Mental Health Services Act Expenditure Report

Fiscal Year 2007 – 2008

A Report to the Legislature in Response to

AB 131, Omnibus Health Budget Trailer Bill
Chapter 80, Statutes of 2005

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Fiscal Year 2007 – 2008

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EXECUTIVE SUMMARY

The passage of Proposition 63, the Mental Health Services Act (MHSA) in November 2004 provides an opportunity to increase funding, personnel and other resources to support county mental health programs and monitor progress toward statewide goals for serving children, transition age youth, adults, older adults and families with mental health needs. The MHSA addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support the local mental health system.

The MHSA imposes a 1 percent income tax on personal income in excess of $1 million. This new tax has generated more than $2.1 billion in additional revenues for mental health services through the end of Fiscal Year (FY) 2006-07 and is anticipated to generate an additional $1.6 billion in FY 2007-08 and $1.7 billion in FY 2008-09 based on the Governor's Proposed Fiscal Year 2008-09 Budget, which equates to $1.5 billion in FY 2007-08 and $1.5 billion in FY 2008-09 on cash basis.

In addition to local planning, the MHSA specifies five major components of a three-year plan around which the Department of Mental Health (DMH) has created an extensive stakeholder process to consider input from all perspectives. Because of the complexity of each component, implementation of the five components is being staggered. More than $640 million has been distributed to local agencies through the end of FY 2006-07. An additional $1.5 billion is anticipated to be distributed in FY 2007-08 and $1.5 billion is anticipated for FY 2008-09 to continue a phased implementation of the MHSA components.

ISSUE STATEMENT

This fiscal report to the Legislature is required by Assembly Bill 131 (Chapter 80, Statutes of 2005), which specifies that the Director of the California Department of Mental Health (DMH) shall submit to the Legislature information regarding the projected expenditure of Proposition 63 funding for each state department, and for each major program category specified in the measure for local assistance and support. The report includes actual local assistance expenditures for FY 2006-07, estimated expenditures for FY 2007-08, and projected expenditures for FY 2008-09.

DMH is required to annually submit two fiscal reports on the MHSA, one in January and the other in conjunction with the Governor's May Budget Revision. DMH has been complying with this mandate since January 2006. In addition to providing information on expenditures, this report provides specific information regarding achievements to date and implementation activities planned for FY 2007-08.

BACKGROUND

A broad continuum of prevention, early intervention and service needs are addressed in the MHSA. The Act also provides for the necessary capital facilities, technology and training elements that will effectively support the local mental health system.

By imposing a 1 percent income tax on personal income in excess of $1 million, the MHSA was projected to generate approximately $254 million in FY 2004-05, $683 million in FY 2005-06, $690 million in FY 2006-07 and increasing amounts thereafter. These were the initial estimates of revenue to be generated by the additional tax. The actual amount collected through the end of FY 2006-07 is more than $2.1 billion. This includes both the income tax payments and interest income earned on the MHS Fund balance.

Table 1 shows actual and estimated MHSA revenue receipts deposited into the Mental Health Services (MHS) Fund, by revenue type in the "Total All Components Section." This revenue is shown below apportioned into the major program categories using the percentages specified in Welfare and Institutions Code (WIC) Section 5892. Actual receipts are shown for FY 2004-05 through FY 2006-07, while estimated receipts are shown for FY 2007-08 and FY 2008-09.

Table 1: Mental Health Services Act (MHSA) Estimated Revenue Receipts
Estimated Based on Governor's Proposed Fiscal Year 2008-09 Budget
(Dollars in Millions)

	Fiscal Year				
	Actual Receipts			Estimated Receipts	
	2004-05	2005-06	2006-07	2007-08	2008-09
Total - All Components					
Cash Transfers	$169.5	$894.6	$938.8	$948.0	$995.0
Annual Adjustment Amount*	$83.6	$0.0	$0.0	$423.7	$436.0
Interest Income	$0.7	$11.2	$40.4	$90.3	$94.6
Estimated Available Revenue	**$253.8**	**$905.8**	**$979.2**	**$1,462.0**	**$1,525.6**
Local Planning					
Cash Transfers	$8.5				
Annual Adjustment Amount	$4.2				
Interest Income	$0.0				
Estimated Available Revenue	**$12.7**				
Community Services and Supports (Excluding Innovation)					
Cash Transfers		$467.4	$490.5	$495.3	$718.4
Annual Adjustment Amount		$0.0	$0.0	$221.3	$314.8
Interest Income		$5.9	$21.2	$47.2	$68.3
Estimated Available Revenue		**$473.3**	**$511.7**	**$763.8**	**$1,101.5**
Workforce Education & Training					
Cash Transfers	$76.3	$89.5	$93.9	$94.8	
Annual Adjustment Amount	$37.6	$0.0	$0.0	$42.4	
Interest Income	$0.3	$1.1	$4.0	$9.0	
Estimated Available Revenue	**$114.2**	**$90.6**	**$97.9**	**$146.2**	
Capital Facilities and Technological Needs					
Cash Transfers	$76.3	$89.5	$93.9	$94.8	
Annual Adjustment Amount	$37.6	$0.0	$0.0	$42.4	
Interest Income	$0.3	$1.1	$4.0	$9.0	
Estimated Available Revenue	**$114.2**	**$90.6**	**$97.9**	**$146.2**	

*Annual adjustment amount is determined in accordance with Section 19602.5(c) of the Revenue and Taxation Code. This amount is deposited into the State Mental Health Services Fund and is available for distribution two years after the revenues are earned with the exception of FY 2004-05 in which funds were considered available in FY 2004-05.

Table 1: Mental Health Services Act (MHSA) Estimated Revenue Receipts (Continued)

	Fiscal Year				
	Actual Receipts			Estimated Receipts	
	2004-05	2005-06	2006-07	2007-08	2008-09
Prevention & Early Intervention (Excluding Innovation)					
Cash Transfers		$170.0	$178.4	$180.1	$179.5
Annual Adjustment Amount		$0.0	$0.0	$80.5	$78.7
Interest Income		$2.1	$7.7	$17.2	$17.1
Estimated Available Revenue		**$172.1**	**$186.1**	**$277.8**	**$275.3**
Innovation for Community Services and Supports					
Cash Transfers		$24.6	$25.8	$26.1	$37.8
Annual Adjustment Amount		$0.0	$0.0	$11.7	$16.6
Interest Income		$0.3	$1.1	$2.5	$3.6
Estimated Available Revenue		**$24.9**	**$26.9**	**$40.3**	**$58.0**
Innovation for Prevention & Early Intervention					
Cash Transfers		$8.9	$9.4	$9.5	$9.5
Annual Adjustment Amount		$0.0	$0.0	$4.2	$4.1
Interest Income		$0.1	$0.4	$0.9	$0.9
Estimated Available Revenue		**$9.0**	**$9.8**	**$14.6**	**$14.5**
State Administration					
Cash Transfers	$8.5	$44.7	$46.9	$47.4	$49.8
Annual Adjustment Amount	$4.2	$0.0	$0.0	$21.2	$21.8
Interest Income	$0.0	$0.6	$2.0	$4.5	$4.7
Estimated Available Revenue	**$12.7**	**$45.3**	**$48.9**	**$73.1**	**$76.3**

MHSA estimated revenues are prepared twice a year in January and May by the California Department of Finance as part of the State Budget process. The revenue estimates encompass a two year period (current fiscal year and budget fiscal year). The distribution percentage for each component is from the MHSA (Welfare and Institutions Code Section 5892).

