



PROMISES STILL TO KEEP: A DECADE OF THE MENTAL HEALTH SERVICES ACT

REPORT #225, JANUARY 2015



LITTLE HOOVER COMMISSION

*DEDICATED TO PROMOTING ECONOMY AND
EFFICIENCY IN CALIFORNIA STATE GOVERNMENT*

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By statute, the Commission is a bipartisan board composed of five public members appointed by the governor, four public members appointed by the Legislature, two senators and two assemblymembers.

In creating the Commission in 1962, the Legislature declared its purpose:

...to secure assistance for the Governor and itself in promoting economy, efficiency and improved services in the transaction of the public business in the various departments, agencies and instrumentalities of the executive branch of the state government, and in making the operation of all state departments, agencies and instrumentalities, and all expenditures of public funds, more directly responsive to the wishes of the people as expressed by their elected representatives...

The Commission fulfills this charge by listening to the public, consulting with the experts and conferring with the wise. In the course of its investigations, the Commission typically empanels advisory committees, conducts public hearings and visits government operations in action.

Its conclusions are submitted to the Governor and the Legislature for their consideration. Recommendations often take the form of legislation, which the Commission supports through the legislative process.

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LITTLE HOOVER COMMISSION

January 27, 2015

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Dear Governor and Members of the Legislature:

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California recently marked the 10th anniversary of a landmark mental health ballot initiative that promised additional help for the severely mentally ill and bold new programs to emphasize prevention and early intervention. The Mental Health Services Act – or Proposition 63 – won a majority vote in November 2004 with promises of fewer mentally ill Californians on the streets and in jail, better community-based care and strict oversight of spending.

Richard Roth
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The act has since raised more than \$13 billion for mental health programs through an income tax surcharge on California's wealthiest residents. By many accounts, the Mental Health Services Act is finding its stride after a decade and has demonstrated successes in improving lives throughout the state. **For oversight, the record is not so notable. After 10 years, the state cannot provide basic answers to basic questions: Has homelessness declined? Are programs helping Californians stay at work or in school? Who is being served and who is falling through the cracks? The state cannot adequately quantify an anecdotal sense that the act has made California a better place for the estimated 2.2 million adults with a mental health need and their families.**

The Little Hoover Commission undertook its study of the Mental Health Services Act as part of a broader review of California's century-old initiative process, which has often proved an effective tool for special interests to steer tax revenue to their causes. The proposition represents a classic case of bypassing the Legislature's budget process to capture an assured funding source – but also of granting the Legislature limited power to amend the act upon its passage. The Legislature is typically powerless to amend ballot initiatives, but in this case, it was given and several times used its power to refashion the original provisions of the act as approved by voters.

The Commission's review of the act provided a unique window to analyze – particularly through the experience of one measure – the arc of the ballot initiative process over an extended period of time. Ballot propositions, in general, can be useful when a societal or large-scale problem is too complicated or controversial to be addressed within the legislative process. Backers of the Mental Health Services Act claimed in 2004 they had no choice but to bypass a Legislature that proved unwilling for decades to adequately fund community mental health programs after the state began closing its hospitals in the 1970s.

Ballot propositions that delegate modest authority to the Legislature to improve the implementation of a ballot measure also can be effective, provided the rules for such alterations are clear. In the case of Proposition 63, the Legislature's intervention and involvement produced mixed results, but generally kept implementation on course through early bureaucratic stumbles and a severe economic downturn that annihilated mental health and social services budgets.

In this review, the Commission learned that **funding provided by Proposition 63 – now more than \$1 billion annually and representing about 25 percent of California's overall mental health spending – continues to evade effective evaluation** due to antiquated state technology and overlapping and sometimes **unaccountable bureaucracies**. The Legislature appropriately empowered the Mental Health Services Oversight and Accountability Commission by making it independent, but it still lacks teeth and shares oversight responsibilities for the act with the Department of Health Care Services. The Legislature should expand the authority of the oversight commission. Specifically, it should have the authority to conduct up-front reviews of the more controversial preventive programs funded by the act and be empowered to impose sanctions if counties misspend funds from the act or fail to file timely reports with the state.

Nationally and globally, mental health professionals and policy analysts are trying to assess whether California's enhanced funding and new prevention-oriented mental health practices are paying dividends. For the sake of its innovative care programs at home and their potential replication elsewhere, **it is imperative that California overcome its bureaucratic and technological obstacles to provide evidence of statewide outcomes instead of success stories from individual programs. Californians still see the mentally ill on their streets and see too often the impacts of mental illness in senseless crimes, suicides and inability to stay in school or on the job.** Without conclusive data no one knows how far the state has come in addressing mental illness through the act and how far it still has to go. The state must make more existing data easily accessible and invest in a modern data collection system using a portion of the Mental Health Services Act state administrative funds.

Clearly, the Mental Health Services Act has promises still to keep. Backers in 2004 promised voters their support would “keep people off the streets, out of the hospital and out of jail,” as well as increase access to programs and services to help people “make the move from tax user to taxpayer.” They also promised a skeptical voting public strict state oversight. **The results on all fronts, even if actually being accomplished, cannot be convincingly demonstrated.** The Commission heard no testimony that the act has not worked, but even initiative backers, along with the Commission, believe the state must streamline its bureaucracy and collect the necessary data to tell the story. The Commission respectfully submits these findings and recommendations regarding improved implementation of the Mental Health Services Act and is prepared to help you take on this challenge.

Sincerely,



Pedro Nava
Chairman

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Table of Contents

A Claim on State Spending: The Voters' 2004 Millionaire's Tax for the Mentally Ill.....	1
Strengthening Oversight.....	15
Improving Transparency and Accountability.....	29
Conclusion.....	47
Appendices & Notes.....	51
Appendix A: Public Hearing Witnesses.....	53
Appendix B: Timeline: The Shaping of California's Mental Health System.....	55
Notes.....	59

Table of Sidebars & Charts

Little Hoover Commission Attention Helped Inform Proposition 63.....	2
Mental Health Services Act State Administration Expenditures.....	8
Apportionment of Mental Health Services Act Funds.....	9
MHSA Revenue Fiscal Years 2004-05 through 2014-15.....	9
Public Mental Health Funding Sources in California.....	10
Before and After: The Client Perspective.....	12
Implementing the Mental Health Services Act: A Small-County Perspective.....	13
Major Players in MHSA's Implementation.....	21
California Reducing Disparities Project.....	33
Community Services and Supports Priority Indicators.....	37
Mental Health Services Act.....	40

A Claim on State Spending: The Voters' 2004 Millionaire's Tax for the Mentally Ill

California voters wield extraordinary powers through the ballot initiative process. Voting at kitchen tables or in person at polling places, they handily bypass the traditional lawmaking and budgeting machinery that governs other states. Each June and November, Californians decide – yes or no – significant questions of crime and punishment, business regulation or environmental and social policy. They also steer billions of state tax dollars toward favored priorities by issuing bonds for stem cell research, children's hospitals, open space acquisition and big-ticket infrastructure.

Discussion has long abounded about the positive and negative impacts of Californians' ability to directly set budget and policy priorities. Many in recent years have expressed concerns that a Progressive Era tool of direct democracy, created to overcome powerful early 20th Century interests in Sacramento, has become a favorite tool for powerful current interests. In all, a wide variety of advocacy groups and backers of causes have submitted over 1,800 initiatives under this century-old voting practice in California. Of all these proposals, 369 qualified for the ballot and voters passed 125.¹

Rarely do voters directly increase income taxes, however. Since 1990, they have done it only twice.² The Commission decided to examine one of those votes, in which a majority of California's voters targeted a minority of the population – wealthy millionaires – for an income tax hike. A permanent 1 percent surtax on the state's highest incomes has since steered approximately \$13.2 billion primarily to caring for the severely mentally ill.

As part of a potential periodic examination of what ballot-budgeting initiatives specifically promised voters – and what they delivered to the street – the Commission reviewed Proposition 63, the Mental Health Services Act (MHSA). Voting majorities in nearly 60 percent of California counties rejected the measure, but statewide it passed with support of 53.8 percent of voters in November 2004.³

Proposition 63 passed in the wake of failed legislative attempts to strengthen a public mental health system that often jailed or turned away the severely mentally ill and had little focus on prevention and early intervention – a problem that persists to some degree today. As now, the public saw the face of mental illness daily in the streets. Among failed attempts to improve the system was a 2001 bill by Assemblymember Helen Thomson that proposed to expand mental health services for adults and children. The bill also proposed creating a commission to engage California communities in reducing the stigma and discrimination often perceived when citizens sought mental health services. The legislation incorporated several Little Hoover Commission recommendations made in its November 2000 report, *Being There: Making a Commitment to Mental Health*. The bill also proposed new General Fund dollars for mental health training and human resource development programs.⁴

Legislators at the time discussed a general lack of baseline funding for the public mental health system. Some contended that the system had never been adequately funded since the state began closing its hospitals in the 1970s. At that critical juncture, California decided that people with mental illness should live in their communities rather than be locked or warehoused in institutions. People with mental illness, it was said, had a right to experience everyday life and would benefit from community-based treatment. For the next several decades, people with mental illness did, in fact, integrate into California communities. They were on street corners and sleeping in parks. They crowded local jails.

Little Hoover Commission Attention Helped Inform Proposition 63

When the Little Hoover Commission last reviewed the state’s mental health system between 1999 and 2000, it found a system that rationed care to those with the most extreme needs – and even then sometimes turned people away or criminalized those needing care. Following its year-long study, the Commission called for major reform, citing billions of dollars the state spent dealing with consequences of untreated mental illness, such as lost productivity, lower property values and quality of life, and increased costs for criminal justice. In its November 2000 report, *Being There: Making a Commitment to Mental Health*, the Commission emphasized the need for the state’s mental health system to focus on successful treatment and recovery for those living with mental illness. It advocated policies to help people function in everyday life and investments in programs to “help first,” rather than let people “fail first,” overcome by fear, stigma and lost hope. The Commission also called for an oversight body to prod change, develop strategies to overcome stigma, detail the state’s need and provide mental health policy advice to the Legislature and Governor. The Commission suggested the composition of this body should reflect the interests of key stakeholders from education, law enforcement, employment and health plans.

The Commission’s report found a receptive audience within the mental health community. Some of the Commission’s recommendations were incorporated into AB 1422, the Thomson legislation that preceded Proposition 63, and ultimately the Mental Health Services Act. Specifically, the act included the Commission’s recommendation to fund programs that promote early intervention and more comprehensive services. It also implemented the Commission’s recommendation to establish an oversight commission which took the form of the Mental Health Services Oversight and Accountability Commission.

Many were in the community, but went unseen while quietly struggling to hold jobs and care for children, burdened by the stigma as well as the disease. Unfortunately, mental health funding did not follow mental health clients out of the hospitals and into California communities.

Further reductions implemented during the recession years of the 1990s exacerbated the system's shortcomings.⁵ Nevertheless, Governor Gray Davis vetoed the Thomson legislation in September 2002, citing insufficient budget resources and suggesting future opportunities "when the State's fiscal health improves."⁶ When it became clear that funding would not come through the legislative process, mental health advocates, including co-author Senator Darrell Steinberg, began to move on another front, crafting the first draft of Proposition 63 to model the failed Thomson bill.⁷

"This initiative was needed because it was clear that there was no way that mental health could ever become a sufficient legislative priority to achieve its needed funding in any other way," Rusty Selix, the initiative's other co-author told the Commission in September 2014. "After 10 years, I still believe that Proposition 63 represents one of the best ever uses of the initiative process [in] accomplishing important public policy goals that could not have been enacted any other way."⁸

Importantly, for this Commission review of state initiatives, Proposition 63's authors included specific language allowing the Legislature to amend the act with a two-thirds vote, so long as the changes were consistent with the act's purpose and intent. The Legislature also can clarify terms of the act by majority vote.⁹

"Knowing that these provisions would govern the public mental health system permanently, we did not have enough confidence that we could be sure we got it right and so we wanted to allow amendments," Mr. Selix explained to the Commission.¹⁰

The Commission's interest in Proposition 63 stems from discussions regarding the power of special or narrow interests to claim a portion of the state's funding stream for specific projects or causes and the Legislature's general inability to modify ballot or bond initiatives approved by voters. With enacted legislation the Governor and Legislature can revisit laws and amend them as needed. But most voter-approved initiatives lock in their statutory provisions, providing the Legislature and Governor limited or no ability to make changes for unintended consequences or other conditions that arise years later. Just as the governor lacks the right to veto laws passed by the initiative process, the Legislature cannot repeal or amend a statutory initiative, unless permitted by the initiative.¹¹

Proposition 63, which now accounts for approximately 25 percent of California's public mental health spending, provides a vivid example of what happens after the majority of voters say yes – and when the Legislature also uses its power to modify what voters approved. The Commission's examination of the Mental Health Services Act offered a case study of best voter intentions that soon encountered bureaucratic entanglements, unforeseen financial circumstances and sometimes dramatic actions taken by the Legislature in response. In the years since its passage, the Legislature has exercised its authority to amend the act four times, in 2009, 2011, 2012 and 2013.¹² A timeline describing these legislative changes, as well as other significant legislative reforms to the public mental health system, is included as Appendix B.

In brief, the state bureaucracy's initial orientation toward process stalled the special tax revenues from getting to the street, which caused the Legislature to curb the state's power and send money directly to counties. For a time, severe state budget cuts during the Great Recession diminished county resources and turned a funding stream meant to supplement existing programs into one that, according to stakeholders, helped sustain the community mental health infrastructure.¹³ Later, policymakers eliminated the Department of Mental Health, shifting responsibility for oversight of the act to various state entities and creating new confusion and oversight challenges. These amendments, however, have resulted in an oversight structure and funding process that is different from what voters initially approved.

At its 2014 hearing, the Commission heard from stakeholders that a bumpy 10-year ride of implementing Proposition 63 has changed the mental health system for the better. In addition to funds provided by the millionaire's tax, they say, the ballot initiative has stimulated a novel approach to mental health treatment that focuses on prevention and early detection. The system is more proactive. Less often is it forced to turn people away until they reach crisis.

Nevertheless, 10 years after the act created its unique funding stream, concerns remain about its implementation. Stakeholders told the Commission that overlapping bureaucratic oversight continues to weaken accountability for the act's performance and outcomes. More importantly, authorities still can't clearly show, much less measure, what more than \$13.2 billion has accomplished in terms of improving services for the estimated one in six California adults with a mental health need or the one in 20 who suffer from a serious mental illness.¹⁴ The Commission's review offers several recommendations to counter these weaknesses and improve implementation of the act for this vulnerable population, while also enhancing public safety and the quality of life in California.

