CALIFORNIA
DEPARTMENT OF MENTAL HEALTH

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Mental Health

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Front cover art "Who I Am On the Outside" mixed media was created by Elizabeth, a consumer participating in the Arts in Mental Health Program, Metropolitan State Hospital. This multi-disciplinary fine arts program gives persons with mental illnesses the opportunity to develop artistic skills, build self-discipline and self-esteem. The image was published in the 1999 Art of Healing Children Calendar

Back cover art, "Electricity," watercolor was created by Everette, a consumer participating in the Arts in Mental Health Program, Metropolitan State Hospital. The image was published in the 1999 Art of Healing Children Calendar.

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PREFACE

The California Department of Mental Health entrusted with leadership of the California mental health system, ensures, through partnerships, the availability and accessibility of effective, efficient, culturally competent services. This is accomplished by advocacy, education, innovation, outreach, understanding, oversight, monitoring, quality improvement, and the provision of direct services.

This document has been developed for the purpose of presenting an overview of the Department of Mental Health's major efforts, giving a brief description of each. These major efforts are designed to fulfill the mission and philosophy of the Department.

In fulfilling the mission of the Department of Mental Health, a series of planning documents have been developed that articulate the steps that will be taken to achieve the Department's goals in specific areas. These plans are the Strategic Plan, the Information Technology Strategic Plan, the Medi-Cal Managed Mental Health Care Plan, and the Strategic Plan on the Future of State Hospitals. These plans provide extensive technical detail and are available upon request.

If you have questions or would like a copy of one of the detailed plans mentioned in this document, please contact:

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INTRODUCTION

Profile of California

California covers 163,707 square miles and has the largest population of any state. If placed on the East Coast, California would stretch from Georgia through Delaware. There are over 33.5 million people in the state which comprises 12.3 percent of the entire nation's population. This is greater than that of Delaware, Maryland, Washington D.C., Virginia, North Carolina, South Carolina, and Georgia combined, and reflects a 26.2 percent increase from 1982 to 1992. California's population is projected to rise to over 34 million people by the end of the century. Los Angeles County alone has more than nine million people. While the San Francisco Bay Area and San Diego County are other major population centers, California also has vast agricultural and rural areas, with the least populated county being Alpine County with only 1,200 people.

California's average per capita income ranks ninth among the states at $20,847. The per capita income for counties ranges from a high of $38,110 to a low of $12,187. The California Employment Development Department reported the annual average unemployment rate for 1997 was 6.3 percent. This rate has declined from 7.2 percent in 1996 as California recovers from a severe economic recession.

The state's population reflects both a cultural and ethnic diversity. It is projected that by the year 2000 the distribution of persons by ethnicity will be 50.7 percent Caucasian, 31.6 percent Hispanic, 6.8 percent African-American and 10.9 percent Asian and Other.

History of Public Mental Health System in California

California has a history of progressive change in its public mental health system. The first of these changes was in 1957 with the Short-Doyle Act. This created the funding structure for the development of community-based mental health services. This was followed in 1968 by the enactment of the Lanterman-PetrisShort (LPS) Act, which established strict standards for involuntary treatment and removed financial obstacles to utilizing community-based services rather than state hospital services. One of the more recent changes in this long trend was Chapter 89, Statutes of 1991 (AB 1288), which realigned fiscal and administrative responsibility under county authority. This represented a landmark action to restructure government. The intent of mental health realignment was to provide a more stable funding base for local mental health programs and appropriately shift program operation and accountability to the local level.

Some of the features of realignment include:

- A stabilization of funding and program delivery for Californians who have mental illness, providing a dedicated funding source with predictable growth. This better enables California's 58 counties to anticipate funding and design programs to meet the locally assessed need. This in turn facilitates significant redesign consistent with Systems of Care (SOC) research findings;

- Placement of responsibility for program design at the local level increases participation in decision making by consumers, family members and advocates, and encourages diversity and program experimentation;

- Integrated planning of community and long-term care systems at the local level because of new flexibility in the use of mental health funds;

- Emphasis on accountability through performance outcomes with the California Mental Health Planning Council (CMHPC) and the local mental health boards having participatory responsibility for overseeing development and implementation of performance outcome measures at the state and local levels; and

- Redefinition of the role of the State to provide system leadership, administration of federal funds, program oversight and evaluation, and to provide specified direct services including state hospitals and services for the forensic population.

