California State Auditor

August 2013

Mental Health Services Act

The State's Oversight Has Provided Little Assurance of the Act's Effectiveness, and Some Counties Can Improve Measurement of Their Program Performance

Report 2012-122

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California State Auditor

Elaine M. Howle State Auditor
Doug Cordiner Chief Deputy

August 15, 2013 2012-122

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

Dear Governor and Legislative Leaders:

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

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

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

Respectfully submitted,

Elaine M. Howle

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State Auditor

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Summary

Results in Brief

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

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

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

Audit Highlights . . .

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

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

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

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

» *Each of the four county departments we reviewed used different and inconsistent approaches in assessing and reporting on their MHSA programs, and the county departments rarely developed specific objectives to assess the effectiveness of the programs.*

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

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

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

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

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

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

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

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

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

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

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

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

Recommendations

Health Care Services

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

- Draft and enter into a performance contract with each county that allows for effective oversight and satisfies the intent of the MHSA, including requiring counties to demonstrate that each of their MHSA programs is meeting its respective intent.
- Conduct comprehensive on-site reviews of counties' MHSA programs, including verifying county compliance with MHSA requirements.

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

- Specify MHSA program goals in their plans and annual updates and include those same goals in contracts with program providers.
- Identify meaningful data that measure the achievement of all their goals, set specific objectives, require their program providers to capture those data, and use those data to verify and report on the effectiveness of their MHSA programs.

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

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

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

Accountability Commission

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

Sacramento, San Bernardino, and Santa Clara

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

Agency Comments

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

Introduction

Background

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

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

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

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

Components of the Mental Health Services Act

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

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

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

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

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

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

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

MHSA Components

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

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

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

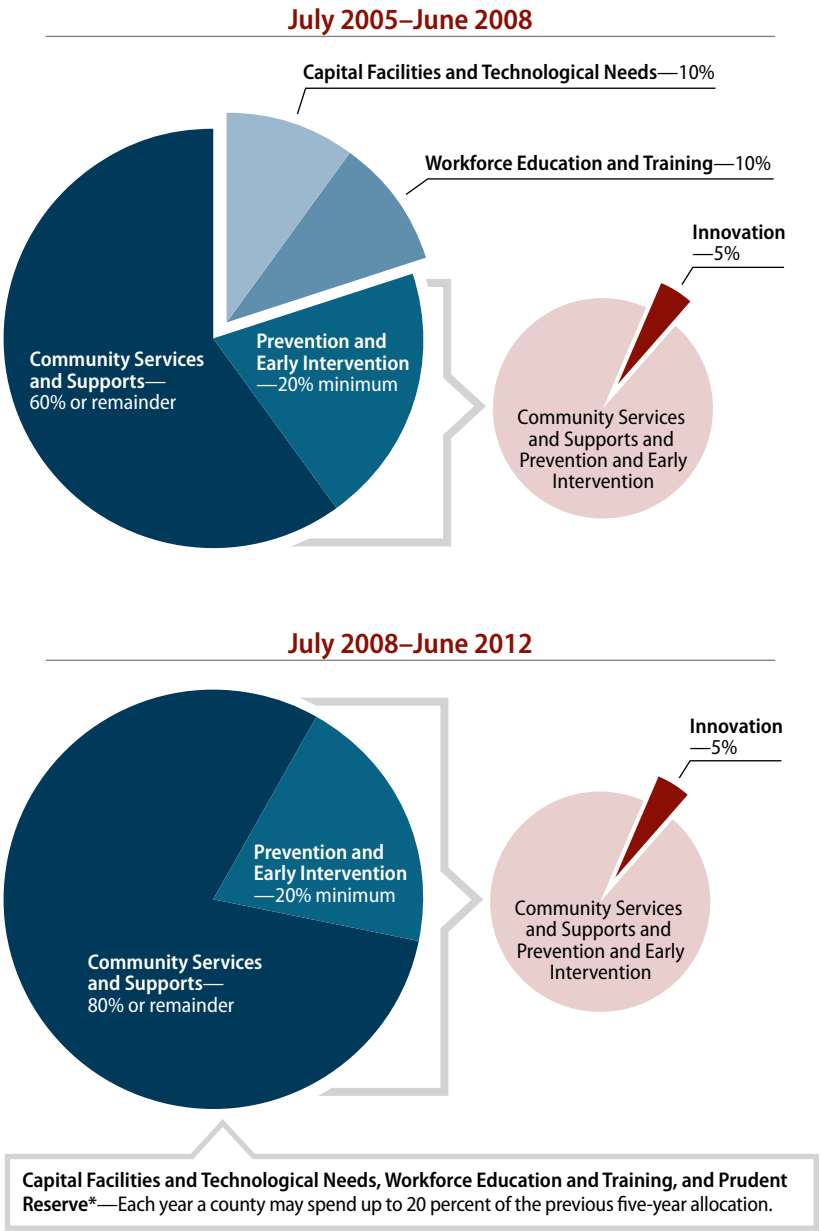
The MHSA calls for counties to spend a certain percentage of funds for Innovation programs that increase access to underserved groups, increase the quality of services, and promote interagency collaboration, among other things. In early 2009, when Mental Health issued guidelines on submitting plans for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

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

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

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

Figure 1
Apportionment of Mental Health Services Act Funds to Counties



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

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

Roles and Responsibilities

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

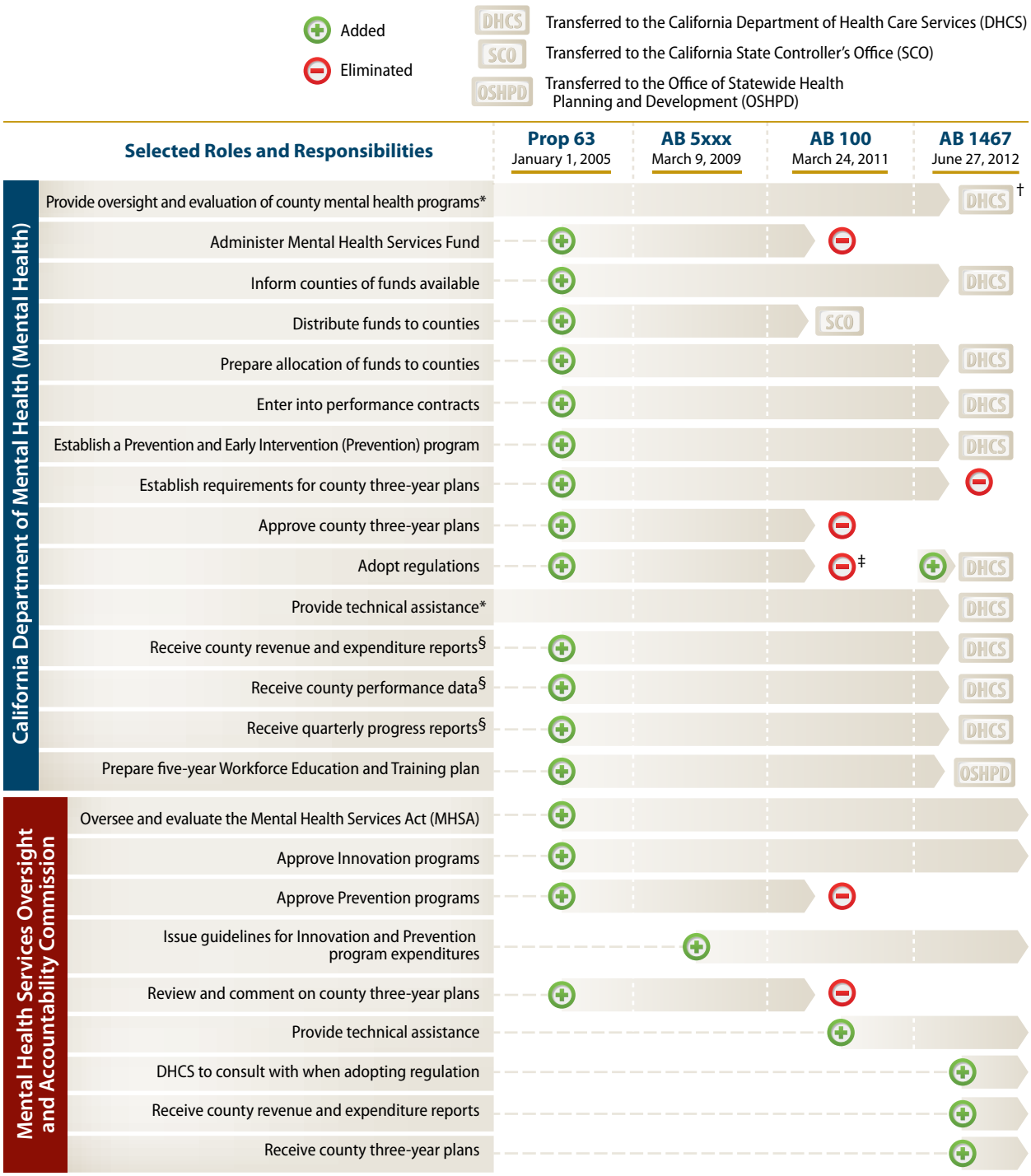
Proposition 63 established the Mental Health Services Oversight and Accountability Commission (Accountability Commission) to oversee certain components of the MHSA. The Accountability Commission consists of 16 voting members either appointed by the governor or granted membership by virtue of their position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

MHSA Funding and State Administration

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

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

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



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

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

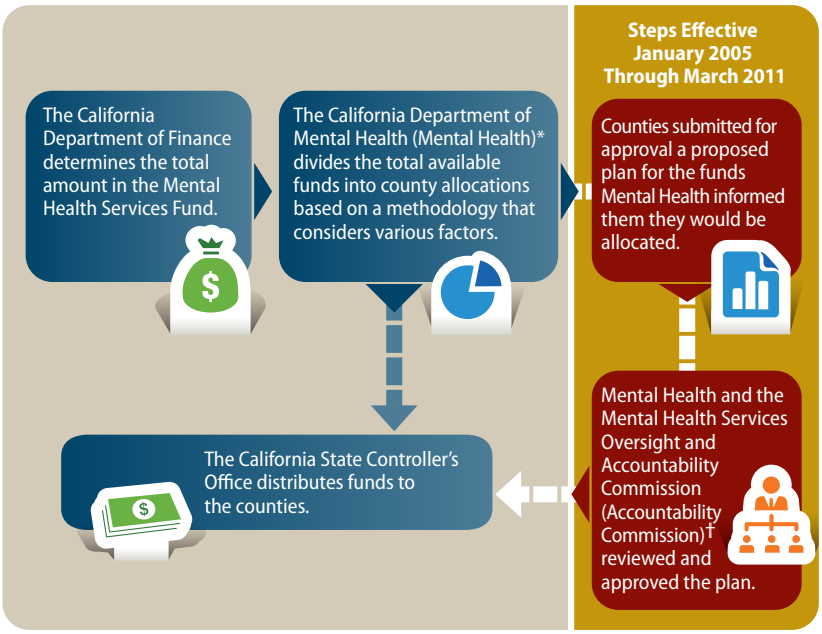
† Although not depicted in the figure, this requirement was transferred by Senate Bill 1009 (Chapter 34, Statutes of 2012), not Assembly Bill 1467.

