implement the project, then issue a bid for vendors to design, develop and build the new system by June 2021.[46] Cost estimates are not yet available. But the initial planning phase will cost nearly $3 million, with the federal government picking up most of the tab.[47]

While recognizing that a process to transition and modernize legacy data systems is complex, the Commission has strong reservations about the current data modernization proposal. It is unreasonable to wait nearly two decades for the state to collect and report data about the Proposition 63 funding stream. Government agencies across the nation – at the federal, state and local levels, are demonstrating that new approaches to data collection and sharing can cost less and be implemented faster than efforts to maintain outmoded technology. For example, the California Department of Social Services in 2015 partnered with Code for America and the federal government's tech innovation team, 18F, to change its approach to procuring technology for a new Child Welfare System. Instead of issuing a massive contract for the project as a whole – traditionally a costly approach with low success rates – the department will build the new system in a series of projects focused on developing and delivering user-centered services and open source practices.[48] The Commission highlighted similar efforts in its 2015 report, *A Customer-Centric Upgrade for California Government.*

Meanwhile, Counties Initiate Their Own MHSA Data Collection Projects

Some counties individually have used MHSA money to develop local data systems to track outcomes. Los Angeles County built an application to measure MHSA outcomes and now produces a quarterly newsletter highlighting outcomes for participants in MHSA-funded programs. Debbie Innes-Gomberg, district chief of the Los Angeles County MHSA Implementation and Outcomes Division, also told the Commission the value of the data is "not just about saying that MHSA has made an impact. It's about making decisions using that data, learning from that data and improving the quality of our services."[49] These reporting practices should be a model for other counties that still lack capacity to report outcomes of MHSA-funded programs.

In the absence of a statewide mental health data system capable of reporting MHSA program outcomes, the County Behavioral Health Directors Association initiated its own data collection project in 2014, association executive director Kirsten Barlow told Commissioners in May. The Measurement, Outcomes and Quality Assessment (MOQA) project enables counties to report collective results of some MHSA programs using data counties already collect. Specifically, it aims to create uniformity in outcome reporting across different types of MHSA-funded programs.[50]

MEASURING MHSA OUTCOMES: IT CAN BE DONE

Los Angeles County now has a decade worth of data for some MHSA-funded programs, which it uses to guide decisions about where to refine or expand services countywide. Using money from the Act, Los Angeles County in 2006 built a data system to capture outcomes of clients enrolled in full-service partnership (FSP) programs – one type of program funded under MHSA Community Services and Supports (CSS). In the years since the county has twice expanded the system to capture outcomes from field capable clinical services (FCSS), another CSS-funded program, as well as Prevention and Early Intervention (PEI) programs.

Through its Outcome Measure Application, the county records and monitors clients' progress and response to services and reviews the impacts that programs have on clients' welfare. For example, data from the system shows that while in FSP programs, clients experience fewer hospitalizations, less homelessness, reduced incarceration and fewer emergency events. Children improve their grades, more adults live independently and some gain employment for the first time. Clients in FCCS programs spend more time engaging in meaningful activities, such as working, volunteering or participating in community activities. PEI clients show dramatic reductions in symptoms; they are less depressed, less anxious, parents report fewer behavior problems and fewer symptoms related to trauma. Reports produced from the data also are shared with providers to encourage them to think about how they use and analyze outcome data in their own programs, county staff said.[51]

The project allows counties to report on outcomes through an online portal, supported and maintained by the California Institute for Behavioral Health Solutions. Currently, the database is set up only to collect outcome data from full-service partnership programs – one of the largest types of programs funded with MHSA Community Services and Supports dollars. Common data elements for these programs include average percent of clients re-hospitalized within 30 days, reduction in homelessness, psychiatric hospitalizations and incarcerations for adults and reduction in trauma symptoms for children. The association is developing additional outcome measures for Prevention and Early Intervention programs.[52] The MOQA database was built with funding from the Department of Health Care Services.

With compiled data, the California Behavioral Health Directors Association, in partnership with the Steinberg Institute, has released two easy-to-understand reports since 2015 showing that participants of county full-service partnership programs help people recover and get better when they have the right kind of support. (The Steinberg Institute is a statewide organization launched in 2015 to advance sound public policy and inspire leadership on mental health issues.) Among 25,418 children and adults served between 2013 and 2014, homelessness and emergency shelter use declined, as did arrests, psychiatric hospitalization and mental health emergencies. Most children did better in school and some adults were able to find jobs after one year in a program.[53] The process also has improved data collection and reporting processes and increased use of data to inform best practices and administrative decisions.[54]

Additionally, reports about the California Mental Health Services Authority's (CalMHSA) statewide Prevention and Early Intervention programs demonstrate reduced stigma and discrimination around mental illness. Investments also have educated many Californians about how to intervene with people at risk for suicide. CalMHSA, created by counties in 2010, uses MHSA funds to implement statewide Prevention and Early Intervention services.[55]

These reports and others demonstrate outcomes for portions of programs funded by the Mental Health Services Act. They begin to paint a statewide picture of what the Act has achieved and are critical for providing policymakers with evidence of how the programs are working. These types of reports demonstrate the type of statewide analysis and reporting that should be the norm for all programs funded by the Act. In the long term, it is not sustainable nor prudent to rely on other organizations to do the work that should be done by the state in its oversight capacity.

The State Still Needs to Improve MHSA Data Collection

State leaders must immediately build on the counties' MOQA project to produce statewide MHSA outcome reports.

IMPROVING DATA COLLECTION, PERFORMANCE MEASURES AND OUTCOMES FOR CALIFORNIA'S YOUTH OFFENDERS

California's juvenile justice data system has lingered without a significant state investment in data modernization for more than two decades. Among its challenges: outdated technology that cannot be upgraded, inability to track important case and outcome information and a lack of performance outcome measures, poor transparency and availability of statewide information, and, fractured data collection and reporting responsibilities among different state agencies and lack of integration with county-level data systems.[59]

To address long-standing concerns about the state's lack of a juvenile justice data system, the Legislature in 2014 established a working group to help clarify what would be needed for the state to build capacity to collect and use juvenile justice data to support evidence-based practices and promote positive outcomes for the children and youth who move through the system. Staff from the Board of State and Community Corrections supported the working group by coordinating meetings, taking notes and drafting reports. After more than a year of meetings, research and deliberation, the working group released a report offering recommendations to improve and modernize the data system, while addressing concerns related to the cost of replacement technology as well as the need to create a system that leverages the infrastructure of existing county data systems.[60]

State mental health leaders, with relevant stakeholders, should collectively identify indicators that will show progress toward reducing the negative outcomes from untreated mental illness. Defined by the Act, those include suicide, incarcerations, school failure or dropping out rate, unemployment, prolonged suffering, homelessness, and removal of children from their homes. Evaluation efforts by the counties show that reporting on these types of indicators is already possible for some components of the Act.