Explanation of Estimated Revenues

The revenues in the preceding Table 1 represent deposits into the MHS Fund on a cash-flow basis. The Governor's Budget, prepared using generally accepted accounting standards, must show the revenue as earned, and therefore, shows accruals for revenues not yet received by the close of the fiscal year. The chart below provides a comparison between estimated revenues on an accrual basis for the Governor's Budget versus cash deposits into the MHS Fund in each fiscal year.

As shown in the chart below, "Cash Transfers" are the same under either accounting approach. These amounts represent the net personal income tax receipts transferred into the MHS Fund in accordance with Revenue and Taxation Code Section 19602.5(b). The accrued revenue shown in the Governor's Budget will not actually be deposited into the MHS Fund until two fiscal years after the revenue was earned. Also, the interest earned on monies in the MHS Fund in the fourth quarter of each fiscal year is not deposited into the MHS Fund until the next fiscal year.

Comparison between Mental Health Services Act Estimated Receipts And Governor's Budget

(Dollars in Millions)

	Fiscal Year		
	2006-07	**2007-08**	**2008-09**
Governor's Proposed FY 2008-09 Budget			
Cash Transfers	$939.0	$948.0	$995.0
Annual Adjustment Amount	$436.0	$545.0	$570.0
Interest Income Earned During Fiscal Year	$58.4	$94.6	$94.6
Estimated Revenues-Governor's Proposed FY 2008-09 Budget	**$1,433.4**	**$1,587.6**	**$1,659.6**
Estimated Receipts-Cash Basis			
Cash Transfers	$938.8	$948.0	$995.0
Annual Adjustment Amount	$0.0	$423.7	$436.0
Interest Income Posted During Fiscal Year	$40.4	$90.3	$94.6
Estimated Available Receipts	**$979.2**	**$1,462.0**	**$1,525.6**

Components of the MHSA

The MHSA specifies five major components of a three-year plan, which DMH's regulations refer to as the Three-Year Program and Expenditure Plan (Three-Year Plan or Plan). DMH has created an extensive stakeholder process for developing this Plan at both the state and local levels to consider input from all perspectives. Local planning efforts involve clients, families, caregivers and partner agencies in identifying community issues related to mental illness and resulting from lack of community services and supports. These efforts also serve to define the populations to be served and the strategies that will be effective for providing the services, to assess capacity, and to develop the work plan and funding requests necessary to effectively deliver the needed services.

Because of the complexity of each of the MHSA components, implementation of the components is being staggered. For each component, the stakeholder process involves the development of discussion documents and a series of general stakeholder meetings and topic-specific workgroups to provide input on critical issues and to advise on implementation policies and processes. Each component addresses critical needs and priorities to improve access to effective, comprehensive, culturally and linguistically competent, expanded county mental health services and supports. Improvement in client outcomes is a fundamental expectation throughout the implementation process. The MHSA specifies the percentage of funds to be devoted to each of the components and requires DMH to establish the requirements for use of the funds.

- **Community Services and Supports (CSS)**—"System of Care Services" described in the MHSA is now called "Community Services and Supports." The CSS are the programs, services, and strategies that are being identified by each County Mental Health Department (County) through its stakeholder process to serve unserved and underserved populations, with an emphasis on eliminating disparity in access and improving mental health outcomes for racial/ethnic populations and other unserved and underserved populations.

- **Workforce Education and Training**—This component targets workforce development programs to remedy the shortage of qualified individuals to provide services to address severe mental illnesses.

- **Capital Facilities and Technological Needs**—This component addresses the capital infrastructure needed to support implementation of the Community Services and Supports and Prevention and Early Intervention programs. It includes funding to improve or replace existing technology systems and for capital projects to meet program infrastructure needs.

- **Prevention and Early Intervention (PEI)**—This component supports the design of programs to prevent mental illnesses from becoming severe and disabling,

with an emphasis on improving timely access to services for unserved and underserved populations.

- **Innovation (5 percent of CSS and 5 percent of PEI)**—The goal of this component is to develop and implement promising practices designed to increase access to services by underserved groups, increase the quality of services, improve outcomes, and to promote interagency collaboration.

Table 2 on the following page displays actual expenditures for FY 2006-07, the estimated budget for FY 2007-08, and the projected budget for FY 2008-09.

Table 2: Mental Health Services Act Expenditures
January 2008

	Actual FY 06-07	Estimated FY 07-08	Projected FY 08-09
State Administrative Costs:*			
Department of Mental Health (DMH)	$15,900,000	$33,007,912	$30,507,912
Mental Health Services Oversight and Accountability Commission (MHSOAC)	$1,028,000	$3,247,088	$3,247,088
Department of Rehabilitation (DOR)	$76,000	$214,000	$209,000
Managed Risk Medical Insurance Board (MRMIB)	$89,000	$158,000	$179,000
State Controller's Office (SCO)	$43,000	$49,000	$42,000
Department of Social Services (DSS)	$394,000	$803,000	$767,000
Department of Education (CDE)	$592,000	$731,000	$707,000
Department of Alcohol & Drug Programs (DADP)	$258,000	$517,000	$507,000
Department of Aging (CDA)	-	$95,000	$95,000
Department of Health Care Services (DHCS)	$70,000	$581,000	$795,000
Department of Consumer Affairs Regulatory Boards (DCA)	-	107,000	$299,000
Administrative Office of the Courts (AOC)	-	-	$431,000
Department of Developmental Services (DDS)	-	-	$1,118,000
Total Administration	**$18,450,000**	**$39,510,000**	**$38,904,000**

Local Assistance:			
Local Planning	-	-	-
Community Services & Supports (CSS) **	$352,073,000	$975,500,000	$921,400,000
Workforce Education & Training	-	$127,700,000	$172,300,000
Capital Facilities & Technological Needs	-	$300,000,000	$148,900,000
Prevention and Early Intervention**	-	$90,200,000	$250,800,000
Total Local Assistance	**$352,073,000**	**$1,493,400,000**	**$1,493,400,000**

GRAND TOTAL	**$370,523,000**	**$1,532,910,000**	**$1,532,304,000**

Prevention & Early Intervention (P/EI)**	-	$90,200,000	$217,400,000
P/EI Innovation**	-	-	$33,400,000
Total P/EI	-	**$90,200,000**	**$250,800,000**

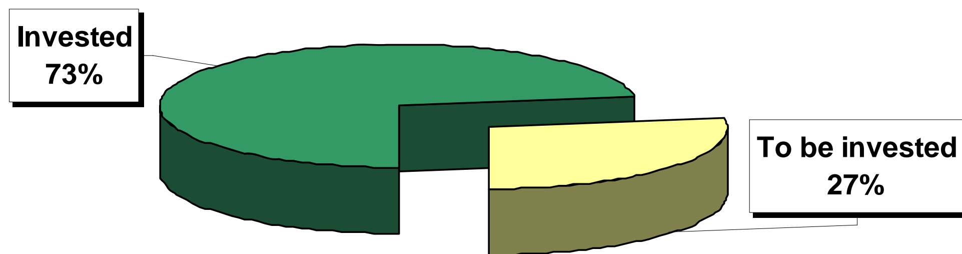
CSS**	$352,073,000	$975,500,000	$829,300,000
CSS Innovation**	-	-	$92,100,000
Total CSS	**$352,073,000**	**$975,500,000**	**$921,400,000**