California, a national leader in mental health system innovation and reform, has a decentralized service delivery system with most direct services provided through the county mental health system. Under managed care, the total number of persons to be served is projected to increase to over 480,000 annually by 1998, with a total expenditure of approximately two billion dollars. The Healthy Families Program to begin July 1998 will further increase the number of children served by the public mental health system.

STATE LEADERSHIP

The California Department of Mental Health (DMH) provides leadership to the mental health system of California. This is accomplished through, among other things, planning to ensure the implementation of the State's mission and goals for mental health services and ensuring that the design and delivery of mental health services are consumer focused, culturally competent and promote family involvement.

Some of the Department's responsibilities are to:

- Facilitate the joint state/county decision making process, including participation of the local advisory boards, the California Mental Health Directors Association (CMHDA) and work as partners with the CMHPC.
- Secure and ensure the continuation of federal funds.
- Continually explore alternatives for increasing funds for services.
- Oversee the delivery of mental health services in California.
- Provide specified mental health services directly or through contract.
- Perform administrative functions necessary to support the Department's operations.

In September 1998, the Department published its annual Strategic Plan. This plan contains goals, strategies, objectives, and performance measures relative to the Department's responsibilities and activities.

Philosophy of Systems of Care

California fully endorses a Systems of Care approach to service delivery. A Systems of Care is a coordinated service delivery structure that ensures timely and appropriate access to all of the services its members need, has partnerships with its consumers and essential agencies and organizations to produce measurable outcomes and consumer satisfaction, and enhances clinical efficacy and cost-effectiveness to manage risk. California is a leader in the provision of public mental health services because of this commonly shared and accepted vision, mission, and service philosophy.

A SOC service delivery approach includes the following factors:

Client-Directed Approach

All services and programs should be client-directed and recognize the rights of persons to define and receive services in the most appropriate and least restrictive environment.

Persons with Mental Illness

Services are provided to persons who require traditional mental health treatment, such as crisis intervention and medications, as well as a variety of rehabilitation services to specifically address the recovery needs of adults with serious and persistent mental illnesses and children with serious emotional disturbances.

Outreach

Services should be accessible to all consumers on a 24-hour basis in times of crisis. Assertive outreach should make services available to individuals who are difficult to reach.

Multiple Disabilities

Services should address the special needs of persons with dual and multiple disabilities.

Quality of Services

Qualified individuals should provide effective services based on measurable outcomes.

Cultural Competence

All services and programs should be sensitive to the populations' diversity.

Community Support

The SOC should incorporate the concept of community support for persons with mental disabilities.

Self-Help

The mental health system should promote the development and use of self-help.

Outcome Measures

The Systems of Care should be developed based on client-directed goals and evaluated by measurable outcomes.

Administration

State and local mental health plans should manage programs in an efficient, timely, and cost-effective manner.

Research

The mental health system should encourage basic research into the nature and causes of mental illnesses and cooperate with research centers in efforts leading to improved treatment methods, service delivery, and quality of life for mental health consumers.

Education on Mental Illness

Consumer and family advocates for mental health should be encouraged and assisted in informing the public about mental illness from their viewpoint and about the needs of consumers and families. Professional organizations should be encouraged to disseminate the most recent research findings on the treatment and prevention of mental illness.

Array of Services

The following array of community and hospital-based services are available to persons who have a mental illness and are provided or arranged for by the local mental health departments:

a) Pre-Crisis and Crisis Services
b) Comprehensive Evaluation and Assessment
c) Individual Service Plan
d) Medication Education and Management
e) Case Management
f) 24-Hour Treatment Services
g) Rehabilitation and Support Services
h) Vocational Rehabilitation
i) Residential Services
j) Services for Homeless Persons
k) Group Services
l) Wrap Around Services

Population Served

In State Fiscal Year (SFY) 1994-95, approximately 347,000 persons received services in California's public mental health system. Of that number, 76,000 were children and adolescents and 271,000 were adults and older adults. Approximately 24,000 children/adolescents and 190,000 adults and older adults have a diagnosis of a major functional disorder. The remainder received services due to other reasons (e.g., court order or assessment only). An additional 130,000 persons were served in the specialty mental health Fee-For-Service (FFS) Medi-Cal system. It is anticipated that other California residents will be provided mental health services to eliminate barriers to employment under welfare reform.

