DEPARTMENT OF FINANCE

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June 3, 2008

Honorable Denise Moreno Ducheny, Chair
Senate Budget and Fiscal Review Committee

Honorable John Laird, Chair
Assembly Budget Committee

Honorable Tom Torlakson, Chair
Senate Appropriations Committee

Honorable Mark Leno, Chair
Assembly Appropriations Committee

Final Report—California Department of Mental Health, Mental Health Services Act Performance Audit

The Department of Finance, Office of State Audits and Evaluations, has completed its performance audit of the Mental Health Services Act (MHSA) for the California Department of Mental Health (DMH).

The DMH's response to our observations is incorporated into this final report. The DMH agreed with our observations and we appreciate its willingness to implement corrective actions. The observations in our report are intended to assist DMH management in improving the effectiveness and efficiency of its MHSA operations. In accordance with Finance's policy of increased transparency, this report will be placed on our website.

We appreciate the assistance and cooperation of DMH staff. If you have any questions regarding this report, please contact Frances Parmelee, Manager, or Cheryl Lyon, Supervisor, at (916) 322-2985.

Sincerely,

David Botelho, Chief
Office of State Audits and Evaluations

Enclosure

cc: On following page

cc: Honorable Bob Dutton, Vice Chair, Senate Budget and Fiscal Review Committee
Honorable Roger Niello, Vice Chair, Assembly Budget Committee
Honorable Elaine Alquist, Chair, Senate Budget and Fiscal Review Committee No. 3
Honorable Patty Berg, Chair, Assembly Budget Subcommittee No. 1
Ms. Elizabeth Hill, Legislative Analyst (3)
Mr. Danny Alvarez, Staff Director, Senate Budget and Fiscal Review Committee
Mr. Bob Franzoia, Staff Director, Senate Appropriations Committee
Mr. Seren Taylor, Staff Director, Senate Republican Fiscal Office
Ms. Diane Cummins, Senate President pro Tempore's Office
Mr. Christopher W. Woods, Chief Consultant, Assembly Budget Committee
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Mr. Peter Schaafsma, Staff Director, Assembly Republican Fiscal Committee
Mr. Ivan Altamura, Chief of Staff, Assembly Republican Leader's Office
Mr. Craig Cornett, Assembly Speaker's Office (2)
Dr. Stephen W. Mayberg, Director, California Department of Mental Health
Mr. Jim Alves, Assistant Secretary, California Health and Human Services Agency
Ms. Elaine Bush, Chief Deputy Director, California Department of Mental Health
Mr. Sean Tracy, Special Projects Manager II, Director's Office, California Department of Mental Health
Mr. Stan Bajorin, Deputy Director, Administration, California Department of Mental Health
Ms. Denise Arend, Deputy Director, Community Services, California Department of Mental Health
Mr. Mark Heilman, Policy Advisor, Community Services, California Department of Mental Health
Ms. Carol Hood, Director of the Mental Health Services Act, Community Program Development, California Department of Mental Health
Mr. Michael Borunda, Assistant Deputy Director, Community Services, California Department of Mental Health
Ms. Sherry Whitt, Executive Director, Mental Health Services Oversight and Accountability Commission

PERFORMANCE AUDIT

California Department of Mental Health
Mental Health Services Act

Prepared By:
Office of State Audits and Evaluations
Department of Finance

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May 2008

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EXECUTIVE SUMMARY

The Mental Health Services Act (MHSA) was enacted January 1, 2005 to provide counties additional resources to expand mental health services offered in their communities. The MHSA requires the Department of Mental Health (DMH) to review and approve each county's *Three-Year Program and Expenditure Plan* (Plan). Pursuant to the 2007-08 Budget Act and an interagency agreement with DMH, the Department of Finance, Office of State Audits and Evaluations, conducted a performance audit of DMH's Plan review and approval process.

An overall documented plan for the development and implementation of the MHSA does not exist. At present, only the Community Services and Supports[1] (CSS) component is fully implemented; therefore, distributions and services for other components have been limited resulting in the perceived notion that the intent of the MHSA is not being adequately met. The CSS Plan review and approval process is consistent with the MHSA, but it is cumbersome and lengthy. Additionally, fund distributions to the counties have been untimely. As of March 31, 2008, approximately $3.2 billion has been collected and $2.9 billion has been allocated for county use. Of the $2.9 billion allocation, $1 billion has been approved for distribution but only $726 million has been distributed to the counties.

Development and Implementation Process

Although DMH has diligently worked to implement the MHSA, a documented plan of the MHSA development and implementation does not exist resulting in a staggered implementation of components, delayed issuance of component guidelines, and fund distribution not in compliance with the MHSA. In addition, entities involved lack effective communication and coordination, and roles and responsibilities are not clearly defined and communicated.

To improve the development and implementation process and comply with the MHSA, DMH should: (1) create a strategic development and implementation plan which addresses component integration, performance measures, and program monitoring efforts, (2) promote effective communication and coordination among entities involved in the MHSA by engaging all relevant parties in policy development, standardizing common processes, and developing communication protocol, and (3) develop regulation to define the roles and responsibilities of each entity involved in the MHSA.

Plan Review and Approval Process

DMH staff have been dedicated and enthusiastic throughout the MHSA development and implementation resulting in program efficiencies with the Plan review and approval process. However, DMH's application of the CSS component guidelines is strict and inflexible. The guidelines include repetitive and redundant information requests and create a labor intensive process requiring extensive administrative tasks at both DMH and the counties. DMH should review and revise guidelines and their application to provide for flexibility and customization. More reliance should be placed on the counties' expertise and the counties should be held accountable for their Plans.

[1] Services for adults and children is commonly referred to by DMH as Community Services and Supports (CSS).

The CSS Plan review process is also lengthy and inefficient. The CSS Plan and Augmentation Plan reviews are not completed within the established time frames. Additionally, lack of established deadlines for the counties' submission of additional requested or missing information delays the process for indefinite lengths of time. For the Prevention and Early Intervention Plans, DMH uses the same review tool as the Mental Health Services Oversight and Accountability Commission (OAC) even though each entity has different review responsibilities. To improve review efficiency, DMH should establish and enforce deadlines for the submittal of additional information from counties. DMH should ensure that the use of the OAC's PEI review tool will enable it to meet its review obligations.

Fund Distribution Process

The DMH recently implemented improvements to the fund distribution process: (1) the MHSA contract process was changed to an Agreement process, which reduced the time required to process payments; (2) a source document verification form was created to verify the accuracy of fund distributions; (3) the fund allocation methodology was changed from accrual basis to cash basis which enables DMH to ensure sufficient funds are available to support the required fiscal year MHSA funding levels, and, DMH now advances 75 percent of the counties' approved Plan amounts to increase cash flow (4).

Despite these changes, the fund distribution process still needs improvement. Specifically, the process to notify the DMH Accounting Unit to issue payment is cumbersome and inefficient. To improve its operations, DMH should develop a formal payment authorization form for use when notifying DMH's Accounting Unit to schedule payments. Further, DMH should ensure policies and procedures are in place to require the prompt processing of county distributions.

DMH should develop a plan to address the observations and recommendations noted in this report. Implementing our recommendations will enable DMH to fulfill the intent of the MHSA and allow counties to readily implement programs and services to effectively treat and support the mentally ill.

For additional information related to the observations discussed above, see the *Results and Recommendations* section of the report. Various appendices were prepared for informational purposes.