The Proposition 63 Campaign: High Expectations for Improvements

Press coverage leading up to the November 2004 election described an emaciated mental health system, largely neglected by the state since it began closing its mental health hospitals in the 1950s, 1960s and 1970s, and shifting responsibility, but not adequate funds, for community-based mental health programs to the counties. Proposition 63 backers told voters that investing in the Mental Health Services Act could greatly reduce costs for incarceration, medical care, homeless shelters and social service programs.¹⁵ As described by its co-author, Rusty Selix, the act intended to achieve three goals: 1) fully fund integrated mental health services for the severely mentally ill, 2) protect existing mental health funding and 3) steer the culture of the state's mental health system toward prevention and early intervention.¹⁶

Proposition 63 backers encountered powerful skepticism, however, about their so-called "ballot box" budgeting approach. The editorial pages of the state's most influential newspapers – the Los Angeles Times, San Diego Union-Tribune, Sacramento Bee, Orange County Register, San Jose Mercury News and Oakland Tribune – urged voters to reject the initiative. Editorials described it as well-intentioned, but "bad public policy" and a poor way to address state budget issues. Some opponents argued that the income tax would be a volatile revenue source and expressed concerns that an extra tax on millionaires might drive some to leave the state.¹⁷

Still, front-page media coverage across the state suggested Proposition 63 would provide a way for California to fulfill a past promise by creating a dedicated funding stream for mental health programs and a built-in accountability system to ensure effective use of the funds. The San Francisco Chronicle, which supported the measure in its editorial pages, told readers the funds would "be directed to programs that use a comprehensive approach to dealing with the mentally ill," and would earmark money for "expanding care and early intervention for children, training and supporting staff for clinics and improving facilities across the state."¹⁸ Los Angeles Times reports stated the measure would pay for mental health services that were in short supply, including:

- "Hundreds more beds, added counseling, more vocational assistance and new prescription drug programs for overrun county clinics.
- Building more clinics and training more mental healthcare workers to address continuing shortages.

- New prevention and early intervention outreach programs to help people showing signs of mental illness get aid before the problem becomes severe.”¹⁹

The Ventura County Star, serving a county that had been plagued by money scandals in its mental health programs, reported that backers had “built tough oversight rules into Proposition 63.” The newspaper stated that funding to counties would be based on how well they demonstrated the effectiveness of the programs included in their annual MHSA plans.²⁰

The State’s Implementation Apparatus

Proposition 63’s victory at the polls quickly ushered in a critical implementation phase by state and county governments that continues to evolve today. The Mental Health Services Act intended to change the way California treated mental illness by expanding the availability of innovative and preventative programs. It also intended to reduce stigma and long-term adverse impacts for those suffering from untreated mental illness and ultimately, make programs accountable for achieving those outcomes.²¹ The act directed the majority of revenues to county mental health programs and services, specifying that counties could spend their share in five separate funding categories, or components:

- 1. *Community Services and Supports (CSS):*** 80 percent of county funding from the Mental Health Services Act treats severely mentally ill Californians through CSS. Within this component counties fund a variety of programs and services to help people recover and thrive, including full service partnerships and outreach and engagement activities aimed at reaching unserved populations. Full service partnerships provide “whatever it takes” services to support those with the most severe mental health challenges. A variety of agencies might participate by providing intensive, team-based services for clients who might have a history of incarceration or homelessness. Services might include therapy or behavioral therapy to help clients reduce their symptoms or case management to get clients housing, employment, education, substance abuse treatment or other social services. The Department of Health Care Services estimates that in fiscal year 2014-15, the act will generate \$1.254 billion for CSS.²²
- 2. *Prevention and Early Intervention (PEI):*** Counties may use up to 20 percent of their MHSA funds for PEI programs, which are designed to identify early mental illness before it becomes severe and disabling. PEI programs are intended to improve timely access to services for underserved populations and reduce

negative outcomes from untreated mental illness, such as suicide, incarceration, school failure or dropping out, unemployment, homelessness and removal of children from homes.²³ Within this category, the Mental Health Services Act encourages counties to take a proactive “help first” approach rather than wait for a condition to become severe and disabling. The Department of Health Care Services estimates that in fiscal year 2014-15, the act will generate \$313.7 million for PEI.²⁴

- 3. *Innovation:*** Counties may use up to 5 percent of the funding they receive for CSS and PEI to pay for new and innovative programs that develop, test and implement promising practices that have not yet demonstrated their effectiveness. Innovation funds are designed to increase access to services, increase the quality of services, improve outcomes and promote interagency collaboration.²⁵ Expenditures in this component are intended to infuse new effective mental health approaches into the mental health system at the county level and throughout the state. The Department of Health Care Services estimates that in fiscal year 2014-15, the act will generate \$82.5 million that can be used for Innovation programs.²⁶

The Mental Health Services Act also required counties to spend a portion of their revenues on two additional components to build the infrastructure to support mental health programs. Since 2008-09, counties have the option of using a portion of their CSS funding in these areas or to build up a prudent reserve:²⁷

- 4. *Workforce Education and Training:*** This component aims to train more people to remedy the shortage of qualified individuals who provide services to address severe mental illness. Counties may use funds to promote employment of mental health clients and their family members in the mental health system and increase the cultural competency of staff and workforce development programs, among other uses.²⁸
- 5. *Capital Facilities and Technological Needs:*** This component finances necessary capital and infrastructure to support implementation of the other programs. It includes funding to improve or replace technology systems and other capital projects.²⁹

Local assistance funds currently are allocated to the counties through a formula developed by the former Department of Mental Health in consultation with the California Mental Health Director's Association in 2005 and updated in 2008. The formula weighs each county's need for mental health services, the size of its population most likely to apply for services (based on its poverty rate and uninsured populations) and the

prevalence of mental illness in the county. Adjustments are made for the cost of living in each county and for other non-MHSA resources available to the county. Additionally, to ensure a minimum funding for rural counties, the formula established a minimum allocation for the CSS and PEI components.³⁰ The Department of Health Care Services currently is responsible for updating the formula for county allocations of MHSA funds.³¹

State Administration Funds. The act also directs up to 5 percent of annual revenues toward state administration and specifies that these funds are to be used by state agencies to “implement all duties pursuant to the [MHSA] programs.” This includes ensuring adequate research and evaluation regarding the effectiveness and outcomes of MHSA services and programs.³² In any given year, the Legislature and Governor may change the percent of funds appropriated for the state’s administration of the act. The Legislature has reduced this cap, to as low as 3.5 percent and has raised it to as high as 5 percent where it stands in 2015. The Legislature exercises its discretion in determining how to allocate the state administration funds to various state entities each year through the annual Budget Act. Currently, 12 state departments, boards and commissions, as well as the adult and juvenile court systems, receive a portion of the state administration funds. The Department of Health Care Services estimates that in fiscal year 2014-15 the act will generate \$86.9 million for state administration.³³

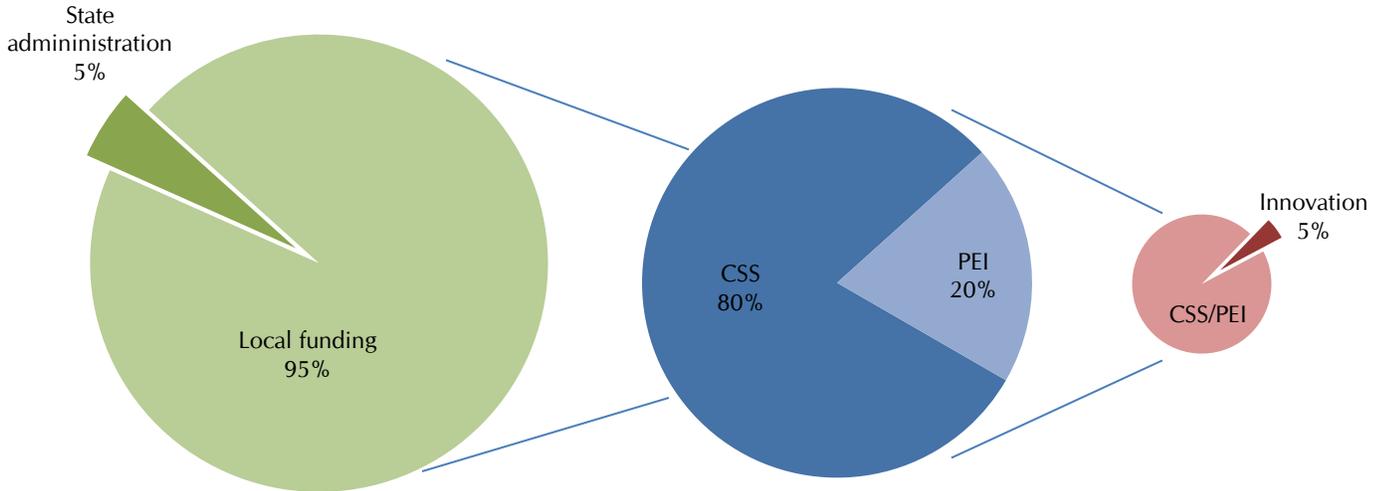
***Mental Health Services Act
State Administration Expenditures***

In fiscal year 2014-15, an estimated \$81 million in revenue generated from the Mental Health Services Act will pay for an array of services across the following 12 state entities:

- Board of Governors of the California Community Colleges
- California Health Facilities Financing Authority
- Department of Developmental Services
- Department of Education
- Department of Health Care Services
- Department of Public Health, Office of Health Equity
- Department of Veterans Affairs
- Financial Information System for California
- Judicial Branch
- Mental Health Services Oversight & Accountability Commission
- Military Department
- Office of Statewide Health Planning and Development
- State Controller’s Office

Source: Department of Health Care Services. May 2014. Mental Health Services Act Expenditure Report. Fiscal year 2014-15.

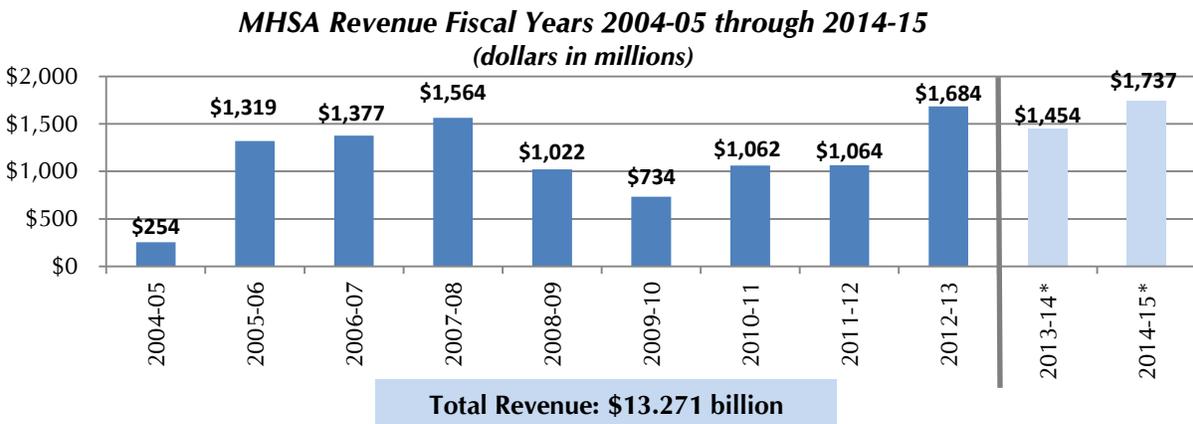
Apportionment of Mental Health Services Act Funds



Source: California State Auditor. Report 2012-122. Also, Mental Health Services Act.

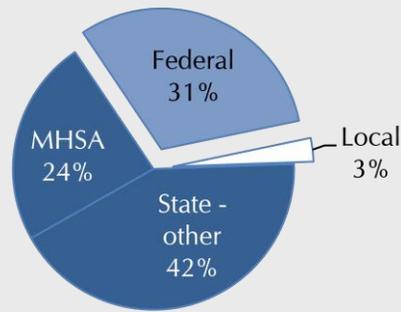
A Decade Later: What Proposition 63 Accomplished

The Mental Health Services Act (MHSA) has generated a powerful funding stream – more than \$13.2 billion, according to the Department of Finance – for the state’s public mental health system since enacted a decade ago.³⁴ In the past five years, this has amounted to more than \$1 billion annually directed toward mental health programs and services, as shown in the table below.



Note: Fiscal Years 2013-14 and 2014-15 reflect estimated revenue amounts.³⁵

Public Mental Health Funding Sources in California



Average Fiscal Years 2011-12 to 2015-16

Federal:

- Federal Medicaid Match: The majority of federal funding for mental health services in California comes through federal matching funds to counties for providing *specialty* mental health treatment to Medi-Cal beneficiaries. Beginning in 2014, a significant new federal match flowed to the state as a result of California’s adoption of a new Medi-Cal benefit for *non-specialty* mental health services to all beneficiaries. Federal reimbursement is based on California’s Federal Medical Assistance Percentage (FMAP), which is 50 percent for all Medi-Cal beneficiaries that qualify for Medi-Cal under pre-Affordable Care Act (ACA) eligibility criteria, such as a disability. However, for those Medi-Cal beneficiaries enrolled under the expanded eligibility criteria established under the ACA, California will receive an enhanced FMAP of 100 percent for 2014 – 2016, which then phases down to a permanent 90 percent match beginning 2020.
- Substance Abuse and Mental Health Services Administration: The mental health block grants are noncompetitive grants that provide funding to counties for substance abuse and mental health services.

State:

- Realignment: A portion of the state’s revenues from sales tax and vehicle license fees is directed to the counties to pay for increased responsibilities for a number of mental health and other programs. Funding supports services provided to individuals who are dangers to themselves or others or who are unable to provide for their immediate needs, community-based mental health services, state hospital services for civil commitments and institutions for mental disease which provide long-term care services.
- Mental Health Services Act: A surtax on personal income over \$1 million which flows to counties for community-based mental health services, prevention and early intervention services, innovative programs, mental health workforce development and others.
- General Fund: Support for the state hospitals and Medi-Cal program constitute the majority of state General Fund spending. Over \$1.5 billion in state General Fund dollars supports inpatient psychiatric and mental health services to inmates and patients at California’s five state hospitals. Additionally, more than \$800 million is spent annually on psychiatric prescription drugs and non-specialty mental health benefits for Medi-Cal beneficiaries, behavioral health therapy for Medi-Cal enrollees with autism up to age 21 and educationally related mental health services for disabled students.