Children's Systems of Care

Based on the success of the planning model developed in Ventura County, legislation was enacted that encouraged the development of organized, community-based Systems of Care (SOC) for children with Serious Emotional Disturbance (SED).

The specifications for the organized SOC require that: 1) services be provided to children with SED; 2) services be culturally competent and child/family centered; 3) families be an integral part of service planning and delivery; and 4) children should, whenever possible, be served at home or in the most home-like setting possible. Additionally, since the system recognizes that many children receive services from more than one agency, (e. g., juvenile justice, education, social services, child welfare and mental health), service delivery should involve formal collaboration and coordination among such agencies.

In California, as elsewhere, there is a strong movement to assure that limited resources are used efficiently, therefore, the SOC specifications require performance outcomes. The performance outcomes articulated in the statute are defined as measurable reductions in group home and state hospital usage, reduced recidivism rates in the juvenile justice system, and increased school attendance/performance rates. Subsequent legislation added measurable improvement in individual and family functional status in a representative sample of enrollees. The SOC now serves more than half of the state's children and families needing such services. DMH remains committed to the goal of a statewide children's SOC. It is the single largest effort, in terms of youth served, in the nation.

Early and Periodic Screening, Diagnosis and Treatment

In accordance with federal statutes which require states to provide diagnostic and treatment services to Medicaid recipients under the age of 21, regardless of whether the state provides the same benefits under its Medicaid Plan, California has expanded the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. The state has increased the number of Medi-Cal providers by adding licensed clinical social workers and marriage, family, and child counselors to the list of Medi-Cal (MC) providers allowed to provide services.

Additionally, for Medi-Cal eligible children needing SOC services, EPSDT funds can now be used by local mental health providers to provide substance abuse services to children with co-occurring mental illness and substance abuse diagnoses.

Early Mental Health Initiative

The Early Mental Health Initiative (EMHI) is part of the continuum of mental health services provided by DMH. As a preventive service for children, the EMHI was established to fund programs which serve young, school aged children in Kindergarten through third grade who are identified as having mild to moderate school adjustment difficulties. The purpose of the EMHI is to ensure that such identified children have a good start in school and to 1) enhance the social and emotional development of young students, 2) to increase the likelihood that students experiencing mild to moderate school adjustment difficulties will succeed in school, 3) to increase personal competencies related to life success and 4) to minimize the need for more intensive and costly services as students grow older. In FY 1996-97, the number of children served was approximately 26,000.

Special Education Program

"Interagency Responsibilities for Providing Services to Handicapped Children," combines educational and mental health resources in an interagency delivery model to provide psychotherapy and other mental health services to students in conjunction with the educational system. The interagency program designates the local mental health programs as being responsible for providing mental health services to pupils who require special education and who have been determined to need mental health treatment to benefit from their education.

ADULT AND OLDER ADULT PROGRAMS

Adult and Older Adult SOC

Background

Systems of Care have been the fundamental organizing principles for children's mental health services for the last decade in California and increasingly throughout the nation. More recently, there has been interest in providing adult and older adult services from SOCs. It is at the county level that adult and older adult SOCs are developed and where implementation is taking place. Two models, the Integrated Service Agency (ISA) and the County Interagency Demonstration (CID) model, have been developed over the past few years. Many counties are implementing programs designed after these models.

The ISA model features voluntary participation of members (clients) in each service identified in a personal service plan, provision of services on a capitated and 24-hour basis to meet all members' needs, including housing, supported and competitive employment, socialization, education, rehabilitation, legal assistance, money management, mental health treatment, and physical health and dental care. Each ISA also provides information, counseling, respite, and other services for relatives of members.