> ***"We wonder whether mental health disparities are being reduced. But because of the lack of data, no one can really prove anything beyond anecdotal examples."***
>
> Stacie Hiramoto, Director, REMHDCO[58]

State leaders also should collect data to better understand who is being served. Throughout the Commission's last review and again at its May 2016 hearing, advocates, stakeholders and members of the public voiced concerns that the state still cannot account for the number of people served by the Act, nor produce basic demographic data. Of particular importance, many said, is reporting data on racial, ethnic and other minority communities so the state can better understand how the Act is reducing disparities in services and guide future spending decisions. They said statewide outcome measures should include demographic information about who benefits from the Act, including their ages, gender, racial and ethnic background and language spoken.

Additionally, state mental health leaders should acknowledge the anxiety that the collection of outcome data can cause. They should emphasize the use of data to improve services and promote best practices, not to sanction poor performers. To ease the anxiety, representatives of those who will collect and use the data should be included in the process to clarify what the state must collect to oversee the Mental Health Services Act. The state's work to build a juvenile justice data system offers a model to begin a conversation about building an appropriate outcome data system for MHSA-funded programs.

The Department of Health Care Services has started a workgroup to identify common ways counties measure and report MHSA and other behavioral health data to the state and to consider what doesn't need to be provided to the state. Membership includes key staff from the oversight commission, Mental Health Planning Council and counties. However, it is not clear from conversations with participants whether this group meets regularly, has an ultimate purpose for meeting, and whether the meetings or meeting materials are available to the public.

The state should leverage the momentum spurred by local data collection efforts, as well as burgeoning coordination among state agencies to review mental health data requirements in order to build a modern, Web-based data collection system to report outcomes from MHSA-funded programs.

Recommendation 5: Before proceeding further with the data modernization project, the Department of Health Care Services should immediately consult with civic technologists and data experts to refine and streamline its approach to modernizing the state's mental health data collection system.

Recommendation 6: The Legislature should establish a Mental Health Services Act (MHSA) data workgroup within the Department of Health Care Services to build on existing county MHSA data collection efforts and develop and support a statewide MHSA database. The workgroup should:

- ***Be comprised of representatives from entities who collect and use mental health data at the state and local levels, stakeholders as well as technology experts and should be supported by department staff.***
- ***Define the statewide outcomes needed to evaluate the MHSA, identify whether existing data collection efforts are sufficient for reporting and articulate the technological needs for such a data collection system. If existing data is not sufficient, the workgroup should recommend how counties and providers might collect the additional data without creating undue work or redundancies for counties and providers.***
- ***Specify how demographic data will be collected, including age, gender, racial and ethnic background and language spoken.***

CALIFORNIANS STILL NEED MEANINGFUL WAYS TO PARTICIPATE IN SPENDING DECISIONS

The Mental Health Services Act established a process – and allocated resources – for stakeholders to participate in county decisions about how to spend MHSA funds. The Act specifically calls for stakeholder involvement in developing counties' three-year program and expenditure plans and annual updates. It also requires counties to "demonstrate a partnership with constituents and stakeholders through the process that includes meaningful stakeholder involvement on mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation and budget allocations."[61] These provisions codify a central and ongoing role for stakeholders in determining how and where counties should invest their MHSA resources.

However, in this review and the last, the Commission heard that some counties fall short in including stakeholders in meaningful decisions. "Proposition 63 included specific requirements that county spending plans be developed through a stakeholder process. Counties have complied with the state requirements," Rusty Selix, MHSA co-author told Commissioners. "Unfortunately that guidance has missed the mark by measuring how many people attended meetings and how many groups the counties reached out to." He explained that counties are not required to describe how the funds are proposed to be spent compared to how they are actually spent. Nor are they required to have meaningful discussions that welcome stakeholder views before and after spending decisions are made.[62] Some stakeholders say spending decisions seem to be made before they are asked to provide input, and that their input is "window dressing."[63]

Boulevard Court Apartments, Sacramento County

Operated by Mercy Housing California, the Boulevard Apartments offer a low-income housing program for homeless people with special needs. Using MHSA funds, the program renovated a formerly dilapidated motel in a high-need neighborhood into a campus with 74 studio and one-bedroom units that offer residents supportive services such as health care education, financial literacy and community involvement. With stable housing in a supportive environment, residents can focus on successfully managing their individual disabilities. (CSS-funded)

"I like being here," one participant said. "The best thing is that it is affordable for me and there's a doctor onsite. Otherwise, it takes two to two and a half hours transportation time by the bus [to get to a doctor]."

"The approach to community engagement matters," Stacie Hiramoto, director of the Racial and Ethnic Mental Health Disparities Coalition, told Commissioners. "A lot of times, counties have a big meeting at a big public place. For many people in underserved communities it's not our culture to come out in public. And, in some of our communities, the stigma regarding mental health issues is actually more acute." Ms. Hiramoto and others also explained there can be language or cultural barriers that impede participation, as well as scheduling barriers that make it difficult for workers to attend meetings during regular business hours.

To make it easier to participate in MHSA planning efforts, stakeholders suggested counties partner with community groups or trusted leaders to figure out the best ways to approach certain cultural groups and show respect for their distinct values. With the help of these partners, counties could advertise meetings in different languages and hold discussions in smaller venues where people feel comfortable. Scheduling meetings in the evening or on weekends also could help working families participate.[64] Additionally, they suggested counties – as well as the state – establish advisory committees that involve consumers, family members and representatives of underserved communities in decisions. Many of these suggestions echo recommendations from various groups, including the Mental Health Planning Council,

the California Stakeholder Process Coalition and the oversight commission to fortify stakeholder engagement in implementation of the Act.[65]

Additionally, clients and advocates suggested the state strengthen the process for stakeholders to report issues and concerns at the local and state levels. Several told Commissioners they are unsure where they should turn when they identify problems with the local planning process and program implementation. Some said they fear retaliation for speaking out against spending decisions or registering a complaint with the local process. Others said that even when local leaders articulate a plan of correction, there is no oversight by the state to ensure that what was promised is done.