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

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

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

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



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

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

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

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

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

Four Counties Selected for Audit

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

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

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

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

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

AGENCY RECEIVING FUNDS	BUDGET	PERCENTAGE OF TOTAL	PURPOSE OF FUNDING
California Department of Mental Health (Mental Health)* – Mental Health Planning Council (Planning Council)	$12,339,000 791,000†	43%	To fund key statewide mental health projects including housing, suicide prevention, mitigation of stigma projects, focused data analysis, and some community-based contracts.
Office of Statewide Health Planning and Development	5,895,000	20	To provide, among other things, educational loan repayments for mental health professionals to encourage work in the public mental health system in positions that have been deemed difficult to fill or hard to retain.
Mental Health Services Oversight and Accountability Commission	5,529,000	19	To oversee, review, and evaluate projects and programs funded by the Mental Health Services Act (MHSA), among other responsibilities.
California State Controller's Office (State Controller's Office)	1,733,000‡	6	To help support the development of a new Human Resource Management System, the 21st Century Project, a payroll system for use by state departments.
Judicial branch	1,063,000	4	To address the increased workload relating to mental health issues in the area of prevention and early intervention for juveniles with mental health illness in the juvenile court system or at risk for involvement in the system.
California Department of Health Care Services (Health Care Services)	865,000	3	To support a contract to develop and implement the interdepartmental California Mental Health Care Management Program, which serves to improve mental health care for Medi-Cal beneficiaries with a severe mental illness or a severe emotional disturbance.
California Military Department	552,000	2	To support a pilot behavioral health outreach program to improve coordination between the California National Guard, local veterans' services, and county mental health departments throughout the State.
California Department of Veterans Affairs	237,000	1	To support statewide administration to inform veterans and family members about federal benefits, local mental health departments, and other services.
Department of Developmental Services	393,000	1.5	To coordinate a statewide community-based system of mental health services for those with developmental disabilities.
California Department of Education	125,000	.5	To support county mental health programs' work with local education agencies, county offices of education, and special education local plan areas to provide necessary services.
Financial Information Systems for California (FI$CAL)	137,000‡	.5	To transform the State's systems and workforce to operate in an integrated financial management system environment. State agencies with accounting systems, including Mental Health, are required to provide funding to the project.
Board of Governors of the California Community Colleges	125,000	.5	To assist in developing policies and practices that address the mental health needs of California community college students.
Totals	**$28,993,000**	**100%**	

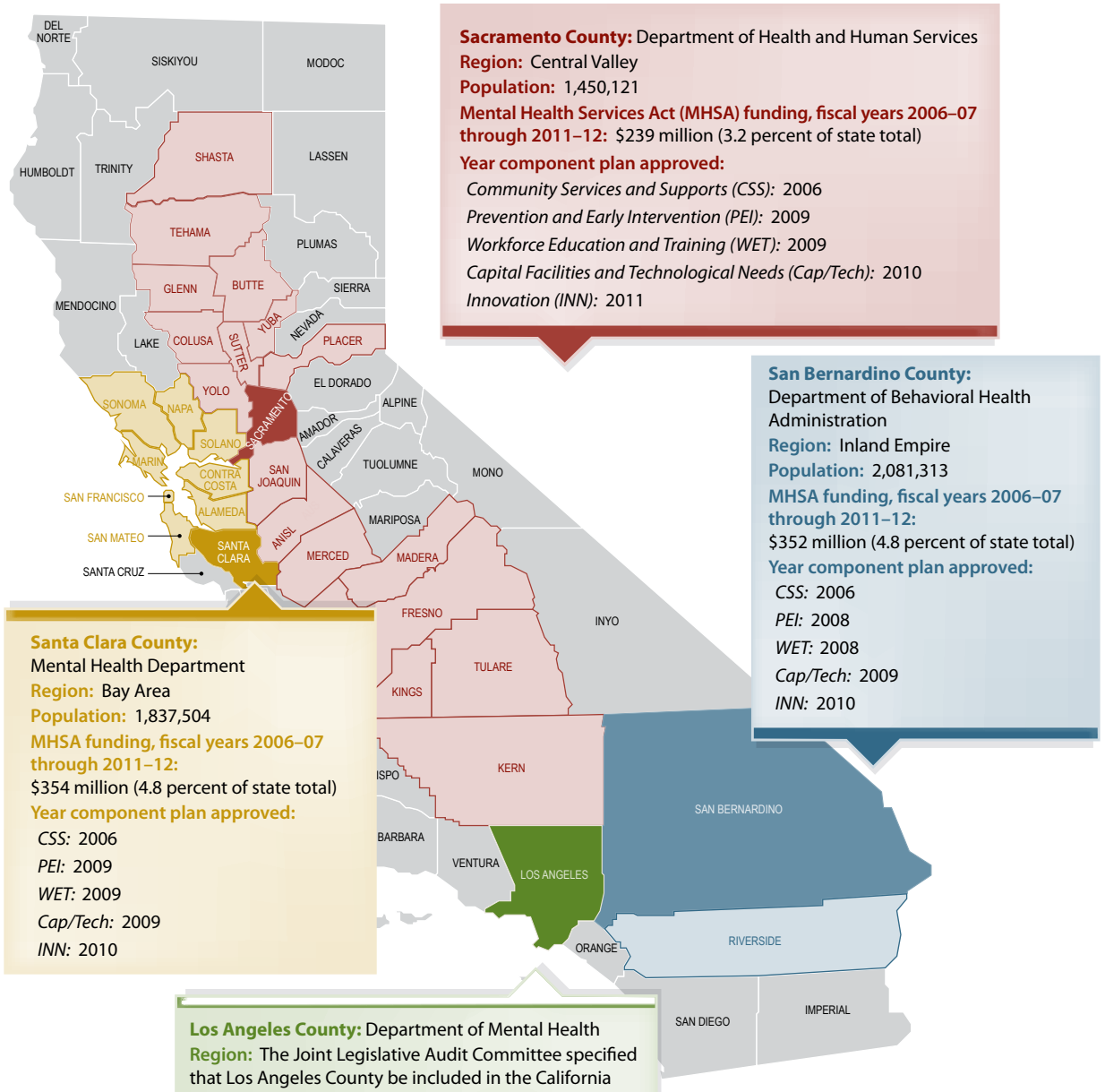
Sources: Fiscal year 2011–12 Budget Act and the *Mental Health Services Act Expenditure Report for Fiscal Year 2011–12*.

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

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

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

Figure 4
Regions and Counties Identified for Audit With Key Information



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

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

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

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

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

Scope and Methodology

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

Table 2
Audit Objectives and the Methods Used to Address Them

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

continued on next page . . .

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

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

continued on next page . . .

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

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

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

Chapter 1

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

Chapter Summary

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Summary of County Plans and Annual Updates

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

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

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

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

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

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

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

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

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

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

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

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

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

Reversion and Nonsupplant Requirements for County Mental Health Services Act Funding

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

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

Source: California Welfare and Institutions Code.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

	FISCAL YEAR	
STATE ENTITY	2011–12	2012–13*
Mental Health Services Oversight and Accountability Commission	$5,340,000	$6,925,000
California Department of Mental Health (Mental Health)†	12,210,000	9,341,000
California Mental Health Planning Council (Planning Council)	791,000‡	770,148

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

There Is No Indication That Mental Health Conducted Systematic MHSA Evaluations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Planning Council Has Not Fulfilled Its MHSA Responsibility

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

California Mental Health Planning Council

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

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

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

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

Counties' MHSA Funding Allocations May Not Be Appropriate

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

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

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

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

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

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

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

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

Recommendations

Legislature

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

Health Care Services

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

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

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

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

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

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

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

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

Accountability Commission

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

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

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

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

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

Planning Council

The Planning Council should do the following:

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

Chapter 2

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

Chapter Summary

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

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

Counties Develop Plans That Summarize MHSA Programs

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

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

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

Mental Health Services Act Component Rollout Dates

2005: Community Services and Supports

2007: Workforce Education and Training

2007: Prevention and Early Intervention

2008: Capital Facilities and Technological Needs

2009: Innovation

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

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

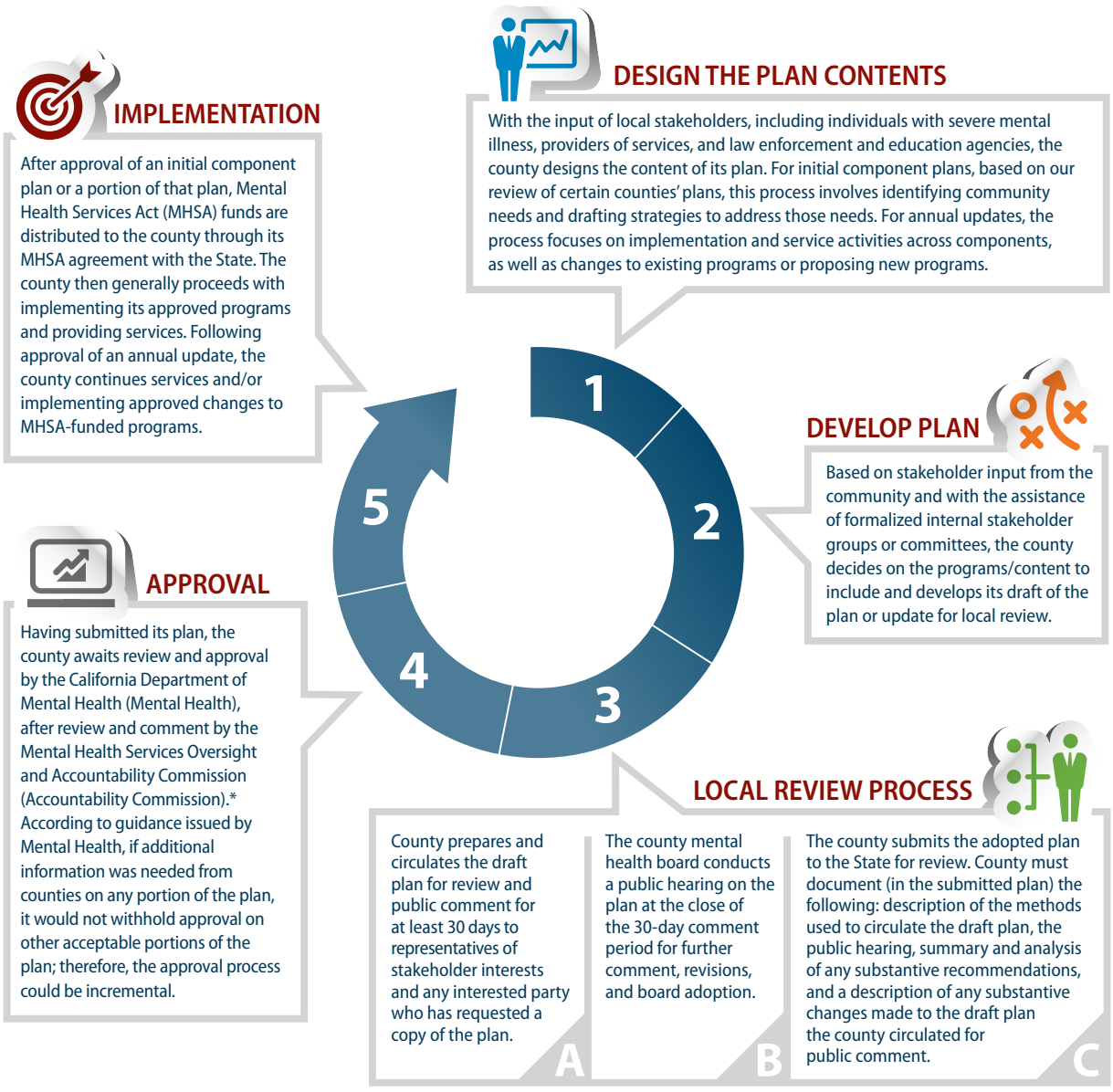
The counties' plans contain program descriptions and typically list program goals. For example, a program goal might be to reduce isolation in seniors or to assist homeless adults diagnosed with mental illness in accessing services. A county can generally include as many programs as it deems necessary,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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Recommendations

California Department of Health Care Services

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

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

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

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

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

Santa Clara

Santa Clara should do the following:

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

- Ensure that all MHSA invoices are adequately supported with information that demonstrates that MHSA services were provided.

Sacramento

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

San Bernardino

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

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

Respectfully submitted,

ELAINE M. HOWLE, CPA
State Auditor

Date: August 15, 2013

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Appendix A

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

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

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

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

COUNTY/ COMPONENT	FISCAL YEAR						TOTAL
	2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	
Alameda							
CSS	$11,145,798	$33,067,500	$22,863,600	$31,914,400	$56,956,441	$26,276,200	$182,223,939
PEI	–	4,301,000	10,366,400	13,902,800	15,557,864	7,081,300	51,209,364
INN	–	–	2,543,800	2,543,800	6,825,900	1,742,400	13,655,900
CAPTECH	–	12,327,100	3,873,200	–	16,200,300	–	32,400,600
WET	3,645,000	3,911,700	1,800,000	–	–	1,800,000	11,156,700
Totals	**$14,790,798**	**$53,607,300**	**$41,447,000**	**$48,361,000**	**$95,540,505**	**$36,899,900**	**$290,646,503**

CSS = Community Services and Supports
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WET = Workforce Education and Training

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COUNTY/ COMPONENT	FISCAL YEAR 2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	TOTAL
Alpine							
CSS	$254,927	$358,300	$622,600	$872,600	$751,314	$718,400	$3,578,141
PEI	–	100,000	150,200	250,200	319,500	126,500	946,400
INN	–	–	62,000	62,000	232,600	44,500	401,100
CAPTECH	–	600,000	188,500	–	788,500	–	1,577,000
WET	225,000	225,000	–	–	450,000	–	900,000
Totals	**$479,927**	**$1,283,300**	**$1,023,300**	**$1,184,800**	**$2,541,914**	**$889,400**	**$7,402,641**
Amador							
CSS	$531,570	$1,355,900	$1,298,300	$1,648,300	$2,074,619	$1,357,100	$8,265,789
PEI	–	100,000	227,600*	327,600*	732,300*	199,700*	1,587,200
INN	–	–	115,200	115,200	367,400	80,000	677,800
CAPTECH	–	600,000	188,500	–	788,500	–	1,577,000
WET	225,000	225,000	–	–	416,200	–	866,200
Totals	**$756,570**	**$2,280,900**	**$1,829,600**	**$2,091,100**	**$4,379,019**	**$1,636,800**	**$12,973,989**
Berkeley City†							
CSS	$896,084	$3,466,100	$1,893,500	$2,687,100	$4,131,965	$2,212,400	$15,287,149
PEI	–	370,300	897,600	1,207,700	1,605,605	614,500	4,695,705
INN	–	–	214,800	214,800	685,200	147,700	1,262,500
CAPTECH	–	1,089,700	342,400	–	1,432,100	–	2,864,200
WET	313,800	343,100	–	–	656,900	–	1,313,800
Totals	**$1,209,884**	**$5,269,200**	**$3,348,300**	**$4,109,600**	**$8,511,770**	**$2,974,600**	**$25,423,354**
Butte							
CSS	$1,999,624	$5,818,700	$3,984,300	$5,340,000	$4,649,400	$4,396,600	$26,188,624
PEI	–	639,300	1,545,000*	2,074,800*	1,883,600*	1,274,700*	7,417,400
INN	–	–	418,100	418,100	1,326,200	285,000	2,447,400
CAPTECH	–	1,849,700	581,200	–	742,061	–	3,172,961
WET	541,800	587,100	–	–	–	–	1,128,900
Totals	**$2,541,424**	**$8,894,800**	**$6,528,600**	**$7,832,900**	**$8,601,261**	**$5,956,300**	**$40,355,285**
Calaveras							
CSS	$609,442	$1,614,800	$1,404,300	$1,754,300	$1,960,526	$1,444,400	$8,787,768
PEI	–	121,100	292,300*	403,300*	417,100*	247,200*	1,481,000
INN	–	–	126,400	126,400	400,300	86,500	739,600
CAPTECH	–	600,000	188,500	–	408,500	–	1,197,000
WET	225,000	225,000	–	–	–	–	450,000
Totals	**$834,442**	**$2,560,900**	**$2,011,500**	**$2,284,000**	**$3,186,426**	**$1,778,100**	**$12,655,368**

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COUNTY/ COMPONENT	FISCAL YEAR 2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	TOTAL
Colusa							
CSS	$430,973	$1,006,200	$1,159,500	$1,509,500	$1,314,300	$1,242,900	$6,663,373
PEI	–	100,000	153,100*	253,100*	225,500*	154,400*	886,100
INN	–	–	101,500	101,500	327,100	72,000	602,100
CAPTECH	–	600,000	188,500	–	325,559	–	1,114,059
WET	225,000	225,000	–	–	–	–	450,000
Totals	**$655,973**	**$1,931,200**	**$1,602,600**	**$1,864,100**	**$2,192,459**	**$1,469,300**	**$9,715,632**
Contra Costa							
CSS	$7,192,809	$20,989,700	$14,657,600	$20,347,300	$17,715,700	$16,752,600	$97,655,709
PEI	–	2,686,300	6,489,100*	8,712,300*	5,154,800	8,104,400*	31,146,900
INN	–	–	1,616,400	1,616,400	3,689,672	1,106,800	8,029,272
CAPTECH	–	7,778,300	2,443,900	–	6,022,200	–	16,244,400
WET	2,276,500	2,461,500	–	–	–	–	4,738,000
Totals	**$9,469,309**	**$33,915,800**	**$25,207,000**	**$30,676,000**	**$32,582,372**	**$25,963,800**	**$157,814,281**
Del Norte							
CSS	$475,514	$1,187,400	$1,224,500	$1,574,500	$1,370,935	$1,296,400	$7,129,249
PEI	–	100,000	187,000	287,000	596,200	148,600	1,318,800
INN	–	–	108,100	108,100	400,500	75,800	692,500
CAPTECH	–	600,000	188,500	–	788,500	–	1,577,000
WET	225,000	225,000	–	–	416,200	–	866,200
Totals	**$700,514**	**$2,112,400**	**$1,708,100**	**$1,969,600**	**$3,572,335**	**$1,520,800**	**$11,583,749**
El Dorado							
CSS	$1,437,533	$5,180,200	$2,853,700	$3,744,800	$4,476,340	$3,083,200	$20,775,773
PEI	–	331,770	1,036,700*	1,385,000*	2,636,699*	850,500*	6,240,669
INN	–	–	292,000	292,000	923,500	198,100	1,705,600
CAPTECH	–	1,235,800	388,300	–	1,624,100	–	3,248,200
WET	365,300	389,700	–	–	389,700	–	1,144,700
Totals	**$1,802,833**	**$7,137,470**	**$4,570,700**	**$5,421,800**	**$10,050,339**	**$4,131,800**	**$33,114,942**
Fresno							
CSS	$8,042,129	$22,362,500	$15,958,200	$22,217,000	$19,343,600	$18,292,000	$106,215,429
PEI	–	2,721,000	6,722,800*	9,168,400*	8,400,200*	5,649,900*	32,662,300
INN	–	–	1,739,800	1,739,800	5,552,100	1,198,500	10,230,200
CAPTECH	–	8,406,100	2,641,200	–	8,022,449	–	19,069,749
WET	2,306,000	2,679,800	–	–	–	–	4,985,800
Totals	**$10,348,129**	**$36,169,400**	**$27,062,000**	**$33,125,200**	**$41,318,349**	**$25,140,400**	**$173,163,478**