The CID model, which grew out of the Ventura model for children, divided that county into 14 small treatment teams serving approximately 200 clients each. These semi-autonomous teams serve a geographic area of the county, with service coordinators serving no more than 25 clients. While dedicated to providing client-driven comprehensive services, the CID model, more so than the ISA model, relies heavily on interagency collaboration and cooperation to meet client needs.

The move toward developing SOCs within the managed care environment coincides with other philosophical and service delivery changes in California's public mental health system. In 1993, California instituted the Medicaid rehabilitation option which broadened both the scope of services and locations where services might be provided. During this recent time period, there has been increasing awareness of the need to actively involve consumers and, when appropriate, their families in planning treatment goals, planning local SOC design, and in roles as providers of services.

There is also the growing recognition that effective services are those that are specifically designed to meet the needs of an individual consumer. Therefore, the cultural, gender and age related issues central to understanding the individual consumer also become essential to providing effective services.

Persons With Dual Diagnosis (SED or Serious Mental Illness/Substance Abuse)

The increasing incidence of persons exhibiting co-occurring mental illness and substance abuse is an issue of national concern. It is estimated that approximately 60 percent of persons with Serious Mental Illness (SMI) also have a substance abuse problem and that up to 90 percent or more of the highest cost users of services and forensics consumers also abuse substances. Approximately 80 percent of youth with SED are believed to have an unaddressed substance abuse problem. In order to address the significant issues that confront health systems attempting to serve persons with co-occurring problems or Dual Diagnosis (DD) and in response to language in the Governor's Budget for FY 1995-96, DMH joined with the Department of Alcohol and Drug Programs (ADP) in establishing a Dual Diagnosis Task Force. Composed of representatives of local mental health directors and alcohol and other drug program administrators, consumer representatives, as well as executive staff of each state department, this task force is developing: 1) jointly funded demonstration programs, 2) training programs to ensure that staff from both systems are capable of working with consumers with DD, 3) the identification and resolution of administrative barriers to integrated services, and 4) common definitions of critical terms. The two departments have developed an Action Plan that sets forth specific activities to ensure that consumers with DD will receive appropriate treatment and services for both disorders, no matter how they initially access services. A state policy statement was issued in 1996, and a Memorandum of Understanding (MOU) between the two departments was signed on August 12, 1996, by the respective department directors.

Employment Services

The importance of employment services for an effective client-directed community support program is widely recognized. Mental health constituency groups representing consumers, family members, employers, service providers, mental health and rehabilitation professionals are developing new patterns of services that are based on this comprehensive community support approach. They express a common set of values that include consumer choice, integrated settings, cultural competency, comprehensive service linkages, natural support (e.g., friends, family and neighbors), career planning, and reasonable accommodations. An Interagency Agreement (IA) between the Department of Rehabilitation and DMH blends resources and staff to provide an administrative team supporting the county cooperative programs in training and technical assistance, program review and development and contract monitoring. A second IA redirects staff at the state hospitals to prepare consumers for vocational services in their communities. Annually, through this collaborative program, 22 local mental health programs and the four state hospitals provide employment services and independent living services to over 7,000 persons with severe psychiatric disabilities. As a

consequence, the actual cost of delivering these services is offset by the contribution to the tax base by these working consumers, as well as avoiding costs in tax supported assistance.

California's B.E.S.T. (Building Employment Service Teams) has been developed statewide to broaden access to local technical expertise and resources and to provide advisory body input. These regional networks include consumers, family members, employers, the Departments of Transportation, Mental Health, and Rehabilitation, and providers all seeking to improve community employment partnerships.

Caregiver Resource Centers

A problem that the service system for older adults shares with that for children is the need for respite care and support services for caregivers. The Department works with the Caregiver Resource Centers (CRC) to implement mental health counseling for family caregivers of persons with cognitive impairments. Seventy percent of these caregivers suffer from depression and can benefit from counseling. The Department administers a statewide system of 11 regional CRCs. The CRCs provide a variety of mandated services including consultation and care planning, mental health counseling, support groups and other supportive services, education and training, and respite care.