In its triennial performance audit of counties, the Department of Health Care Services reviews whether counties have an issue resolution process for the Mental Health Services Act and that they maintain a log of all issues received and the dates they were resolved. The department does not, however, review the quality of these processes nor does it assess whether they are sufficient for capturing and responding to concerns.

In response to concerns about the adequacy of the issue resolution process, the oversight commission has begun a formal project to review the process and identify opportunities to clarify and strengthen ways for stakeholders to raise concerns and for those concerns to be addressed, the oversight commission's executive director told the Commission. The Commission commends this effort and encourages the oversight commission to develop tools and templates to improve the local issue resolution process, including making it easier for clients, advocates and others to learn how to engage and how and where to elevate their issue to the state, if necessary.

Recommendation 7: The Mental Health Services Oversight and Accountability Commission should provide guidance to counties on best practices in engaging stakeholders in MHSA planning processes, and offer training and technical assistance if necessary. Additionally, the oversight commission should develop standards and a template for counties to create consistency in reporting and responding to concerns about the Mental Health Services Act. The oversight commission and the Department of Health Care Services should clarify the process for elevating issues or concerns related to the Mental Health Services Act from the local level to the state.

Navigation Teams, Los Angeles County

Eight navigation teams work regionally across the county to help individuals and families access mental health and other supportive services. Navigation Team members help quickly identify available services tailored to a client's cultural, ethnic, age and gender identity, and follow up with clients to ensure they received the help they need. Team members also build an active support network through partnerships with community organizations and service providers and map availability of local services and supports in the area. (CSS-funded)

A team member described the program as concierge mental health services – "navigators help people directly link to the services they need."

COUNTIES NEED MORE WAYS TO SHARE SUCCESS

The Mental Health Services Act provides Innovation funds for counties to experiment with promising practices that have not yet proven effective. This financial commitment allows local communities throughout the state to become testing grounds for new and innovative mental health programs and practices. Brought to scale, successful programs could transform the way mental health services are delivered in the state. However, key to that transformation is the ability of local mental health leaders, providers and clients and their families to regularly share information and lessons learned about what's working, what's not and why.

Counties and providers currently have several venues to share best practices and lessons learned. For example, Mike Kennedy, Sonoma County's Behavioral Health Division Director, told the Commission in September 2014 that counties can learn about successful approaches in other counties through the County Behavioral Health Directors Association and its subcommittees, conferences and forums.[66] The associations' MHSA committee also holds monthly conference calls or meetings to share information about programs funded by the Mental Health Services Act.

The Transitional Age Youth Behavioral Health Hostel – The STAY, San Bernardino County

The hostel offers a short-term crisis residential program for up to 14 Transition Age Youth between ages 18 to 25 who are experiencing an acute psychiatric episode or crisis and is the first crisis residential treatment facility in the county. Services are culturally and linguistically appropriate, with a particular emphasis on diverse youth (African American, Latino, LGBTQ, etc.) as well as former foster youth or youthful offenders. The hostel is primarily peer run by individuals representing the county's diverse ethnic communities and cultures. (INN-funded)

Additionally, the department, oversight commission and individual counties occasionally contract with the California Institute for Behavioral Health Solutions to develop training programs on evidence-based practices, hold conferences and policy forums, among other consultative activities. The nonprofit institute, established in 1993, helps health professionals and others improve the lives of people with mental health and substance use challenges. When the Mental Health Services Act was initially passed, the Department of Mental Health contracted with the institute to help counties develop and run full-service partnership programs. With input from state and local mental health leaders, providers, clients and family members, the institute developed toolkits to help providers implement full-service partnership programs, ensure ongoing quality improvement and improve access to care for unserved and underserved ethnic and cultural groups.[67] The institute has not yet been approached to coordinate similar training around successful MHSA Innovation programs.[68]

Despite existing efforts to collaborate, the Commission heard from stakeholders that more is needed and suggested the state could play a key role in fostering information sharing and by providing additional technical assistance. At each county visited, the Commission heard providers say in various ways, "I'm not sure if other counties have a program like this."

One member of an award-winning MHSA-funded Innovation program in Long Beach lamented, "I've been thinking about putting together a training program because no one seems to have anything like this. But I just haven't found the time."

Another provider – a "navigator" who links individuals and family members to appropriate mental health services, and provides referrals and responds to pleas for help – said she wishes for a way to "connect the connectors." She explained that while she and the other "navigators" are familiar with the various programs in her

county, it would be helpful also to know what is available elsewhere. "It would be great to have conferences, more provider-to-provider learning opportunities," she said. "If we don't see anything outside our county, we're not learning."

The state could spread promising practices across communities and county boundaries by collecting information from successful Innovation programs and working with providers to develop training programs and share best practices.

The oversight commission has the statutory authority to establish technical advisory committees, employ technical assistance staff and other appropriate strategies as necessary to perform its duties.[69] But, according to its executive director, "the oversight commission does not currently have the staff to provide technical assistance and training on how innovation can be transformative." Nor does it "currently have the capacity to fully disseminate information on the lessons learned through innovation investments."

The oversight commission requested, and received in the 2016-17 budget funding for additional staff to better document how counties are innovating, what has worked and why. The oversight commission plans to develop tools and provide technical assistance around Innovation programs, as well as disseminate best practices. It also intends to reach out to partners in the business community, universities, foundations and federal agencies, as well as counties and service providers, to leverage innovation as a strategy for transformational change, the executive director said.[70] Again, this is a promising vision, but more must be done to ensure that counties get the help they need to leverage best practices across the state, fulfilling one of the original intentions of the Mental Health Services Act.

To scale up promising MHSA-funded Innovation programs, mental health practitioners need more opportunities to learn from each other about what's working well so that successful programs can be replicated. As part of its oversight responsibilities, the oversight commission should prioritize fostering the transformational potential of the Mental Health Services Act's Innovation programs.

Recommendation 8: The Mental Health Services Oversight and Accountability Commission should identify best practices in counties achievements with MHSA programs, and provide training and technical assistance to disseminate these practices statewide. It also should develop regular opportunities to convene local mental health leaders and practitioners to spread lessons learned beyond county borders.

Crisis Respite Center, Sacramento County

Since opening in December 2013, the Crisis Respite Center provides crisis intervention services that reduce law enforcement calls and unnecessary emergency room visits. The program stabilizes adults experiencing mental health crises with 24/7 drop-in services in a warm and supportive setting. The program provides a stable, supportive environment to help "guests" explore their crises with a solution-oriented mindset. (CSS-funded, formerly INN)

A client reflected, "Here I had the chance to settle down and think straight *because* I felt safe. I had the chance to regroup coming here."