Local:

- Various sources: Counties collect local property taxes, patient fees, payments from private insurance companies to fund mental health services and other funding sources which they primarily use for their maintenance of effort – the level of spending required to receive their portion of state realignment revenue for mental health services. Funds may also go toward Medi-Cal services allowing the county to draw down additional federal dollars, or on services not reimbursable through Medi-Cal.

Sources: Mental Health Services Oversight and Accountability Commission, Financial Oversight Committee. January 22, 2015. Financial Oversight Report. Also, Legislative Analyst’s Office. November 4, 2013. “The 2013-14 Budget: California Spending Plan.” Also, California HealthCare Foundation. July 2013. “A Complex Case: Public Mental Health Delivery and Financing in California.” Also, Department of Finance, Governor’s Proposed Budget, FY 2015-16, Department of Health Care Services. Also, SB 852 (Leno), Chapter 25, Statutes of 2014.

The act was designed to provide new funding to expand mental health services statewide, not to serve as the sole funding source for county mental health programs and services, Jessica Cruz, executive director of National Alliance on Mental Illness, California explained in testimony.³⁶ And between 2010-11 and 2014-15, money from the act accounted for about a quarter of funding for all of the state's public mental health system, as shown in the chart below.³⁷

At the county level, MHSA funds are woven into a complex funding stream that includes federal and state dollars, as well as various local resources. "MHSA funds act as both the primary funding source for programs, as well as the match for Medi-Cal services that fund recovery-oriented mental health services and supports," Debbie Innes-Gomberg, District Chief of Los Angeles County's MHSA implementation and outcomes division, explained to Commissioners in September 2014. "As a result, MHSA funding is embedded within the Los Angeles County Department of Mental Health outpatient system of care for children, transition age youth, adults and older adults and is integral to our recovery-oriented outpatient service delivery system."³⁸

Throughout its study process, the Commission heard enthusiastic support for the Mental Health Services Act and the changes these funds have generated within the state's public mental health system.

Some witnesses and stakeholders described in general terms how the act has achieved the outcomes promised to voters. "MHSA programs have served hundreds of thousands of Californians over the past 10 years," Ms. Cruz told the Commission. "These programs have reduced hospitalization, homelessness, suicide, and incarcerations... [and] help people achieve recovery and obtain meaningful places in society."³⁹

Others, like Larry Poaster, Mental Health Services Oversight and Accountability Commissioner and former Stanislaus County behavioral health director, credited the act with sustaining the state's mental health system through a period of severe economic recession, protecting mental health programs and services at a time when many others experienced deep cuts. In his testimony to the Commission, Mr. Poaster reflected that "had there not been an MHSA during the worst parts of the recession, the impact on the overall system would have been catastrophic."⁴⁰

But beyond providing financial stability, stakeholders also credited the act's historic financial commitment, and its particular focus on prevention and early intervention, with vastly transforming the mental health system. Instead of just focusing on those with the most severe

Before and After: The Client Perspective

Though California decided decades before the Mental Health Services Act that people with mental illnesses should live in their communities rather than locked institutions, the state failed to follow through with adequate funding, services and facilities. As a result, people with mental illnesses were visible on the streets, sleeping in city parks or housed in jails and prisons. They faced more stigma than support.

Though these conditions still exist, the Mental Health Services Act has begun to shift the paradigm of programs and care with new emphasis on wellness, recovery, resilience and hope. Many programs supported by the act are designed to catch people who might otherwise fall through the cracks, particularly those unable or reluctant to seek care in traditional institutional or office settings. For example, a renter in Los Angeles County threatened with eviction due to hoarding, enrolled in weekly counseling sessions conducted by volunteer peer counselors and was able to remain in his apartment.

Other programs aim to prevent mental illness from developing or worsening. New counseling programs helped one young woman identify her special education needs and transfer to a new school to thrive. Another MHSA program helped a mother teach her two-year-old daughter the words to express her feelings and better manage stressful situations. Other programs provide “whatever it takes” support to restore stability to people with mental illness compounded by drug abuse, homelessness or unemployment. Often, these programs mean fewer days being homeless, hospitalized or jailed.

After receiving care funded by the act, one client reflected: “When I started experiencing hope, life seemed more livable. I began to look forward to the coming days. I became busier and more productive.” While recovery will be a “long journey,” she said she knows now where to get help and “looks forward to seeing how the rest of life unfolds.”

Sources: Little Hoover Commission. November 2000. *Being There: Making a Commitment to Mental Health*. Also, Los Angeles County Department of Mental Health. 2010. *Transformations: How the Mental Health Services Act is Changing Lives in Los Angeles*. Also, California Behavioral Health Director’s Association. “Measures, Outcomes, and Quality Assessment at a Glance.

needs, the Commission heard that the act is providing Californians more comprehensive mental health treatment options.⁴¹

“I cannot fathom what the mental health system would look like without Proposition 63 because of the flexibility it has given the system to focus more on the community, parents and consumers,” Mike Kennedy of Sonoma County told Commission staff. Before Proposition 63, he explained, California had a “fail first” system. “To get in the door, you had to be at a really severe level. Now, I have staff in high schools and colleges working to do early intervention with students.”⁴²

Ms. Innes-Gomberg testified to the Commission how funding from the Mental Health Services Act allowed Los Angeles County to establish new and never-done-before prevention programs, early intervention programs that have been proven to work and innovative projects that are intended to help shape decisions about the county’s system of care. “The MHSA has really, I think, achieved many of its goals,” she said. “And what I mean by that is that it has really served to transform our system of care and to augment our system of care... It really has served to create a full continuum of care.”⁴³

Addressing the Remaining Weaknesses

Despite the act’s many perceived successes, the Commission also

heard testimony about significant weaknesses that the state and counties must address to better channel its funding streams and honor promises made to voters in 2004. Critical among them is strengthening state and county oversight of spending and programs for mentally ill Californians. Equally critical: improving public transparency about where the money goes and the outcomes it produces.

The Commission heard that legislative reforms changed the governance system for the better, clearing the path for money to get to the counties, and ultimately to the streets. However, some stakeholders said these changes have left the state without a strong oversight body empowered to monitor and oversee expenditures, and impose sanctions when necessary to ensure the act is implemented as intended. These issues are discussed further beginning on page 13.

Additionally, the Commission heard that many basic facts about the act's outcomes remain unknown. Participants at the Commission's September hearing said state administrators cannot answer seemingly straightforward questions about the number of individuals served through MHSA programs, the amount of money raised and distributed through the act and the nature and quality of services clients received.

Implementing the Mental Health Services Act: A Small County Perspective

More than half of the state's counties have populations of 200,000 or less, presenting unique challenges in implementing the Mental Health Services Act. Smaller counties generally face staffing challenges – both within their own departments and in the broader mental health community, representatives from the County Behavioral Health Directors Association told Commission staff. A single staffer, for example, might implement the Mental Health Services Act in a rural county, whereas a highly-populated county would assign the responsibility to an entire unit of staff within its behavioral health department.

As in other health care fields, it also is hard for small counties to maintain an adequate corps of well-trained mental health professionals. Some counties have dealt with these challenges by pooling their funds regionally. Facing local shortages of psychiatrists, for example, some counties have collectively used funds from the act to pay off school loans for psychiatrists attracted to their remote locations.

Small counties also traditionally lack specialty skills in assembling tax credits and other layered funding sources to build supportive housing for their mentally ill residents. Consequently, they have been unable to apply for housing funds available from the Mental Health Services Act. Starting in 2015, however, they will be able to gain access to these funds by applying directly to the Department of Health Care Services through a partnership with the California Housing Finance Agency, representatives from the County Behavioral Health Directors Association told Commission staff.

Sources: Adrienne Shilton, Senior Associate, California Institute for Mental Health. December 22, 2014. Personal communication. Also, California Office of Statewide Health Planning and Development. Mental Health Services Act, Central Region partnership implementation progress report. Accessed on December 22, 2014 at http://www.oshpd.ca.gov/HPEF/Text_pdf_files/WET/Central_ImplementationReport.pdf

Most importantly, they said the state still cannot accurately say how effectively services and programs supported by the act have helped those with mental illness get better or prevented others from developing a severe or disabling mental illness. These issues are discussed further beginning on page 25.

Until the state and counties better address these problems, the act's achievements will remain cloudy, potentially leaving successful programs vulnerable to further legislative action.

Commission Study Process

The Commission approached its review of Proposition 63 with the intention of studying what happens after voters approve a ballot initiative that steers significant tax dollars to specific programs and services. On September 23, 2014, the Commission held a hearing to review the Mental Health Services Act as one example of how initiatives are used to fund special programs. Hearing witnesses included Rusty Selix, co-author of the initiative, leaders from two organizations that represent mental health clients and their families, as well as officials at the Mental Health Services Oversight and Accountability Commission and the Department of Health Care Services. It also included officials from the Los Angeles County Department of Mental Health and Sonoma County Department of Health Services who administer MHSA programs in their respective counties. The Commission also received extensive public comments from leaders inside the state and county mental health systems, clients, advocates for the mentally ill, researchers and members of the California Reducing Disparities Project. A list of invited witnesses from this hearing is included in Appendix A. Video coverage of the September 2014 hearing is available through the Commission's website at www.lhc.ca.gov.

The Commission's hearing provided an opportunity to assess the outcome of an individual ballot initiative 10 years after its passage and begin to identify lessons to improve the writing and implementation of future initiatives. In particular, the hearing helped Commissioners better understand the state's oversight mechanisms for Proposition 63's considerable revenue stream and learn about the range of outcomes resulting from California's ballot-box investment in mental health services. The following chapters in this report detail the Commission's findings and recommendations.

Strengthening Oversight

When voters raised the income taxes of California’s millionaires in 2004, they simultaneously approved a statewide governance system to administer and oversee mental health programs funded by this new tax. Proposition 63 supporters expected state-level oversight and evaluation of program funding to be of utmost importance, said Jessica Cruz, executive director of the National Alliance on Mental Illness, California, to Commissioners in September 2014. However, from the start, responsibility was diffused among various entities at the state and local levels. Though 10 years has passed and the Legislature has at times intervened, the state has yet to develop a cohesive system for governing the Mental Health Services Act. This ongoing weakness has implications for effective oversight and evaluation of the use of the funds, and ultimately, confidence that an important public investment is being spent well and delivering desired results.

Challenges from the Start: Multiple Bureaucracies, a Confusion of Oversight

The Mental Health Service Act established a governance system where a patchwork of local and state entities shared overlapping responsibility to implement and oversee the local assistance programs funded by the act in five component areas: Community Services and Supports (CSS), Prevention and Early Intervention (PEI), Innovation, Workforce Education and Training and Capital Facilities and Technology Needs.

Initially, the Department of Mental Health and the Mental Health Services Oversight and Accountability Commission (oversight commission), a 16-member statewide board created by the act, shared responsibility to review and approve county spending plans. Each entity was to help assure that funds were spent in accordance with the intent and purpose of the act before funds were released to counties. As a division within the Department of Mental Health, the oversight commission held primary responsibility to review and approve county PEI and Innovation plans and to oversee implementation activities in those components as well as in CSS. The act instructed the oversight commission to refer critical issues related to county performance to the Department of Mental Health. The department held power to address local shortcomings by imposing administrative sanctions such as

withholding funds and requiring the county to enter into negotiations to comply with state laws and regulations. The department also could refer issues to the courts.⁴⁴

Critics said early implementation was neither smooth nor swift. Some called the oversight structure complicated and redundant due to reviews and approvals by both the Department of Mental Health and the oversight commission. Key complaints zeroed in on unwieldy state government processes that seemed to be amassing a bureaucracy around the new MHSA funds rather than speedily moving them to counties for programs and services. Stakeholders' considerable frustrations with the state's initial implementation of Proposition 63 included:

Undefined Roles and Responsibilities: The act identified numerous entities responsible for its implementation, including the Department of Mental Health, the oversight commission, the Mental Health Planning Council, counties and stakeholder community groups. However, a 2008 Department of Finance audit concluded the act did not clearly define their individual roles. The act stipulated that the Department of Mental Health would develop regulations for itself and designate local agencies to implement the act. The audit, however, found that the department never exercised its authority. Various roles and responsibilities evolved happenstance based on each entity's interpretation.⁴⁵

Staggered Implementation: Many complaints stemmed from the mental health department's staggered implementation of the act, issuing separate guidelines for county plans for each of the five components beginning with the primary Community Services and Supports component in 2005. (The oversight commission issued guidelines for PEI programs in 2007 and for Innovation programs in 2009.⁴⁶) The act required counties to develop three-year plans with significant input from stakeholders, along with annual updates describing how they would use the act's money for the five component areas. The department's staggered implementation strategy made it impossible for counties, which were required by the act to conduct a stakeholder-involved planning process for allocating funds, to develop comprehensive plans for their use. Instead counties had to undergo labor-intensive and time-consuming processes to develop plans for each individual component.⁴⁷

Onerous Plan Requirements: From the start, the Department of Mental Health received considerable complaints about onerous plan requirements in which counties had to account in detail how they would spend funds and implement programs.⁴⁸ A 2008 performance audit conducted by the Department of Finance found that CSS guidelines did not reflect the diversity of the state's 58 counties and as a result, county plans ranged in size from 300 pages to 1,000 pages. The department's

initial review process also exceeded its 90-day timeframe for the majority of counties. For seven counties, the department's review times ranged from 180 days to 336 days.⁴⁹ With funding tied to approval of county plans, and approval of county plans being slow, distribution of funds to the counties became significantly delayed.

Lack of Coordination: Initially, counties submitted three-year spending plans for Community Services and Supports, Workforce Education and Training and Capital Facilities and Technology Needs programs to the state mental health department for approval. The department worked with counties to develop their plans and monitor implementation. County spending plans for the Prevention and Early Intervention and Innovation programs went to a separate agency, the oversight commission, for review and approval. However, if the oversight commission or the department identified a problem with a county's plan, either could work directly with the county to seek additional information and ultimately stall the review process.⁵⁰

A Flawed Fund Distribution Process: The Department of Finance's 2008 audit found the Department of Mental Health's process to steer Proposition 63 funds to counties quickly proved cumbersome and inefficient, bogged down by lack of policies and procedures to process payments. The audit concluded this process, too, reduced cash flows to counties.⁵¹

Overall, these issues contributed to a frustrating sense among stakeholders and Proposition 63 supporters of bureaucratic entanglement and stalled implementation. The state, devoting its energies in the initial years to launching and refining a process to implement the act, eventually added to this frustration by providing little oversight of whether the programs they funded helped the mentally ill.