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COUNTY/ COMPONENT	FISCAL YEAR 2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	TOTAL
Glenn							
CSS	$486,119	$1,189,200	$1,234,500	$1,584,500	$1,379,600	$1,304,600	$7,178,519
PEI	–	100,000	188,500*	288,500*	261,900*	175,500*	1,014,400
INN	–	–	108,700	108,700	348,300	76,200	641,900
CAPTECH	–	600,000	188,500	–	–	–	788,500
WET	225,000	225,000	1,800,000	–	–	1,800,000	4,050,000
Totals	**$711,119**	**$2,114,200**	**$3,520,200**	**$1,981,700**	**$1,989,800**	**$3,356,300**	**$13,673,319**
Humboldt							
CSS	$1,294,231	$4,405,400	$2,553,400	$3,340,600	$2,908,500	$3,439,460	$17,941,591
PEI	–	370,200	892,700*	1,200,200*	1,087,600*	47,940*	3,598,640
INN	–	–	258,700	258,700	430,700	175,800	1,123,900
CAPTECH	–	1,068,100	335,600	–	–	–	1,403,700
WET	313,700	337,200	–	–	–	–	650,900
Totals	**$1,607,931**	**$6,180,900**	**$4,040,400**	**$4,799,500**	**$4,426,800**	**$3,663,200**	**$24,718,731**
Imperial							
CSS	$1,716,012	$5,475,500	$3,408,200	$4,576,900	$3,985,000	$3,768,400	$22,930,012
PEI	–	503,600	1,249,900*	1,706,600*	2,607,876*	1,052,500*	7,120,476
INN	–	–	353,200	353,200	1,123,400	242,200	2,072,000
CAPTECH	–	1,568,900	492,900	–	2,061,800	–	4,123,600
WET	426,800	503,000	–	–	929,800	–	1,859,600
Totals	**$2,142,812**	**$8,051,000**	**$5,504,200**	**$6,636,700**	**$10,707,876**	**$5,063,100**	**$38,105,688**
Inyo							
CSS	$373,705	$730,600	$783,600	$1,033,600	$1,380,500	$851,000	$5,153,005
PEI	–	100,000	152,100	252,100	153,700	128,400	786,300
INN	–	–	72,800	72,800	234,500	51,400	431,500
CAPTECH	–	600,000	188,500	–	788,500	–	1,577,000
WET	225,000	225,000	–	–	416,200	–	866,200
Totals	**$598,705**	**$1,655,600**	**$1,197,000**	**$1,358,500**	**$2,973,400**	**$1,030,800**	**$8,814,005**
Kern							
CSS	$7,048,579	$19,040,100	$13,868,500	$19,210,900	$16,726,300	$15,817,000	$91,711,379
PEI	–	2,333,700	5,764,300*	7,851,800*	14,982,431*	4,838,700*	35,770,931
INN	–	–	1,503,100	1,503,100	2,539,100	1,034,300	6,579,600
CAPTECH	–	7,165,600	2,251,400	–	6,006,056	–	15,423,056
WET	1,977,700	2,297,000	–	–	50	–	4,274,750
Totals	**$9,026,279**	**$30,836,400**	**$23,387,300**	**$28,565,800**	**$40,253,937**	**$21,690,000**	**$153,759,716**

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COUNTY/ COMPONENT	FISCAL YEAR 2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	TOTAL
Kings							
CSS	$1,511,485	$4,674,600	$2,936,100	$3,870,700	$7,763,463	$3,186,900	$23,943,248
PEI	–	367,924	1,024,200	1,389,300	2,933,300	705,500	6,420,224
INN	–	–	298,300	298,300	945,900	203,500	1,746,000
CAPTECH	–	1,254,300	394,100	–	1,648,400	–	3,296,800
WET	353,600	402,400	–	–	403,000	–	1,159,000
Totals	**$1,865,085**	**$6,699,224**	**$4,652,700**	**$5,558,300**	**$13,694,063**	**$4,095,900**	**$36,565,272**
Lake							
CSS	$760,035	$2,162,400	$1,615,300	$1,985,000	$2,300,502	$1,634,300	$10,457,537
PEI	–	178,400	427,300*	571,900*	927,548*	350,900*	2,456,048
INN	–	–	150,000	150,000	546,300	100,900	947,200
CAPTECH	–	600,000	188,500	–	613,500	–	1,402,000
WET	225,000	225,000	–	–	416,250	–	866,250
Totals	**$985,035**	**$3,165,800**	**$2,381,100**	**$2,706,900**	**$4,804,100**	**$2,086,100**	**$16,129,035**
Lassen							
CSS	$479,453	$1,187,500	$1,228,100	$1,578,100	$1,430,600	$1,299,300	$7,203,053
PEI	–	100,000	186,000	286,000	148,400	148,000	868,400
INN	–	–	108,200	108,200	400,900	75,900	693,200
CAPTECH	–	600,000	188,500	–	788,500	–	1,577,000
WET	225,000	225,000	–	–	450,000	–	900,000
Totals	**$704,453**	**$2,112,500**	**$1,710,800**	**$1,972,300**	**$3,218,400**	**$1,523,200**	**$11,241,653**
Los Angeles							
CSS	$90,691,911	$260,220,300	$180,588,300	$255,155,500	$319,091,506	$210,077,200	$1,315,824,717
PEI	–	34,001,800	82,273,100*	110,567,500*	122,608,254*	67,946,000*	417,396,654
INN	–	–	20,294,900	20,294,900	50,730,032	13,909,700	105,229,532
CAPTECH	–	98,053,039	33,479,200	–	88,232,464	–	219,764,703
WET	34,667,140	31,370,800	1,800,000	–	37,868,778	1,800,000	107,506,718
Totals	**$125,359,051**	**$423,645,939**	**$318,435,500**	**$386,017,900**	**$618,531,034**	**$293,732,900**	**$2,165,722,324**
Madera							
CSS	$1,514,515	$5,173,200	$3,020,000	$4,037,700	$3,515,500	$3,324,400	$20,585,315
PEI	–	438,900	1,087,300*	1,485,000*	1,411,400*	915,500*	5,338,100
INN	–	–	311,100	311,100	522,300	213,200	1,357,700
CAPTECH	–	1,367,200	429,600	–	1,796,800	–	3,593,600
WET	371,900	435,700	–	–	–	–	807,600
Totals	**$1,886,415**	**$7,415,000**	**$4,848,000**	**$5,833,800**	**$7,246,000**	**$4,453,100**	**$31,682,315**

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COUNTY/ COMPONENT	FISCAL YEAR 2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	TOTAL
Marin							
CSS	$1,727,527	$6,189,900	$3,711,600	$5,124,500	$5,067,750	$4,219,100	$26,040,377
PEI	–	632,800	1,543,200*	2,095,200*	1,906,100*	1,288,600*	7,465,900
INN	–	–	402,000	402,000	1,481,800	276,100	2,561,900
CAPTECH	–	1,893,900	595,100	–	1,085,740	–	3,574,740
WET	536,300	596,900	–	–	130,200	–	1,263,400
Totals	**$2,263,827**	**$9,313,500**	**$6,251,900**	**$7,621,700**	**$9,671,590**	**$5,783,800**	**$40,906,317**
Mariposa							
CSS	$380,977	$748,200	$792,600	$1,042,600	$1,166,284	$858,500	$4,989,161
PEI	–	100,000	152,200	252,200	379,000	128,500	1,011,900
INN	–	–	73,400	73,400	236,400	51,800	435,000
CAPTECH	–	600,000	188,500	–	–	–	788,500
WET	225,000	225,000	–	–	–	–	450,000
Totals	**$605,977**	**$1,673,200**	**$1,206,700**	**$1,368,200**	**$1,781,684**	**$1,038,800**	**$7,674,561**
Mendocino							
CSS	$926,687	$3,137,200	$1,851,400	$2,361,000	$2,645,881	$1,943,800	$12,865,968
PEI	–	150,000	587,600*	786,700*	1,713,266*	482,900*	3,720,466
INN	–	–	181,400	181,400	663,000	122,700	1,148,500
CAPTECH	–	704,500	221,400	–	925,900	–	1,851,800
WET	225,000	225,000	–	–	–	–	450,000
Totals	**$1,151,687**	**$4,216,700**	**$2,841,800**	**$3,329,100**	**$5,984,047**	**$2,549,400**	**$20,036,734**
Merced							
CSS	$2,534,123	$6,692,200	$4,971,600	$6,737,600	$3,833,833	$5,547,300	$30,316,656
PEI	–	769,500	1,902,600*	2,592,700*	2,377,400*	1,598,100*	9,240,300
INN	–	–	522,700	522,700	1,663,400	358,600	3,067,400
CAPTECH	–	2,385,600	749,600	–	394,620	–	3,529,820
WET	652,000	760,000	–	–	–	–	1,412,000
Totals	**$3,186,123**	**$10,607,300**	**$8,146,500**	**$9,853,000**	**$8,269,253**	**$7,504,000**	**$47,566,176**
Modoc							
CSS	$321,891	$556,400	$712,000	$962,000	$1,114,405	$792,100	$4,458,796
PEI	–	100,000	151,200*	251,200*	245,945*	152,500*	900,845
INN	–	–	68,000	68,000	253,900	48,300	438,200
CAPTECH	–	600,000	188,500	–	788,500	–	1,577,000
WET	225,000	225,000	–	–	–	–	450,000
Totals	**$546,891**	**$1,481,400**	**$1,119,700**	**$1,281,200**	**$2,402,750**	**$992,900**	**$7,824,841**