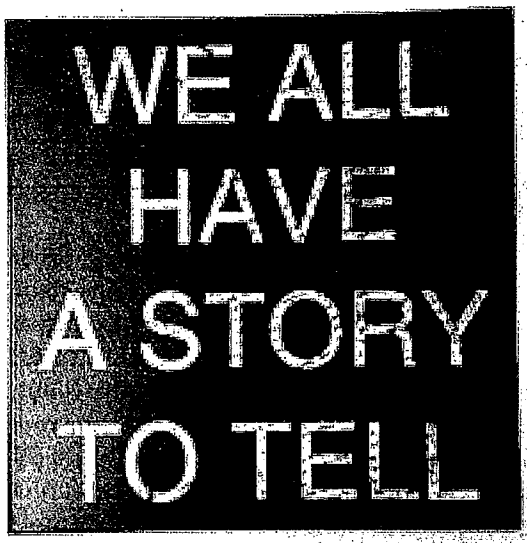


Photo by Little Hoover Commission staff at the Crisis Respite Center – Transforming Lives, Cultivating Success in Sacramento, California.

APPENDICES

Appendix A: Public Hearing Witnesses

Public Hearing Revisiting the Mental Health Services Act
May 26, 2016

Jane Adcock, Executive Officer, California Mental Health Planning Council

Kirsten Barlow, Executive Director, County Behavioral Health Directors Association

Karen Baylor, Deputy Executive Director of Mental Health and Substance Use Disorder Services, California Department of Health Care Services

Phillip Deming, Chair, San Diego County Behavioral Health Advisory Board

Toby Ewing, Executive Director, Mental Health Services Oversight & Accountability Commission

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition

Debbie Innes-Gomberg, District Chief, Los Angeles County MHSA Implementation and Outcomes Division

Daphne Shaw, Councilmember, California Mental Health Planning Council

Rusty Selix, MHSA Co-Author and Executive Director of Policy and Advocacy, Mental Health America of California

Darrell Steinberg, Former Senate President Pro Tem and Founder, Steinberg Institute

Appendix B: Recommendations from the Little Hoover Commission's January 2015 report, *Promises Still to Keep: A Decade of the Mental Health Services Act*

Recommendation 1: The Legislature should expand the authority of the Mental Health Services Oversight and Accountability Commission. Specifically, it should:

- Strengthen the ability of the state to conduct up-front reviews of the more controversial programs funded by the act before funds are expended by requiring the oversight commission to review and approve county Prevention and Early Intervention plans annually, as it currently does for Innovation plans.
- Refine the process by which the state responds to critical issues identified in county three-year plans or annual updates to ensure swift action. Empower the oversight commission to impose sanctions, including the ability to withhold part of the county's MHSA funds, if and when it identifies deficiencies in a county's spending plan. Decisions of the oversight commission should become mandatory unless they are overturned by the Department of Health Care Services within a reasonable period, such as 60 days.

Recommendation 2: To provide greater oversight and evaluation of the state administrative funds, the oversight commission should annually develop recommendations for and consult with the Department of Finance before the funds are allocated.

Recommendation 3: To make MHSA finances more transparent and make it easier for voters, taxpayers and mental health advocates, consumers and their families to see how and where the money is spent and who benefits from its services, the Mental Health Services Oversight and Accountability Commission should add to and update material on its website to include:

- MHSA revenues, by component and annual allocations, and the cumulative total revenue since voters approved the act.
- Data about who benefits from the act, including the number of individuals served, their ages, gender, racial and ethnic background and language spoken.
- Data to demonstrate statewide trends on key indicators such as rates of homelessness and suicide that show how well the act's programs help those living with mental illness to function independently and successfully.
- A rotating showcase of model programs in each of the component areas to clearly demonstrate examples of what works.
- All county MHSA plans and reports submitted to the state, including:
  - ✓ MHSA annual revenue and expenditure reports.
  - ✓ Three-year program and expenditure plans and annual updates.
  - ✓ Other relevant mental health reports, such county cultural competence plans that describe how a county intends to reduce mental health service disparities identified in racial, ethnic, cultural, linguistic and other unserved and underserved populations.

Recommendation 4: To promote meaningful accountability of the MHSA, the state needs access to reliable, timely information that allows it to monitor effective progress toward the act's goals. The Mental Health Services Oversight and Accountability Commission and Department of Health Care Services should:

- Immediately develop a formal plan and timeline to implement a comprehensive, statewide mental health data collection system capable of incorporating data for all MHSA components, as well as other state behavioral and mental health programs.
    - ✓ This plan should address how the development of such a data collection system would be funded and should use a portion of the MHSA state administrative funds to support the effort.
- Regularly report to the Legislature on the progress made in developing this data system and identify challenges that arise.

Appendix C: Examples of Statutory Roles and Responsibilities Assigned to Mental Health Agencies

State law – California's Welfare and Institutions Code – prescribes various roles and responsibilities for state and local agencies to implement the Mental Health Services Act. Examples of some of these roles and responsibilities are included below.

Code Section	Description	DHCS	MHSOAC	MHPC	Other	County	CBHDA
5655	DHCS shall, upon request and with available staff, provide consultation services to the local mental health directors, local governing bodies and local mental health advisory boards. If the director of DHCS considers any county to be failing, in a substantial manner, to comply with any provision of this code or any regulation, the director shall order the county to appear at a hearing, before the director or the director's designee, to show cause why the department should not take action. If the director finds there has been a failure, the DHCS may withhold part or all of state mental health funds for the county, require the county to enter into negotiations for the purpose of ensuring county compliance with those laws and regulations and bring court action as appropriate to compel compliance.	✓					
5722	The MHPC shall have the powers and authority necessary to, among other duties, review, assess and make recommendations regarding all components of California's mental health system, review program performance in delivering mental health services by annually reviewing performance outcome data, identify successful programs for recommendation and for consideration of replication in other areas, advise the DHCS if a county's performance is failing, advise the Legislature, DHCS and county boards on mental health issues and the policies and priorities the state should be pursuing in developing its mental health system.			✓			
5845 (a)	MHSOAC established to oversee: Part 3: the Adult and Older Adult Mental Health System of Care, Part 3.1: Human Resources, Education and Training Programs, Part 3.2: Innovative Programs, Part 3.6: Prevention and Early Intervention Programs, Part 4: Children's Mental Health Services Act		✓				
5845 (d) (6)	In carrying out its duties, the MHSOAC may, among other things, obtain data and information from DHCS, OSHPD or other state or local entities that receive MHSA funds for the commission to utilize in its oversight, review, training and technical assistance, accountability and evaluation capacity regarding projects and programs supported with the MHSA funds	✓	✓		✓		✓
5845 (d) (9)	Advise the Governor or Legislature regarding actions the state may take to improve care and services for people with mental illness.		✓				
5845 (d) (10)	If the commission identifies a critical issue related to the performance of a county mental health program, it may refer the issue to the DHCS.	✓	✓				
5845 (d) (11)	Assist in providing technical assistance to accomplish the purposes of Part 3, Part 4 in collaboration with the DHCS and in consultation with the CBHDA	✓	✓				✓