Empowered by Proposition 63 to Respond, the Legislature Intervenes

Less than five years after voters enacted Proposition 63, and largely in response to concerns raised in the Department of Finance's audit, the Legislature first exercised its authority to amend the act. In the years since, it has made three additional – and in some cases, significant – amendments, which are summarized below and in a timeline in Appendix B. Stakeholders credited the Legislature with removing burdensome administrative requirements and generally streamlining the flow of money to the counties. But others say these changes produced a new funding process and a local oversight structure significantly different from what voters enacted in 2004.

Clarifying Role of Oversight Commission. Lawmakers first amended the act in 2009, moving the Mental Health Services Oversight and Accountability Commission out of the Department of Mental Health and authorizing the oversight commission to obtain data from the mental health department and local entities that receive MHSA funds. By 2010, the oversight commission had shifted its focus from reviewing and approving PEI plans to evaluating the act's outcomes and studying the appropriate and effective use of MHSA funds, its executive director told the Commission.⁵² Hampering the oversight commission, however, was its dependence on other entities to provide data necessary for its evaluations. This complication continues to impede the commission and is discussed further in the next chapter. The legislation also gave the oversight commission authority to issue guidelines for how counties would spend MHSA funds on some of the act's more controversial – but also cutting-edge – Prevention and Early Intervention and Innovation programs.⁵³

Shifting Oversight Responsibilities to Counties. In 2011, frustrated by the state's lengthy approval process and delays in getting money to the counties, the Legislature introduced more significant amendments, including one redirecting \$861 million of MHSA funds away from expanding and adding new programs to propping up existing General Fund programs devastated by state budget cuts. Lawmakers also amended the act to require the State Controller's Office to provide counties their MHSA funds directly in monthly lump sum installments. This change eliminated state approval of county mental health plans. Now county boards of supervisors "self-certify" their plans in accordance with requirements of the act.⁵⁴ While the Legislature made these changes to speed the flow of MHSA money to counties, it reduced the state's ability to oversee use of the funds. Previously, county allocations were distributed by component, making it easier to understand how each county invested its MHSA dollars.

Oversight Responsibility Changes Hands at the State, Overlap Remains. In 2012, lawmakers again introduced major reform to the state's mental health system, producing significant consequences for who would oversee the Mental Health Services Act and how. To streamline the state's administration of its mental health programs, lawmakers eliminated the Department of Mental Health and transferred many of its MHSA-related functions to the Department of Health Care Services.⁵⁵

Lawmakers also codified requirements for counties to provide the oversight commission annual revenue and expenditure reports to facilitate the commission's financial oversight of MHSA expenditures. The oversight commission regained authority to approve county plans for developing Innovation programs before funds were distributed to

counties. However, decisions about the vast majority of spending through Community Services and Supports and Prevention and Early Intervention programs remained with the counties, which continue to submit plans for these programs to the state for review, but not approval.⁵⁶ In 2013, lawmakers further empowered the oversight commission to issue regulations for Prevention and Early Intervention and Innovation programs, which will be adopted by early June 2015.⁵⁷ Responsibility for regulating other components remained with the department. The department told the Commission it is currently updating regulations related to Community Services and Supports, Capital Facilities and Technology Needs and Workforce Education and Training.⁵⁸

“At this time, I believe that all of [the amendments] have improved the functioning of the act,” Rusty Selix, Proposition 63 co-author, told the Commission.⁵⁹ Yet, the Commission also heard from stakeholders suggesting that current state oversight remains a confusing patchwork of overlapping responsibilities. More, they said, the multiple government entities overseeing today’s MHSA’s funding streams and programs still cannot systematically or comprehensively evaluate outcomes to demonstrate what the act has accomplished.

Governing the MHSA Today: Oversight Challenges Persist

Despite well-intentioned state efforts to improve the MHSA’s implementation, today’s newer landscape of multiple-entity oversight can still baffle stakeholders. The Legislature’s initial modifications empowered the Mental Health Services Oversight and Accountability Commission by making it independent of the Department of Mental Health. Yet both continued to share oversight responsibility for the act.

The Legislature’s more recent modifications largely preserved this original structure of diffused authority, with the Department of Health Care Services rather than the Department of Mental Health, sharing primary oversight for the act with the Mental Health Services Oversight and Accountability Commission. Both entities also collectively regulate how counties spend MHSA funds. The oversight commission, however, must rely on the department and counties to provide the data it needs to evaluate programs funded by the act. Getting that data can sometimes prove difficult.

Indeed, some believe that despite the Legislature’s attempts to improve initially-blurred governance of the act, state oversight continues to be muddled, confusing and inadequate. “Right now, with the dissolving of [the Department of Mental Health], we have five different state organizations that are overseeing the different funding sources,” Jessica

Cruz, executive director of the National Alliance on Mental Illness, California, told Commissioners in September 2014.⁶⁰ The roles of these entities and others involved in implementing the act are summarized in the box on the following page.⁶¹

Stakeholders told the Commission that the partnership between the department and the oversight commission appears collaborative. Both recently conducted efforts to improve mental health data systems and held joint discussions regarding ways to improve data quality.⁶² Yet challenges also abound in this governing arrangement. In some respects the two state entities could hardly be more different.

The department is massive and focused on an entire health care universe that includes Medi-Cal, the Affordable Care Act, dental health, substance use disorder services and long-term care. Mental health is a small piece of its portfolio and the MHSA even less so. Put simply, “DHCS is the statutory entity for the administration and implementation of the MHSA as well as the overall public mental health system,” one member of the oversight commission explained. “They are the owners of the major data systems by which counties report information to the state. This includes accumulating financial information as well as outcomes [for the MHSA].”

The oversight commission is independent, small and responsible only for the MHSA’s 25 percent share of California’s overall mental health care spending. Yet, the oversight commission is reliant on the department and counties for the data it needs to fulfill its evaluation function.

Little State Oversight of County Expenditures, Implementation

Among the consequences of the Legislature’s modifications of the original 2004 Mental Health Services Act, few are bigger than the current overall lack of state control over how counties spend their funds. The Legislature’s changes provided a significant win for local control of MHSA spending that the original act did not. Counties now enjoy great flexibility in determining where and how to deliver the vast majority of services funded by Proposition 63. Only small-scale plans for innovative and experimental programs require approval from the oversight commission before funds are released.

Amplifying local control is not out of step with the initial design of Proposition 63, which created a client- and family-driven decision process that weighed heavily toward spending priorities set by local stakeholders. But unlike the checks and balances that often govern public spending, counties, in this sphere, have a one-stop accountability structure in which the boards of supervisors approve MHSA plans and then also allocate the MHSA funds for them.

Major Players in MHSAs Implementation

California's Counties: County boards of supervisors approve counties' three-year program and expenditure plans and annual updates. Prior to adoption, a county's mental health director or auditor controller must certify that its mental health program and expenditure plans comply with the Mental Health Services Act. Counties must submit their plans to the oversight commission and Department of Health Care Services for review, but no longer require their approval.

Mental Health Services Oversight and Accountability Commission (oversight commission): With 30 positions and an operating budget of approximately \$9 million in 2014-15, the oversight commission monitors and evaluates use of funds in each of the five MHSAs components and researches and evaluates the effectiveness of MHSAs services and their outcomes. To date, it has launched dozens of new evaluation projects ranging from descriptive studies to complex services outcome studies for multiple components. It also:

- Advises the Governor and Legislature on ways to improve care and services for people with mental illness.
- Provides training and technical assistance to counties.
- Develops regulations for the Prevention and Early Intervention and Innovation components and approves county innovation plans.

In addition to its oversight role, the commission administers \$32 million in annual grants to fund triage staff that will provide crisis support services, such as brief, therapeutic intervention and intensive case management in participating counties.

Department of Health Care Services, Mental Health Services Division (DHCS): With 19 positions and an operating budget of more than \$9.3 million in fiscal year 2014-15 devoted to the MHSAs, the department's mental health services division provides fiscal and program oversight of counties' use of MHSAs funds. The department collects MHSAs data from the counties, develops and monitors counties' performance contracts and conducts annual fiscal data reviews and triennial on-site reviews and:

- Reviews the MHSAs allocation methodology and monitors distribution and reporting of MHSAs funds.
- Develops and reviews county revenue and expenditure reports.
- Develops regulations for the Community Services and Supports, Workforce Education and Training and Capital Facilities and Technological Needs components.
- Administers contracts with several entities related to statewide prevention and early intervention activities.

The department is the only state entity with ability to require corrective action of the counties regarding the act.

Office of Statewide Health Planning and Development (OSHPD): When the Department of Mental Health was dismantled in 2012, OSHPD assumed responsibility for preparing the MHSAs five-year Workforce Education and Training plan. With 15 positions and an operating budget of approximately \$3.87 million in fiscal year 2014-15, OSHPD conducts various planning activities including psychiatric residency programs, a statewide technical assistance center to support county health agencies, a residency program for physician assistance in mental health and a mental health loan assumption program to encourage professionals to practice in underserved locations in the state.

California Mental Health Planning Council: Established in 1993 in response to the Legislature's realignment of mental health program responsibility and funding to the counties, the council advises the DHCS mental health policy, provides oversight of OSHPD's Education and Training plan development and also reviews and approves each five-year Education and Training plan. The council consists of 32 members appointed by DHCS and eight state department representatives. Half of the appointees are family members, direct consumers of mental health services or people who represent organizations that advocate on behalf of people with mental illness.

Office of Health Equity, California Department of Public Health: Established in June 2012, the Office of Health Equity works to align state resources and programs to reduce health and mental health disparities, with special attention focused on disadvantaged, vulnerable, or isolated communities. The office consists of 17 employees and received \$60 million of MHSAs state administration funds to implement the statewide California Reducing Disparities Project over the course of four fiscal years 2012-13 through 2016-17. The project is designed to improve access, quality of care, and increase positive outcomes for racial, ethnic and Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) communities in the public mental health system.

Many stakeholders recognize the value of community involvement in prioritizing funding, and equally recognize that individual counties have their own priorities and needs. One stakeholder called the local emphasis “the best piece of the act.” But some also see a variety of local decision-making processes and lack of a state oversight body to ensure statewide consistency in local programs as an implementation weakness. Others expressed concerns to the Commission that counties lack staff with sufficient knowledge of the act to ensure appropriate types of expenditures. For example, local mental health boards – required by the act to advise boards of supervisors on the content of county MHSA plans – often lack adequate funding and staff to carry out meaningful advisory roles, Rusty Selix told the Commission. He said the sometimes-limited makeup of mental health boards also can fail to include the views and needs of unrepresented client groups.⁶³

The annual budget process in California’s 58 counties triggered additional concerns about lack of transparency or meaningful ways for participants to engage in decision-making. The Commission heard, for example, that stakeholders hesitate to speak out against county decisions for fear of losing funding for their priorities in the next budget cycle. They suggested that dominant local voices often hold sway over county spending priorities while groups that lack an organized presence or maintain a low profile due to the stigma of mental illness are excluded. Without a broader statewide oversight body, advocates said there is nowhere to voice concerns about county spending except to those making the actual decisions.⁶⁴

Stacie Hiramoto, another advocate, told the Commission that at the state “there is a culture of accommodating and supporting the counties, even when community stakeholders [consumers, family members, community providers and representatives of underserved racial, ethnic and cultural communities] are advocating for stronger oversight and accountability in terms of administration of the MHSA.”⁶⁵

“If a county is not adhering to the vision of the MHSA, there is no statewide oversight body with authority over county MHSA funding distribution that would be able to oversee the process,” Jessica Cruz, executive director of National Alliance on Mental Illness, California, told the Commission. “In fact, the counties providing services are the ones who are creating them, and if someone has a problem, they have to attempt to go to those in power which will more than likely result in status quo.”⁶⁶ Ms. Cruz recommended giving a statewide agency the authority to approve, oversee and fund county plans and programs. She argued that this extra layer of review would enable the state to provide better guidance to counties and ultimately create better outcomes for consumers.⁶⁷

Still, as demonstrated by the act's initial implementation, comprehensive state oversight of county MHSA spending plans has its own potential shortcomings. Early state oversight created an overly bureaucratic, paper-heavy process that ultimately slowed the flow of funding to the counties and delayed delivery of critical services for those with the most severe mental illnesses. The majority of money from the act – 80 percent – is sent to the counties to fund proven programs for the severely mentally ill. It is important that the department continue to monitor this spending and equally important that the oversight commission study program outcomes to better understand how they are helping people lead better lives. But building an additional bureaucratic layer of state review for proven programs might prove excessive and could once again slow the flow of funding to the counties.

By design, however, not all programs funded by the act are built on proven models. Through its Prevention and Early Intervention and Innovation components, the act allows counties to spend approximately 25 percent of their MHSA dollars on new and innovative community-defined or promising practices designed to help people before they are formally diagnosed with a severe mental illness. The act directed a large part of this pot to brand new preventative programs meant to end the pattern whereby children have to fail in school or at home before their mental health problem is identified and treated and before adults drop out of college or lose their job, Mr. Selix told the Commission.⁶⁸ These programs have the most potential to increase culturally competent services to racial and ethnic communities and reduce disparities across the state, Stacie Hiramoto, director of the Racial and Ethnic Mental Health Disparities Coalition, told the Commission.

Counties only started introducing these programs in 2009 – due to MHSA's initially-staggered implementation schedule – and are just beginning to develop the data to demonstrate the results. Without comprehensive outcome data, some programs have attracted criticism within the mental health community and from those who believe the act's funds should be directed solely towards those with severe mental illness. The media has amplified the concerns. Media reports in mid-2012 strongly criticized various programs being funded by the MHSA, citing state spending for “acupuncture, art and drama classes, sweat lodges for American Indians, parenting courses for Spanish-speakers and massage chairs for students in Southern California.”⁶⁹ Reports also criticized expenditures for anti-bullying programs, horseback riding therapy, yoga classes and gardens for rural Asian refugees.

“Every objective review [of Prevention and Early Intervention programs] has found those critics to be off-base, generally reflecting a lack of appreciation of the value of prevention and early intervention versus

focusing all funds on people who are already severely disabled,” Mr. Selix told the Commission.⁷⁰ Until the state evaluates whether these programs have tangible benefits, critics could continue to single them out.

In the meantime, to quell concerns about expenditures on these sometimes controversial programs, the state should bolster oversight of the Prevention and Early Intervention plans, as it already does for the Innovation plans, which require oversight commission review and approval before money goes out. Before the Legislature changed the plan approval process, the oversight commission had established a track record of approving both plans in a timely manner – just 28 days.⁷¹ Indeed, lawmakers already have granted the oversight commission responsibility to regulate the Prevention and Early Intervention programs. The regulations, expected to be adopted in June 2015, “will clarify what data reporting is necessary, and when, and how often this data reporting must happen.” They also will establish a more standardized process for obtaining consistent county data.⁷² Like Innovation programs, Prevention and Early Intervention programs are unique, and because of their new and different approaches to treatment, counties and stakeholders could benefit from additional technical assistance from the state as well as approval.⁷³ Many others too believe upfront review of the PEI programs by a state entity could enhance confidence in the way counties spend this portion of their funds.