BACKGROUND, OBJECTIVES, SCOPE, AND METHODOLOGY

BACKGROUND

The California Department of Mental Health (DMH) has worked to transform and improve the state's mental health systems of care by working with the mental health constituency to develop a system of partnerships and coordinated interagency efforts. These models have provided the framework for success in developing programs and coordinating services in the treatment of children, adults, and older adults who are mentally ill.

Proposition 63, known as the Mental Health Services Act (MHSA), was enacted on January 1, 2005. The MHSA provides an opportunity to increase funding, personnel, and other resources to support county mental health programs and monitor progress toward statewide goals for children, transition age youth, adults, older adults, and families. The MHSA imposes a 1 percent income tax on personal income in excess of $1 million.

Counties are to plan and develop a *Three-Year Program and Expenditure Plan* (Plan) with local stakeholders, including adults and older adults with severe mental illness; families of children, adults, and older adults with severe mental illness; providers of services; law enforcement agencies; schools; and social services agencies. In addition to Community Program Planning (CPP), the MHSA outlines five main components of a county's Plan for the expansion of mental health services:

- Services for adults and children [Referred to by DMH as Community Services and Supports (CSS)]
- Workforce Education and Training (WET)
- Capital Facilities and Technological Needs (CAPTECH)
- Prevention and Early Intervention (PEI)
- Innovation

The MHSA requires DMH to enter into contracts (Agreements) with participating counties who then submit an integrated Plan that includes programs for the five components bulleted above. DMH is responsible for establishing the requirements for the Plan's contents, determining the amount of funds available, and providing each county with an allocation based on MHSA requirements. As of March 31, 2008, approximately $3.2 billion has been collected and $2.9 billion has been allocated for county use. Of the $2.9 billion allocation, $1 billion has been approved for distribution and $726 million has been distributed to the counties. Distributions are only made to counties that have an approved Plan and Agreement in place.

The MHSA established the Mental Health Services Oversight and Accountability Commission (OAC) to oversee certain components, ensure funds are being spent in accordance with the intent and purpose of the MHSA, and refer any critical issues related to county performance to DMH. All of the OAC's decisions and recommendations factor in the perspective and participation of members and others suffering from severe mental illness including their family members.

The Mental Health Planning Council (Council) is also an entity involved in the implementation of the MHSA. The Council's responsibilities include reviewing and approving the Education and Training Development Program five-year plan developed by the DMH, and advising and providing oversight to the DMH on education and training policy and plan development. In accordance with its responsibilities under the Welfare and Institutions Code Section 5772(c)(2), the Council shall include the MHSA programs in its program performance review of the DMH.

The responsibility of reviewing the Plan for each component is split between the DMH and OAC; however, each entity has the ability to provide comments for components it is not primarily responsible for.

Review and Approval Responsibility by Component

Component	Responsible Party	
	OAC	DMH
CSS	×	✓
WET	×	✓
CAPTECH	×	✓
PEI	✓	×
Innovation	✓	×

✓ = Has primary responsibility

× = Has comment responsibility

For the counties' use in preparing their Plans, DMH issued *Three-Year Program and Expenditure Plan Guidelines* (Guidelines) for CSS, WET, CAPTECH, and PEI[2]. Once Guidelines are issued, counties can submit a Planning Request to receive planning funds for use in developing a component Plan. Once developed, the Plan is submitted to DMH and OAC for review and approval. Upon approval, implementation funds are distributed to the counties.

In December 2007, DMH implemented a new fund distribution process. Each county receives 75 percent of the approved annual Plan amount upon Plan approval and execution of an Agreement, or at the start of the fiscal year, whichever is later. The remaining 25 percent is to be distributed upon submission of required reports which include the semi-annual Local Mental Health Service Fund Cash Flow Statement and the Annual MHSA Revenue and Expenditure Report.

OBJECTIVES and SCOPE

In accordance with the 2007-08 Budget Act and DMH's interagency agreement, the Department of Finance, Office of State Audits and Evaluations, conducted a performance audit of the MHSA. The audit's objectives were to:

- Determine the extent to which DMH's review process of Plans is consistent with the MHSA.
- Determine how DMH protocols for the review of Plans could be adjusted to improve efficiency.
- Review DMH's process for distributing funds to the counties and make recommendations to improve timeliness of such distributions.

[2] At the time of this report, guidelines for Innovation have not been issued.

The audit did not include an assessment of the efficiency or effectiveness of local MHSA programs and services or the overall implementation of the MHSA by DMH. Further scope limitations to this audit were as follows:

- Limited stakeholders were solicited for input; however, community service groups were not solicited at all.
- CSS is the only fully implemented component. All other components are still in early stages of implementation; therefore, other components were not fully evaluated.
- Guidelines for Innovation have not been issued by DMH; therefore, they were not compared to the MHSA for consistency, and processes were not evaluated.

This performance audit was conducted in accordance with *Generally Accepted Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our observations and recommendations based on our audit objectives. We believe the evidence obtained provides a reasonable basis for our observations and recommendations based on our audit objectives.

METHODOLOGY

To evaluate DMH's review process of Plans and determine compliance with the MHSA, interviews were conducted with the following entities: DMH's MHSA program, policy, and accounting staff; the OAC; the California Mental Health Director's Association (CMHDA); and the California Institute for Mental Health (CiMH). Topics discussed include:

- Roles and responsibilities
- DMH's development and implementation of the MHSA
- Plan review and approval processes
- Fund distribution process

Additional steps were performed to meet the audit's objectives:

- Review of the MHSA, MHSA regulations, and Plan guidelines to gain an understanding of the requirements, roles, and responsibilities.
- Review of financial reports, DMH reports, information notices and letters, and other stakeholder reports.
- Analysis of the web-based survey results of county Mental Health Directors. The web-based survey's response rate of 59 percent provided information to assist with observation and recommendation development.
- Met with San Diego County MHSA representatives to obtain feedback regarding the planning and implementation of the MHSA.
- Analysis of MHSA payments made to counties to determine the timeliness of distributions.

Recommendations were developed based on the evaluation of data and documentation obtained, and discussions with DMH, OAC, CMHDA, CiMH, and county staff. For informational purposes, the following appendices have been prepared:

- Appendix 1: Two high level process flow diagrams that provide an overview of the current Plan review process.
- Appendix 2: Results of our web-based survey of county Mental Health Directors.

The audit was performed during the period January 30, 2008 through May 9, 2008.

STAFF:

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The Mental Health Services Act (MHSA) requires the Department of Mental Health (DMH) to review and approve the counties' *Three-Year Program and Expenditure Plan* (Plan). The CSS Plan review and approval process is consistent with the MHSA; however, DMH developed and implemented a cumbersome and lengthy process. Additionally, fund distributions to the counties have been untimely. The MHSA was enacted January 1, 2005 to provide counties with additional resources to expand mental health services offered in their communities. At present, only the CSS component is fully implemented; therefore, distributions and services for other components have been limited resulting in the perceived notion that the intent of the MHSA is not being adequately met. Although many improvements have been made since the enactment of the MHSA, our observations are relevant to the current processes given that all components have not been fully developed and implemented.

For reference, the acronyms below are used throughout this section of the report:

- Community Program Planning (CPP)
- Services for adults and children [Referred to by DMH as Community Services and Supports (CSS)]
- Workforce Education and Training (WET)
- Capital Facilities and Technological Needs (CAPTECH)
- Prevention and Early Intervention (PEI)
- Mental Health Services Oversight and Accountability Commission (OAC)

DEVELOPMENT AND IMPLEMENTATION PROCESS

DMH's MHSA development and implementation process is inefficient. Specifically, an overarching plan for MHSA development and implementation is not documented; ineffective communication and coordination of entities involved exist; and roles and responsibilities are not clearly defined and communicated.