Code Section	Description	DHCS	MHSOAC	MHPC	Other	County	CBHDA
5845 (d) (12)	The MHSOAC may work in collaboration with DHCS and the Mental Health Planning Council, and in consultation with the CBHDA, in designing a comprehensive joint plan for a coordinated evaluation of client outcomes in the community-based mental health system, including but not limited to parts listed in 5845(a). The California Health and Human Services Agency shall lead this comprehensive joint plan effort.	✓	✓	✓	✓		✓
5897 (c)	The DHCS shall implement the provisions of Part 3, Part 3.2, Part 3.6 and Part 4 through the annual county mental health services performance contract.	✓				✓	
5897 (d)	The DHCS shall conduct program reviews of performance contracts to determine compliance. Each county performance contract shall be reviewed at least once every three years, subject to available funding.	✓				✓	
5897 (e)	When a county mental health program is not in compliance with its performance contract, the department may request a plan of correction with a specific timeline to achieve improvements. The department shall post on its website any plans of correction requested and the related findings.	✓				✓	
5898	The DHCS, in consultation with the MHSOAC, shall develop regulations, as necessary, for the DHCS, the MHSOAC, or designated state and local agencies to implement this act.	✓	✓		✓	✓	
5899 (b)	The DHCS, in consultation with the MHSOAC and CBHDA shall revise the instructions for the Annual Mental Health Services Act Revenue and Expenditure Report by July 1, 2017, and as needed thereafter, to improve the timely and accurate submission of county revenue and expenditure data.	✓	✓			✓	

Notes:
DHCS: California Department of Health Care Services
MHSOAC: Mental Health Services Oversight and Accountability Commission
MHPC: California Mental Health Planning Council
Other: A state agency, other than DHCS, MHSOAC, MHPC
CBHDA: County Behavioral Health Directors Association, formerly, County Mental Health Directors Association

Appendix D: County Submission Status of MHSA Annual Revenue and Expenditure Reports (as of August 26, 2016)

County	Fiscal Year	
	13-14	14-15
Alameda		
Alpine		
Amador		
Berkeley City	✓	✓
Butte	✓	✓
Calaveras	✓	✓
Colusa	✓	✓
Contra Costa	✓	✓
Del Norte	✓	✓
El Dorado	✓	✓
Fresno	✓	✓
Glenn	✓	✓
Humboldt	✓	
Imperial	✓	✓
Inyo	✓	✓
Kern	✓	
Kings	✓	✓
Lake		
Lassen	✓	
Los Angeles		
Madera		
Marin		
Mariposa		
Mendocino	✓	
Merced	✓	
Modoc	✓	✓
Mono	✓	✓
Monterey		
Napa		
Nevada	✓	

County	Fiscal Year	
	13-14	14-15
Orange	✓	✓
Placer		
Plumas		
Riverside	✓	
Sacramento		
San Benito	✓	
San Bernardino	✓	✓
San Diego	✓	✓
San Francisco	✓	✓
San Joaquin		
San Luis Obispo	✓	✓
San Mateo		
Santa Barbara		
Santa Clara		
Santa Cruz	✓	
Shasta	✓	
Sierra		
Siskiyou		
Solano	✓	✓
Sonoma		
Stanislaus	✓	✓
Sutter-Yuba		
Tehama	✓	✓
Tri-City	✓	✓
Trinity	✓	
Tulare	✓	✓
Tuolumne	✓	✓
Ventura	✓	✓
Yolo		

Source: Kendra Penner, Legislative Coordinator, Department of Health Care Services. August 30, 2016. Personal communication with Commission staff.

Total FY 13-14	**37**
Total FY 14-15	**26**

NOTES

1 Department of Health Care Services (DHCS). January 2016. Mental Health Services Act Expenditure Report: Fiscal year 2016-2017. Also, Mental Health Services Oversight and Accountability Commission (MHSOAC). "Proposition 63 History." Accessed August 5, 2016 at http://mhsoac.ca.gov/history

2 Secretary of State Kevin Shelley. November 2, 2004. Official Voter Information Guide. Page 34.

3 Welfare & Institutions Code, Sections 5845(d)(11), 5845(d)(12), 5898, 5899(a-b).

4 Welfare & Institutions Code, Section 5655.

5 DHCS. See Endnote 1.

6 Karen Baylor, Deputy Director of Mental Health and Substance Use Disorder Services, DHCS. July 12, 2016. Personal communication with Commission staff.

7 Toby Ewing, Executive Director, MHSOAC. May 26, 2016. Testimony to the Commission. Accessed September 8, 2016 at http://calchannel.granicus.com/MediaPlayer.php?view_id=7&clip_id=3752.

8 Department of Health Care Services. September 23, 2015. MHSUDS Information Notice: 15-042. Subject: Annual review protocol for consolidated Specialty mental health services and other funded services for fiscal year 2015-16.

9 Karen Baylor, Deputy Director of Mental Health and Substance Use Disorder Services, DHCS. May 26, 2016. Testimony to the Commission.

10 Welfare & Institutions Code, Section 5899.

11 Kendra Penner, Legislative Coordinator, Department of Health Care Services. August 30, 2016. Personal communication with Commission staff.

12 Karen Baylor, Deputy Director of Mental Health and Substance Use Disorder Services, DHCS. September 23, 2014 and May 26, 2016. Written testimony to the Commission.

13 Welfare & Institutions Code, Section 5655. Also, Karen Baylor. See Endnotes 6 and 12.

14 Brian Sala, Deputy Director, and Filomena Yeroshek, Chief Counsel, MHSOAC. July 8, 2016. Personal communication with Commission staff.

15 DHCS. See Endnote 1.

16 Rusty Selix, Executive Director of Policy and Advocacy, Mental Health America of California. May 26, 2016. Written testimony to the Commission.