No One-Stop Authority to Sanction Counties that Mishandle Funds

One especially confusing segment of Mental Health Services Act oversight revolves around the diffused authority of the oversight commission and the health care services department to require corrective action when counties mishandle funds. The two entities share authority to oversee county spending, but not to correct errors or abuses. This diffused authority undermines effective oversight of funds approved by voters in 2004. As described earlier, lawmakers created the dilemma when they sped the flow of money to counties by eliminating requirements for the state to approve most county MHSA program and expenditure plans.

The State’s Review Role. Counties are still required to send their three year program and expenditure plans to the oversight commission, describing how they will use the funds in accordance with the act.⁷⁴ They also must provide annual updates describing changes to those plans. The oversight commission is required only to receive these plans. Nonetheless, as part of its oversight function, it reviews them to ensure compliance with the act. In their reviews, oversight commission staff said they occasionally have identified instances where counties inappropriately spent MHSA money. Violations include directing all funds to programs for the severely mentally ill without funding

prevention and early intervention programs as required by law. Others include failing to spend MHSA money in a timely manner or using it to supplant other program funds.⁷⁵ Though the oversight commission can and does help counties correct some of these issues, it is not empowered to require counties to correct their actions. Instead the oversight commission is directed by law to refer any critical performance issues it identifies to the department for a response.⁷⁶

The department then can withhold mental health funds from counties or require counties to enter into negotiations to comply with laws and regulations. The deputy director in charge of mental health and substance use programs told the Commission the department reviews issues identified by the oversight commission and determines if further action is required under current laws, regulations and performance contracts. Stakeholders told the Commission, however, the department does not always exercise this authority in a timely manner and that at least one case has been pending for two years. The deputy director told Commission staff the two year case is only one example and doesn't accurately reflect how long the process will take in the future. She said the department is currently "improving administrative capabilities to provide increased oversight and monitoring."⁷⁷ Indeed, the department has recently developed a draft protocol to ensure that it handles future critical performance issues in an effective and consistent manner.⁷⁸

Counties' Role to Report Spending and Program Implementation. As described above, lawmakers in 2012 codified the requirement for counties to submit electronically annual revenue and expenditure reports to both the Department of Health Care Services and the oversight commission.⁷⁹ The department also is authorized to withhold MHSA funds if counties fail to meet reporting deadlines.⁸⁰

While the department reviews these reports to verify the accuracy and appropriateness of county's expenditures, these reports also are a critical evaluative tool for the oversight commission because they show how counties spend MHSA funds, quantify the total funds generated for the mental health system and provide information to evaluate of each of the MHSA components. However, not all counties submit these reports to the state in a timely or consistent manner. As of December 2014, both the oversight commission and department had received these reports from all counties for fiscal years 2009-10 and 2010-11 (but were missing reports from several counties for fiscal year 2011-12).⁸¹ More current financial information is not yet available (the department has plans to issue instructions for the counties to submit reports through fiscal years 2014-15 by early summer 2015).⁸² Taking these steps to fill the gaps in financial reporting is critical to the oversight commission's ability to hold counties accountable for their MHSA expenditures. Additionally, without

such information, the commission is limited in its ability to monitor and evaluate the statewide impact of MHSA funding.

“We also need to know where all of the funding not spent on comprehensive services has gone and how big the gap is in achieving our goals in each county. This is still a missing set of data,” Rusty Selix told the Commission. “It appears as though the oversight commission has the authority to require this information from counties. However, there might be a need to strengthen the authority of the commission to obtain the information it may need.”

The success of the act depends on the success of the counties. However, stakeholders told the Commission that until a state watchdog agency can ensure repercussions for counties that fail to provide required information about their implementation of the act, the state will not be able to collect data consistently and its evaluative efforts will continue to be hampered.⁸³ It is therefore imperative that the state exercises its authority to ensure that each county spends the money as allowed by law – and is sanctioned accordingly if it does not comply. Equally imperative is that counties fulfill their reporting obligations in a complete and timely manner. To ensure consistency among counties statewide, stakeholders recommended that “there should be a statewide oversight that has teeth for enforcement.”⁸⁴ Like the department, the oversight commission should be empowered to work directly with counties to address deficiencies and require corrective action, including the ability to withhold MHSA funds, to ensure compliance if necessary.

Weak Oversight of State Administration Funds

The MHSA allows the state to allocate a small percentage of funds to state entities involved in administrative duties related to the act. The Department of Health Care Services estimates that in fiscal year 2014-15 it will allocate \$86.9 million in MHSA state administration funds to 12 state entities. Some of those entities include the mental health department, oversight commission, Department of Public Health, the state’s Judicial Branch, Military Department, Department of Education and Department of Veterans Affairs.

The former Department of Mental Health used to coordinate interagency partnerships among the various entities that received MHSA state administration funds. As part of its oversight function, the department would coordinate annual budget change proposals from entities seeking a portion of the MHSA state administrative funds. If approved through the budget process, the department would establish memorandums of understandings with receiving agencies based on their budget change proposals. The memorandums of understanding clarified expectations

and responsibilities around how the receiving entities would use the MHSA funds. The department also monitored expenditures through work plans and progress reports submitted by receiving entities.⁸⁵

The Department of Health Care Services assumed responsibility for administering the MHSA fund since the dissolution of the Department of Mental Health. But it has not instituted its predecessor's approach to overseeing allocation of the state administrative funds. Today, departments submit budget change proposals for state administrative funds directly to the Department of Finance and finance analysts may seek additional input from the department or the oversight commission. Funds are allocated through the state budget process.⁸⁶ The Department of Health Care Services describes administrative expenditures for state entities receiving MHSA funds in its annual Mental Health Services Act Expenditure Report. Though the level of detail provided varies, the report generally describes the amount and number of positions funded by the MHSA and includes an overview of the program's activities.⁸⁷

Though the oversight commission is not formally involved in decisions about how these funds are used, its financial oversight committee recently began inviting entities that receive part of the MHSA state administrative funds to report their uses to the oversight commission.⁸⁸ To date, five state entities have made presentations to the committee on their use of MHSA funds: the Judicial Council, Office of Statewide Health Planning and Development, Department of Developmental Services, Department of Education and Military Department. According to the subcommittee's chair, it is developing a format for sharing findings from these presentations to the full oversight commission.⁸⁹

Rather than evaluate the merits of funding each individual program, the state should comprehensively evaluate its spending to ensure program purposes and efforts align with the context of the act and its various goals. Also, because the funds stem from a surtax – by nature, a variable revenue stream – the state also must be capable of prioritizing spending to best meet the goals and intent of the act, particularly in times when requests exceed available revenue. By strengthening its reporting of how these funds are used, as well as the outcomes they are achieving, the state could model the type of accountability that is needed for all of the act's expenditures and ultimately, help to build confidence that the act is achieving its goals.

Summary

Despite the Legislature's interventions to streamline the governance and financial outlays of the Mental Health Services Act, the state still lacks a strong oversight body that is empowered to monitor and oversee

expenditures. Nor can the state effectively impose sanctions, when necessary, to ensure the act is implemented and delivers the results voters were promised. Primary responsibility for overseeing the act continues to be shared by two entities at the state level. But stakeholders said these entities have yet to provide comprehensive oversight the state needs to demonstrate that \$1 billion a year or more is funding appropriate and effective mental health programs and services. The Department of Health Care Services is still relatively new to its mental health responsibilities. And it is simultaneously focused on the much larger task of implementing federal health care reform and transforming Medi-Cal, the state's version of the federal Medicaid program that provides health insurance for low-income, senior and disabled Californians. The Mental Health Oversight and Accountability Commission is designed to provide the kind of monitoring and evaluative efforts the state lacks. But it is not currently empowered to do so. The time is opportune for policy leaders to re-evaluate this shared governance of the Mental Health Services Act so that oversight and enforcement responsibilities are clear and the state is more responsive to its county partners and mental health system stakeholders.

Recommendations

Recommendation 1: The Legislature should expand the authority of the Mental Health Services Oversight and Accountability Commission. Specifically, it should:

- ❑ Strengthen the ability of the state to conduct up-front reviews of the more controversial programs funded by the act before funds are expended by requiring the oversight commission to review and approve county Prevention and Early Intervention plans annually, as it currently does for Innovation plans.
- ❑ Refine the process by which the state responds to critical issues identified in county three-year plans or annual updates to ensure swift action. Empower the oversight commission to impose sanctions, including the ability to withhold part of the county's MHSA funds, if and when it identifies deficiencies in a county's spending plan. Decisions of the oversight commission should become mandatory unless they are overturned by the Department of Health Care Services within a reasonable period, such as 60 days.

Recommendation 2: To provide greater oversight and evaluation of the state administrative funds, the oversight commission should annually develop recommendations for and consult with the Department of Finance before the funds are allocated.

Improving Transparency and Accountability

Voters in 2004 were told their investment in the Mental Health Services Act would likely trim millions of dollars from costs of incarceration, medical care, homeless shelter and social service programs by helping Californians with serious mental illness get better care and support. The act would save more by getting in front of this health problem and preventing mental illness from becoming debilitating. Despite apparent successes in both realms after 10 years, the state entities in charge of overseeing the act have yet to produce data to fully demonstrate the act’s statewide achievements and its overall progress toward these intended results.

“The act transformed the mental health system and is helping tens of thousands of people,” Senator Darrell Steinberg told the Commission chair and staff as he reflected on successes of the Community Services and Supports programs that provide wrap-around supportive care for the severely mentally ill. However, without collecting data and aggregating results to demonstrate similar successes of Prevention and Early Intervention and Innovation programs, Senator Steinberg said he feared critics would continue to argue that the state is spending money on “soft” programs.

“It’s a gift from the people,” he said. “It ought to be pushed to be even better.”⁹⁰

Critical Questions Remain Unanswered

Commission witnesses largely confirmed Senator Steinberg’s assessment of an act that has successfully provided care and services to thousands while also focusing the system on prevention and early detection of mental illness. Yet witnesses also shared his concerns about a lack of hard data to demonstrate or confirm those successes statewide. Indeed, there remains today a lack of easily accessible information about how much revenue the act has generated, how and where the mental health system has invested the money, who those investments have benefitted and how they have improved mental health services in California. To provide voters with confidence that money is being spent as promised,

the state needs to be able to answer basic questions about how the act has been implemented and what it has achieved.

How Much Money is Being Spent? And Where?

To be confident that the state is appropriately spending MHSA dollars, Californians should be able to see exactly how much money has been raised through the Mental Health Services Act and have at least a broad understanding of how and where that money is being spent, by county and by component. However, in researching this topic, the Commission found that basic and up-to-date financial information about MHSA revenues and expenditures is widely scattered across the websites of key state oversight entities and is not easy to locate.⁹¹

Information about the Mental Health Services Act is available on websites of the Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, as well as a separate website maintained by the oversight commission – prop63.org. Though all provide some description of the act, its source of revenue and purposes, none give a current or complete statewide financial picture. Additional information about the act is scattered across various county websites, as well as other organizations that are affiliated with implementing the act.

California's 58 counties are required to report to the state how they intend to use MHSA funds in their three-year program and expenditure plans and annual updates. However, neither the department's nor the oversight commission's website contains a complete online repository of these plans. (The oversight commission maintains an archive of approved county Prevention and Early Intervention plans through fiscal year 2009-10, as well as approved Innovation plans.) Without a single repository for information about the act, those interested in understanding or comparing county plans must separately visit each county's website.

Similarly, counties are required to send revenue and expenditure reports to the state that certify how they used their MHSA funds. However, these reports are not consistently available on state websites. The Department of Mental Health used to post these reports online, but the Department of Health Care Services has not continued the practice (though their website still hosts counties' reports from fiscal years 2008-09 and 2009-10).⁹² As of December 2014, the department's website said these reports were "pending" and they were not readily available on the oversight commission's website.⁹³

Though the Department of Health Care Services annually compiles financial information about the act into an annual revenue and expenditure report for the Legislature, it only provides summary information by component area for local expenditures and explains in greater detail how the state administrative funds are spent.⁹⁴ This annual compilation is likely helpful for experts who work in the Capitol or those who monitor the act at a high level, but does not allow for county-by-county comparisons. Previous Department of Mental Health reports summarized approved allocations by county and by component for each fiscal year.⁹⁵ The best, most detailed information about how counties use their MHSA funds in each of the component areas comes from outside organizations, not from the state's oversight bodies. Since 2012, National Alliance on Mental Illness, California, a grass roots organization representing families and individuals whose lives have been affected by serious mental illness, has compiled information from all 58 counties into an annual report that describes each county's MHSA program, population served and the name and contact information for each county's MHSA coordinator or link to its county website.⁹⁶

Who is Being Served?

Of California's 26.9 million adults, 2.2 million or 8.3 percent, have a mental health need, according to the Mental Health Services Oversight and Accountability Commission.⁹⁷ Mental health needs tend to be greater for women, younger adults, the poor, the uninsured, and some ethnic groups, such as Native Americans.⁹⁸ Though improving the lives of these individuals is core to the purpose and intent of Mental Health Services Act, witnesses at the September hearing told the Commission the state cannot account for the overall number of people served by the act or produce basic demographic data to understand who has benefited from Proposition 63's historic investment.

Part of the problem is that the oversight commission's evaluations must rely on data gathered from counties by the Department of Health Care Services. But counties do not collect demographic data in a consistent manner across the state. Nor do all consistently or completely comply with reporting requirements. A lack of standard practices in gathering up-front client information and demographics, such as race and ethnicity, makes it difficult for the state to say with authority who has been helped by programs funded with MHSA dollars. "We need reliable data that measures client-level outcomes that can be scaled up to produce program, county and state results," Dr. David Pating, chair of the oversight commission's evaluation committee told the Commission.⁹⁹

Lack of this data limits the oversight commission in the types of conclusions it can draw about the act's impact. It has said, for example,

that Prevention and Early Intervention programs have reached an increasing number of people across all age groups, or that an increasing proportion of children, transition-age youth and older adults are participating in full-service partnership programs within the Community Services and Supports component.¹⁰⁰ But it lacks data necessary to report with certainty how many people were helped overall, how many were helped within each component area, and how different groups of people (as measured by age, gender, race, ethnicity, socioeconomic status) fare compared to others.¹⁰¹

This lack of data is particularly concerning for advocates for the state's varied ethnic communities who fear there are gaps between needs and services tailored to their communities. These stakeholders explained that the state lacks critical data to help evaluators track where mental health services are provided, understand their effectiveness and identify remaining needs. Without data on gender identity, for example, the state cannot know if care to the LGBTQ population is sufficient or effective. Similarly, better data on the settings where services are provided, including the correctional system, could help the state analyze the quality and appropriateness of those services. More information about the composition of the mental health workforce, including the number and availability of bicultural or bilingual staff, could target training and recruitment efforts to fill specific gaps. Many of these recommendations are included in the research and findings of the California Reducing Disparities Project, which is described further in the box below.