P/EI Innovation**	-	-	$33,400,000
CSS Innovation**	-	-	$92,100,000
Total Innovation	-	-	**$125,500,000**

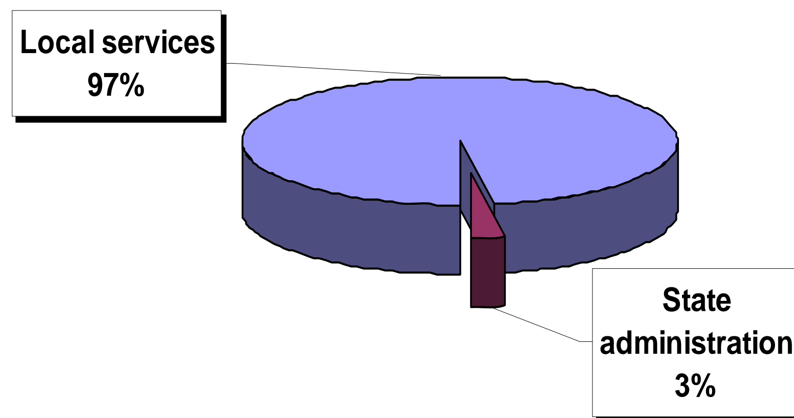
* The MHSA allows 5 % of the total annual revenue received for the Fund for costs incurred by DMH, the MHSOAC, and the MHPC in implementing duties pursuant to MHSA programs.
** Includes funds available for Innovative Programs pursuant to Welfare and Institutions Code Section 5892(a)(6).

The following charts reflect the detail of funding for MHSA statewide through September 30, 2007. These charts demonstrate that the majority of MHSA funds statewide have been invested and that these investments have been in local services rather than State administration.

Three-quarters of MHSA Funds Invested*



Most MHSA Funds Invested in Local Services*



*Investments include distributions and commitments.

Overall, as of September 30, 2007, more than $2.7 billion has been deposited into the MHS Fund, $725 million has been distributed to local agencies for Local Planning and CSS, and more than $1.2 billion has been committed for CSS, WET and PEI. More recently, $345 million was committed for Capital Facilities and Technological Needs pending the release of the Plan requirements.

Mental Health Services Fund Status
By Component, through September 30, 2007
(Dollars in Millions)

Component	Resources	Distributions	Commitments	To Be Invested
Local Planning	$12.7	$12.7		
Community Services & Supports[a]	1,387.3	712.3	573.3	101.7
Innovation - Community Services & Supports	69.6			69.6
Workforce Education & Training	367.4		200.0	167.4
Capital Facilities & Technology	367.4			367.4
Prevention & Early Intervention	481.0		481.0	0.0
Innovation - Prevention & Early Intervention	25.3			25.3
State administration	74.9	42.6	9.0	23.3
Total	**$2,785.6**	**$767.6**	**$1,263.3**	**$754.7**

Notes:
[a] Includes redistribution of $64.4 million from unauthorized State administration funding.
"Resources" = Actual deposits, including accrued revenue from prior years and interest earned.

STATE ADMINISTRATIVE EXPENDITURES

In addition to DMH and the Mental Health Oversight and Accountability Commission (MHSOAC), eight state departments, the Managed Risk Medical Insurance Board (MRMIB), the State Controller's Office (SCO), and the Administrative Office of the Courts (AOC) will be allocated MHSA funding in 2008-09. The eight departments are the Department of Rehabilitation (DOR), the Department of Social Services (DSS), the Department of Education (CDE), the Department of Alcohol and Drug Programs (ADP), the Department of Aging (CDA), the Department of Health Care Services (DHCS), the Department of Consumer Affairs (DCA) Board of Behavioral Sciences, and the Department of Developmental Services (DDS). Refer to Table 2 on Page 10 for detail on state support funding for FY 2006-07, FY 2007-08, and FY 2008-09.

DMH (FY 2006-07: $15,900,000; FY 2007-08: $33,007,912; FY 2008-09: $30,507,912): to continue its statutory requirement to implement and administer the MHSA by funding the conversion of limited term positions to permanent positions, resources to absorb the increased workload, and the overall support for implementation of all MHSA components, as well as funding for the MHSOAC.

- **MHSOAC** (FY 2006-07: $1,028,000; FY 2007-08: $3,247,088; FY 2008-09: $3,247,088): to support the increase in operating costs and contracts associated with statutory requirements to provide oversight of the MHSA.

Table 3, State Administrative Costs, Department of Mental Health ONLY, page 17, details expenditures for FY 2006-07 and FY 2007-08.

DOR (FY 2006-07: $76,000; FY 2007-08: $214,000; FY 2008-09: $209,000): to assist DMH in implementing its duties pursuant to the CSS program by paying for two positions to provide information and technical assistance to numerous counties and DOR districts to aid in the development of new or expanded cooperative contracts and new collaborative relationships. The purpose of this allocation is to ensure that the appropriate state and county agencies give full consideration to concerns about quality, structure of service delivery, and access to services. During FY 06/07 DOR staff held discussions with DOR's Independent Living section staff to facilitate information and resource sharing between Independent Living Centers (ILCs) and county mental health programs. ILCs provide direct services to all people with disabilities including advocacy, independent living skills training, community referrals, and benefits counseling. The ILCs were provided information about local mental health programs to facilitate local relationships and to increase the number of clients with mental illness served through the local ILCs. During FY 06/07, the DMH/DOR collaboratively funded 112 days of training and technical assistance in 20 different counties. These trainings were designed to support local County efforts to implement the MHSA and reinforce the recovery model consistent with MHSA philosophy and intent. In addition, they encourage and foster the development of local relationships between county mental health and DOR to serve mutual clients and blend staff and resources to maximize funding.

MRMIB (FY 2006-07: $89,000; FY 2007-08: $158,000; FY 2008-09: $179,000): to assist DMH in implementing its duties pursuant to the CSS program by paying for one position to ensure effective coordination of services and collaboration between providers and administrators providing services to children who are Seriously Emotionally Disturbed (SED) in the Healthy Families Program (HFP). The purpose of this allocation is to ensure that the appropriate state and county agencies give full consideration to concerns about quality, structure of service delivery, and access to services. Accomplishments in FY 06-07 included completion of an implementation timeline for the recommendations from the University of California, San Francisco (UCSF) report "The Healthy Families Program and the Seriously Emotionally Disturbed (SED) Carve-Out;" completion of the "2004 Healthy Families Program Mental Health Utilization Report;" and development of mental health fact sheets, including information such as mental health screening and assessment, provision of alcohol and drug services once the benefit limits have been reached, use of subcontractors for mental health services, substitution of benefits, provision of SED services if the county has a waiting list, and assignment of mental health liaisons. MRMIB also joined the Co-Occurring Joint Action Council (COJAC).

SCO (Human Resource Management System) (FY 2006-07: $43,000; FY 2007-08: $49,000; FY 2008-09: $42,000): to assist DMH in implementing its duties pursuant to the CSS program by paying for the new Human Resource Management System (HRMS)/Payroll system, also known as the 21st Century Project, which replaces the existing SCO employment and payroll systems. The new HRMS is expected to improve business practices and streamline administrative operations. Special fund sources are assessed their share of the cost of developing the systems to implement the newly required business process changes.