17 Toby Ewing. See Endnote 7, hearing video at 1:50:04 to 1:51:37.

18 Welfare & Institutions Code, Section 5772(b) and (c).

19 Welfare & Institutions Code, Sections 5820 and 5821.

20 DHCS. See Endnote 1.

21 Welfare & Institutions Code, Sections 5847 and 5848.

22 AB 1618 (Committee on Budget). Chapter 43, Statutes of 2016. Also, Welfare & Institutions Code, Section 5848(e).

23 Brian Sala. See Endnote 14.

24 Josephine Black, Chairperson, and Jane Adcock, Executive Officer, California Mental Health Planning Council. May 26, 2016. Written testimony to the Commission.

25 Darrell Steinberg, former Senate Pro Tem and Founder, Steinberg Institute. May 26, 2016. Testimony to the Commission.

26 MHSOAC. See Endnotoe 1.

27 MHSOAC. "County Submitted Reports." Accessed August 5, 2016 at http://mhsoac.ca.gov/county-submitted-reports. Also, "Ensuring Fiscal Accountability" at http://mhsoac.ca.gov/ensuring-fiscal-accountability. Also, "Measuring Outcomes" at http://mhsoac.ca.gov/measuring-outcomes.

28 DHCS. See Endnote 1.

29 Matthew Gallagher, Program Director, California Youth Empowerment Network. May 5, 2016. Public comment to the Commission.

30 Sally Zinman, Executive Director, California Association of Mental Health Peer Run Organizations. May 25, 2016. Written testimony to the Commission.

31 Toby Ewing. See Endnote 7.

32 Brian Sala, Deputy Director, MHSOAC. July 29, 2016. Personal communication with Commission staff.

33 AB 1618. See Endnote 22. Also, Welfare & Institutions Code, Section 5899.

34 Kendra Penner. See Endnote 11.

35 Rusty Selix, Executive Director of Policy and Advocacy, Mental Health America of California. May 2016, Testimony to the Commission.

36 DHCS. See Endnote 1.

37 Kevin Shelley. See Endnote 2. Pages 107-108.

38 Welfare & Institutions Code, Section 5892(d). Also, DHCS. See Endnote 1.

39 Toby Ewing. See Endnote 7.

40 Financial Oversight Committee, MHSOAC. Minutes. March 27, 2015. Accessed July 18, 2016 at http://archive.mhsoac.ca.gov/Meetings/docs/Meetings/2015/March/FOC/FOC_032715_Agenda.pdf.

41 The WayBack Machine Internet Archive. Captured January 21, 2012,

http://www.dmh.ca.gov/Prop_63/MHSA/State_Interagency_Partners.asp.

42 Darrell Steinberg. May 5, 2016. Steinberg Institute and County Behavioral Health Directors Association press event. Sacramento, California.

43 Josephine Black and Jane Adcock. See Endnote 24.

44 Toby Ewing. See Endnote 7.

45 Karen Baylor. See Endnote 9.

46 Kendra Penner, Legislative Coordinator, DHCS. July 27, 2016. Personal communication to Commission staff. Also, Renay Bradley, Director of Research and Evaluation, MHSOAC. June 10, 2016. "MHSOAC Data Strengthening Efforts."

47 Kendra Penner, Legislative Coordinator, DHCS. July 29, 2016. Personal communication to Commission staff.

48 Dan Hon. November 30, 2015. Code for America Blog Archive. "A New Approach to Procuring Government Technology in California." Accessed July 28, 2016 at https://www.codeforamerica.org/blog/2015/11/30/a-new-approach-to-procuring-government-technology-in-california/. Also, V. David Zvenyach and Andre Francisco, 18F. March 22, 2016. "From 1,500 pages to 10: Helping California buy a new Child Welfare System." Accessed July 28, 2016 at https://18f.gsa.gov/2016/03/22/helping-california-buy-a-new-child-welfare-system/.

49 Debbie Innes-Gomberg, District Chief, Los Angeles County MHSA Implementation and Outcomes Division. May 26, 2016. Testimony to the Commission.

50 Adrienne Shilton, Director of Intergovernmental Affairs, County Behavioral Health Directors Association of California. July 7, 2016. Personal communication to Commission staff.

51 Debbie Innes-Gomberg, District Chief, and Kara Taguchi, Phys.D., Los Angeles County MHSA Implementation and Outcomes Division. June 16, 2016. Personal communication with Commission Staff. Long Beach, California. Also, Debbie Innes-Gomberg, See Endnote 49.

52 Kirsten Barlow, Executive Director, Mary Ader, Deputy Director of Legislative Affairs and Adrienne Shilton, Director of Intergovernmental Affairs, County Behavioral Health Directors Association. July 6, 2016. Sacramento, CA. Personal communication with Commission staff.

53 Steinberg Institute and County Behavioral Health Directors Association. May 5, 2016. Changes to Number of Clients After Entering Full Service Partnership Program.

54 Adrienne Shilton. See Endnote 50.

55 Wayne Clark, Executive Director, California Mental Health Services Authority. May 20, 2016. Written testimony to the Commission.

56 Josephine Black, Chairperson, Mental Health Planning Council (MHPC). June 8, 2016. "Letter to Honorable Kevin de Leon, President Pro Tempore, California State Senate RE: No Place Like Home Legislation – Oppose unless amended." Also, Josephine Black, Chairperson, MHPC. June 24, 2016. "Letter to Assembly Member Kevin McCarty RE: AB 2017 College Mental Health Services Program – Oppose."

57 AB 847 (Mullin and Ridley-Thomas), AB 1618 (Committee on Budget), AB 2017 (McCarty), SB 614 (Leno), SB 852 (Budget Trailer Bill).

58 Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition. May 26, 2016, Testimony to the Commission.

59 California Juvenile Justice Data Working Group. January 2016. "Rebuilding California's Juvenile Justice Data System: Recommendations to Improve Data Collection, Performance Measures and Outcomes for California Youth."

60 California Juvenile Justice Data Working Group. See Endnote 59.

61 Welfare & Institutions Code, Section 5848(a).

62 Rusty Selix. See Endnote 16.

63 Racial and Ethnic Mental Health Disparities Coalition (REMHDCO). July 20, 2016. Survey on Proposition 63/Mental Health Services (MHSA) community planning process.

64 REMHDCO. See Endnote 63.

65 California Mental Health Planning Council. December 2015. "We're Listening: A Community Dialogue on Mental Health." Also, Resource Development Associates for the MHSOAC. August 8, 2014. "MHSA Community Program Planning Processes – Promising CPP Practices." Also, the California Stakeholder Process Coalition April 2012. "Transforming California Mental Health System through Consumer Engagement."