Acquired Traumatic Brain Injury Project

The Department is conducting a pilot project to establish post-acute continuum of care models for persons with acquired traumatic brain injury. The purpose of the project is to demonstrate the effectiveness of a coordinated service approach assisting persons with brain injury to attain productive, independent lives which may include paid employment. The project sites located in Sacramento, Capitola in Santa Cruz County, Los Angeles and Fullerton became operational in April 1990.

Services are provided directly or by arrangement and include care coordination, supported employment, intensive day treatment, and structured living arrangements for persons with acquired traumatic brain injury. Funding for this project is from the Traumatic Brain Injury Fund which is supported by fines and assessments made following seat belt violations.

MANAGED MEDICAID (MEDI-CAL) MENTAL HEALTH CARE IN CALIFORNIA

Over the last few years, there has been a move nationally to change the orientation of health care from the delivery of episodic treatment of illness to the planned provision of primary care, and other necessary services, in an integrated, coordinated system of service delivery. This coordinated system of care is known as managed care. Managed care, broadly stated, is a planned, comprehensive approach to the provision of health care which combines clinical services and administrative procedures within an integrated, coordinated system. This system is carefully constructed to provide timely access to care and services in a cost-effective manner. In a managed care system, individual providers are linked together under the umbrella of a single entity, the managed care plan. Managed care's emphasis on access to health care is intended to increase the utilization of primary care services whenever possible and thus reduce the unnecessary use of emergency rooms and inpatient services. Similarly, managed care's focus on mental health preventive services concentrates on promotion of a person's ability to function in the community.

The design of managed mental health care for California's Medi-Cal program includes statewide implementation of a single managed mental health care plan in each county. The implementation of managed care with the county as the plan is the logical extension of the state and county relationship. It will not require major shifts in governance or in financing of care for persons with mental illness or emotional disturbance. The counties are the primary sources of service to persons with mental illness and emotional disturbance and have the ability to provide continuity of care for those periods when persons are not eligible for Medi-Cal but still require services to maintain themselves in the community. Additionally, the counties are responsible for the provision of many high cost public services used by persons with mental illness when timely, effective treatment is not provided.

The Department's Medi-Cal Managed Mental Health Care Plan demonstrates its commitment to quality in meeting the mental health care needs of the citizens of California. Throughout the planning process, the Department has been committed to public involvement in all stages of development. In October 1993, the Managed Care Steering Committee was established with a membership representing over 40 organizations. These organizations include other state departments, providers, consumers, family members, advocates and other interested parties. Since that time, the Department's staff have met regularly with this group and associated subcommittees for the purpose of informing the public and soliciting input regarding specific implementation issues.

STATE HOSPITAL SERVICES

Current State Hospital Services

The DMH is responsible for the direct operation of four state hospitals: Atascadero, Metropolitan, Napa, and Patton. In addition, the Department through an agreement with the California Department of Corrections provides mental health services at the California Medical Facility at Vacaville. All four state hospitals are fully licensed and accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), the national accrediting body. The Psychiatric Program at Vacaville is licensed and adheres to the standards of JCAHO but is not accredited. The DMH also provides services for developmentally disabled forensic clients who are at Napa State Hospital.

State Hospital Inpatient Populations

The patients served by the DMH are often classified on the basis of the legal class or type of commitment proceeding that resulted in their placement in a state hospital. There are two basic types of commitments: a civil commitment and a judicial commitment. Civil commitments are referred to as Lanterman-Petris-Short (LPS) commitments and result when, upon psychiatric evaluation, a person is found to be a danger to themselves, or others, or to be gravely disabled as a result of their mental disorder. The Judicially Committed or Penal Code (JCIPC) commitments, often referred to as forensic commitments, result from a person allegedly, or in fact, committing a crime and subsequently being found to be suffering from a mental disorder. A historical perspective of the state hospital system's population shows that there has been a significant drop in the LPS population since 1991 when the "realignment" of state programs to local government control occurred, along with an upward trend in the forensic population beginning in 1993. Before realignment, the population in the state hospitals was divided at about 50 percent LPS and 50 percent forensic. At present, approximately 30 percent of current state hospital patients are referred by local community mental health programs through involuntary civil commitment procedures, and 70 percent are forensic, coming from either the court system or through a referral from the California Department of Corrections (CDC).