Observation 1: Undocumented Plan for MHSA Development and Implementation

DMH's plan for MHSA development and implementation is not documented and readily available to the public. Upon enactment of the MHSA, DMH conducted numerous meetings with stakeholders and counties to develop a vision and plan for development and implementation. Interviews with DMH staff indicate these meetings resulted in a mutual agreement to deviate from certain MHSA requirements. The deviations resulted in the staggered implementation of components, delayed issuance of component guidelines, and funding distributions not in compliance with the MHSA.

Although DMH indicated that all stakeholders were in agreement with the deviations, the overarching plan and vision was not sufficiently documented. Without a fully developed source document to reference, short-term as well as long-term goals are not known to all, and counties and stakeholders are limited from effectively planning or creating programs within their communities. Further, the deviations contributed to the inefficient Plan review and fund distribution processes.

Staggered Implementation of Components

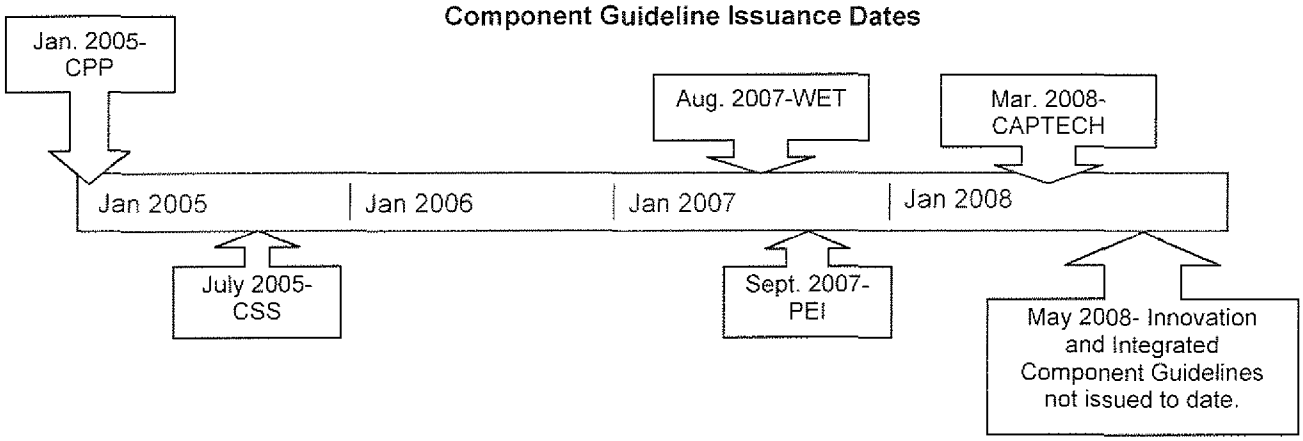
Aspects relating to the integration of individual component Plans were not addressed during the initial development and implementation stages. As a result, the current regulations and guidelines do not support the MHSA requirement of a single integrated Plan. All guidelines are "stand-alone" and support component by component, staggered Plans with integration occurring after all components have been individually developed. However, interrelated components and overlapping areas exist yet are not acknowledged under the current implementation process. For example, the community planning process requires counties to coordinate and conduct various meetings with stakeholders in their communities, which is labor intensive and timely. Under the current implementation process, counties are required to conduct planning meetings for each component individually rather than collaboratively.

Because the staggered implementation process did not consider final integration, counties will be required to integrate programs initially created independent of one another into one Plan. Although counties and stakeholders mutually agreed to this approach, staggered implementation is not in compliance with the MHSA and contributes to an inefficient process.

Delayed Issuance of Component Guidelines

If a fully developed and documented plan was created, issuance of guidelines would have been timely and strategically planned. As depicted below, the CPP guidelines were issued in January 2005 and the CSS guidelines were issued six months after MHSA enactment. The WET and PEI guidelines were issued one month apart in 2007 placing a burden on counties to plan and develop individual Plans concurrently. Further, this process resulted in portions of component guidelines being duplicative of one another and not addressing integration. See *Observation 4: Deficiencies in Application of CSS Guidelines* for additional details. Three years after enactment, Innovation and Integration guidelines still await issuance. Because of the delayed issuance of component guidelines, counties are prohibited from seeking funds until a specific component guideline is released, postponing creation and implementation of programs and services.

Component Guideline Issuance Dates



Fund Distribution Not in Compliance with the MHSA

Because the issuance of guidelines was delayed and Plan development and fund distribution is dependent on the guidelines, funds have not been distributed as prescribed by the MHSA. MHSA Section 5892 prescribes the allocation of funds among the specified components. Once allocated, funds are available for distribution. The following table depicts the allocation prescribed by the MHSA in comparison to distributions made by DMH:

Fund Allocation Prescribed by MHSA versus DMH Distributions

Component	2004-05		2005-06		2006-07		2007-08	
	MHSA	DMH	MHSA	DMH	MHSA	DMH	MHSA	DMH
CSS (a)			X	X	X	X	X	X
PEI (a) (b)			X		X		X	X
WET (b)	X		X		X		X	X
CAPTECH	X		X		X		X	
CPP	X	X						
State Implementation	X	X	X	X	X	X	X	X

(a) Five percent of the allocation shall be used for Innovation programs.

(b) Distribution is for planning estimate funds only.

Per the MHSA, funds were allocated in 2004-05 for WET, CAPTECH, CPP, and State Implementation; however, funds were only distributed for CPP and State Implementation. Similarly, in 2005-06 and 2006-07, funds were allocated for CSS, PEI, WET, CAPTECH, and State Implementation; however, only CSS and State Implementation funds were distributed. During 2007-08, planning funds have begun to be distributed for the PEI and WET components. Although DMH staff indicates this distribution method was agreed upon in partnership with the counties and stakeholders, it resulted in counties developing programs and services without knowing the adequacy of staffing, capital facilities, and technological needs. As a result, an inefficient MHSA planning process is created. Further, counties cannot begin the implementation of programs and services until receipt of program funding; therefore, the methodology of distributing funds directly impacts those in need.

Recommendations:

A. Create and document a strategic development and implementation plan which includes clear guidance on component integration, performance measures, and program monitoring efforts. Ensure this plan is adhered to, communicated to affected entities, and made readily accessible on DMH's MHSA website.

B. Create one set of comprehensive integrated guidelines addressing all components. The guidelines should allow for the integrated implementation of the remaining components (PEI, WET, CAPTECH, and Innovation) and the submittal of one integrated Plan.

C. Develop and document a funding distribution plan and ensure funds are distributed to counties timely and in compliance with the MHSA.

Observation 2: Ineffective Communication and Coordination

Ineffective communication and coordination exists amongst DMH, the counties, and the OAC. Communication and coordination issues at DMH has hindered the implementation of the MHSA, and has resulted in inconsistent internal processes, confusing and inconsistent guidance to counties, and untrained DMH staff.

MHSA Program versus MHSA Policy

Program staff are not required to be involved in the development stages of policy. Because of their minimal participation in the development stage, Program staff have not provided adequate or consistent guidance to counties which reflects poorly on the competency of DMH staff. DMH county liaisons do not appear to be sufficiently trained on pertinent program issues or well versed on fiscal issues or policies.

In our web-based survey[3], counties were asked about their overall experience with DMH staff specific to the knowledge of subject matter, quality of response provided, and accuracy of information received. The results indicate that their experience was satisfactory but additional comments we received contradicted this rating. Of the 17 additional comments received, 11 explained that staff were not readily able to answer questions, response times were slow, and inconsistent information was provided. County staff, at times, have chosen to directly contact DMH's fiscal consultant in the Policy Unit for guidance rather than the appropriate Program staff.