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COUNTY/ COMPONENT	FISCAL YEAR 2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	TOTAL
Mono							
CSS	$356,737	$669,800	$759,900	$909,900	$1,081,775	$831,500	$4,609,612
PEI	–	100,000	151,700	251,700	208,750	128,000	840,150
INN	–	–	71,200	71,200	204,800	50,400	397,600
CAPTECH	–	600,000	188,500	100,000	53,772	–	942,272
WET	225,000	225,000	–	–	–	–	450,000
Totals	**$581,737**	**$1,594,800**	**$1,171,300**	**$1,332,800**	**$1,549,097**	**$1,009,900**	**$7,239,634**
Monterey							
CSS	$3,885,218	$10,515,500	$7,765,900	$10,576,700	$9,208,800	$8,708,200	$50,660,318
PEI	–	1,357,700	3,264,100*	4,362,400*	3,952,300*	2,678,600*	15,615,100
INN	–	–	837,400	837,400	1,402,400	571,200	3,648,400
CAPTECH	–	3,882,200	1,219,800	–	–	–	5,102,000
WET	1,150,600	1,225,200	–	–	–	–	2,375,800
Totals	**$5,035,818**	**$16,980,600**	**$13,087,200**	**$15,776,500**	**$14,563,500**	**$11,958,000**	**$77,401,618**
Napa							
CSS	$1,136,972	$3,840,200	$2,343,900	$3,107,500	$2,901,700	$2,558,500	$15,888,772
PEI	–	346,100	842,600*	1,141,000*	2,378,800*	1,064,900*	5,773,400
INN	–	–	240,500	240,500	762,900	164,100	1,408,000
CAPTECH	–	1,031,000	323,900	–	1,100,856	–	2,455,756
WET	293,300	324,900	–	–	574,200	–	1,192,400
Totals	**$1,430,272**	**$5,542,200**	**$3,750,900**	**$4,489,000**	**$7,718,456**	**$3,787,500**	**$26,718,328**
Nevada							
CSS	$1,012,437	$3,367,287	$2,058,300	$2,598,300	$3,011,875	$2,139,300	$14,187,499
PEI	–	262,600	627,700	838,600	693,450	427,900	2,850,250
INN	–	–	199,100	199,100	359,213	134,300	891,713
CAPTECH	–	745,100	234,100	–	30	–	979,230
WET	225,000	232,000	–	–	–	–	457,000
Totals	**$1,237,437**	**$4,606,987**	**$3,119,200**	**$3,636,000**	**$4,064,568**	**$2,701,500**	**$19,365,692**
Orange							
CSS	$25,757,558	$70,799,600	$52,212,700	$72,573,400	$63,187,200	$59,752,100	$344,282,558
PEI	–	9,755,200	23,561,700*	31,517,400*	28,637,000*	19,367,400*	112,838,700
INN	–	–	5,787,600	5,787,600	18,410,300	3,958,900	33,944,400
CAPTECH	–	28,308,300	8,894,500	–	15,559,675	–	52,762,475
WET	8,267,200	8,948,100	–	–	–	–	17,215,300
Totals	**$34,024,758**	**$117,811,200**	**$90,456,500**	**$109,878,400**	**$125,794,175**	**$83,078,400**	**$561,043,433**

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COUNTY/ COMPONENT	FISCAL YEAR 2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	TOTAL
Placer							
CSS	$2,284,145	$6,479,900	$4,593,100	$6,249,400	$6,776,853	$4,888,035	$31,271,433
PEI	–	701,400	1,769,300*	2,416,500*	3,505,525*	1,494,900*	9,887,625
INN	–	–	483,800	483,800	1,541,300	589,865	3,098,765
CAPTECH	–	2,276,500	715,300	–	1,943,002	–	4,934,802
WET	594,400	735,700	1,800,000	–	710,005	1,800,000	5,640,105
Totals	**$2,878,545**	**$10,193,500**	**$9,361,500**	**$9,149,700**	**$14,476,685**	**$8,772,800**	**$54,832,730**
Plumas							
CSS	$392,188	$886,900	$1,039,000	$1,458,000	$1,197,900	$1,200,400	$6,174,388
PEI	–	100,000	152,100	252,100	149,500	128,400	782,100
INN	–	–	98,000	98,000	365,500	69,800	631,300
CAPTECH	–	600,000	188,500	–	788,500	–	1,577,000
WET	225,000	225,000	69,000	–	71,500	–	590,500
Totals	**$617,188**	**$1,811,900**	**$1,546,600**	**$1,808,100**	**$2,572,900**	**$1,398,600**	**$9,755,288**
Riverside							
CSS	$16,878,027	$43,990,700	$33,610,600	$47,117,200	$51,294,200	$38,793,200	$231,683,927
PEI	–	5,612,500	14,190,600*	19,468,200*	26,816,452*	12,040,800*	78,128,552
INN	–	–	3,673,500	3,673,500	11,519,251	2,539,300	21,405,551
CAPTECH	–	18,358,100	5,768,100	–	17,826,200	–	41,952,400
WET	4,756,400	5,941,900	–	–	30	–	10,698,330
Totals	**$21,634,427**	**$73,903,200**	**$57,242,800**	**$70,258,900**	**$107,456,133**	**$53,373,300**	**$383,868,760**
Sacramento							
CSS	$10,021,351	$31,272,200	$19,822,329	$27,976,100	$33,141,107	$23,754,100	$145,987,187
PEI	–	3,630,500	8,969,700*	12,246,700*	21,657,600*	7,546,300*	54,050,800
INN	–	–	2,267,300	2,267,300	8,379,100	1,565,200	14,478,900
CAPTECH	–	11,242,700	4,174,871	875,000	1,797,290	–	18,089,861
WET	3,076,700	3,574,100	–	–	–	–	6,650,800
Totals	**$13,098,051**	**$49,719,500**	**$35,234,200**	**$43,365,100**	**$64,975,097**	**$32,865,600**	**$239,257,548**
San Benito							
CSS	$737,007	$2,056,100	$1,580,000	$1,930,000	$2,329,200	$1,589,000	$10,221,307
PEI	–	166,300	398,700	531,600	282,075	270,800	1,649,475
INN	–	–	145,000	145,000	455,200	97,400	842,600
CAPTECH	–	600,000	188,500	–	788,500	–	1,577,000
WET	225,000	225,000	–	–	–	–	450,000
Totals	**$962,007**	**$3,047,400**	**$2,312,200**	**$2,606,600**	**$3,854,975**	**$1,957,200**	**$14,740,382**

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COUNTY/ COMPONENT	FISCAL YEAR 2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	TOTAL
San Bernardino							
CSS	$17,340,108	$45,307,600	$34,194,700	$47,400,100	$41,393,300	$39,143,000	$224,778,808
PEI	–	5,936,400	14,610,400*	19,825,800*	18,150,610*	12,213,200*	70,736,410
INN	–	–	3,737,900	3,737,900	6,311,400	2,570,200	16,357,400
CAPTECH	–	18,162,500	5,706,700	–	1,819,498	–	25,688,698
WET	5,030,900	5,780,200	1,800,000	142,000	–	1,800,000	14,553,100
Totals	**$22,371,008**	**$75,186,700**	**$60,049,700**	**$71,105,800**	**$67,674,808**	**$55,726,400**	**$352,114,416**
San Diego							
CSS	$25,671,808	$72,951,300	$52,232,700	$73,166,800	$68,058,657	$60,240,700	$352,321,965
PEI	–	9,733,400	23,625,400*	31,805,200*	31,185,555*	19,554,300*	115,903,855
INN	–	–	5,816,200	5,816,200	12,260,950	3,991,400	27,884,750
CAPTECH	–	28,417,800	8,928,900	–	34,358,758	–	71,705,458
WET	8,248,700	9,062,100	–	–	40	–	17,310,840
Totals	**$33,920,508**	**$120,164,600**	**$90,603,200**	**$110,788,200**	**$145,863,960**	**$83,786,400**	**$585,126,868**
San Francisco							
CSS	$5,386,299	$17,873,300	$11,570,900	$16,467,000	$16,454,050	$13,557,900	$81,309,449
PEI	–	2,269,600	5,445,300*	7,358,500	11,585,019*	3,758,400*	30,416,819
INN	–	–	1,313,800	1,313,800	4,200,900	904,300	7,732,800
CAPTECH	–	6,313,100	1,983,600	–	6,148,350	–	14,445,050
WET	1,923,400	2,026,600	–	–	1,172,159	–	5,122,159
Totals	**$7,309,699**	**$28,482,600**	**$20,313,600**	**$25,139,300**	**$39,560,478**	**$18,220,600**	**$139,026,277**
San Joaquin							
CSS	$5,645,671	$15,207,900	$11,097,800	$15,292,600	$15,347,167	$12,591,000	$75,182,138
PEI	–	1,865,100	4,575,900	6,214,900	4,337,500	3,156,600	20,150,000
INN	–	–	1,197,800	1,197,800	3,816,200	822,700	7,034,500
CAPTECH	–	5,673,500	1,782,600	–	7,456,100	–	14,912,200
WET	1,580,600	1,796,700	–	–	–	–	3,377,300
Totals	**$7,226,271**	**$24,543,200**	**$18,654,100**	**$22,705,300**	**$30,956,967**	**$16,570,300**	**$120,656,138**
San Luis Obispo							
CSS	$2,317,778	$6,906,700	$4,167,425	$5,901,550	$5,100,150	$5,101,800	$29,495,403
PEI	–	760,000	1,832,100*	2,451,000*	2,224,000*	1,505,600*	8,772,700
INN	–	–	487,300	487,300	1,545,200	331,900	2,851,700
CAPTECH	–	2,168,000	1,126,675	294,950	294,950	–	3,884,575
WET	644,100	692,400	–	–	–	–	1,336,500
Totals	**$2,961,878**	**$10,527,100**	**$7,613,500**	**$9,134,800**	**$9,164,300**	**$6,939,300**	**$46,340,878**