"LGBTQ people face harm every day," Pasha Mikalson, project director with Mental Health America of Northern California told Commissioners in September 2014. "But not being counted, and therefore remaining invisible in this system, represents an absolutely preventable harm and also an enormous disparity."¹⁰²

"We don't come to the traditional mental health system because it doesn't fix us. It makes us feel worse. It actually makes us sicker," Janet King, community relations coordinator with the Native American Health Center told the Commission. "We need our own indigenous system of care [and] our own best practices. And that's what the MHSA has allowed us to do and has great potential for us to do more of."¹⁰³

"We want to get historically traumatized and at-risk audiences served early, in order to short-circuit some of the law enforcement treatment African Americans with mental illness typically received," Nicelma King, project director of the African American strategic plan workgroup told the Commission. "Our community needs access to jobs and job training, not just more antipsychotic medication."¹⁰⁴

Though advocates discussed the potential for the act to address the unique needs of the state’s diverse communities, they said the evaluations have not yet produced the evidence to show that these new programs are working. “The Mental Health Services Act has undoubtedly increased the potential for more culturally competent services to be provided to racial and ethnic communities and for disparities to be reduced,” Stacie Hiramoto, director of the Racial and Ethnic Mental Health Disparities Coalition, told the Commission. “However, there is very little evidence in the way of formal studies or evaluations regarding whether the MHSA has actually reduced disparities or increased culturally competent services.” As a result, she explained, the state cannot determine the extent to which the act has reduced disparities in services for racial and ethnic minorities.¹⁰⁵

California Reducing Disparities Project

In 2009, in order to reduce mental health disparities and improve the health of California’s diverse population, the California Department of Mental Health – now the California Department of Public Health’s Office of Health Equity – launched the California Reducing Disparities Project. It was a multi-year project that allocated over \$3 million of Mental Health Services Act funding to identify and develop community-defined treatment practices to improve access, services, outcomes and quality of care for diverse racial, ethnic and cultural groups. The project focused on identifying unique mental health needs of five population groups: African Americans, Asian/Pacific Islanders, Latinos, Native Americans and Lesbian, Gay, Bisexual, Transgender and Questioning. As part of the project, five strategic planning workgroups comprised of community members and leaders developed population-specific reports highlighting new practices and recommendations for their respective communities.

Source: California Health Equity. 2013. “California Reducing Disparities Project (CRDP) Population Reports.” Reports available at <http://cahealthequity.org/california-reducing-disparities-project-crdp-population-reports/>.

Stakeholders recommended that people who are knowledgeable about disparities and committed to reducing them, and not simply those who belong to or represent racial or ethnic communities, should be at the table in local and state-level discussions about oversight and evaluation of the act.

At its October 23, 2014 meeting, the oversight commission voted to incorporate reducing disparities in access to mental health services into its evaluation work plan and to continue to plan how to get the data necessary to evaluate projects based on how they will reduce racial and ethnic disparities.¹⁰⁶ The Commission commends this action as a step in the right direction, while recognizing that the oversight commission must ensure that it succeeds in obtaining necessary data and incorporating in its evaluations reviews of the effectiveness of MHSA-funded programs in reducing disparities.

Has the Act Achieved Its Goals?

The Commission recognizes that the success of the state’s mental health programs cannot be measured through evaluation of the act alone. But after a decade and an investment of more than \$13 billion, it is

reasonable for Californians to expect to better understand how the Mental Health Services Act has lived up to expectations promised in the Proposition 63 campaign.

The Mental Health Services Oversight and Accountability Commission has a statutory mandate to evaluate how MHSA funds have been used, what outcomes have resulted from those investments and how to improve the services and programs to maximize positive outcomes for all populations. Since 2010, the oversight commission has developed and refined its strategy for evaluating the act's outcomes through its adoption of a MHSA evaluation master plan.¹⁰⁷ The oversight commission is working with key stakeholders to modify and improve existing performance indicators and identify new indicators that will provide a broader measure of the impact of the act and support quality improvement efforts at the state and local levels. Future performance monitoring will incorporate additional measures that include community level indicators that assess the potential impact of the MHSA on California as a whole, its executive director told the Commission.¹⁰⁸ In the meantime, the oversight commission has launched dozens of evaluation projects for programs in multiple components.¹⁰⁹

Though the oversight commission's evaluation studies are available online for the public and other interested parties to review, none speak directly to the state's progress toward broad goals identified in the act. Instead, efforts generally focus on individual program evaluation. As such, these studies cannot answer these types of questions:

- Have statewide rates of incarceration and homelessness declined?
- Are Californians getting the help they need to stay in school or continue working?
- How have statewide rates of suicide changed since the Mental Health Services Act was enacted?
- Are more programs available to meet California's diverse cultural and linguistic needs?
- Which Californians are being served and who is falling through the cracks?

The state now needs to begin to answer those, and similar, broad questions so it can better tell the story of how this special tax has improved California's mental health system and enacted the reforms intended by voters in 2004. Until the state can better demonstrate that the Mental Health Services Act has helped reduced negative outcomes associated with untreated mental illness and describe how the programs have contributed to Californians' improved mental health and emotional well-being, critics likely will continue to question the effectiveness of the

act. Ultimately, such questioning can erode public confidence in state government's ability to hold up its side of the bargain and deliver societal benefits promised in a ballot initiative. Worse, a growing erosion of public confidence in this measure in particular could encourage a policy atmosphere for diverting the money or even a movement to rescind the act.

How Has the Act Helped Improve Lives?

Basic fiscal and program information combined with treatment outcome data could be a powerful tool for helping legislators and others better understand the state's mental health needs and the act's successes in addressing those needs. But the state does not yet have the capability to conduct this type of analysis, Rusty Selix explained in testimony to the Commission. "At the state level, there is more data analysis and reporting needed to develop the foundation to do the real work, which is to shine a bright light on the counties and providers who are having the greatest success and educating the others on the changes they need to make."¹¹⁰

Representatives from the state entities in charge of overseeing the act told the Commission that the state still lacks data to answer the question: Are people getting better as a result of these MHSA services?

"Do we know the efficacy of these programs?" Karen Baylor, deputy director of the Department of Health Care Services asked. "No, we don't."¹¹¹

One significant hurdle stands out: The oversight commission, which is in charge of evaluating the act, does not have access to complete and timely data about counties' programs in the various component areas. To conduct its analyses, the oversight commission must rely on county data obtained from the Department of Health Care Services, which has owned the state's mental health data systems since the Department of Mental Health was dismantled in 2012. Problems stemming from these data systems dominated testimony at the Commission's September 2014 hearing. Witnesses attributed the lack of evaluation data to an "antiquated" state data infrastructure that, despite recent investment of approximately \$3 million of MHSA funds to upgrade the department's data systems, has serious problems. In addition, the systems only provide limited data (specifically, client outcome data for those participating in one type of CSS program – full-service partnerships) that is useful for the type of regular assessment the oversight commission wants to conduct.¹¹²

“We have a legacy [data] system,” Richard Van Horn, chair of the Mental Health Services Oversight and Accountability Commission told Commissioners, “[but] we need to have a system, statewide, where counties can talk to each other, agencies can talk to each other and all can talk to the state.” And, he said, the ideal system would be fully interactive and allow the state to “talk back” so we can communicate evaluation results back to the counties, not just get the data from them.¹¹³

In addition, the state’s mental health data system is limited by “input” challenges related to how data is collected, verified, validated, corrected and ultimately entered into the system. According to a report of the oversight commission, client information is not consistently entered during intake processes, making it difficult to measure individual change over time. Counties do not all submit their data to the state in a timely manner. Nor do they collect data in a consistent manner across counties. Additionally, at the state level, data submitted by the counties might get tied up in department processes for review and certification before it is available for analysis by the oversight commission.¹¹⁴ Experts told the Commission that counties’ ability to report and analyze MHSA outcomes varies based on the type of data system they have established. Only some counties, like Los Angeles, produce advanced reports for some of their MHSA programs that describe how many people are able to continue working, remain at home or out of jail as a consequence of accessing mental health services they needed.¹¹⁵ Taken together, these inconsistencies ultimately hinder the state’s ability to conduct statewide evaluations of the act.

Witnesses told the Commission that without a stronger data system that produces accurate, complete, meaningful and timely data, the state will be unable to produce a comprehensive, outcome-based evaluation of the MHSA funds. “Ultimately, these data systems are unable to provide the detailed client, program or county results that we’ve deemed important in the MHSA evaluation master plan,” explained Dr. Pating, chair of the oversight commission’s evaluation committee. “In the long term, a new statewide mental health data system will be needed.”¹¹⁶

Evaluating Outcomes In the Meantime

Despite these difficulties described above, the oversight commission has moved forward with evaluation efforts in several of the component areas:

Community Services and Supports. This largest share of MHSA funds to counties, up to 80 percent, supports a variety of programs and services to help people recover from mental illness and thrive, including full-

service partnerships and outreach and engagement activities aimed at reaching unserved populations.

To monitor the success of programs and services funded within this component, the oversight commission, along with partners, identified a list of 12 priority indicators intended to measure consumer outcomes and system performance.¹¹⁷

Noting its challenges with the overall data quality, reliability and availability to adequately calculate progress on all 12 indicators, the oversight commission nevertheless decided to proceed with its analyses using the data it had available. A May 2014 report funded by the oversight commission analyzed CSS data to identify trends among the priority indicators and interpret and discuss implications of consumer outcomes and the system’s performance. Though findings were limited due to issues with the data sources, the report begins to present a snapshot of who these program are serving and how well they fare.¹¹⁸

Analysis by the oversight commission suggests that since the act’s passage, more people have received expanded services provided by full-service partnership programs. The commission also suggested that more previously underserved populations are accessing these services. A greater number of program participants also reported increased access to primary care physicians, while fewer had substance abuse related emergencies or were homeless, incarcerated or in an emergency shelter.¹¹⁹

Yet, the oversight commission also noted that its ability to calculate the state’s progress on priority indicators will continue to be stalled by flaws with the state’s data collection system. As previously described, large amounts of data are missing. Without more complete data, the oversight commission notes it will be unable to “draw comprehensive conclusions regarding the impact of the MHSA or confidently make comparisons across years or between service areas.” Especially troubling: These analyses cannot yet account for consumer’s race and ethnicity.¹²⁰

Prevention and Early Intervention. In addition to funding services for people with severe mental illness, the Mental Health Services Act funded new county programs to steer underserved populations such as

**Community Services and Supports
Priority Indicators**

Consumer Outcomes

1. School attendance
2. Employment
3. Homelessness and housing
4. Arrests

System Performance

5. Demographic profile of consumers served
6. Demographic profile of new consumers
7. Penetration of mental health services
8. Access to a primary care physician
9. Perceptions of access to services
10. Involuntary status
11. Consumer well-being
12. Satisfaction with services

Source: UCLA Center for Healthier Children, Families & Communities. May 20, 2014. California’s Mental Health Services Act – Statewide Evaluation. Priority Indicators Trends Report – Executive Summary (Deliverable 2.G.2).

traumatized youth, isolated seniors and culturally and linguistically diverse communities to services and reduce negative outcomes of untreated mental illness. The act also established clear goals for programs within this component: specifically, that programs should emphasize strategies to reduce suicide, incarcerations, school failure or dropout, unemployment, prolonged suffering, homelessness and removal of children from their homes.¹²¹

Programs to accomplish these goals were brand new for counties, Rusty Selix told the Commission. Measurement of their success can take many years “because what we are looking for is not direct results, but a reduction in the number of people who ‘fail first.’”¹²² Today, approximately 76 percent of counties offer preventative programs for people at risk of a serious mental illness. About 69 percent offer early intervention programs and 71 percent offer programs that focus on identifying people with a mental illness and linking them to treatment.¹²³ Counties, now, are beginning to evaluate the outcomes of these programs to better understand how they are bringing about change. A survey conducted by the oversight commission found that nearly 40 counties have completed an evaluation or are in the process of doing so for at least one of their PEI projects. Many have evaluated all of their PEI programs.¹²⁴ Still, the relative newness of these programs has made statewide evaluation difficult and various challenges remain.