We also asked respondents to identify a major weakness during the development and implementation of the MHSA. Sixty-nine percent of the respondents reported communication from DMH to the counties was a major weakness. Respondents also noted communication from DMH was very sparse and answers provided were vague. Further, inconsistent guidance was provided resulting in Plans being later questioned or returned for additional information in the review and approval process. Confusion and irritation of county staff exists because sufficient and consistent guidance is not being provided by DMH.

Component versus Component

Component Plans are tracked inconsistently among DMH Units. Specifically, DMH records WET Plans' review start date as the day the WET Plan is received. This is in contrast to CSS and PEI Plans which begins tracking on the day the Plans are considered complete. As a result, component tracking processes cannot be measured or compared with one another and established review time frames cannot be consistently applied.

Coordination of DMH and OAC

As depicted in the *Review and Approval Responsibility by Component* table located in the Background section of this report, DMH and the OAC have responsibilities over specific components. However, if the OAC has an issue with a component it only has comment responsibility over, the OAC can contact counties directly seeking additional information and stall the review process. DMH may act similarly with the PEI and Innovation Plans. Having both the OAC and DMH contacting counties for additional information causes confusion within the counties.

Recommendations:

A. Require MHSA Program staff participation during the policy development stage for program consultation. The Program staff should serve as active participants and subject matter experts throughout the development of policy.

B. Standardize common program processes that are universal amongst component areas.

[3] Refer to Appendix 3 for the results of our web-based survey.

C. Conduct training prior to the release of new policies to maintain a high level of competency at all staff levels and to ensure consistent guidance is provided.

D. Work cooperatively with the OAC to develop a communication protocol where only one entity requests additional information from the counties and communicate the protocol to counties.

Observation 3: Undefined Roles and Responsibilities of MHSA Entities

Entities involved in MHSA development and implementation have unclear roles. The MHSA stipulates DMH shall develop regulations, as necessary, for itself and designated local agencies to implement the MHSA. Although DMH stated they have been working on clarifying roles since MHSA enactment, the roles and responsibilities for itself and each involved entity have yet to be defined and communicated as of May 2008.

The MHSA identifies the implementation participants—DMH, OAC, Mental Health Planning Council, counties, and stakeholder community groups—but the responsibilities of each are loosely defined. Since MHSA enactment, the roles and responsibilities have evolved based on each entity's interpretation. Some of these interpretations may overstep the intentions of the MHSA, limit other entities' functionality, and create duplicative tasks. For example, counties reported in our web-based survey that their authority over community-centered MHSA programming is limited due to the detailed oversight by DMH, which the counties believe goes beyond the intent of the MHSA. Additionally, stakeholder community groups have expressed that because they are included in the CPP, then they are entitled to certain MHSA funding. In certain instances, these stakeholders have sought MHSA funding directly from DMH. Defining and documenting the roles and responsibilities of each entity involved in the MHSA will establish boundaries, eliminate confusion amongst all parties, and provide consistency and understanding amongst the MHSA program operations.

Recommendations:

A. Work collaboratively with each entity to come to an agreement on the roles and responsibilities. Ensure consistency and functionality with the MHSA.

B. Develop regulations that define roles and responsibilities of each entity involved in the MHSA and communicate roles and responsibilities to affected parties.

PLAN REVIEW AND APPROVAL PROCESS

DMH staff have been dedicated and enthusiastic throughout the development and implementation of the MHSA and continue to increase efficiency and effectiveness. For example, DMH staff conducted multiple work groups and formed steering committees seeking feedback from various stakeholders to assist in the development and implementation of the MHSA. Further, the CSS component staff have refined the review tools developed for the initial CSS Plan reviews to more accurately track the review of subsequent Plans, Plan updates, and Plan augmentations. We found the CSS Plan review and approval process is consistent with the MHSA; however, the process developed is cumbersome and lengthy.

Observation 4: Deficiencies in Application of CSS Guidelines

The MHSA charges DMH with developing guidelines and regulations to assist counties with the implementation of the MHSA. Our web-based survey found 72 percent of the respondents observed major weaknesses in the development and implementation of the MHSA guidelines.

Counties reported that the CSS guidelines created by DMH are complex, require excessive detail, and include repetitive and redundant information requests. The guidelines also do not reflect the diversity of the counties such as size, experience, and available resources. As a result, counties created CSS Plans—ranging from 300 to 1,000 pages—tailored to fit the specific guidelines rather than meeting the needs of their communities. For example, one respondent stated that DMH imposed activities that it deemed important, which did not coincide with the results of the local planning process. Another respondent reported that CSS guidelines encouraged local planning, but the DMH approval process circumvented the local planning process.

Consequently, cumbersome information requests and strict guideline application has created an ineffective and inefficient CSS Plan review and approval process. In reviewing Plans, DMH has strictly applied the guidelines and has not allowed any room for flexibility. If Plans did not follow the guidelines exactly or omitted required templates, the Plans were returned for even minute details. Several respondents commented that in following the Plan guidelines, the same information had to be repeated numerous times, which significantly increased the volume of the document. Other survey respondents commented that the templates are overly burdensome, repetitive, and filled with redundancies – Exhibit 4 was specifically referenced. An additional example provided that the guidelines detail the criteria to follow, then the county was asked to restate the same criteria in their Plan.

Because Plans had not yet been processed for the other components, the DMH has the opportunity to assess the CSS Plan review process and incorporate the below recommendations that, in effect, should increase the efficiency of the process for the remaining Plans.

Recommendations:

A. Review and revise guidelines to eliminate repetitive and redundant requirements and allow for customization of templates to fit the specific needs of the community being served.

B. Allow counties to submit integrated Plans based on broad concepts rather than exact details.

C. Review the DMH's and OAC's application of component guidelines. Revise internal policies to allow for flexibility of reporting requirements.

D. Place more reliance on the counties' expertise, but hold them accountable for their Plans. Ensure performance measures and monitoring procedures of counties are appropriately developed and implemented.

E. Continually assess and revise the Plan review process and implement efficiencies as identified.

Observation 5: Inefficient Review Processes

As stated in the above observation, excessive detailed requirements and inflexible application of guidelines impairs DMH's ability to timely review Plans and reduces the effective and efficient implementation of MHSA programs and services in the communities.

Review Times

DMH's review and approval of CSS Plans does not meet the internally established review time frame of 90 days. From September 2005 through January 2008, DMH received and reviewed 57 CSS Plans. Of the 57 Plans, 51 Plans had review times greater than 90 days. Of the 51 Plans, the average number of days at the county was 55 days and the average days at DMH was 132 days. The table below shows seven Plan reviews which exceeded 180 days. Six of the seven Plans had the majority of review time occurring at DMH. At the time of our audit, Tuolumne County had been under review at DMH for 257 days, and had not been issued a post review letter.

Initial CSS Plans Review
Number of Days at County and DMH for Review and Revisions
For the Period September 2005 – January 2008

County	Days at County for Revisions	Days at DMH for Review
Amador	211	336
Imperial	77	224
Kings	166	277
Lassen	256	232
Siskiyou	121	185
Tuolumne	n/a	n/a
Ventura	49	185

DMH's review and approval of CSS Plan Augmentation Requests also did not meet the established review time frames. DMH established review times of 30 to 60 days depending on the type of Augmentation Request. As of February 2008, 85 requests had been received and 63 of those had been approved. The number of review days of the approved requests ranged from 1 to 192 days, which includes days at the county and DMH. Thirty-one of the 63 approved requests (49 percent) were processed within the pre-established time frames. The remaining 22 requests pending approval have already exceeded the established review time frames. Lengthy reviews prevent programs and services from being developed and implemented in communities.