DSS (FY 2006-07: $394,000; FY 2007-08: $803,000; FY 2008-09: $767,000): to assist DMH in implementing its duties pursuant to the CSS program by paying for five positions to provide essential leadership, oversight, and expertise to social services and mental health partners at both state and local levels in order to ensure that Counties meet requirements of the MHSA and WIC Section 18250, commonly referred to as Senate Bill 163 Wraparound. The purpose of this allocation is to ensure that the appropriate state and county agencies give full consideration to concerns about quality, structure of service delivery, and access to services. Staff are engaged in projects that further support and expand the availability of intensive services for children and families. DSS was involved with DMH in ongoing MHSA Three-Year Program and Expenditure Plan reviews as well as Prevention and Early Intervention component activities.

CDE (FY 2006-07: $592,000; FY 2007-08: $731,000; FY 2008-09: $707,000): to assist DMH in implementing its duties pursuant to the CSS program by funding three positions and contract funds to implement a project entitled "Building Collaboration for Mental Health Services in California's Schools." The objectives of this project are to develop strategic partnerships between the mental health and education communities,

beginning with superintendents and mental health directors. The purpose of this allocation is to ensure that the appropriate state and county agencies give full consideration to concerns about quality, structure of service delivery, and access to services. The eleven regional training events for FY 2007-08 are currently underway with the goal of providing resources on mental health in schools and developing and strengthening collaborative efforts between the two systems. CDE reappropriated $289,000 to FY 2007-08 to provide training to local education agencies on various aspects of the MHSA, through a Spring Finance Letter. The reappropriation was requested and approved due to start-up delays in contracting for the delivery of the training.

ADP (FY 2006-07: $258,000; FY 2007-08: $517,000; FY 2008-09: $507,000): to assist DMH in implementing its duties pursuant to the PEI and CSS programs by funding two positions, one to focus on prevention issues and the other on treatment. The major work of ADP, through its Co-Occurring Disorders (COD) Unit, is to implement interagency initiatives of the Mental Health Services Act. The purpose of this allocation is to ensure that the appropriate state and county agencies give full consideration to concerns about quality, structure of service delivery, and access to services. Accomplishments for FY 06-07 included: creation of Websites for COD and the COJAC, development of the COJAC Screening Tool, development of a Funding Matrix that indicates available funding sources for COD treatment, ongoing staff support from the COD unit to the COJAC Policy Council, COJAC Workgroup and the five COJAC subcommittees, and development of potential collaboration strategies for Alcohol and Other Drug treatment and prevention providers.

CDA (FY 2006-07: $0; FY 2007-08: $95,000; FY 2008-09: $95,000): to assist DMH in implementing its duties pursuant to the CSS program by providing CDA with $95,000 through a Spring Finance Letter to fund one position to coordinate efforts to improve access to mental health services for older adults with disabilities. The purpose of this allocation is to ensure that state and county agencies give full consideration to concerns about access to services for clients and their families.

DHCS (FY 2006-07: $70,000; FY 2007-08: $581,000; FY 2008-09: $795,000): to assist DMH in implementing its duties pursuant to the CSS program by funding one position to address increased workload in Medi-Cal as a result of the MHSA. Examination of potential changes in Medi-Cal requirements (including waiver amendments and subsequent program evaluation) to promote consistency with the MHSA vision and values is a primary objective. This allocation also supports three positions to manage and support a contract to develop and implement the interdepartmental California Mental Health Disease Management (CalMEND) program. The primary goal of CalMEND is to improve mental health outcomes, while managing costs for persons with certain severe mental disorders served by the State of California departments and agencies.

DCA (FY 2006-07: $0; FY 2007-08: $107,000; FY 2008-09: $299,000): to assist DMH in implementing its duties pursuant to the WET program by funding one position to serve as a liaison to DMH to help ensure that educational and examination requirements for licensure of various disciplines within the State's mental health workforce continue to be relevant within a transforming system. DCA will also address workforce issues that limit consumer access to mental health services.

DDS (FY 2006-07: $0; FY 2007-08: $0; FY 2008-09: $1,118,000): to assist DMH in implementing its duties pursuant to the CSS program by implementing services and trainings at the local level to more effectively address the needs of consumers who have both a developmental disability and a co-occuring mental illness (dually diagnosed). The purpose of this allocation is to ensure that state and county agencies give full consideration to concerns about the quality and structure of services. Funds will provide consultation services, Service Provider, and Family/Consumer training, Best Practice training, and launching regional planning projects.

AOC (FY 2008-09: $431,000): to assist DMH in implementing its duties pursuant to the CSS program by supporting two positions to address the increased workload related to mental health issues in the courts and to develop a research component to evaluate court appointed programs for people with mental illness. These positions will assist the courts in their efforts to respond more effectively to people with mental illness involved in the court by identifying best practices, conducting needs assessments, analyzing cost-benefit outcomes of court programs and services, and collaborating with a variety of stakeholders, including local departments of mental/behavioral health, treatment/service providers, and court users and their families.

Table 3: State Administrative Costs
Department of Mental Health ONLY (Excludes MHSOAC)
Fiscal Years 2007-08 and 2008-09

FISCAL YEAR (FY) 2007-08

	FY 2007-08
Personal Services	$11,868,912
Operating Expenses	$6,107,000
Contracts	414,740,000
Current Year Total at 2007-08 Budget Act	**$32,715,912**
The following adjustments were reflected in the 2008-09 Governor's Budget for FY 2007-08	
Current Year Total at 2007-08 Budget Act	**$32,715,912**
Increases	
MO1 CEA GSI Allocations (Personal Services)	$3,000
Employee Compensation Drill (Personal Services)	$320,000
Total Increases	**$323,000**
Subtotal	**$33,038,912**
Decreases	
DTS Rate Adjustment	-$31,000
Total Decreases	**-$31,000**
Current Year Total at Governor's Budget	**$33,007,912**

FISCAL YEAR (FY) 2008-09

The following adjustments were reflected in the Governor's Budget for FY 2008-09:	FY 2008-09
Current Year Total at 2007-08 Budget Act	**$32,715,912**
Increases:	
Employee Compensation	$350,000
MO1 CEA GSI Allocation (Personal Services)	$3,000
ProRata Adjustment	$390,000
Operating Expenses Price Increase	$693,000
Total Increases	**$1,436,000**
Subtotal	**$34,151,912**
Decreases:	
Less one-time costs eliminated from the FY 2008-09 Budget:	
Operating Expenses	-$3,613,000
DTS Adjustment	-$31,000
Total Decreases	**-$3,644,000**
Budget Year Total at Governor's Budget	**$30,507,912**

IMPLEMENTATION ACTIVITIES IN FY 2006-07 and FY 2007-08

Stakeholders Process

Since passage of the Mental Health Services Act in November 2004, DMH has committed to an extensive and transparent stakeholder process, beginning with its first General Stakeholders Meeting held in December 2004. As of May 2007, DMH has convened twenty-five (25) general and workgroup-specific stakeholders meetings and twenty-three (23) statewide conference calls. The summer and early fall of 2007 also proved to be a busy time with DMH convening an additional 18 meetings/forums throughout the State to solicit input from stakeholders on various MHSA components and programs. In addition, DMH continues to encourage stakeholders to provide input on MHSA-related issues and policies through the general MHSA email address, the toll-free MHSA phone line, and the MHSA Website.