The future LPS population is very difficult to predict; however, a continuing decline is expected. The JC/PC population is expected to grow. Changes in law now allow for the detention and treatment of individuals defined as Sexually Violent Predators (SVP). This new category of patients is expected to grow substantially in the next five years.

Recognition For Services

The state hospitals have received public recognition in a number of areas. These areas include the provision of effective treatment for patients difficult to treat in local communities; public art works projects and the Arts in Mental Health program. National recognition has been given for the "Full Contact Defense Training" developed by Atascadero State Hospital. The "Easy Street Program" at Patton State Hospital has been recognized as a model program to teach patients psychosocial skills enabling them to be more independent in the community. In addition, Atascadero State Hospital has been accredited with commendation in the last two JCAHO surveys, which means it is in the top ten percent of hospitals nationwide. Recognition has also been given to research projects concerning schizophrenic and pharmacological studies with California universities at several of the state hospitals.

Forensic Services

The DMH provides both inpatient and outpatient treatment to the state's forensic patient population. Inpatient services are provided at Atascadero, Metropolitan, Napa and Patton State Hospitals. The Department is most directly involved with the correctional system in California through operation of the Acute Psychiatric Program at Vacaville. The DMH also administers, through a series of contract providers, the Forensic Conditional Release Program (CONREP), which is an outpatient, community-based treatment and supervision program. The CONREP is DMH's statewide system of community-based assessment, treatment and supervision services for judicially committed persons placed on outpatient status. The intent of the program is to prevent criminal reoffense, to provide a full range of mental health services to this population, and to successfully reintegrate them into their community. The CONREP staff work directly with local mental health authorities, private providers, and other interested local officials to define local program needs; negotiate service contracts; establish minimum levels for treatment and core performance standards; monitor contracted services and related fiscal, billing, and data requirements; and to prepare for the inclusion of any sexually violent predators conditionally released by the courts in the future.

Sex Offender Commitment Program

As a result of concerns regarding the risk to public safety that occurs when violent sex offenders are released from prison into the community, Governor Wilson proposed legislation which was enacted effective January 1, 1996. These provisions established a new category of civil commitment for persons found, when release from prison is imminent, to be sexually violent predators as specifically defined in the law. The initial term of commitment is up to two years and may be renewed until the individual's behavior has so changed that he or she is no longer considered likely to commit an act of sexual violence.

The DMH evaluates individuals referred by the CDC as potentially meeting specified prescreening criteria to be considered sexually violent predators. This evaluation is conducted in accordance with a standardized assessment protocol that has been developed by DMH and extensive collection and review of information on the individual's criminal history. This protocol requires clinical evaluations of the individual for the existence of a mental disorder, as well as factors known to be associated with the risk of reoffense among sex offenders. Persons meeting these criteria are referred by the Director of DMH to the county district attorney or county counsel for potential commitment by the judicial system.

Individuals committed in accordance with this statute will be committed to the custody of DMH for treatment in a secure facility. The treatment protocol developed by DMH is in accordance with current state of the art standards for the treatment of sex offenders.

SYSTEM ACCOUNTABILITY THROUGH PERFORMANCE-BASED OUTCOMES

Realignment mandated the development and implementation of an outcome monitoring system. The Department, in partnership with the California Mental Health Directors Association and the California Mental Health Planning Council, convened a Performance Outcome Committee (POC) to address this issue. This POC developed a list of values that exemplifies shared goals for the mental health system and for the manner in which individuals should be served by that system. These values embrace the philosophy that persons with mental disabilities can be better served when the service is consumer centered. Building on the agreed upon values, measurable outcomes were developed that might be expected to result from the provision of effective mental health services. The outcomes to be measured are the need for supervision in an individual's living situation, social support network, employment and financial status, physical health, productive daily activities, and involvement with criminal justice.