Deadlines

Neither DMH nor the OAC has established deadlines for the submission of additional requested information at any stage of the review process. Counties can use as much time as needed to submit additional information. DMH believes if counties want to receive funding, they will be motivated to submit supporting information as quickly as possible. However, the establishment of reasonable deadlines can provide the counties, DMH, and OAC with an indication of progress and allows the Plan review team—which comprises of external and internal parties—to effectively coordinate schedules. Deadlines should be negotiated on an individual basis to accommodate each county's needs. Failure to set deadlines or due dates may result in counties not properly prioritizing Plan completion and delays in the review process and the distribution of funds.

Review Tools

Both DMH and OAC plan to use the same review tool for the PEI expenditures planning requests and Plans. Using the same review tool may result in a duplication of efforts and an inefficient review process. MHSA Section 5847(b) states that DMH's review of the PEI Plans shall be limited to ensuring the consistency of the programs with the other portions of the Plan and providing review and comment to the OAC. Because Plans for PEI had not been received at the time of our audit, we were not able to test the functionality of the review tool with respect to DMH's responsibilities. As such, DMH should ensure that the use of the OAC's PEI review tool will enable it to meet its review obligations.

Recommendations:

A. Reassess established Plan and Augmentation Request review time frames to determine practicality. If not practical, revise time frames accordingly.

B. Negotiate reasonable deadlines for the submittal of requested information from the counties. Follow-up as necessary to ensure information is submitted timely.

C. Review the use of the OAC's PEI review tool to ensure responsibilities for Plan review are appropriately met. If not, develop a PEI review tool that is tailored to DMH's responsibilities.

FUND DISTRIBUTION PROCESS

DMH recently implemented the following practices to improve the MHSA fund distribution process:

- *Change to Agreement Process*: Under the revised Agreement process, DMH can unilaterally modify a county's Agreement based on its approved Plan or Plan update, reducing the processing time taken to add or adjust approved funding. The Agreement has also provided counties with fiscal information, enabling counties to see maximum available funds, approved funding, and funds distributed by each component.

- *Use of a Source Document Verification Form:* This allows for the timely identification of payment errors such as an overpayment or a miscalculation in payment amount. To date, DMH has identified and corrected two payment errors through this new process.

- *Change to Cash Basis:* DMH's change from accrual basis to cash basis allocations will enable DMH to ensure sufficient funds are available to support the funding levels for each component for the following fiscal year. Revenue will accumulate for 12 months in the Mental Health Services Fund prior to distribution in the following fiscal year.

- *Change to Distribution Methodology*: DMH changed its distribution methodology to advance 75 percent of a county's approved Plan amount at the beginning of the fiscal year or after approval of its Plan, whichever is later. This distribution methodology allows for increased cash flow to the counties.

We encourage DMH to continue developing and implementing processes that increase cash flow to the counties and eliminate inefficient steps in the MHSA process. However, the process remains flawed and fund distributions are still untimely.

Observation 6: Fund Distribution Process Needs Improvement

Flaws in the fund distribution process remain that prevent the efficient processing of county payments and decrease cash flow to the counties. Improvement is needed in the processing of Exhibit As and distribution of payments.

Exhibit A

The process of attaching Exhibit As to the Payment Authorization email sent to the Accounting Unit for scheduling payments is cumbersome, inefficient, and may cause delays in county payments. Each county's Agreement includes an Exhibit A (a seven-page document) that provides the budget detail for each component, such as maximum available funds, approved funding, and funds distributed per fiscal year. To trigger payment to counties, the Program staff sends an "Authorization to Pay" email to the Accounting Unit to schedule payments. The Exhibit A for each county listed to receive payment is also attached to the email. To determine and schedule payment, the Accounting Unit opens each Exhibit A attachment to find the payment amount(s) highlighted in gray.

With this process, there is an inherent risk a county's Exhibit A can be misplaced or overlooked while scheduling payment. For example, one payment was delayed 25 days because the Accounting Unit overlooked the county's Exhibit A attached to the "Authorization to Pay" email. DMH found the error while reconciling counties to be paid with the county payments issued records. Although DMH has a process in place to reconcile the county payments, significant delays could occur because the reconciliation process is not performed until the end of each month.

Payments

Payments issued under the new distribution methodology are untimely. At the time of our review, DMH had issued eight payments under the new policy. For seven of the eight payments, DMH took 18 to 36 days to issue funds. The number of days was calculated from the execution date of the Agreement to the date payment was scheduled to the county. In addition to the payment that was delayed in the *Exhibit A* section above, significant delays were noted for three other payments. Payment delays occurred because the Business Services Contracts and Procurement Unit did not timely forward the counties' executed Agreements to the County Contracts and Technical Assistance Unit to trigger payment. One Agreement was held for 20 days while two other Agreements were held for 31 days. Untimely distributions prevent counties from effectively planning and implementing programs and services for the mentally ill.

Recommendations:

A. Develop a formal payment authorization form that details the county payments for issuance. Use this form to notify the Accounting Unit to schedule payments.

B. Require the Business Services Contracts and Procurement Unit to promptly process and forward executed Agreements to the County Contracts and Technical Assistance Unit. Develop internal policies that require payment to counties within a reasonable time after Agreement execution and/or Agreement modification.