The oversight commission has not yet adopted system-wide performance indicators for the prevention and early intervention component, its representatives said. Additionally, the oversight commission has identified various challenges to evaluating PEI programs. For example, commission officials said it receives minimal PEI outcome data from counties, and the data it receives varies from county to county. Often, data is provided in narrative form, making it difficult to analyze. Additionally, guidelines for counties to submit PEI program data have not been updated since 2008 when issued by the former Department of Mental Health. These guidelines do not require counties to evaluate all of their PEI programs, but do require them to identify target outcomes for each PEI program. “These barriers have created challenges when trying to understand the utility of the PEI component to achieve MHSA goals across the state,” Sherri Gauger, the oversight commission’s executive director, said in testimony to the Commission.¹²⁵

Despite these challenges, an evaluation report by the oversight commission highlighted positive preliminary findings of early intervention programs in a subset of counties:

- Children and youth showed improved social competence and skills,

- Programs for transition aged youth may have positive impacts of higher employment, less homelessness and fewer encounters with the legal system, and
- Parent-focused programs may result in improved parenting skills, family function and decreased depression, stress and anxiety.¹²⁶

Still, its analysis also found that some counties lacked internal capacity or guidance needed to develop and meet their evaluation goals. Data on individual services also was inconsistent or unavailable across counties.¹²⁷

Mission: Find Ways to Successfully Tell the Proposition 63 Story

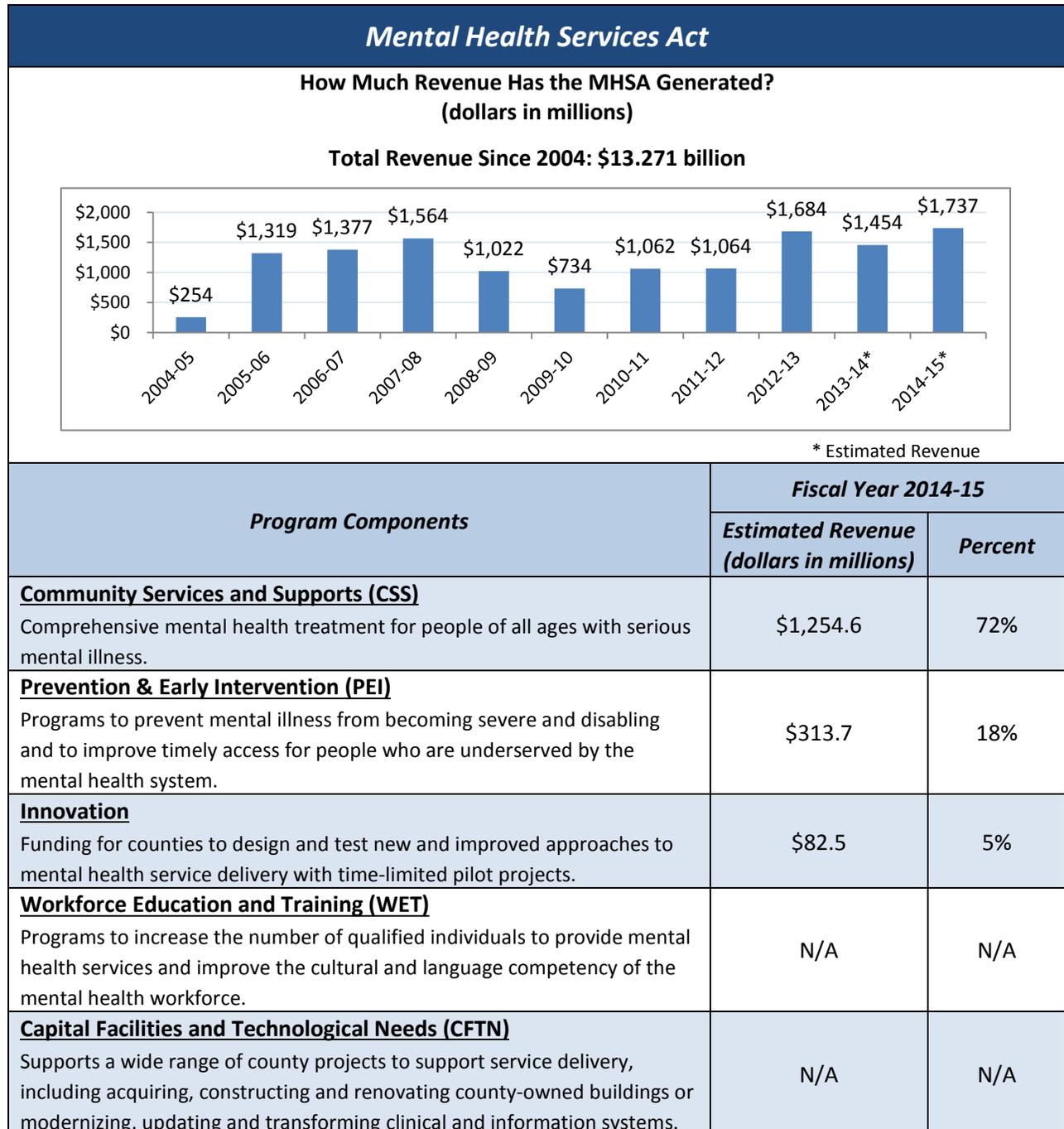
Though the oversight commission and health care services department are planning ways to improve evaluation efforts through better data collection – an important undertaking in its own right – steps can be taken today to better demonstrate to voters, taxpayers, lawmakers and, importantly, mental health clients, families and advocates how the state is using this voter-approved investment.

Improving Transparency and Financial Accountability Online

To begin to address critics' concerns about where and how the MHSA dollars are spent, while also improving accountability to the public, lawmakers and others, the entities responsible for overseeing the act could better organize and consolidate existing financial information online. A model exists in the state's bond accountability website. After voters passed a series of bond measures in November 2006, Governor Schwarzenegger directed the Department of Finance to create a website for the public to readily access information on how the bond money would be used. Though not without its flaws,¹²⁸ the website – www.bondaccountability.ca.gov – includes overviews of the various programs and projects funded by the bonds as well as detailed information about expenditures including a project's name, description, objectives, amount of funding allocated, location and contact information. In particular, the website for Proposition 1B, transportation bonds, provides a range of information to accommodate those with only a broad interest to those seeking detailed information about where the funds were spent.

Building on this model, the state could use existing MHSA financial and program data to create a website that accounts for MHSA fund revenues and expenditures. At a minimum, the website should provide a fiscal

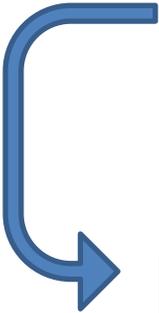
snapshot of both overall and current year revenues and allocations by program component areas, including information on the state’s annual expenditures of the state administration funds. To help interested parties better understand where the money is spent, the site should allow users to see how much money counties receive by component area – and similarly, how much state agencies receive – and include a description of the funded programs with links to program websites. Among possible models is the example below:



State Administration		
Supports administrative functions at the state level, including evaluation of the Mental Health Services Act.	\$86.9	5%
Total All Components	\$1,737.7	100%

Community Services and Supports

County	Current Fiscal Year Allocation
Alameda	\$
Alpine	\$
Amador	\$
Butte	\$
Calaveras	\$



Alameda County Community Services and Supports

Program Name/Description	Component
<u>Support Housing for Transition Age Youth</u> Provides permanent supportive housing for youth who are homeless, aged out of foster care, leaving the justice system or residential treatment.	Full Service Partnership
<u>Greater HOPE</u> Adds housing, personal service coordination and medication capacity to existing mobile homeless outreach provider in South and East County.	Full Service Partnership
<u>CHOICES for Community Living/Recovery Education Centers</u> Integrates supportive housing, supportive employment, peer counseling and case management to enable clients to graduate from Service Teams system.	Full Service Partnership
<u>Forensic Assertive Community Treatment</u> Creates a multi-disciplinary community treatment team and community support center for adults with extensive criminal justice histories and those experiencing their first or second incarceration.	Full Service Partnership
<u>Mental Health Court Specialist</u> Team of mental health staff at Alameda courtrooms to provide assessment, treatment and advocacy for defendants with serious mental illness.	Outreach & Engagement / System Development

In addition to providing accessible financial and program information summaries, the state should maintain an easily-accessible online archive of MHSA plans and reports that it is required to receive from the counties, including three-year program and expenditure plans and annual updates and revenue and expenditure reports. Where possible, the archive should include other related documents, such as county cultural competence plans that describe how counties plan to address the cultural and linguistic needs of their diverse communities through their mental health system.¹²⁹ Improved accessibility to these types of reports would make it easier for consumers, families, advocates and stakeholders to compare programs across communities, research

successful practices, evaluate and measure how counties are addressing diverse cultural needs and reducing disparities, and effectively advocate for community needs.

Monitoring Progress Toward Statewide Mental Health Goals

Despite significant data limitations, the oversight commission has begun to evaluate Community Services and Supports and Prevention and Early Intervention programs – programs that together receive the lion’s share of county MHSA funds. This work is both important and admirable. Yet, more can be done to help Californians better understand how this unique surtax has helped drive statewide progress toward the act’s goals.

The oversight commission’s website currently hosts a wealth of evaluation information. It describes its evaluation plans and priorities, houses an extensive body of reports and includes other documents. But this information is not organized in a way that makes it easy for an interested, but uninformed, Californian, to understand how the state is monitoring and evaluating progress towards the act’s goals. Instead, individuals must cull through multiple and often lengthy reports.

The oversight commission could easily improve transparency by reorganizing information on its website, helping an interested individual better understand who has benefitted from MHSA-funded programs and how they have been helped. The oversight commission should begin by highlighting indicators already identified as important. For example:

- To begin to address the question of whom the act serves, the oversight commission should include, to the extent possible, data on its website detailing the number of individuals served, their ages, gender, racial and ethnic backgrounds and languages spoken.
- To address how the act had helped improve lives for those living with severe mental illness, the oversight commission could more visibly post information on key indicators – much of which is already available in the oversight commission’s priority indicators trends reports.
- To better understand how prevention programs are working throughout California, the oversight commission could share data on the rates of negative statewide outcomes that result from untreated mental illness. The data would highlight rates of suicide, incarceration, school failure and dropping out of school. It also would show rates of unemployment, prolonged suffering, substance abuse, homelessness, removal of children from homes and recidivism rates among juvenile offenders.¹³⁰

In sharing this information online, the oversight commission should replicate the approach it has taken in written reports that both analyze trends and clearly communicate any limitations with the data. Ideally, this level of transparency will allow interested Californians to better understand what the act has achieved, and also, help to identify where service gaps or challenges remain.

Building Infrastructure Necessary for Evaluation

The state must do a better job of answering critical questions about the act's achievements and evaluating programs to determine what really works. The state ultimately must also serve as the authoritative voice about what programs and services are effective in helping people get better and stay well. By disseminating proven practices in treatment and prevention, the state could be a resource to counties seeking to identify model programs and help ensure those types of programs are adopted statewide.

But the state can't play this role until it addresses the inadequacy of its mental health data system. Stakeholders told the Commission the system has reached the end of its usefulness despite significant investment of MHSA funds to prop it up. To analyze and evaluate MHSA-supported programs statewide, the state needs a data system that can deliver information from the local clinical level directly to the state, they said. Such a system would then allow the state to monitor outcomes for all mental health programs – from those serving the severely mentally ill to those trying to prevent mental illness from escalating – and compare results across counties.

As a first step to rectify this problem, the oversight commission voted in October 2014 to conduct a feasibility study assessing what mental health data is currently available within the Department of Health Care Services' behavioral health data systems. The study will likewise identify the oversight commission's current data and reporting needs and identify gaps between what it needs and resources available to get the data. A final report and blueprint estimating costs of improving state data systems is due to the commission in February 2015.¹³¹

While this is a step in the right direction and will likely provide important information about the state's data needs, it does not guarantee any next steps. The state then should take immediate action to ensure it is prepared to act on the findings of the study. The oversight commission and department should develop a formal plan and timeline to build and implement a comprehensive, statewide mental health data collection system capable of tracking data for all MHSA-funded programs, as well as the state's other behavioral and mental health programs.

Recognizing that building this type of data system may come at significant cost, the oversight commission and department should consider in their plan various funding options. One option in particular should be evaluated. The plan should consider using some of the act's state administration funds to build an appropriate data collection system. Use of those funds may easily be justified given the system's critical role in evaluating effectiveness of services provided through this act.

To ensure that progress is made in a timely manner, the oversight commission and department should also regularly report to the Legislature on their progress in developing this data system, as well as identify challenges that may arise.

Summary

Though the act appears successful in improving the range of mental health services provided in California, the state must now take steps to ensure that it can demonstrate those outcomes to voters, taxpayers, mental health advocates, patients and their families. As a start, the Mental Health Services Oversight and Accountability Commission must improve transparency about how much money the act generates each year and where and how it is spent. Further, the oversight commission must be able to better tell who has benefitted from the act and how. The commission's ability to tell this story will provide a basis for continued state support of these programs. It also will allow counties to adapt successful models to their communities. The state must act to overcome its technology infrastructure problem and create a mental health data system with improved data collection capacity. This system would help the oversight commission better evaluate and communicate the act's effectiveness, identify areas for further improvement and inform future policy decisions.

Recommendations

Recommendation 3: To make MHSA finances more transparent and make it easier for voters, taxpayers and mental health advocates, consumers and their families to see how and where the money is spent and who benefits from its services, the Mental Health Services Oversight and Accountability Commission should add to and update material on its website to include:

- ❑ MHSA revenues, by component and annual allocations, and the cumulative total revenue since voters approved the act.

- ❑ Data about who benefits from the act, including the number of individuals served, their ages, gender, racial and ethnic background and language spoken.
- ❑ Data to demonstrate statewide trends on key indicators such as rates of homelessness and suicide that show how well the act's programs help those living with mental illness to function independently and successfully.
- ❑ A rotating showcase of model programs in each of the component areas to clearly demonstrate examples of what works.
- ❑ All county MHSA plans and reports submitted to the state, including:
 - ✓ MHSA annual revenue and expenditure reports.
 - ✓ Three-year program and expenditure plans and annual updates.
 - ✓ Other relevant mental health reports, such county cultural competence plans that describe how a county intends to reduce mental health service disparities identified in racial, ethnic, cultural, linguistic and other unserved and underserved populations.

Recommendation 4: To promote meaningful accountability of the MHSA, the state needs access to reliable, timely information that allows it to monitor effective progress toward the act's goals. The Mental Health Services Oversight and Accountability Commission and Department of Health Care Services should:

- ❑ Immediately develop a formal plan and timeline to implement a comprehensive, statewide mental health data collection system capable of incorporating data for all MHSA components, as well as other state behavioral and mental health programs.
 - ✓ This plan should address how the development of such a data collection system would be funded and should use a portion of the MHSA state administrative funds to support the effort.
- ❑ Regularly report to the Legislature on the progress made in developing this data system and identify challenges that arise.

Conclusion

Since voters passed Proposition 63 in November 2004, the Mental Health Services Act has survived serious challenges – from excessive bureaucracy that made distributing money to counties overly complicated to the Great Recession that brought deep cuts to the state’s social service infrastructure. Through it all, state lawmakers played a key role in guiding implementation, an assignment typically not granted to the Legislature when voters pass ballot initiatives.

Stakeholders expressed to the Commission a strong sense of pride that the act has helped redefine how mental health services are provided in California, reorienting the system toward wellness, recovery and hope. While steering up to 80 percent of funding toward Californians with the most serious mental illnesses, an accompanying emphasis on innovative and preventative programs opened doors to new and experimental ways to reach people who might otherwise not seek help. These aspects of the act have been invaluable in expanding the range of mental health services for Californians. Stakeholders also expressed optimism for the future. The act has endured through its growing pains. Implementation is hitting its stride and settling in for the long run.

The state bureaucracy’s current management arrangement, as ordered by the Legislature, is a step in the right direction, providing greater independence for the Mental Health Services Oversight and Accountability Commission and a new partnership in oversight with the Department in Healthcare Services. But in its review, the Commission found bureaucratic confusion remains and the oversight commission still lacks the authority envisioned to ensure that the annual \$1 billion investment in the mental health system is achieving what voters intended. The Legislature must take the next step and grant the oversight commission the authority to review the more controversial prevention-oriented programs funded by the act before they are implemented, have a role in deciding how the state administrative portion of the funding is allocated and be empowered to impose sanctions if counties misspend funds from the act or fail to file timely reports with the state.