The Department developed and implemented an Adult Performance Outcome Survey (APOS) based on the values outlined above. The APOS was conducted statewide with data collected over a one-year period. The results of the APOS were used in developing the Department's current performance outcome strategies.

The Children and Youth Performance Outcome Program is a system modeled after the evaluation system that is in place in children's SOC counties. Implementation by non-SOC counties began in 1996 and statewide implementation is expected in 1998. A significant feature of this system is the value to the clinician, consumer, and family in the treatment planning.

The Performance Outcome System for Adults and Older Adults are undergoing pilot testing in several counties. The results will provide the state, counties and the CMHPC with information on the feasibility of using a variety of standardized instruments to measure consumer functioning, quality of life, consumer satisfaction, and the cost effectiveness of services.

The performance outcome programs have been designed to be dynamic systems which lead to quality improvement and cost-effective services which directly involve the recipient of services and his/her support network in treatment planning. The identification of "best practices" is a long-term goal.

THE ROLE OF SUPPORTIVE SERVICES

The Department of Mental Health and the state mental health delivery system depend on the support of the Department's administrative services staff. Administrative Services is comprised of six units: **Special Projects, Office of Regulations, Financial Services, Human Resources, County Financial Program Support, and Information Technology.** Special Projects has responsibility for strategic planning, mentor program, policy development and implementation. The Office of Regulations is responsible for all aspects of regulation development in accordance with the Administrative Procedure Act. Financial Services has responsibility for development of the Department's annual budget and for contracts and records management. Human Resources has responsibility for personnel transactions, employee safety and training, labor relations and business services. County Financial Program Support develops and implements policies for Short-Doyle/Medi-Cal and block grant programs, and monitors the distribution of sales tax and vehicle license fees to counties. They also develop and review annual county cost reports and conduct year-end settlements with each county. Information Technology assists in enhancing the delivery of mental health services through state-of-the-art technology.

Program Compliance is comprised of four units: **Licensing and Certification, Medi-Cal Oversight, Audits, and Preadmission Screening and Resident Review (PASARR).** Licensing and Certification licenses Psychiatric Health Facilities and Mental Health Rehabilitation Centers, and certifies programs in Skilled Nursing Facilities/Special Treatment Programs and Community Residential Treatment Systems facilities. Medi-Cal Oversight conducts on-site reviews of 58 community mental health programs and certifies eligible mental health providers for Medi-Cal participation. Fiscal Audits is responsible for conducting financial and compliance audits of public and private organizations providing mental health services in the state of California. PASARR is the oversight function of a federally mandated screening process to determine at admission whether nursing facility (NF) referrals and residents with a diagnosis of serious mental illness are in need of NF care and/or psychiatric specialized services.

The Director's Office consists of a cluster of offices, **Legislation, Human Rights, Legal Services, and Community and Consumer Relations and Multicultural Services**. The Office of Legislation produces legislative documents which: 1) provide information to the Governor's Office and the Legislature regarding the impact of proposed changes to existing statute; 2) provide implementation plans for new laws; 3) propose changes or modifications to existing statute; and 4) report information to the Legislature. The Office of Human Rights ensures that mental health laws, regulations and policies regarding the rights of recipients of mental health services are observed. The office also ensures that employees of DMH and applicants have equal employment opportunities. The

Office of Legal Services provides legal services to the Department including: providing legal advice, representation at administrative/personnel hearings, acting as liaison with the Office of the Attorney General, state and local agencies and the federal government, and providing investigative services. The Office of Community and Consumer Relations serves as the Department's public information office, and ensures a client-centered approach to policy making and service delivery. The office also facilitates the partnership relationship with the statewide mental health constituency including mental health directors, minority service coordinators, client and family groups, and local boards and commissions. The Department established the Office of Multicultural Services in December 1997. The duties and responsibilities of the Office of Multicultural Services include: promoting cultural competence and leadership within California's public mental health system, developing a cultural competence plan for the Department of Mental Health in order to achieve a culturally competent workforce, working with professional schools to address cultural competence curriculum, developing policy and procedures addressing issues of cultural and linguistic competence to improve the quality and appropriateness of mental health services in California, and supporting the development of cultural competence in the implementation of managed care.