APPENDIX 1

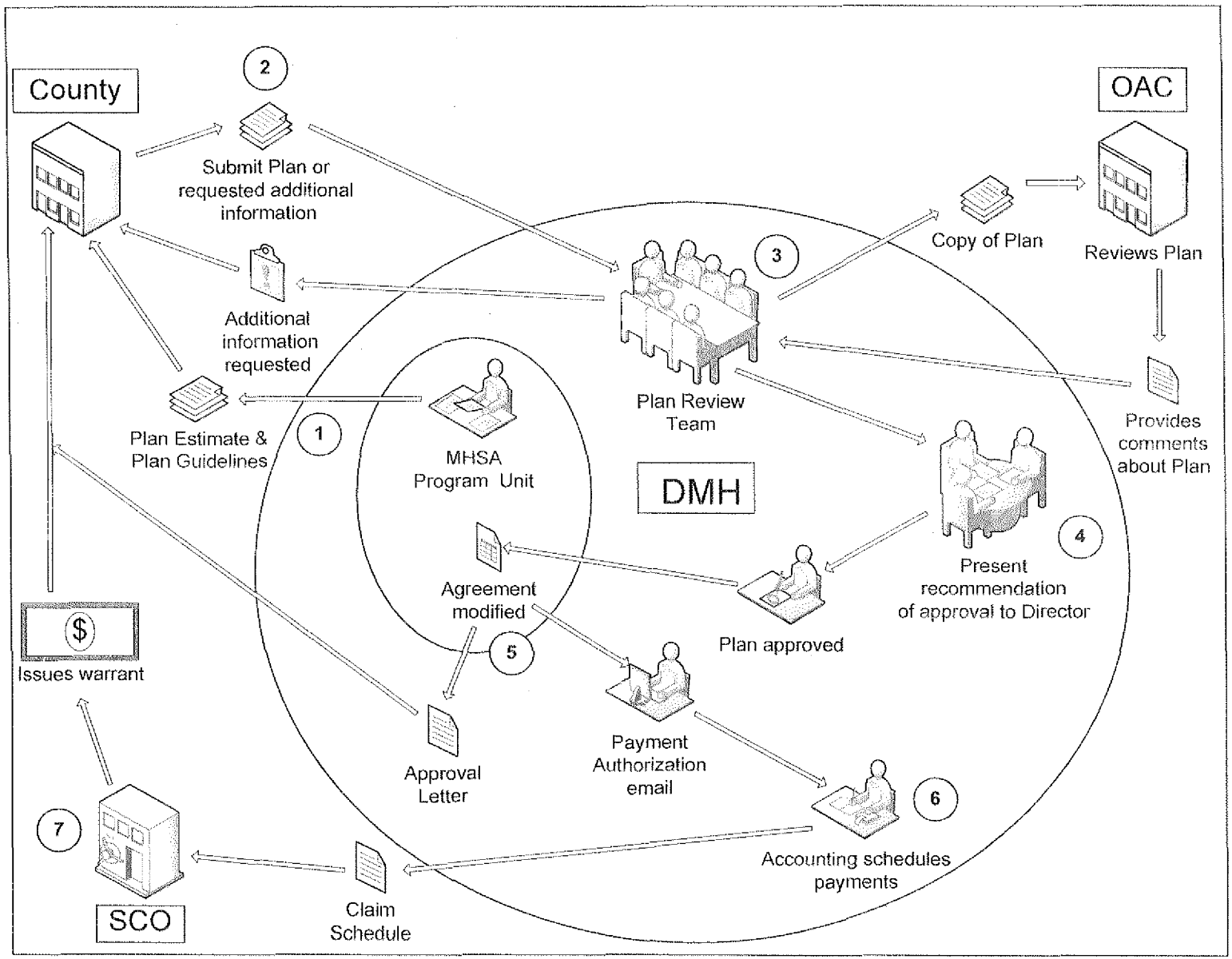
Plan Review Process Flow Diagrams

The following MHSA Plan review process flow diagrams illustrate the interfaces amongst the counties, DMH, OAC, and the State Controller's Office (SCO). These diagrams include only the major processing steps and are intended to be a high level representation of the Plan review process for the following MHSA component Plans:

- Services for adults and children [Referred to by DMH as Community Services and Supports (CSS)]
- Prevention and Early Intervention (PEI)
- Workforce Education and Training (WET)
- Capital Facilities and Technological Needs (CAPTECH)
- Innovation

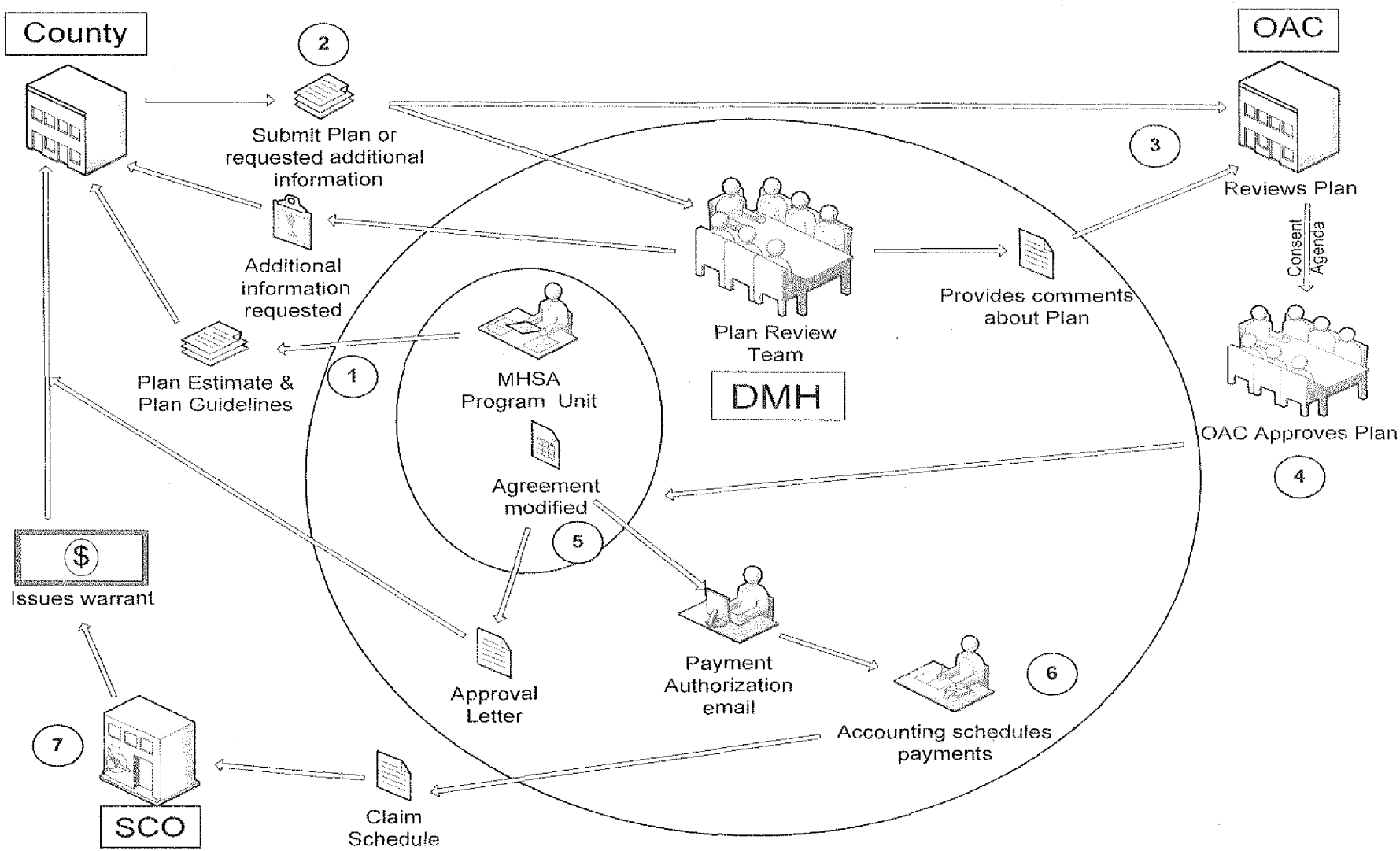
The DMH does not have control of the entire Plan Review Process. Activities outside the circle are not controlled by DMH.

Plan Review Process for CSS, WET, and CAPTECH



The DMH does not have control of the entire Plan Review Process.

Plan Review Process for PEI and Innovation



The DMH does not have control of the entire Plan Review Process.

APPENDIX 2

This appendix includes the results of our web-based survey of the county Mental Health Directors. Comments for each individual question and answers provided for questions 26 and 27 were omitted to ensure anonymity of respondents

MHSA County Survey

1. What population size does your County serve?

	Response Percent	Response Count
1 - 100,000	31.4%	11
100,001 - 200,000	11.4%	4
200,001 - 750,000	25.7%	9
750,001 - 2,000,000	17.1%	6
Greater than 2,000,000	14.3%	5
answered question		35
skipped question		0

2. How would you rate DMH's overall development and implementation of the MHSA?

	Response Percent	Response Count
Could have been slower	3.1%	1
Slow	59.4%	19
About right	21.9%	7
Fast	0.0%	0
Could have been faster	15.6%	5
Comments		15
answered question		32
skipped question		3

3. What do you think would have been the best way to develop and implement the MHSA?

	Response Percent	Response Count
The way it is now, staggered by component	20.0%	6
As an integrated plan with all components submitted together	23.3%	7
Broken into two phases (for example, Phase 1: Workforce Education and Training (WET) and Capital Facilities and Technological Needs (CAPTEC) and Phase 2: Community Services and Supports (CSS), Prevention and Early Intervention (PEI), and Innovative Programs (Innovation)	33.3%	10
Other (please specify)	23.3%	7
answered question		30
skipped question		5