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COUNTY/ COMPONENT	FISCAL YEAR 2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	TOTAL
San Mateo							
CSS	$5,022,392	$15,083,100	$10,472,300	$14,546,300	$12,665,000	$11,976,500	$69,765,592
PEI	–	1,989,300	4,749,800*	6,341,600*	10,494,687*	5,847,400*	29,422,787
INN	–	–	1,163,000	1,163,000	4,279,100	794,700	7,399,800
CAPTECH	–	5,539,300	1,740,400	–	1,992,724	–	9,272,424
WET	1,685,900	1,751,700	–	–	1,717,340	–	5,154,940
Totals	**$6,708,292**	**$24,363,400**	**$18,125,500**	**$22,050,900**	**$31,148,851**	**$18,618,600**	**$121,015,543**
Santa Barbara							
CSS	$3,853,402	$11,527,900	$7,582,206	$10,474,700	$9,120,002	$8,624,200	$51,182,410
PEI	–	1,346,800	3,236,300*	4,321,500*	6,813,610*	2,653,400*	18,371,610
INN	–	–	829,800	829,800	2,948,600	565,700	5,173,900
CAPTECH	–	3,830,200	1,203,400	–	–	–	5,033,600
WET	1,141,400	1,213,700	115,294	–	1,328,994	–	3,799,388
Totals	**$4,994,802**	**$17,918,600**	**$12,967,000**	**$15,626,000**	**$20,211,206**	**$11,843,300**	**$83,560,908**
Santa Clara							
CSS	$13,521,652	$39,490,800	$28,814,300	$38,732,100	$48,528,816	$33,536,100	$202,623,768
PEI	–	5,663,100	13,664,300*	18,321,000*	37,640,067*	11,254,700*	86,543,167
INN	–	–	3,263,200	3,263,200	11,720,900	2,238,600	20,485,900
CAPTECH	–	16,205,300	5,091,700	–	9,459,000	–	30,756,000
WET	4,799,400	5,171,300	–	2,000,000	2,000,000	–	13,970,700
Totals	**$18,321,052**	**$66,530,500**	**$50,833,500**	**$62,316,300**	**$109,348,783**	**$47,029,400**	**$354,379,535**
Santa Cruz							
CSS	$2,393,226	$6,876,300	$4,902,500	$6,660,600	$7,414,350	$5,483,900	$33,730,876
PEI	–	857,400	2,049,400*	2,736,300*	3,902,394*	1,678,400*	11,223,894
INN	–	–	527,600	527,600	1,674,100	359,500	3,088,800
CAPTECH	–	2,394,000	752,200	–	3,146,200	–	6,292,400
WET	726,600	758,000	–	–	–	–	1,484,600
Totals	**$3,119,826**	**$10,885,700**	**$8,231,700**	**$9,924,500**	**$16,137,044**	**$7,521,800**	**$55,820,570**
Shasta							
CSS	$1,712,376	$5,998,200	$3,362,700	$4,464,700	$3,887,301	$3,676,000	$23,101,277
PEI	–	508,500	1,233,800	1,664,400	1,160,400	847,000	5,414,100
INN	–	–	346,800	346,800	1,099,800	236,500	2,029,900
CAPTECH	–	1,501,000	471,600	–	1,972,600	–	3,945,200
WET	431,000	472,600	–	–	–	–	903,600
Totals	**$2,143,376**	**$8,480,300**	**$5,414,900**	**$6,475,900**	**$8,120,101**	**$4,759,500**	**$35,394,077**

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Sierra							
CSS	$271,896	$405,200	$644,800	$894,800	$1,155,424	$736,700	$4,108,820
PEI	–	100,000	150,400	250,400	326,633	126,700	954,133
INN	–	–	63,500	63,500	237,900	45,400	410,300
CAPTECH	–	600,000	188,500	–	788,500	–	1,577,000
WET	225,000	225,000	–	–	31,590	–	481,590
Totals	**$496,896**	**$1,330,200**	**$1,047,200**	**$1,208,700**	**$2,540,047**	**$908,800**	**$7,531,843**
Siskiyou							
CSS	$588,535	$1,533,500	$1,374,300	$1,724,300	$1,957,175	$1,419,700	$8,597,510
PEI	–	112,300	265,900*	369,600*	891,900*	225,600*	1,865,300
INN	–	–	122,800	122,800	451,000	84,400	781,000
CAPTECH	–	600,000	188,500	–	788,500	–	1,577,000
WET	225,000	225,000	–	–	416,200	–	866,200
Totals	**$813,535**	**$2,470,800**	**$1,951,500**	**$2,216,700**	**$4,504,775**	**$1,729,700**	**$13,687,010**
Solano							
CSS	$3,258,606	$9,382,600	$6,642,100	$9,143,000	$7,960,501	$7,527,700	$43,914,507
PEI	–	1,138,100	2,776,700*	3,753,900*	2,618,800*	3,111,800*	13,399,300
INN	–	–	718,900	718,900	1,390,050	493,000	3,320,850
CAPTECH	–	3,165,123	1,073,800	–	3,681,923	–	7,920,846
WET	1,216,877	1,076,500	–	–	(252,377)	–	2,041,000
Totals	**$4,475,483**	**$14,762,323**	**$11,211,500**	**$13,615,800**	**$15,398,897**	**$11,132,500**	**$70,596,503**
Sonoma							
CSS	$3,741,594	$11,152,000	$7,518,500	$10,235,200	$11,812,783	$8,426,900	$52,886,977
PEI	–	1,340,200	3,198,500*	4,260,000*	9,306,300*	2,612,600*	20,717,600
INN	–	–	813,300	813,300	2,986,900	553,900	5,167,400
CAPTECH	–	3,741,900	1,175,700	–	4,120,361	–	9,037,961
WET	1,135,800	1,180,000	–	–	2,145,400	–	4,461,200
Totals	**$4,877,394**	**$17,414,100**	**$12,706,000**	**$15,308,500**	**$30,371,744**	**$11,593,400**	**$92,271,138**
Stanislaus							
CSS	$4,293,970	$14,335,000	$8,502,900	$11,684,900	$10,173,700	$9,620,600	$58,611,070
PEI	–	1,414,500	3,475,800*	4,719,300*	4,314,900*	2,906,400*	16,830,900
INN	–	–	914,400	914,400	2,912,500	627,800	5,369,100
CAPTECH	–	4,327,200	1,359,600	–	5,686,800	–	11,373,600
WET	1,198,800	1,369,300	–	–	–	–	2,568,100
Totals	**$5,492,770**	**$21,446,000**	**$14,252,700**	**$17,318,600**	**$23,087,900**	**$13,154,800**	**$94,752,770**

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Sutter-Yuba							
CSS	$1,761,564	$5,196,400	$3,568,300	$4,510,900	$5,043,253	$3,714,000	$23,794,417
PEI	–	447,900	1,076,200*	1,444,500*	2,434,400*	1,036,800*	6,439,800
INN	–	–	344,500	344,500	1,258,600	232,900	2,180,500
CAPTECH	–	1,343,200	422,100	–	1,765,300	–	3,530,600
WET	450,000	450,000	–	–	900,000	–	1,800,000
Totals	**$2,211,564**	**$7,437,500**	**$5,411,100**	**$6,299,900**	**$11,401,553**	**$4,983,700**	**$37,745,317**
Tehama							
CSS	$716,402	$2,652,700	$1,555,100	$1,929,300	$1,679,800	$1,588,500	$10,121,802
PEI	–	162,900	404,400	550,600	823,100	278,900	2,219,900
INN	–	–	144,500	144,500	527,700	97,800	914,500
CAPTECH	–	600,000	188,500	–	788,500	–	1,577,000
WET	225,000	225,000	–	–	450,000	–	900,000
Totals	**$941,402**	**$3,640,600**	**$2,292,500**	**$2,624,400**	**$4,269,100**	**$1,965,200**	**$15,733,202**
Tri City†							
CSS	$1,907,890	$5,976,200	$3,721,400	$4,989,000	$2,362,389	$4,107,700	$23,064,579
PEI	–	702,900	1,621,200	2,116,400	2,975,582	1,086,600	8,502,682
INN	–	–	402,600	402,600	1,472,300	271,500	2,549,000
CAPTECH	–	2,059,600	647,100	–	2,706,700	–	5,413,400
WET	595,800	548,200	–	–	1,144,000	–	2,288,000
Totals	**$2,503,690**	**$9,286,900**	**$6,392,300**	**$7,508,000**	**$10,660,971**	**$5,465,800**	**$41,817,661**
Trinity							
CSS	$355,222	$648,900	$755,600	$1,005,600	$127,725	$827,900	$3,720,947
PEI	–	100,000	151,600	251,600*	1,091,975*	152,900*	1,748,075
INN	–	–	70,900	70,900	194,200	50,200	386,200
CAPTECH	–	600,000	188,500	–	500	–	789,000
WET	225,000	225,000	–	–	140,000	–	590,000
Totals	**$580,222**	**$1,573,900**	**$1,166,600**	**$1,328,100**	**$1,554,400**	**$1,031,000**	**$7,234,222**
Tulare							
CSS	$4,105,199	$11,056,200	$7,577,700	$11,085,300	$10,399,375	$9,126,900	$53,350,674
PEI	–	1,322,300	3,259,800	4,435,000	2,012,425	2,250,300	13,279,825
INN	–	–	865,300	865,300	3,189,300	594,400	5,514,300
CAPTECH	–	4,060,300	1,775,700	–	5,336,000	–	11,172,000
WET	1,120,600	1,293,900	–	–	2,246,400	–	4,660,900
Totals	**$5,225,799**	**$17,732,700**	**$13,478,500**	**$16,385,600**	**$23,183,500**	**$11,971,600**	**$87,977,699**