Community Services and Supports

CSS refers to "System of Care Services" as required by the MHSA in Welfare and Institutions Code Sections 5813.5 and 5878.1 to 5878.3. The change in terminology differentiates MHSA Community Services and Supports from existing and previously existing System of Care programs funded at the federal, state and local levels. The MHSA requires that "each county mental health program shall prepare and submit a three-year plan which shall be updated at least annually and approved by the DMH after review and comment by the Oversight and Accountability Commission." The MHSA further requires that "the department shall establish requirements for the content of the plans." Annual updates of the County three-year plan will be required pursuant to MHSA requirements. The requirements for the content of the Plans and the emergency regulations can be located on the DMH Website at: http://www.dmh.ca.gov/mhsa.

DMH developed guidelines for the Three-Year Program and Expenditure Plan for CSS with stakeholder participation in early 2005 and released them in final form on August 1, 2005. No specific due date was provided for Counties to submit their Three-Year Program and Expenditure Plans and, as of November 2007, fifty-seven (57) County Plans have been received and fifty-five (55) Plans have been approved for funding. Table 4 on the following page indicates the status of MHSA implementation as of November 2007.

Table 4: Mental Health Services Act Implementation as of November 2007

Community Services and Supports	Plans Submitted	Plans Approved
Community Program Planning	59	59
Initial Plan	57	55
FY 07/08 Initial Expansion $114.5M	30	19*
FY 07/08 One-Time Augmentation $64.4M	1	0
MHSA Housing Program	0	0

* As of November 2007, the remaining 11 are still under review.

Governor's Homeless Initiative

The Governor's Homeless Initiative (GHI) was established as a result of the passage of Proposition 46 and leverages MHSA funds to encourage development of supportive housing projects that target chronically homeless individuals with serious mental illness. Proposition 46 allocated approximately $38 million for use under this program. An additional $3.15 million from MHSA funds in FY 2005-06 were set aside to provide funding for rental subsidies and pre-development costs. This GHI does not provide a specific date for applications to be submitted and it provides for a non-competitive application process.

Counties are an essential component of this effort to maximize housing options for individuals eligible for services under the MHSA and they must provide a long-term commitment to fund supportive services for a project to qualify for approval under the Governor's Homeless Initiative. To date, over $19 million in GHI funds has been awarded to seven projects located throughout California. Approximately $17 million remain available for new projects. Housing projects funded under this program are eligible for limited, designated operating subsidies. DMH will transfer $697,500 in subsidies to the Department of Housing and Community Development (HCD) this fiscal year for projects approved for funding and ready for occupancy. Additional funding will be available in future years for future projects.

Mental Health Services Act Housing Program

California counties have committed $400 million for the MHSA Housing Program to finance the capital costs associated with development, acquisition, construction, and/or rehabilitation of permanent supportive housing for individuals with mental illness and their families, with special emphasis on homeless individuals. This funding for the MHSA Housing Program will also make available needed resources for operating subsidies. Eight percent of both capital funds and operating subsidies will be set aside for small Counties to ensure that the program addresses their unique needs.

This effort builds on the interagency collaboration established in November 2005 with the Governor's Homeless Initiative. The program is to be jointly administered by the Department of Mental Health and the California Housing Finance Agency (CalHFA), on behalf of county mental health departments, with the advice and assistance of an implementation work group. For the past year, DMH and CalHFA have worked closely with the MHSA Housing Program work group to develop the technical requirements and process for applying for the MHSA funds that have been designated for the new program. The work group includes representatives of the California Mental Health Directors Association (CMHDA), the Governor's Office, the Department of Housing and Community Development (HCD), the Tax Credit Allocation Committee (TCAC), the Corporation for Supportive Housing (CSH), and Housing California, as well as several housing developers.

Following a statewide MHSA stakeholder process and presentations to the MHSOAC, the MHSA Housing Program application was released in August 2007. DMH and CalHFA have conducted a series of MHSA Housing Program Application Workshops in key locations throughout California as well as a range of training activities focused on understanding all aspects of this new permanent supportive housing program. Applications for the MHSA Housing Program will be submitted on an ongoing basis and will be reviewed by both DMH and CalHFA.

MHSA Implementation Study

DMH contracted with a study team to explore the planning and early implementation of the CSS component of the MHSA. The study team brought together people with consumer and family member experience and individuals involved in public mental health leadership, management, research and evaluation, and cultural competence. The overall purpose of the study was to gain useful knowledge about what transpired thus far in the ongoing implementation process of CSS as well as the early development of other MHSA components. The study is being conducted in three phases. Two phases have been completed. The first phase of the study was documented in the report entitled, *Mental Health Services Act Implementation Study: Community Services and Supports State Planning Process,* completed in June 2007. This report covered preliminary findings about the state's planning process, its CSS plan guidelines, and CSS plan review process. A second phase of the study was documented in the report entitled, *Mental Health Services Act Implementation Study: Planning and Early Implementation of Community Services and supports in Seven Counties,"* completed in November 2007. This report covered the planning and early implementation in selected Counties.

Results of the study to-date have been mixed. In general, the overall impression from the Counties was that enthusiasm and commitment to the CSS effort was extremely high. Expectations for increases in services, particularly among those who had been active in supporting the proposition, were positive. The first transformational feature recognized by study participants was the unprecedented planning process undertaken

by DMH for the implementation of the CSS component. DMH undertook an eight-month planning effort which engaged a broader range of constituencies than any previous planning process. The level of involvement, particularly of adult consumers, marked a turning point for the State's public mental health system.

On the other hand, the planning process drew substantial attention to the issue of disparities among ethnic populations and promoted a deeper level of understanding of the issues underlying these disparities. It was generally felt that efforts to engage representatives of diverse ethnic/cultural groups were not sufficiently successful. This experience made clear the need to increase and undertake more appropriate outreach efforts. Based on this feedback, DMH has subsequently enhanced its stakeholder process to include an ethnic-specific process utilizing cultural brokers to engage active participation from certain ethnic and cultural communities and specific processes to obtain feedback from transition aged youth.

Overall, the greatest transformation resulting from CSS implementation is thought to be the increased consumer involvement in planning and services and its anticipated effect on improving the system. The biggest worry expressed by study participants was that overall funding levels will not be sufficient to overcome institutional barriers to making the kinds of changes needed to really transform the current mental health system.

Fiscal Policy Clarification

In December 2007, DMH revised and clarified many of the MHSA fiscal policies in order to simplify program administration and expedite distribution of funds to the Counties. Specifically, DMH streamlined the State/County performance contract (MHSA Agreement), changed many of the cash management policies, and provided guidance on the use of unexpended funds from prior years.

DMH included provisions in the MHSA Agreement with Counties to allow the addition of funding to the MHSA Agreement upon approval of a Plan update. This should expedite the distribution of funding by allowing Counties to rely on Board approval of MHSA Plans and by not requiring Board approval of each successive agreement modification.

DMH is also moving to a cash-based system which ensures that sufficient MHSA funds are available to support the total funding level by component for the subsequent fiscal year. This means that revenues will accumulate for 12 months in the State Mental Health Services (MHS) Fund prior to distribution in the subsequent State fiscal year but will allow substantial cash payments to each County at the beginning of each fiscal year. Under the new fiscal policy, each County will receive 75 percent of the approved annual Plan amount upon Plan approval (and execution of a MHSA Agreement) or at the start of the fiscal year, whichever is later. The remaining 25 percent will be distributed upon submission of required reports, which include the semi-annual Local

MHS Fund Cash Flow Statement and the Annual MHSA Revenue and Expenditure Report. It is envisioned that a County that submits the above reports when due will be able to access the remaining 25 percent of their approved amount by March 1st of the fiscal year.