During the course of the review, many also shared frustration over the state’s inability to address a significant long-running barrier. As described many times in this report, that is the technology challenge that

makes it hard, if not impossible, to demonstrate success or back up perceived outcomes with facts and data. Once again, the state is hampered by antiquated data systems. Overwhelmingly the Commission heard that more must be done, and soon, to build the infrastructure necessary for the state to effectively oversee and evaluate the impact of this significant investment. The Commission recommends that the oversight commission improve public access to the data and county plans that already exist and to do a better job of showcasing model programs. The oversight commission, working with Department of Healthcare Services, must immediately develop a formal plan and timeline to implement a comprehensive, statewide mental health data collection system. The Legislature should consider using a portion of the Mental Health Services Act state administrative funds to pay for the data system.

Moving forward, communities and mental health advocates need to better understand how local programs are helping people recover. They need to know who might be falling through the cracks, and what other communities are doing to serve hard-to-reach populations. State lawmakers and local government leaders need better information to assess the state's progress in delivering mental health services and to identify shortcomings. But the audience is even broader: As California continues to experiment with mental health treatment programs, particularly for prevention and early intervention, its successes likely will inform how care is provided throughout the United States. Having data that ensures the best possible implementation will make the transformative effect of this act even more significant.

The Commission's review of Proposition 63 and its aftermath began with a simple question: Should the Legislature have more authority to tinker with successful ballot measures crafted often by special interests and sometimes carving out a revenue stream for their own purposes. This review offers unique insight into what happens long after voters say yes on election day. Proposition 63, in which a voting majority hiked income taxes for millionaires, can be described as extraordinary, establishing a powerful, continuing funding stream for mental health needs that usually fly well below the popular radar. We cannot know how implementation might have differed had the authors of this initiative not allowed for legislative involvement. But, in this case, the ability of lawmakers to amend the act, once implemented, appears to have allowed it to weather changes in the state's policy and fiscal environment while generally staying on course toward outcomes promised in 2004.

One final important question must address how much these successes might be due to the tone set by the leadership of the Legislature. To date, all significant amendments have been made under the watchful eye

of Senator Darrell Steinberg, Senate President Pro Tem from 2008 through 2014, and co-author of the Mental Health Services Act. Going forward, it will be beneficial to watch how the Legislature, under new leadership, uses its authority to guide implementation of the act. Though Proposition 63 alone would not make the case that allowing legislative amendments after an initiative passes should be routine, it does provide a case study that illustrates the potential for its benefits.

Additionally, the scope of this study purposely was limited to reviewing the oversight mechanisms for the Mental Health Services Act funds and the outcomes resulting from the state's historic investment in mental health services. However, revenue generated from the Mental Health Services Act only accounts for about 25 percent of the state's overall mental health funding. To better understand how the state manages and evaluates its broader mental health system, the state should consider reviewing governance among the various departments, councils and commissions involved in the system. Such a review might help the state consider whether opportunities exist to streamline oversight and reporting requirements for counties, improve coordination and leverage resources to best infuse the values of the Mental Health Services Act throughout the entire mental health system.

Appendices & Notes

✓ ***Public Hearing Witnesses***

✓ ***Timeline: The Shaping of California's Mental Health System***

✓ ***Notes***

Appendix A

Public Hearing Witnesses

*Public Hearing on the Mental Health Services Act
September 23, 2014
Sacramento, California*

Karen Baylor, Deputy Executive Director of Mental Health and Substance Use Disorder Services, California Department of Health Care Services

Michael Kennedy, Behavioral Health Division Director, Sonoma County Department of Health Services

Renay Bradley, Director of Research and Evaluation, Mental Health Services Oversight & Accountability Commission

David Pating, Vice Chair, Mental Health Services Oversight & Accountability Commission

Jessica Cruz, Executive Director, National Alliance on Mental Illness California

Larry Poaster, Commissioner, Mental Health Services Oversight & Accountability Commission

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition

Rusty Selix, Executive Director, California Council of Community Mental Health Agencies

Debbie Innes-Gomberg, District Chief, Mental Health Services Act Implementation and Outcomes Division, Los Angeles County Department of Mental Health

Appendix B

Timeline: The Shaping of California's Mental Health System

1950's – State operates eight hospitals serving 36,319 mental health clients (1956-57), but deinstitutionalization is becoming the predominant mental health public policy in the nation.

1957 Short-Doyle Act: creates framework and funding for local governments to develop community-based mental health programs.

1960's – *Nurse Ratched*, the sadistic nurse portrayed in the book and film “One Flew Over The Cuckoo’s Nest,” famously symbolizes institutional indifference to the mentally ill. California continues movement toward deinstitutionalization.

1966 California establishes Medi-Cal program, with the State and Federal government sharing the costs of providing some mental health services.

1967 Lanterman-Petris-Short Act establishes standards and legal procedures for civil commitments to a mental hospital, ending the inappropriate, indefinite and involuntary commitment of mentally ill people. Also, increases state funding for community mental health programs.

1969 California begins closing three state hospitals.

1970's – Deinstitutionalization is failing because financial support did not follow patients into the community. Governor Ronald Reagan vetoes legislation to move state funds to community programs, resulting in state's failure to distribute savings achieved through the closures of state hospitals to the community mental health system.

1980's – State allocations to counties to support community mental health are severely diminished due to inflation. Counties ability to fund mental health system is diminished further by passage of Proposition 13 in 1978. Homelessness and incarceration of mentally ill increases. Concerns rise about system's ability to meet needs of communities of color.

1984 **AB 3622**, Special Education Pupils Program, requires schools to educate, mental health departments to treat, and social services to oversee placement of children with severe mental illness.

1987 **AB 377** expands pilot program to test the effectiveness of community- and home-based services for severely emotionally disturbed children.

1988 **AB 3777**, Wright, McCorquodale, Bronzan Act, moves California toward integrated and community-based “system of care” for adult mental health clients. Bill authorizes funding for three pilot projects in Ventura, Los Angeles and Stanislaus Counties as alternative to state hospitalization.

1989 The state begins reducing its General Fund commitment to mental health services. Because these services are not established as “entitlements,” it is difficult for them to compete for state General Fund dollars through times of economic recession and diminishing state revenues.

1990's – The California Mental Health Planning Council reports that California's mental health system is inadequate financially and suffers from a lack of clear governance structure. While the state controls the funding and the counties are responsible for providing services and operating programs, neither is fully accountable.

1990 State projects a \$14 billion General Fund shortfall and leaders look to cut various programs, including those pertaining to mental health. **AB 904** mandates the California Planning Council to create a Mental Health Master Plan.

- 1991** **AB 1288**, the Bronzan-McCorquodale Act, or Realignment I, uses funds raised by an increase in the state sales tax and vehicle license fee to shift fiscal and administrative responsibility for many mental health services from the state to counties, institutionalizes the “systems of care” service delivery model consisting of consumer- and family-focused services, personal service plans, coordinated care, intensive case management assistance and measureable and accountable delivery of services.
- 1995** California moves to implement Medi-Cal Mental Health Managed Care. Each county establishes a single Mental Health Plan for providing Medi-Cal services.
- 1999** **AB 34** provides funding for three pilot programs to provide integrated services to the homeless. Proves successful in lowering hospitalization, incarceration and homelessness.

2000’s – *California voters approve landmark initiative to invest in mental health services, including preventive and new and innovative models of care. The Great Recession lessens impact of new funds.*

- 2000** Little Hoover Commission issues *Being There: Making a Commitment to Mental Health*, and calls for a transformation of the state’s mental health system.
AB 2034 expands the 1999 AB 34 pilot program to more than 30 counties.
- 2001** Little Hoover Commission issues *Young Hearts & Minds: Making a Commitment to Children’s Mental Health*, and calls for a redesign and integration of services provided to mentally ill children.
- 2002** **AB 1421**, Laura’s Law, allows counties to provide court-ordered outpatient treatment or anti-psychotics for people with serious mental illness.
- 2004** **53.8 percent of voters approve Proposition 63, the Mental Health Services Act.**
- 2005** Proposition 63 implementation begins January 1; establishes the Mental Health Services Oversight and Accountability Commission (MHSOAC) within the Department of Mental Health to oversee MHSA programs.
- 2009** **AB 5xxx** separates the MHSOAC from the Department of Mental Health and requires it to issue guidelines for INN and PEI component programs and speeds state approval for county mental health program plans.

2010’s – *Amid federal health care reform, Legislature shifts more oversight responsibility for the Mental Health Services Act to the counties.*

- 2010** The federal Patient Protection and Affordable Care Act requires health insurance plans offered through new health insurance exchanges to provide a minimum package of essential health benefits, including mental health and substance use disorder services.
- 2011** **AB 100**, aiming to speed funds to counties, significantly reduces the state’s role in administering the MHSA. Eliminates state reviews of county mental health plans, requiring MHSOAC only to provide training and technical assistance for county mental health planning. Transfers administrative responsibilities of MHSA funds from the Department of Mental Health to the State Controller and reduces the cap of state administrative funds from 5 to 3.5 percent.

The 2011-12 budget includes a one-time use of \$861 million MHSA funds, most of which is used to support realignment of fiscal responsibility for two Medicaid programs: mental health managed care, including inpatient and psychiatric and outpatient services primarily for adults, and early and periodic screening, diagnosis and treatment (EPSDT), a federally mandated program requiring a broad range of screening, diagnosis and medically necessary treatment services to Medi-Cal beneficiaries under age 21.
- 2012** **AB 1467**, part of a package of bills to eliminate the Department of Mental Health, transfers responsibility for administering MHSA to Department of Health Care Services beginning July 1, 2012. Also expands the MHSOAC’s role of providing evaluations, training and technical assistance. Requires counties to provide the commission with three-year program and expenditure plans and annual updates, but does not specify what the commission must do with these plans.

SB 1009 completes reorganization of mental health services out of the Department of Mental Health effective July 1, 2012.

2013 SB 82, the Investment in Mental Health Wellness Act, aims to improve access to mental health crisis services. Uses a portion of MHSA state administration funds to expand crisis beds and mobile crisis capacity.

AB 82 requires the MHSOAC to work with DHCS and others to design a comprehensive joint plan for a coordinated evaluation of client outcomes in the community-based mental health system.

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Little Hoover Commission Members

CHAIRMAN PEDRO NAVA (*D-Santa Barbara*) Appointed to the Commission by Speaker of the Assembly John Pérez in April 2013. Advisor to telecommunications industry on environmental and regulatory issues and to nonprofit organizations. Former state Assemblymember. Former civil litigator, deputy district attorney and member of the state Coastal Commission. Elected chair of the Commission in March 2014.

VICE CHAIRMAN LOREN KAYE (*R-Sacramento*) Appointed to the Commission in March 2006 and reappointed in December 2010 by Governor Arnold Schwarzenegger. President of the California Foundation for Commerce and Education. Former partner at KP Public Affairs. Served in senior policy positions for Governors Pete Wilson and George Deukmejian, including cabinet secretary to the Governor and undersecretary for the California Trade and Commerce Agency.

ASSEMBLYMEMBER KATCHO ACHADJIAN (*R-San Luis Obispo*) Appointed to the Commission by Speaker of the Assembly John Pérez in July 2011. Elected in November 2010 to the 33rd Assembly District and re-elected to the 35th District in November 2012 and 2014. Represents Arroyo Grande, Atascadero, Grover Beach, Guadalupe, Lompoc, Morro Bay, Paso Robles, Pismo Beach, San Luis Obispo, Santa Maria and surrounding areas.

DAVID BEIER (*D-San Francisco*) Appointed to the Commission by Governor Edmund G. Brown, Jr. in June 2014. Managing director of Bay City Capital. Former senior officer of Genetech and Amgen. Former counsel to the U.S. House of Representatives Committee on the Judiciary. Serves on the board of directors for the Constitution Project.

SENATOR ANTHONY CANNELLA (*R-Ceres*) Appointed to the Commission by the Senate Rules Committee in January 2014. Elected in November 2010 and re-elected in 2014 to the 12th Senate District. Represents Merced and San Benito counties and a portion of Fresno, Madera, Monterey and Stanislaus counties.

JACK FLANIGAN (*R-Granite Bay*) Appointed to the Commission by Governor Edmund G. Brown, Jr. in April 2012. A member of the Flanigan Law Firm. Co-founded California Strategies, a public affairs consulting firm, in 1997.

DON PERATA (*D-Orinda*) Appointed to the Commission in February 2014 and reappointed in January 2015 by the Senate Rules Committee. Political consultant. Former president pro tempore of the state Senate, from 2004 to 2008. Former Assemblymember, Alameda County supervisor and high school teacher.

ASSEMBLYMEMBER ANTHONY RENDON (*D-Lynwood*) Appointed to the Commission by Speaker of the Assembly John Pérez in February 2013. Elected in November 2012 and re-elected in 2014 to represent the 63rd Assembly District. Represents Bell, Cudahy, Hawaiian Gardens, Lakewood, Lynwood, Maywood, Paramount and South Gate and the North Long Beach community.

SENATOR RICHARD ROTH (*D-Riverside*) Appointed to the Commission by the Senate Rules Committee in February 2013. Elected in November 2012 to the 31st Senate District, representing Corona, Coronita, Eastvale, El Cerrito, Highgrove, Home Gardens, Jurupa Valley, March Air Reserve Base, Mead Valley, Moreno Valley, Norco, Perris and Riverside.

DAVID A. SCHWARZ (*R-Beverly Hills*) Appointed to the Commission in October 2007 and reappointed in December 2010 by Governor Arnold Schwarzenegger. Partner in the Los Angeles office of Irell & Manella LLP and a member of the firm's litigation workgroup. Former U.S. delegate to the United Nations Human Rights Commission.

JONATHAN SHAPIRO (*D-Beverly Hills*) Appointed to the Commission in April 2010 and reappointed in January 2014 by the Senate Rules Committee. Writer and producer for FX, HBO and Warner Brothers. Of counsel to Kirkland & Ellis. Former chief of staff to Lt. Governor Cruz Bustamante, counsel for the law firm of O'Melveny & Myers, federal prosecutor for the U.S. Department of Justice Criminal Division in Washington, D.C., and the Central District of California.

SUMI SOUSA (*D-San Francisco*) Appointed to the Commission by Speaker of the Assembly John Pérez in April 2013. Officer of policy development for San Francisco Health Plan. Former advisor to Speaker Pérez. Former executive director of the California Health Facilities Financing Authority.

“Democracy itself is a process of change, and satisfaction and complacency are enemies of good government.”

*Governor Edmund G. “Pat” Brown,
addressing the inaugural meeting of the Little Hoover Commission,
April 24, 1962, Sacramento, California*