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

COUNTY/ COMPONENT	FISCAL YEAR 2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	TOTAL
Tuolumne							
CSS	$693,980	$1,959,500	$1,520,700	$1,870,700	$2,122,475	$1,540,300	$9,707,655
PEI	–	151,000	357,800	475,300	313,050	242,900	1,540,050
INN	–	–	138,200	138,200	469,650	93,400	839,450
CAPTECH	–	600,000	188,500	–	372,047	–	1,160,547
WET	225,000	225,000	–	–	–	–	450,000
Totals	**$918,980**	**$2,935,500**	**$2,205,200**	**$2,484,200**	**$3,277,222**	**$1,876,600**	**$13,697,702**
Ventura							
CSS	$6,810,115	$18,815,700	$11,671,400	$18,726,100	$26,904,863	$15,417,800	$98,345,978
PEI	–	2,414,300	5,853,700*	7,849,800*	13,676,217*	4,826,700*	34,620,717
INN	–	–	1,483,000	1,483,000	5,085,650	1,014,000	9,065,650
CAPTECH	–	7,091,300	4,174,700	–	4,213,527	–	15,479,527
WET	2,046,000	2,240,500	–	–	2,575,830	–	6,862,330
Totals	**$8,856,115**	**$30,561,800**	**$23,182,800**	**$28,058,900**	**$52,456,087**	**$21,258,500**	**$164,374,202**
Yolo							
CSS	$1,838,123	$6,225,800	$3,692,900	$4,975,000	$9,786,617	$4,096,100	$30,614,540
PEI	–	570,700	1,407,100*	1,908,100*	3,180,183*	1,175,900*	8,241,983
INN	–	–	386,700	386,700	1,422,400	264,700	2,460,500
CAPTECH	–	1,730,800	543,800	–	1,696,975	–	3,971,575
WET	483,700	558,800	–	–	577,625	–	1,620,125
Totals	**$2,321,823**	**$9,086,100**	**$6,030,500**	**$7,269,800**	**$16,663,800**	**$5,536,700**	**$46,908,723**
Statewide							
CSS	$320,453,101	$918,430,987	$644,124,260	$896,588,050	$982,640,247	$741,431,795	$4,503,668,440
PEI	–	114,756,594	278,600,000	376,000,000	469,648,647	232,062,340	1,471,067,581
INN	–	–	71,000,000	71,000,000	197,705,668	48,957,265	388,662,933
CAPTECH	–	343,115,862	114,091,446	1,269,950	280,725,187	–	739,202,445
WET	106,070,717	110,000,300	9,184,294	2,142,000	60,892,214	9,000,000	297,064,525
Totals	**$426,523,818**	**$1,486,303,743**	**$1,117,000,000**	**$1,347,000,000**	**$1,991,611,963**	**$1,031,451,400‡**	**$7,381,256,524**

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

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

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

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

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Appendix B

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

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

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

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

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

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

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

PROGRAM/ACTION TITLE	DESCRIPTION	FISCAL YEAR						AGE GROUP TARGETED			
		2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Community Services and Supports											
Planning, Outreach, and Engagement	Implements strategies to increase awareness of the Mental Health Services Act (MHSA) among unserved, underserved, and inappropriately served populations, including outreach to the homeless and development of the County Department of Mental Health's Division of Empowerment and Advocacy.	✓	✓	✓	✓	✓	✓	●*	●*	●*	●*
Service Area Navigators	Funds persons who work to link needed services to members of the community. Teams are age-group specific.	✓	✓	✓	✓	✓	✓	●*	●*	●*	●*
Prevention and Early Intervention											
Early Start Suicide Prevention	Contains several suicide prevention components, including increasing the capacity and quality of the suicide prevention hotline; increasing public awareness efforts; providing training; providing support groups; and offering activities targeted toward diverse and at-risk populations.			✓	✓	✓	✓	●	●	●	●
Early Start School Mental Health Initiative	Implements a school threat assessment response team to identify at-risk students, and provides services in all Los Angeles service areas.			✓	✓	✓	✓	●	●	●	●
Early Start Anti-Stigma and Discrimination	Implements client-focused strategies, family support and education, and broader community advocacy strategies to reduce stigma and discrimination in communities.			✓	✓	✓	✓	●	●	●	●
School-Based Services	Provides several interventions to build resiliency in children, identify as early as possible children and youth who have risk factors, and provide on-site services to address nonacademic problems.				✓	✓	✓	●	●		
Family Education and Support Services	Provides interventions to build competencies, capacity, and resilience in parents, family members, and other caregivers. Concentrates on parental skill building in a variety of settings.				✓	✓	✓	●	●	●	●
At-Risk Family Services	Provides training and assistance to families of children at risk for out-of-home placements, builds skills for families with difficult children, and provides support to families with histories that place them at risk.				✓	✓	✓	●	●	●	●

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PROGRAM/ACTION TITLE	DESCRIPTION	FISCAL YEAR						AGE GROUP TARGETED			
		2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Prevention and Early Intervention ▼											
Trauma Recovery Services	Provides short-term crisis counseling to clients, family, and staff affected by a traumatic event, and provides intensive services to trauma-exposed youth.				✓	✓	✓	●	●	●	●
Primary Care and Behavioral Health Services	Develops mental health services within primary care clinics, and helps prevent patients at clinics from developing severe behavioral health issues.				✓	✓	✓	●	●	●	●
Early Care and Support for Transition-Age Youth	Includes three components for transition-age youth: building resiliency and increasing protective factors, addressing depressive disorders, and minimizing impact for youth who may be in the early stages of mental illness.				✓	✓	✓	●	●	●	
Juvenile Justice Services	Builds resiliency and protective factors among youth and children exposed to risk factors, promotes coping and life skills, and identifies mental health issues among youth in the juvenile justice system as early as possible.				✓	✓	✓	●	●	●	
Early Care and Support for Older Adults	Establishes the means to identify and link older adults who need treatment but are reluctant, are hidden, or are unknown; to prevent and alleviate depressive disorders; and to provide brief mental health treatment for older adults.				✓	✓	✓		●	●	●
Improving Access for Underserved Populations	Builds resiliency and increases protective factors among non-English-speaking or limited-English-speaking and other underserved populations, identifies at-risk individuals, and provides culturally and linguistically appropriate mental health services.				✓	✓	✓	●	●	●	●
American Indian Project	Builds resiliency and increases protective factors among children, youth, and their families; addresses stressful forces in children's and youth's lives; and identifies as early as possible children and youth who have risk factors.				✓	✓	✓	●	●	●	●

PROGRAM/ACTION TITLE	DESCRIPTION	FISCAL YEAR						AGE GROUP TARGETED			
		2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Innovation											
Integrated Clinic Model	Provides integrated care in a large, complex urban environment specifically targeting the most vulnerable populations and integrating primary care sites with mental health services. The program focuses on individuals eligible for specialty mental health services who could benefit from primary health and/or substance abuse services.				✓	✓	✓	†	†	†	†
Integrated Mobile Health Team Model	Provides integrated care in a geographically widespread, complex urban environment, managing it under one agency and increasing access to services by leveraging multiple funding sources.				✓	✓	✓	†	†	†	†
Community-Designed Integrated Service Management Model	Provides integrated care in a diverse urban environment by differentiating specific needs and approaches for five underrepresented ethnic communities, focusing on community self-direction for integrated service delivery. Peers are integrated into the mix of formal and nontraditional providers.				✓	✓	✓	†	†	†	†
Integrated Peer-Run Model	Provides peer-run integrated services and peer-run crisis houses to expand the potential of peer-run services. Peer-run integrated services management addresses physical health, mental health, and substance abuse issues.				✓	✓	✓	†	†	†	†
Workforce Education and Training											
Workforce Education and Training Coordination	Funds staffing for the planning and development of the county workforce plan.			✓	✓	✓	✓	NA	NA	NA	NA
County of Los Angeles Oversight Committee	Funds a committee to guide and support the implementation of the county plan.			✓	✓			NA	NA	NA	NA
Transformation Academy Without Walls	Provides a training program aimed at improving the skills of the mental health workforce. Includes standard curricula and incorporates coaching and mentoring.			✓	✓	✓	✓	NA	NA	NA	NA

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PROGRAM/ACTION TITLE	DESCRIPTION	FISCAL YEAR						AGE GROUP TARGETED			
		2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Workforce Education and Training ▼											
Recovery-Oriented Supervision Trainings	Immerses supervisors in the basic tenets of the MHSA, provides them with updated information on issues related to recovery and wellness, and teaches them how to integrate clients and family members into the mental health workforce.					✓	✓	NA	NA	NA	NA
Interpreter Training Program	Offers training in phases: trains interpreters for mental health settings, trains mental health providers in how best to use interpreters, and offers technical assistance and follow-up support.			✓	✓	✓	✓	NA	NA	NA	NA
Training for Community Partners	Offers training on symptomatology and on how to access health services to community partners, including law enforcement, probation departments, and child protective services.			✓	✓	✓	✓	NA	NA	NA	NA
Intensive Mental Health Recovery Specialist Training Program	Offers training for entry-level professionals who represent the linguistic and cultural diversity of those receiving services. Efforts are also made to recruit and match trainees with ideal field placement.			✓	✓	✓	✓	NA	NA	NA	NA
Expand Employment and Professional Advancement Opportunities for Consumers in the Public Mental Health System	Increases training and employment of clients in the public mental health system and decreases barriers to employment. Specifically targets older adults and transition-age youth.			✓	✓	✓	✓	NA	NA	NA	NA
Expand Employment and Professional Advancement Opportunities for Parent Advocates, Child Advocates, and Caregivers in the Public Mental Health System	Helps develop skills needed to perform community outreach, advocacy, and leadership duties, with a focus on teaching participants how to navigate systems including mental health, schools, regional centers, and child protective services. Targets parents, child advocates, and caregivers of children.				✓	✓	✓	NA	NA	NA	NA
Expand Employment and Professional Advancement Opportunities for Family Member Advocates in the Public Mental Health System	Trains family members of clients to develop or augment skills related to community outreach, advocacy, and leadership, and decreases barriers to employment.				✓	✓	✓	NA	NA	NA	NA