Another new fiscal policy is the maintenance of a local prudent reserve for CSS. Pursuant to WIC Section 5847, which requires the establishment of a prudent reserve as part of an approved plan, DMH developed financial models to determine the impact on services and programs if MHSA revenues are below recent averages adjusted by changes in the state population and the California Consumer Price Index. Based on these models, DMH, in consultation with the OAC and the CMHDA, determined that a level of 50 percent of the most recent annual approved CSS funding level should be the prudent reserve amount for each County. Each County should maintain the 50 percent prudent reserve at the local level and fully fund the prudent reserve by July 1, 2010, unless the County would have to reduce MHSA services below those funded in FY 2007-08 (including services funded with the FY 2007-08 CSS augmentation and CSS administration) in order to reach the 50 percent prudent reserve.

DMH clarified that MHSA funds should be expended and accounted for on a first-in, first-out (FIFO) basis (i.e., the first dollar distributed to the County is the first dollar spent on services irrespective of the fiscal year). Each County will identify unspent funds and the use of such unspent funds through the annual Plan update process. Unexpended funds will be considered available to fund services in subsequent years and a County may dedicate unspent funds to the local prudent reserve. Each County will also be allowed to retain unspent funds as an operating reserve to allow for unexpected expenditures and/or lower than anticipated off-setting revenues.

A County may subsequently submit a request (through a Plan update) to use funds remaining in prior year Planning Estimates as long as the County can demonstrate sustainability. DMH will review the reasonableness of any such proposals and take into account such factors as: interest earned on the local Mental Health Services fund balance; current and projected costs, including anticipated cost of living increases; caseload growth; anticipated increases in other revenues; whether the expenditure is non-recurring; and/or the impact of other structural reforms such as reduced reliance on higher levels of care.

Training and Technical Assistance

MHSA requires DMH to provide technical assistance and training to Counties. Due to the aggressive timeline for conducting this process, it was critical that consultants with extensive background and knowledge of state and county mental health program issues assist with the development of training principles and products. DMH issued a contract to the California Institute for Mental Health (CiMH) as it has this level of expertise and collaborative working relationship with Counties.

Technical assistance and trainings are being provided to assist Counties with strategies and information necessary to implement the MHSA components, especially the CSS component. Specifically, technical assistance activities include:

- Regional technical assistance meetings for County MHSA Planning Teams focusing on planning and implementation issues;
- Leadership Institutes for medical directors and physicians related to MHSA planning and implementation;
- Project management for planning and implementing the MHSA;
- Building housing partnerships in preparation for housing development projects;
- Regional trainings for members of the Local Mental Health Boards and Commissions to learn about their roles in the MHSA implementation;
- Regional trainings on development and implementation of Full Service Partnerships;
- Regional shared learning sessions for MHSA Coordinators;
- Regional trainings for data and financial staff related to MHSA data and fiscal requirements;
- Video conferences and Web casts to roll out MHSA component requirements;
- Consultation to small Counties on conceptualizing the CSS component of the Three-Year Plan and on Evidence Based Practices;
- Publication of a booklet on stories of the MHSA stakeholder process;
- Development of a curriculum Leadership Institute for consumers, family members and parent partners;
- Transformation Community Learning Collaborative;
- Web casts on specific interventions and programs that can be implemented with MHSA;
- An inventory of trainers and consultants who can help Counties and providers in their MHSA planning and implementation; and,
- Technical assistance for the development of regional Workforce Education and Training collaboratives.

The emphasis for technical assistance has shifted from planning to implementation, starting with the regional meetings of the MHSA Coordinators who meet face-to-face quarterly and by phone in the intervening months. A list of contacts was developed which MHSA Coordinators use to share strategies, policies, job descriptions, etc.

Four two-day trainings on Full Service Partnerships (FSPs) for all ages were conducted throughout the State. One training specifically focused on the needs of small Counties. CiMH conducted a needs assessment of the Counties to identify their training and technical assistance needs for implementing and maintaining FSPs.

A Community Development Team (CDT) involving four to six counties provides technical assistance in the implementation of Wraparound Programs. The CDT planned and implemented a Web cast on Fidelity Monitoring and Outcome Evaluation to discuss the fidelity monitoring and outcome evaluation tools that will be used in the Wraparound Community Development Team project.

Technical assistance has been provided to some small Counties in the planning process for developing the CSS component of the Three-Year Plans. Continuing technical assistance to the small Counties includes telemedicine, primary care collaborations, workforce development, and research on and implementation of evidence-based practices for rural areas.

Development has begun on four videos, one for each of the major racial and ethnic groups to promote the MHSA and assist the Counties in garnering participation from members of these diverse communities.

Four regional trainings were conducted for members of the Local Mental Health Advisory Board/Commission (MHAB/C) in the spring. Trainings were designed to provide training to the Mental Health Board/Commission members on topics related to their role in the implementation of MHSA, utilization of data and orientation for new members of Boards and Commissions.

Four project management workshops were conducted for MHSA Coordinators and their planning/implementation teams, including one specifically for small Counties.

Collaborative efforts are underway with mental health and education leaders in the five CMHDA regions to develop workforce collaborative strategies.

Workforce Education and Training

In the Workforce Education and Training component, the MHSA specifies that each County shall submit to DMH a needs assessment identifying shortages in each professional and other occupational categories and a plan to increase the supply of professional and other staff that county mental health programs anticipate they will require. DMH is required to identify the total statewide needs for each professional and other occupational categories, and develop a five-year education and training development plan (Five-Year Plan).

DMH has continued to work with stakeholders in all policy and program formulations, to include the development of state and county responsibilities in the administration of Workforce Education and Training funds, and the development of budget and funding categories.

DMH has established an initial funding level of $100 million for local Workforce Education and Training efforts and $100 million for proposed State administered projects. Of this total, $15 million has been allocated for planning and early implementation. DMH has released the early implementation funding guidelines. Two thirds of the Counties have applied and been approved for the early implementation funding.

DMH has constructed a comprehensive statewide needs assessment methodology that includes workforce data forms that accompany guidelines to Counties for completing the Workforce Education and Training component of the Three-Year Plans. DMH is also in the process of designing a methodology to evaluate the impact education and training programs are having on the public mental health workforce.

DMH has released guidelines to Counties on how to complete the Workforce Education and Training component of their Plans. To assist Counties in preparing their Plans, DMH has held a series of Regional Roundtables to provide training and technical assistance on the County guidelines.

DMH is continuing to work with the Office of Statewide Health Planning and Development (OSHPD) to streamline the process by which Counties and communities can apply for federal designation as Mental Health Professional Shortage Areas. In 2001, the California Mental Health Planning Council (CMHPC) reported that "counties reported that having a shortage area designation is a powerful recruitment tool." However, many Counties also reported that the process of putting together an application for designation is often lengthy and cumbersome. DMH is therefore working with OSHPD to streamline the application process.