4. What have you observed to be major strengths in the MHSA development and implementation (Check all that apply):

	Response Percent	Response Count
No strengths observed	6.9%	2
Planning - State Level	6.9%	2
Planning - Local Level	79.3%	23
Distribution of funds	17.2%	5
Communication from DMH to the Counties	10.3%	3
Plan Requirements	17.2%	5
Other (please specify)	27.6%	8
answered question		29
skipped question		6

5. What have you observed to be major weaknesses in the MHSA development and implementation (Check all that apply):

	Response Percent	Response Count
No weaknesses observed	3.4%	1
Planning - State Level	65.5%	19
Planning - Local Level	13.8%	4
Distribution of funds	41.4%	12
Communication from DMH to the Counties	69.0%	20
Plan Requirements	72.4%	21
Other (please specify)	31.0%	9
answered question		29
skipped question		6

6. Please rate your participation with assisting DMH on the MHSA development and implementation of the Regulations (CCR Title 9, Chapter 14) and component Guidelines.

	Response Percent	Response Count
Not involved	46.4%	13
Moderately involved	25.0%	7
Heavily involved	28.6%	8
Comments		3
answered question		28
skipped question		7

7. Please rate your satisfaction with the ability to provide input to the DMH regarding the MHSA Regulations and component Guidelines.

	Response Percent	Response Count
Not satisfied	17.9%	5
Moderately satisfied	46.4%	13
Satisfied	35.7%	10
Extremely Satisfied	0.0%	0
Comments		4
answered question		28
skipped question		7

8. Do you think the Regulations accurately depict the requirements of the MHSA?

	Accurate	Slightly accurate	Slightly inaccurate	Inaccurate	Not observed	Response Count
General Regulations	57.7% (15)	15.4% (4)	11.5% (3)	0.0% (0)	15.4% (4)	26
CSS Component	53.8% (14)	11.5% (3)	23.1% (6)	3.8% (1)	7.7% (2)	26
Comments						7
answered question						26
skipped question						9

9. Do you think the component Guidelines accurately depict the requirements of the MHSA?

	Accurate	Slightly accurate	Slightly inaccurate	Inaccurate	Not observed	Response Count
CSS	40.0% (10)	28.0% (7)	24.0% (6)	4.0% (1)	4.0% (1)	25
PEI	36.0% (9)	32.0% (8)	20.0% (5)	4.0% (1)	8.0% (2)	25
WET	40.0% (10)	24.0% (6)	20.0% (5)	4.0% (1)	12.0% (3)	25
Comments						6
answered question						25
skipped question						10

10. Do you think the Information Notices issued by DMH accurately depict the requirements of the MHSA?

	Accurate	Slightly accurate	Slightly inaccurate	Inaccurate	Not observed	Response Count
CSS	**48.0% (12)**	32.0% (8)	12.0% (3)	4.0% (1)	4.0% (1)	25
PEI	**44.0% (11)**	36.0% (9)	8.0% (2)	4.0% (1)	8.0% (2)	25
WET	**44.0% (11)**	32.0% (8)	12.0% (3)	0.0% (0)	12.0% (3)	25
					Comments	6
					answered question	25
					skipped question	10

11. Please rate the CSS Guidelines with respect to the following:

	Poor	Satisfactory	Excellent	Not observed	N/A	Rating Average	Response Count
Ease of understanding	29.2% (7)	**62.5% (15)**	0.0% (0)	4.2% (1)	4.2% (1)	1.78	24
Helpful	25.0% (6)	**62.5% (15)**	4.2% (1)	4.2% (1)	4.2% (1)	1.87	24
Clarity of examples	20.8% (5)	**62.5% (15)**	4.2% (1)	8.3% (2)	4.2% (1)	2.00	24
Templates provided	25.0% (6)	**62.5% (15)**	4.2% (1)	4.2% (1)	4.2% (1)	1.87	24
Redundancy of information required	**54.2% (13)**	33.3% (8)	0.0% (0)	4.2% (1)	8.3% (2)	1.50	24
					If poor, please briefly explain.		16
					answered question		24
					skipped question		11

12. Please rate the PEI Guidelines with respect to the following:

	Poor	Satisfactory	Excellent	Not observed	N/A	Rating Average	Response Count
Ease of understanding	20.8% (5)	62.5% (15)	4.2% (1)	4.2% (1)	8.3% (2)	1.91	24
Helpful	25.0% (6)	58.3% (14)	4.2% (1)	4.2% (1)	8.3% (2)	1.86	24
Clarity of examples	29.2% (7)	54.2% (13)	4.2% (1)	4.2% (1)	8.3% (2)	1.82	24
Templates provided	16.7% (4)	58.3% (14)	8.3% (2)	8.3% (2)	8.3% (2)	2.09	24
Redundancy of information required	29.2% (7)	37.5% (9)	4.2% (1)	12.5% (3)	16.7% (4)	2.00	24
					If poor, please briefly explain.		12
					answered question		**24**
					skipped question		**11**

13. Please rate the WET Guidelines with respect to the following:

	Poor	Satisfactory	Excellent	Not observed	N/A	Rating Average	Response Count
Ease of understanding	25.0% (6)	45.8% (11)	12.5% (3)	8.3% (2)	8.3% (2)	2.05	24
Helpful	20.8% (5)	50.0% (12)	12.5% (3)	8.3% (2)	8.3% (2)	2.09	24
Clarity of examples	12.5% (3)	58.3% (14)	8.3% (2)	12.5% (3)	8.3% (2)	2.23	24
Templates provided	12.5% (3)	54.2% (13)	12.5% (3)	12.5% (3)	8.3% (2)	2.27	24
Redundancy of information required	16.7% (4)	50.0% (12)	8.3% (2)	12.5% (3)	12.5% (3)	2.19	24
					If poor, please briefly explain.		11
					answered question		**24**
					skipped question		**11**

14. What is your opinion regarding the County Plan requirements for the following MHSA components:

	Inflexible	About right	Flexible	N/A	Response Count
CSS	50.0% (12)	37.5% (9)	8.3% (2)	4.2% (1)	24
PEI	20.8% (5)	62.5% (15)	4.2% (1)	12.5% (3)	24
WET	12.5% (3)	58.3% (14)	12.5% (3)	16.7% (4)	24
				Comments	6
				answered question	24
				skipped question	11

15. The amount of detail requested for the Plans is:

	Too much	Just about right	Not enough	N/A	Response Count
CSS	83.3% (20)	12.5% (3)	0.0% (0)	4.2% (1)	24
PEI	37.5% (9)	37.5% (9)	4.2% (1)	20.8% (5)	24
WET	29.2% (7)	50.0% (12)	4.2% (1)	16.7% (4)	24
				Comments	8
				answered question	24
				skipped question	11

16. DMH's Plans review process is:

	Poor	Satisfactory	Excellent	Not observed	N/A	Rating Average	Response Count
Transparent	37.5% (9)	54.2% (13)	0.0% (0)	4.2% (1)	4.2% (1)	1.70	24
Collaborative	25.0% (6)	54.2% (13)	16.7% (4)	0.0% (0)	4.2% (1)	1.91	24
Helpful	33.3% (8)	50.0% (12)	12.5% (3)	0.0% (0)	4.2% (1)	1.78	24
Informative	20.8% (5)	62.5% (15)	12.5% (3)	0.0% (0)	4.2% (1)	1.91	24
Consistent	50.0% (12)	41.7% (10)	0.0% (0)	4.2% (1)	4.2% (1)	1.57	24
Timely	62.5% (15)	33.3% (8)	0.0% (0)	0.0% (0)	4.2% (1)	1.35	24
Thorough	0.0% (0)	66.7% (16)	29.2% (7)	0.0% (0)	4.2% (1)	2.30	24
					if poor, please briefly explain.		19
					answered question		24
					skipped question		11