66 Mike Kennedy, Director, Sonoma County Behavioral Health Division. September 23, 2014. Written testimony to the Commission.

67 California Institute for Behavioral Health Solutions. FSP Toolkits. Accessed July 21, 2016 at http://www.cibhs.org/introduction/fsp-toolkits.

68 Sandra Naylor Goodwin, President and CEO, California Institute for Behavioral Health Solutions. July 21, 2016. Personal communication with Commission staff.

69 Welfare & Institutions Code, Section 5845.

70 Toby Ewing. See Endnote 7. Also, California Enacted Budget. MHSOAC. Accessed July 21, 2016 at http://www.ebudget.ca.gov/2016-17/pdf/Enacted/GovernorsBudget/4000/4560.pdf.

Little Hoover Commission Members

CHAIRMAN PEDRO NAVA *(D-Santa Barbara)* Appointed to the Commission by Speaker of the Assembly John Pérez in April 2013. Advisor to telecommunications industry on environmental and regulatory issues and to nonprofit organizations. Former state Assemblymember. Former civil litigator, deputy district attorney and member of the state Coastal Commission. Elected chair of the Commission in March 2014.

VICE CHAIRMAN JACK FLANIGAN *(R-Granite Bay)* Appointed to the Commission by Governor Edmund G. Brown Jr. in April 2012. A member of the Flanigan Law Firm. Co-founded California Strategies, a public affairs consulting firm, in 1997.

SCOTT BARNETT *(R-San Diego)* Appointed to the Commission by former Speaker of the Assembly Toni Atkins in February 2016. Founder of Scott Barnett LLC, a public advocacy company, whose clients include local non-profits, public charter schools, organized labor and local businesses. Former member of Del Mar City Council and San Diego Unified School District Board of Trustees.

DAVID BEIER *(D-San Francisco)* Appointed to the Commission by Governor Edmund G. Brown Jr. in June 2014. Managing director of Bay City Capital. Former senior officer of Genetech and Amgen. Former counsel to the U.S. House of Representatives Committee on the Judiciary. Serves on the board of directors for the Constitution Project.

SENATOR ANTHONY CANNELLA *(R-Ceres)* Appointed to the Commission by the Senate Rules Committee in January 2014. Elected in November 2010 an re-elected in 2014 to the 12th Senate District. Represents Merced and San Benito counties and a portion of Fresno, Madera, Monterey and Stanislaus counties.

ASSEMBLYMEMBER CHAD MAYES *(R-Yucca Valley)* Appointed to the Commission by former Speaker of the Assembly Toni Atkins in September 2015. Elected in November 2014 to the 42nd Assembly District. Represents Beaumont, Hemet, La Quinta, Palm Desert, Palm Springs, San Jacinto, Twentynine Palms, Yucaipa, Yucca Valley and surrounding areas.

DON PERATA *(D-Orinda)* Appointed to the Commission in February 2014 and reappointed in January 2015 by the Senate Rules Committee. Political consultant. Former president pro tempore of the state Senate, from 2004 to 2008. Former Assemblymember, Alameda County supervisor and high school teacher.

ASSEMBLYMEMBER SEBASTIAN RIDLEY-THOMAS *(D-Los Angeles)* Appointed to the Commission by former Speaker of the Assembly Toni Atkins in January 2015. Elected in December 2013 to represent the 54th Assembly District. Represents Century City, Culver City, Westwood, Mar Vista, Palms, Baldwin Hills, Windsor Hills, Ladera Heights, View Park, Crenshaw, Leimert Park, Mid City, and West Los Angeles.

SENATOR RICHARD ROTH *(D-Riverside)* Appointed to the Commission by the Senate Rules Committee in February 2013. Elected in November 2012 to the 31st Senate District. Represents Corona, Coronita, Eastvale, El Cerrito, Highgrove, Home Gardens, Jurupa Valley, March Air Reserve Base, Mead Valley, Moreno Valley, Norco, Perris and Riverside.

JONATHAN SHAPIRO *(D-Beverly Hills)* Appointed to the Commission in April 2010 and reappointed in January 2014 by the Senate Rules Committee. Writer and producer for FX, HBO and Warner Brothers. Of counsel to Kirkland & Ellis. Former chief of staff to Lt. Governor Cruz Bustamante, counsel for the law firm of O'Melveny & Myers, federal prosecutor for the U.S. Department of Justice Criminal Division in Washington, D.C., and the Central District of California.

JANNA SIDLEY *(D-Los Angeles)* Appointed to the Little Hoover Commission by Governor Edmund Brown Jr. in April 2016. General counsel at the Port of Los Angeles since 2013. Former deputy city attorney at the Los Angeles City Attorney's Office from 2003 to 2013.

HELEN TORRES *(NPP-San Bernardino)* Appointed to the Little Hoover Commission by Governor Edmund Brown Jr. in April 2016. Executive director of Hispanas Organized for Political Equality (HOPE), a women's leadership and advocacy organization.

SEAN VARNER *(R-Riverside)* Appointed to the Little Hoover Commission by Governor Edmund Brown Jr. in April 2016. Managing partner at Varner & Brandt LLP where he practices as a transactional attorney focusing on mergers and acquisitions, finance, real estate and general counsel work.

Full biographies available on the Commission's website at www.lhc.ca.gov.

"Democracy itself is a process of change, and satisfaction and complacency are enemies of good government."

Governor Edmund G. "Pat" Brown,
addressing the inaugural meeting of the Little Hoover Commission,
April 24, 1962, Sacramento, California

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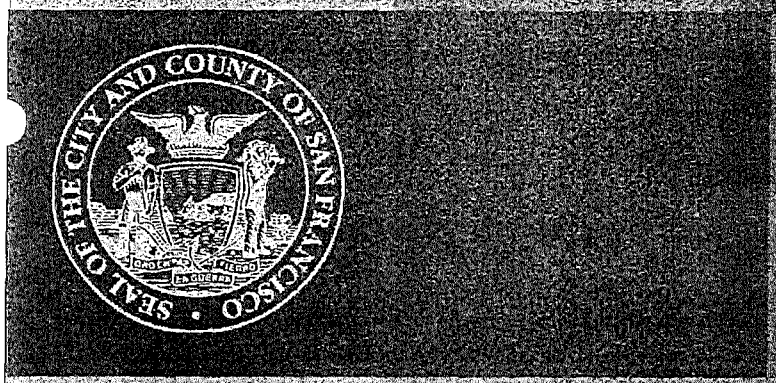