All elements of the Five-Year Plan have now been vetted through the stakeholder process. DMH is working with the CMHPC's Human Resources Committee to ensure that the Five-Year Plan meets the CMHPC's need to evaluate the long-term impact of the Five-Year Plan on the public mental health system.

Statewide contracts with trainers and consultants are continuing through this fiscal year. These are entities that have a proven track record of providing training and technical assistance as envisioned by the Act. These include:

- **Organizational Change Support –** CiMH continues its expanded statewide training and technical assistance mission of supporting county mental health programs. This expansion includes ongoing technical assistance for organizational development toward consumer and family member-driven, evidence-based service delivery as envisioned by the Act, and facilitating regional learning collaborative networks to plan and implement new practices.

- **Financial Incentive Program –** The California Social Work Educational Consortium (CalSWEC) expanded its existing stipend program to provide financial incentives for students in master's level social work programs committed to working in community public mental health. Ninety-five percent (95%) of the one hundred seventy-three (173) graduates available for employment are currently employed in the public mental health system. Similar stipend programs are being proposed for future years.

- **Statewide Constituency Partnerships –** The statewide constituency organizations of the California Network of Mental Health Clients (CNMHC), United Advocates for

Children and Families (UACF), California Mental Health Association (MHA-CA) and the National Alliance for the Mentally Ill – California (NAMI) have expanded their efforts to reach consumers and family members with self-help technical assistance and train-the-trainer curricula, such as Educate, Equip and Support – Building Hope, Peer-to-Peer, Family-to-Family, and Wellness Recovery Action Planning. These curricula will promote the meaningful inclusion and employment of consumers and family members at all levels of the public mental health system.

Additional state administered programs and activities are in the developmental stage. DMH is facilitating a stakeholder process to ensure that these proposed programs and activities adhere to the intent of the MHSA, that counties agree to dedicate their funds for this purpose, and that the authority to establish these programs is obtained.

Capital Facilities

A portion of the MHSA funds from FY 2004-2005 through FY 2007-2008 has been specifically set aside for the Capital Facilities and Technological Needs component of the Three-Year Plan. This is to enable Counties to support their capital facilities and technology needs to provide CSS and PEI services. In subsequent fiscal years, Counties may continue to use a portion of their MHSA CSS funding for Capital Facilities and Technological Needs, as specified in the MHSA.

Each County's plan for the use of Capital Facilities funds should support the goals of the MHSA in a manner consistent with the County's Three-Year Program and Expenditure Plan. The County must clearly show how its planned use of the Capital Facilities funds will produce long-term impacts with lasting benefits that move the mental health system towards the goals of wellness, recovery, resiliency, cultural competence, and expansion of opportunities for accessible community-based services for clients and their families. These efforts should include development of a variety of community-based facilities which support integrated service experiences that are culturally and linguistically appropriate and an increase in peer support and consumer-run services.

Capital Facilities funding will be utilized to acquire, construct, and/or renovate facilities that provide services and/or treatment for those with severe mental illness, or that provide administrative support to MHSA funded programs. DMH will review and approve proposals based on guidelines developed with extensive input from stakeholders and other interested parties. In addition, technical assistance will be provided to Counties to insure proposals are consistent with the Capital Facilities guidelines and the MHSA goals.

In developing the Capital Facilities guidelines, DMH collaborated with the CMHDA and conducted statewide stakeholder meetings which culminated in a statewide conference call on the proposed Capital Facilities guidelines in late spring. DMH anticipates release of final guidelines this winter which will allow Capital Facilities funds to be distributed in 2008.

Technological Needs

The MHSA provides funding for County technology projects that will improve the access and delivery of mental health services. DMH is responsible for ensuring that the MHSA funds are appropriated to County technology projects that are consistent with MHSA goals and objectives and are well-planned, well-managed, and executed properly. In order to allocate funds appropriately, DMH created a process in which Counties submit their technology funding requests for approval in accordance with DMH guidelines. DMH then works directly with each County technology representative (usually the Chief Information Officer) to develop a comprehensive understanding of the technology project and the anticipated results, and make any required modifications prior to approval. Once the approval is granted, funds are released to the County in support of the project. DMH then continues to work in an oversight capacity with the County in order to ensure the project's success.

DMH evaluates and approves technology requests within the context of two goals: 1) modernize and transform clinical and administrative information systems to improve quality of care, operational efficiency, and cost effectiveness, and 2) increase consumer and family empowerment by providing the tools for secure consumer and family access to health information within a wide variety of public and private settings.

The long-term technology goal of DMH is to develop an Integrated Information Systems Infrastructure where all Counties have integrated information systems that can securely access and exchange information. This infrastructure will allow different County systems to share information across a secure network environment both inside and outside their respective counties. Counties and their contract providers, hospital emergency departments, laboratories, pharmacies, and consumers and their families could all securely access and exchange information through the infrastructure. This long-term goal will be achieved as each County assesses its current state of technology readiness and moves through a continuum of improvements over time.

To facilitate the long-term technology transformation, DMH developed minimum statewide standards for mental health Electronic Health Record (EHR) systems. The EHR system is the foundation for an Integrated Information Systems Infrastructure. It is a secure, real-time, point-of-care, client-centric, information resource for service providers. The ability to share timely, accurate and secure access to the client's health and healthcare information is facilitated by the use of uniform standards to transfer information from one source to another. To achieve statewide technology transformation, DMH will periodically specify increasingly complex minimum standards so that Counties and their vendors will be able to adapt their systems while meeting their current business needs.

As with the Capital Facilities component, in developing the Technological Needs guidelines, DMH collaborated with CMHDA and conducted statewide stakeholder meetings and a statewide conference call on the proposed Technological Needs

guidelines. DMH anticipates release of final guidelines this winter which will allow Technological Needs funds to be distributed in 2008.

Prevention and Early Intervention

MHSA authorizes DMH to establish program requirements for the Prevention and Early Intervention (PEI) component of the MHSA. In addition, the MHSA authorizes the MHSOAC to approve program expenditures for PEI. Because of this unique relationship, DMH and MHSOAC continued to work closely together during the past year to develop PEI's program and funding requirements. In January 2007, MHSOAC approved PEI's proposal for principles and funding criteria, which was based on collaboration with DMH, CMHDA, CMHPC, and stakeholders. This document served as the foundation for the development of the "Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan of the MHSA" (also known as the "PEI Guidelines").

DMH conducted two stakeholder meetings in April, one in northern and one in southern California, and a statewide stakeholder conference call in July, to solicit input on the draft PEI program guidelines. DMH contracted with the UC Davis Center for Reducing Health Disparities to obtain input from underserved and ethnic communities, and, through a contract with Pacific News Services, DMH obtained input from focus groups for transition age youth (14 – 25 years of age).

DMH posted the proposed PEI guidelines and all corresponding documents on the DMH website in September 2007. Counties are beginning to initiate their PEI planning process and DMH anticipates that the County will submit the PEI component of their Plan starting in early 2008, with contracts in place and funding released in Spring of 2008.

The Governor directed DMH to convene a Suicide Prevention Plan Advisory Committee to advise DMH on the development of the California Strategic Plan for Suicide Prevention. The committee has met several times. The Strategic Plan is now in draft form and will continue to be reviewed and refined by the committee, incorporating stakeholder input and comments from national experts. Once the advisory committee has completed its draft of the Plan, it will undergo internal review within DMH, then will be reviewed by the Health and Human Services Agency. The Plan will be submitted to the Governor by May 2008, with public distribution planned shortly thereafter.