17. How would you rate DMH's overall development and implementation of the CSS component?

	Could have been slower	Slow	About right	Fast	Could have been faster	Response Count
Plan submission to approval	4.2% (1)	41.7% (10)	37.5% (9)	0.0% (0)	16.7% (4)	24
Plan approval to payment	4.2% (1)	37.5% (9)	41.7% (10)	4.2% (1)	12.5% (3)	24
Plan submission to payment	0.0% (0)	50.0% (12)	37.5% (9)	4.2% (1)	8.3% (2)	24
					Comments	4
					answered question	24
					skipped question	11

18. Do you think the Community Program Planning (CPP) process for the CSS component was:

	Response Percent	Response Count
Not comprehensive enough	0.0%	0
Comprehensive	75.0%	18
Too comprehensive	25.0%	6
Comments		6
answered question		24
skipped question		11

19. Do you think the level of CPP supporting documentation required for submittal to the DMH was:

	Response Percent	Response Count
Too little	0.0%	0
About Right	41.7%	10
Too much	58.3%	14
Comments		2
answered question		24
skipped question		11

20. Do you think the same local planning process should be required for the other MHSA components?

	Yes	No	Other (Please Specify)	Response Count
Process	41.7% (10)	54.2% (13)	4.2% (1)	24
Level of Supporting Documentation Required	16.7% (4)	79.2% (19)	4.2% (1)	24
Comments				11
answered question				24
skipped question				11

21. Have you submitted the following required documents:

	Yes	No	Response Count
MHSA Agreement	78.3% (18)	21.7% (5)	23
Annual MHSA Revenue and Expenditure Report	82.6% (19)	17.4% (4)	23
Semi-Annual Cash Flow Statement	91.3% (21)	8.7% (2)	23
		If no, please state primary reason.	8
		answered question	23
		skipped question	12

22. DMH recently revised its distribution policy to advance 75% of component funds upon Plan approval (and execution of the MHSA Agreement) or at the beginning of the fiscal year, whichever is later. Please rate your opinion on the policy change:

	Response Percent	Response Count
Agree with change	78.3%	18
Do not agree with change	8.7%	2
Policy still needs improvement	8.7%	2
No opinion	4.3%	1
	Comments	3
	answered question	23
	skipped question	12

23. Please rate the following with respect to the new distribution policy:

	Poor	Satisfactory	Excellent	N/A	Response Count
Timeliness of distributions	13.0% (3)	60.9% (14)	13.0% (3)	13.0% (3)	23
Appropriateness of distribution percentage (ie. 75%)	13.0% (3)	60.9% (14)	17.4% (4)	8.7% (2)	23
Process of distribution (ie. planning portion, component by component)	17.4% (4)	65.2% (15)	8.7% (2)	8.7% (2)	23
				If poor, please briefly explain.	8
				answered question	23
				skipped question	12

24. Please rate your overall experience with DMH staff pertaining to the following:

	Poor	Satisfactory	Excellent	Not observed	Rating Average	Response Count
Professionalism	4.3% (1)	47.8% (11)	47.8% (11)	0.0% (0)	2.43	23
Customer Service	21.7% (5)	47.8% (11)	30.4% (7)	0.0% (0)	2.09	23
Timeliness of response	26.1% (6)	52.2% (12)	21.7% (5)	0.0% (0)	1.96	23
Knowledge of subject matter	30.4% (7)	65.2% (15)	4.3% (1)	0.0% (0)	1.74	23
Quality of response	26.1% (6)	65.2% (15)	8.7% (2)	0.0% (0)	1.83	23
Accuracy of information provided	34.8% (8)	60.9% (14)	4.3% (1)	0.0% (0)	1.70	23
Ability to resolve your questions or concerns	34.8% (8)	47.8% (11)	13.0% (3)	4.3% (1)	1.87	23
				If poor, please briefly explain.		17
				answered question		23
				skipped question		12

25. Please rate your overall experience with the Oversight and Accountability Commission staff pertaining to the following:

	Poor	Satisfactory	Excellent	Not observed	Rating Average	Response Count
Professionalism	0.0% (0)	47.8% (11)	26.1% (6)	26.1% (6)	2.73	23
Customer Service	13.0% (3)	21.7% (5)	17.4% (4)	47.8% (11)	3.00	23
Timeliness of response	4.3% (1)	30.4% (7)	13.0% (3)	52.2% (12)	3.13	23
Knowledge of subject matter	13.0% (3)	30.4% (7)	21.7% (5)	34.8% (8)	2.73	23
Quality of response	13.0% (3)	17.4% (4)	21.7% (5)	47.8% (11)	3.04	23
Accuracy of information provided	8.7% (2)	30.4% (7)	21.7% (5)	39.1% (9)	2.91	23
Consistency of information provided	17.4% (4)	26.1% (6)	17.4% (4)	39.1% (9)	2.73	23
Ability to resolve your questions or concern	17.4% (4)	26.1% (6)	13.0% (3)	43.5% (10)	2.83	23
				If poor, please briefly explain.		9
				answered question		23
				skipped question		12

26. How can the MHSA development and implementation be more effective?

	Response Count
	16
answered question	16
skipped question	19

27. Please provide any additional comments about the MHSA development, planning, review, or implementation.

	Response Count
	7
answered question	7
skipped question	28

CALIFORNIA DEPARTMENT OF
Mental Health

1600 9th Street, Sacramento, CA 95814
(916) 654-2309

June 2, 2008

David Botelho
Department of Finance
Office of State Audits and Evaluations
300 Capitol Mall, Suite 801
Sacramento, CA 95814

Dear Mr. Botelho:

Re: California Department of Mental Health, Mental Health Services Act Performance Audit

We are in receipt of your May 2008 report on the Performance Audit of the Department of Mental Health's (DMH) Mental Health Services Act (MHSA) program.

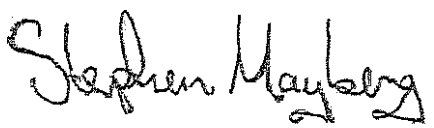
As you know from your review, this multifaceted complex program has experienced significant evolution from its inception in January 2005 to the current environment of ongoing program adjustment and improvement. We appreciate your staff's efforts to understand not only our early struggles, as we worked to develop a program responsive to stakeholder input, but also our work to transform the delivery of local mental health services as the authors the Act envisioned.

We agree with your observations that our initial processes may have been overly burdensome and while we acknowledge the need to become more responsive, we are proud that with the exception of one component, to date all components envisioned by the Act have been developed and implemented. Counties are able to request and receive funding to expand these important services and a significant number of Californians have received vital assistance to meet their mental health needs.

We are appreciative that your review found and acknowledged significant progress that DMH has already made to address areas of inefficiency in the management of the MHSA program. We find your observations to be helpful and we are optimistic that DMH can and will work successfully with our partners to streamline our processes, clarify roles and responsibilities and improve the approval of county Plans and the distribution of needed funds to local mental health programs.

I would also like to acknowledge and express our appreciation for the professionalism, dedication and cooperation exhibited by your staff during this audit. We look forward to using your work as a basis for further program improvement.

Sincerely,



STEPHEN W. MAYBERG, Ph.D.
Director