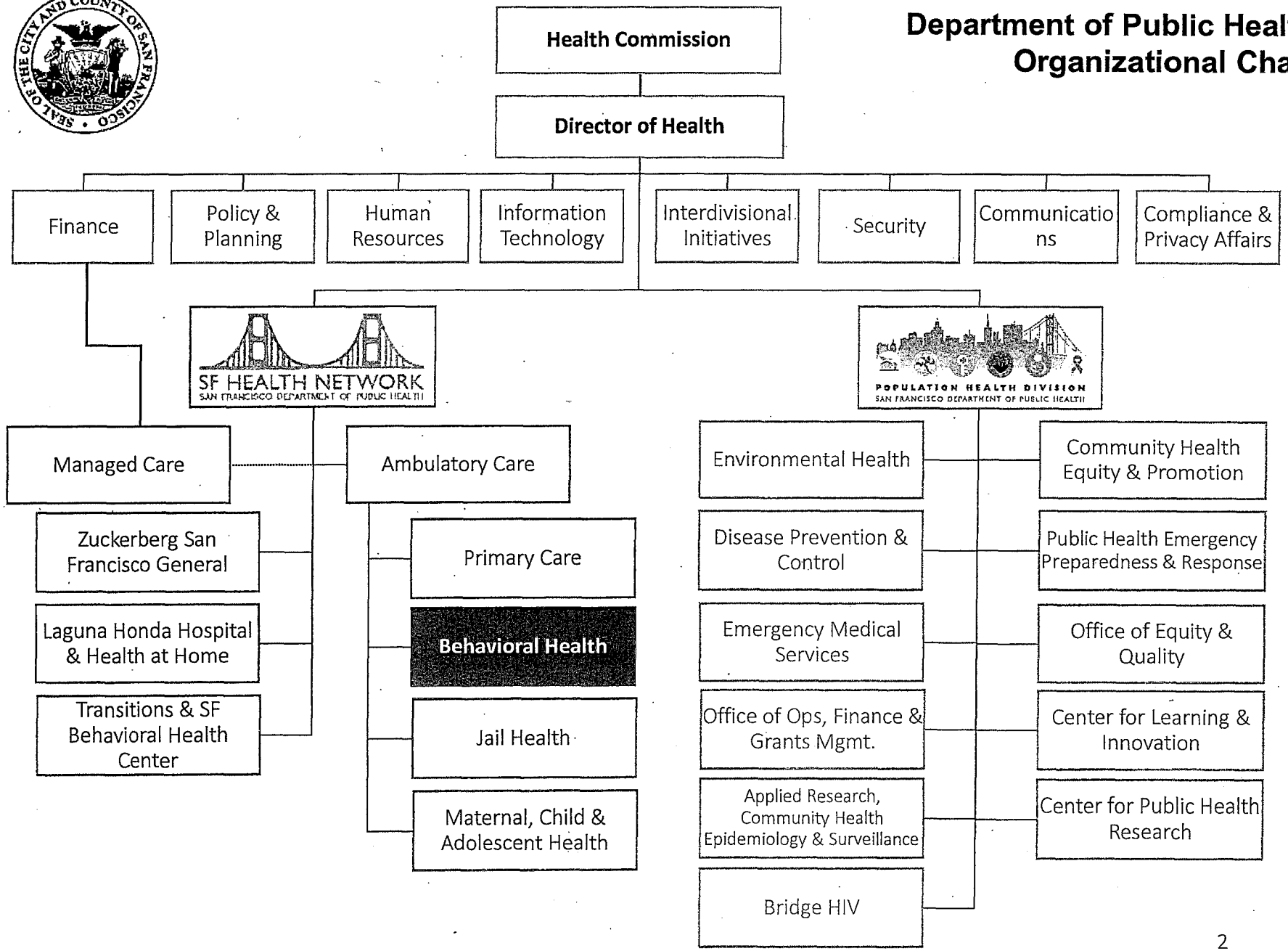
SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Mental Health Services Act – 3-Year Integrated Plan Fiscal Years 17/18 – 19/20

Presentation to the Board of Supervisors
September 28, 2017

1209

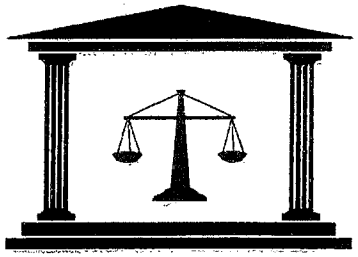
Department of Public Health Organizational Chart



1210

MHSA Overview

SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH



- Enacted into law in 2005
- 1% tax on personal income over $1 million
- Designed to transform the mental health system to address unmet needs
- Based on a set of core principles

✓ Cultural Competence
✓ Community Collaboration
✓ Client and Family Member Inclusion
✓ Integrated Service Delivery
✓ Wellness and Recovery

San Francisco MSHA Service Categories

SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

MHSA Components	San Francisco Service Categories
Community Services and Support (CSS)	Recovery-Oriented Treatment Services
	Peer-to-Peer Support Services
	Vocational Services
	Housing (for Full Service Partnerships *(FSP)* clients)
Prevention and Early Intervention (PEI)	Mental Health Promotion & Early Intervention (PEI) Services
Workforce Education and Training (WET)	Behavioral Health Workforce Development & Training
Capital Facilities and Technological Needs (CF/TN)	Capital Facilities/Information Technology

Innovations (INN) Component/Funding is integrated into all SF MHSA Service Categories.

Plan Development

SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

- County mental health programs are required to prepare and submit a Three-Year Program and Expenditure Plan (Plan) and an Annual Update report for MHSA programs and expenditures.
  - To provide an overview of progress, highlight outcome data, and any amendments to the plan.

- Stages of plan development:
  - ★ Community Program Planning ★ 30-day Public Posting for Public Comment
  - ★ Public Hearing at Mental Health Board ★ Adoption of Plan by Board of Supervisors

- This 3-Year Plan was developed in collaboration with behavioral health consumers, their families, peers, service providers and other stakeholders.

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Next Three Years
Looking Ahead

SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

1. Monitor No Place Like Home (NPLH) housing bond. 

2. Propose New Innovation Programs to the State: 
   a) Intensive Case Management (ICM) Flow (FY 17/18)

3. Monitor and continue to evaluate <u>81 current MHSA programs</u> 

4. Coordinate the solicitation of proposals to continue programs *(Request for Proposals/Qualifications)* 

5. Monitor Revenues and Expenditures 

Program Contact

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SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

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