Innovation

The goals for Innovation funding are to increase access to underserved groups, to increase the quality of services, including better outcomes, to promote interagency collaboration, and to increase access to services.

The MHSA authorizes DMH to establish program requirements for the Innovation component. In addition, the MHSA authorizes MHSOAC to approve the Innovation program expenditures. Because of this unique relationship, DMH and MHSOAC are working closely to craft the program and funding requirements for the Innovation component. MHSOAC convened an Innovation Committee which developed working definitions of Innovation, Innovation Need, and Innovative Response. This work culminated in the development of an Innovation Proposal that was presented and approved by MHSOAC at its November 2007 meeting. DMH has the responsibility for developing guidelines and for reviewing local Plans for the Innovation component. MHSOAC will have primary responsibility for approving the Innovation component of the Plans.

Outcomes Reporting

The majority of Counties have been fully trained in the outcomes assessment protocol and data capture/reporting requirements for Full Service Partnership Programs. All Counties that have implemented Full Service Partnership programs are currently collecting outcomes. The process for data submission and reporting for Full Service Partnership programs has been streamlined through the development of the Data Collection and Reporting system (DCR).

The DCR provides Counties with two options for submitting data to DMH: via on-line direct key entry or via batch submittal from their own systems using schema-based extensible mark-up language (XML). Those counties that are using the direct on-line key entry system are actively submitting outcomes to DMH through the DCR system. For those Counties that opted to use their own systems to collect and submit FSP data, DMH and County staff are preparing for XML batch submittal to begin in early 2008.

Most Counties are also regularly submitting Quarterly Reports for each approved CSS program. These reports provide information about the number of individuals who have received services through an approved program for each quarter. In order to streamline the reporting process, the Performance Outcomes and Quality Improvement unit has developed an on-line direct key entry system for submitting these reports. The system was implemented November 2007.

A new Evaluation Coordination Committee is being formed that will include members from DMH, the MHSOAC and CMHPC with representation from CMHDA, providers, clients and families. This committee will coordinate the development and prioritization of performance measurement targets and methods for various aspects of MHSA implementation, including Community Services and Supports, Prevention and Early Intervention, Innovation, and Workforce Education and Training.

Because performance measures selection includes the consideration of technology options available to improve workflow processes, data quality, and the feasibility of data collection, DMH information technology personnel, performance measurement

personnel, and numerous stakeholders statewide continue to collaborate toward enhancing information management infrastructures that support performance measurement and accountability reporting.

Mental Health Services Oversight and Accountability Commission

The MHSOAC continues in its efforts to recommend policies and strategies to further the vision of transformation and address barriers to systems change, as well as providing oversight to ensure funds being spent are true to the intent and purpose of the Mental Health Services Act. In this capacity, the MHSOAC has been working collaboratively with the Department of Mental Health, the California Mental Health Planning Council, the California Mental Health Directors Association, stakeholders, and other constituency groups.

The MHSOAC has drafted an 18 month Work Plan covering the period January 1, 2007 through June 30, 2008, which spans FY 2006-07 and FY 2007-08. It is intended to be a blueprint to satisfy all of the MHSOAC's objectives. It proposes an MHSOAC mission, identifies goals, defines the MHSOAC core roles and responsibilities as specified in the Act, spells out long-term and short-term strategies and provides an organizational structure to fulfill the MHSOAC's responsibilities.

The proposed mission statement of the MHSOAC is to provide the vision and leadership, in collaboration with clients, their family members and underserved communities, to ensure Californians understand mental health is essential to overall health. The mission also would hold public systems accountable and provide oversight for eliminating disparities, promote mental wellness, recovery and resiliency, and ensure positive outcomes for individuals living with serious mental illness and their families.

The roles and responsibilities of the MHSOAC include:

- In collaboration with clients, family members, and underserved communities, provide the vision, leadership and oversight necessary to prevent mental illness from becoming severe and disabling and transform the public and private systems charged with providing services, care and support to Californians living with mental illness.

- Oversee the implementation of MHSA Parts 3 and 4, Community Services and Supports (Adults, Older Adults and Children's System of Care); Part 3.1, Human Resources; Part 3.2, Innovative Programs; and Part 3.6, Prevention and Early Intervention. Hold the State and Counties accountable for developing and implementing transformative programs.

    - Review and comment on the Community Services and Supports, Capital Facilities and Technological Needs, and Workforce Education and Training components of the Counties' Three-Year Plans.

    - Review, comment, and approve expenditures in MHSA County, as well as statewide Plans for Prevention and Early Intervention and Innovation programs.

- In collaboration with clients, family members, and underserved communities, develop strategies to combat and overcome stigma.

- Advise the Governor and Legislature regarding actions the State may take to improve care and services for individuals experiencing mental illness.

- Ensure transparency in the planning, implementation, and the outcomes of the MHSA.

- Develop additional and necessary strategies to accomplish any objective or provision of the MHSA. Include clients, families, and underserved communities in the development of such strategies.

The MHSOAC will adopt four key strategies to fulfill its roles and responsibilities and to achieve its mission. Key strategies remain consistent from year to year. The four strategies are:

1. Ensure transparency of the Mental Health Services Act through communication with and education of the public.

2. Provide oversight over the Mental Health Services Fund and ensure accountability to the intent and purpose of the MHSA by:

    a. Reviewing and providing comment on Community Services and Supports, Workforce Education and Training, and Capital Facilities and Technological Needs components of the Counties' Three-Year Plans. For these components, recommend transformation principles and implementation strategies to DMH to include in local Plan requirements.

    b. Assisting DMH in developing County and statewide Plan requirements for PEI and Innovation; review, comment, and provide final approval on County and statewide plan expenditures for the PEI and Innovation components of the Plans.

3. Establish expectation for statewide outcomes accountability.

4. Develop and advance a statewide policy agenda that promotes systems transformation.

The MHSOAC has taken several actions since July 1 of 2007:

- Adopted the Student Mental Health Initiative in response to the tragedy at Virginia Polytechnic Institute. A total of $60 million is proposed over four years to improve

mental health supports on selected K-12 schools, community colleges, California State Universities and University of California campuses.

- Adopted a Plan review process and a Plan review tool for the PEI component of the Three-Year Plan.
- Engaged in budget approval for PEI Community Program Planning funding requests.
- Reauthorized the Co-occurring Disorders Workgroup to continue development of policy for individuals with co-occurring mental illness and substance abuse problems.
- Adopted a resource paper for the Innovation component of the MHSA, including recommendations which will serve as the foundation for guidelines and regulations currently under development by the Department of Mental Health (DMH).

During the first six months of 2008, the MHSOAC will be engaging in the following activities:

- Reviewing and approving PEI component of the Counties' Three-year Plans.
- Providing review and comment to DMH in response to the Workforce, Education, Training components of the Counties' Three-Year Plans, when these are turned in by Counties.
- Providing review and comment to DMH regarding Housing Initiative applications.
- Providing review and comment to DMH regarding Capital and Technology applications which Counties will be submitting.
- Providing review and comment to DMH regarding Community Services and Supports augmentation funding and Counties' plans to use this funding.
- Approving Innovation component funding levels.

The MHSOAC looks forward to an active and productive agenda for the rest of the fiscal year and looks forward to working with the Governor and the Legislature to provide transformed mental health for all Californians.