PROGRAM/ACTION TITLE	DESCRIPTION	FISCAL YEAR						AGE GROUP TARGETED			
		2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Workforce Education and Training											
Mental Health Career Advisors	Develops a group of advisors who will work with newly entering and/or existing mental health staff to help them as they enter and remain in the mental health workforce.				✓	✓	✓	NA	NA	NA	NA
High School Through University Mental Health Pathways	Expands academic programs to promote mental health careers to high school, community college, and university students, especially in communities or areas of the county where ethnically diverse populations reside.				✓	✓	✓	NA	NA	NA	NA
Market Research and Advertising Strategy for Recruitment of Professionals in the Public Mental Health System	Establishes a collaboration with an academic institution, research institute, or think tank to conduct market research and formulate advertising strategies to identify ways of attracting and targeting new professionals into the public mental health field.			✓	✓	✓	✓	NA	NA	NA	NA
Partnership with Educational Institutions to Increase the Number of Mental Health Professionals in the Public Mental Health System	Works with educational institutions currently producing, or that may in the future produce, mental health professionals in key high-need disciplines to expand capacity for developing additional mental health professionals.			✓	✓	✓	✓	NA	NA	NA	NA
Recovery-Oriented Internship Development	Works with degree-granting institutions providing recovery-oriented classroom instruction to develop relationships with nontraditional providers, and works with existing providers to increase the number of internships available.				✓	✓	✓	NA	NA	NA	NA
Tuition Reimbursement Program	Provides up to $5,000 per year for tuition expenses for individuals interested in entering or enhancing skills for the mental health field who meet certain criteria.				✓	✓	✓	NA	NA	NA	NA
Associate and Bachelor Degree 20/20 and/or 10/30 Program	Targets individuals currently working in public mental health who are interested in advancing in their career by obtaining an associate- or a bachelor-level degree. Program pays for a portion of their salaries to allow students to meet academic responsibilities.					✓	✓	NA	NA	NA	NA

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PROGRAM/ACTION TITLE	DESCRIPTION	FISCAL YEAR						AGE GROUP TARGETED			
		2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Workforce Education and Training											
Stipend Programs for Psychologists, Masters of Social Work, Masters of Family Therapy, Psychiatric Nurse Practitioners, and Psychiatric Technicians	Seeks to expand the number of psychologists, masters in social work, marriage and family therapists, psychiatric nurse practitioners, and psychiatric technicians in the county by offering stipends in the programs that will represent underserved ethnic groups.			✓	✓	✓	✓	NA	NA	NA	NA
Loan Forgiveness Program	Explores loan forgiveness to programs that complement existing programs and meet the need for a linguistically and culturally competent workforce based on geographic, cultural, and linguistic needs.				✓	✓	✓	NA	NA	NA	NA
Capital Facilities and Technological Needs											
Integrated Behavioral Health Information System	Provides clinicians direct access to current client clinical records regardless of where each client was seen previously in the network, including medication history, recent assessments, treatment plans, and clinical notes. It also provides an improved means of measuring and reporting MHSA outcomes.				✓	✓	✓	NA	NA	NA	NA
Contract Provider Technology Project	Provides contract providers with a means to pursue technology improvements in support of MHSA activities. Distributes MHSA information technology funds to more than 125 contract providers to pursue predetermined technological projects.				✓	✓		NA	NA	NA	NA
Consumer/Family Access to Computer Resources Project	Promotes client/family growth and autonomy, provides basic computer skills training to clients allowing them to effectively use computer resources available to them and provides appropriate access to technical assistance resources.				✓	✓		NA	NA	NA	NA
Personal Health Record Awareness and Education	Develops written and online awareness and educational materials with the target audiences of client/family and mental health services provider.				✓	✓		NA	NA	NA	NA
Data Warehouse Redesign Project	Based on the implementation of electronic health records, prepares the county to store new clinical, administrative, and financial data sources as well as establishes resources for warehousing legacy data.				✓	✓		NA	NA	NA	NA

PROGRAM/ACTION TITLE	DESCRIPTION	FISCAL YEAR						AGE GROUP TARGETED			
		2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Capital Facilities and Technological Needs											
Telepsychiatry Feasibility Study and Recommendation Project	Hires a consultant to identify opportunities for a variety of telepsychiatry projects, research the possible benefits of widespread and systematic adoption of telepsychiatry, and make recommendations regarding the value of implementing telepsychiatry.				✓			NA	NA	NA	NA
Telepsychiatry Implementation Project	Extends functionality of the existing telepsychiatry pilot to meet the MHSA information technology goal of modernizing and transforming clinical and administrative information systems.					✓		NA	NA	NA	NA

Sources: MHSA component plans and annual updates prepared by the Los Angeles County Department of Mental Health.

NA = Not applicable. Workforce Education and Training and Capital Facilities and Technological Needs generally include efforts that focus on expanding, educating, and training the local public mental health workforce and improving infrastructure. Because programs within these components are not designed to provide direct mental health services, no age group is targeted.

✓ = Program appears in a plan applicable for the fiscal year.

● = County plan indicated that program targeted this age group.

* The county's plans did not specify an age group this program served; based on the program description, it reasonably serves all age groups.

† The county's Innovation component plan did not identify specific age groups for this program. We, therefore, could not determine which discrete age groups the program targeted.

Table B.2
County of Sacramento Department of Health and Human Services: Mental Health Services Act Services Planned Programs/Actions by Component
Fiscal Years 2006–07 Through 2011–12

PROGRAM/ ACTION TITLE	DESCRIPTION	FISCAL YEAR						AGE GROUP TARGETED			
		2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Community Services and Supports ▼											
Transitional Community Opportunities for Recovery and Engagement (TCORE)	Provides community-based services for those leaving or at risk of entering acute care settings and who are not linked to ongoing mental health services.	✓	✓	✓	✓	✓	✓		●	●	●
Sierra Elder Wellness*	Provides specialized geriatric psychiatric support, multidisciplinary mental health assessments, treatment, and intensive case management services for individuals with multiple co-occurring mental health, physical health, and/or substance abuse and social service needs requiring intensive case management services.	✓	✓	✓	✓	✓	✓			●	●
Permanent Supportive Housing Program	Consists of three components: (1) offers same-day access to services such as mental health assessments and medication, and limited temporary housing; (2) provides short-term housing and focuses on rapid access to permanent housing and Full-Service Partnership (Partnership) level of services for moderate and episodic intensive-level service needs; and (3) provides permanent supportive housing and a Partnership level of mental health services.	✓	✓	✓	✓	✓	✓	●	●	●	●
Transcultural Wellness Center	Addresses the mental health needs of the Asian/Pacific Islander community, taking into account the cultural and religious beliefs and values, traditional and natural healing practices, and ceremonies this community recognizes.	✓	✓	✓	✓	✓	✓	●	●	●	●
Wellness and Recovery Center	Consists of three components: (1) two community-based, multi-service centers that provide a supportive environment offering choice and self-directed guidance for recovery and transition into community life; (2) peer support services for individuals linked to the TCORE clinics serving adults; and (3) program promoting and advocating for client involvement in the mental health system through a wide array of services and supports including advocacy, system navigation, training, support groups, and psycho-educational groups.	✓	✓	✓	✓	✓	✓	●	●	●	●

PROGRAM/ ACTION TITLE	DESCRIPTION	FISCAL YEAR						AGE GROUP TARGETED			
		2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Community Services and Supports ▼											
Adult Full-Service Partnership	Contains two components serving adults with persistent and significant mental illness. Services include case management, benefits acquisition, crisis response, intervention and stabilization, medication evaluation and support, and effective ongoing specialty mental health services. Supports include housing, employment, education, and transportation.				✓	✓	✓		●	●	●
Juvenile Justice Diversion and Treatment Program	Provides screenings, assessments, and intensive mental health services and Partnership supports to eligible youth and their families involved in the juvenile justice system.				✓	✓	✓	●	●		
Prevention and Early Intervention ▼											
Suicide Prevention Program	Consists of five components focusing on suicide prevention and education: (1) a 24-hour telephone crisis line, (2) brief individual and group bereavement counseling services, (3) support groups and services designed to encourage healing for those coping with a loss by suicide, (4) services designed to reduce isolation and decrease the risk of suicide, and (5) field-based flexible services to community members experiencing a crisis. Services include assessment, support services, and linkage to ongoing services and supports.				✓	✓	✓	●	●	●	●
Strengthening Families Program	Contains five components: (1) provides behavioral consultations to preschools and early care learning environments designed to increase teacher awareness about the meaning of behavior; (2) provides health exams, assessments, referrals, and treatment services for children from birth to 5 years old who are placed into protective custody; (3) trains school staff to educate others on anti-bullying strategies; (4) implements prevention approaches for youth age 6 to 18 and families to improve social skills, increase protective factors, prevent youth violence, and reduce or eliminate family conflict; and (5) independent living program expanded to non-foster, homeless, and lesbian, gay, bisexual, transgender, and questioning youth age 16 to 25 to gain life skills.					✓	✓	●	●	●	●

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PROGRAM/ ACTION TITLE	DESCRIPTION	FISCAL YEAR						AGE GROUP TARGETED			
		2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Prevention and Early Intervention											
Integrated Health and Wellness Program	Consists of two components: (1) provides assessment, early identification, and treatment of the onset of psychosis and (2) serves adults demonstrating early signs of isolation and depression through socialization opportunities, skill-building groups, transportation services, and collaboration with health care providers.					✓	✓	●	●	●	●
Mental Health Promotion Project	Increases awareness about mental health issues and reduces stigma and discrimination toward individuals and families living with mental illness.					✓	✓	●	●	●	●
Innovation											
Respite Partnership Collaborative	Establishes a collaborative to learn whether a partnership with a community-based organization can, among other things, lead to new partnerships that can help address crisis and other mental health issues in Sacramento.					✓	✓	●	●	●	●
Workforce Education and Training											
Workforce Staffing Support	Facilitate the implementation of Workforce Education and Training efforts across the county.			✓	✓	✓	✓	NA	NA	NA	NA
System Training Continuum	Expands training capacity of mental health staff, system partners, consumers, and family members.			✓	✓	✓	✓	NA	NA	NA	NA
Office of Consumer and Family Member Employment	Seeks to develop entry and employment opportunities to address occupational shortages.			✓	✓	✓	✓	NA	NA	NA	NA
High School Training	Introduces mental health career information to high school students.			✓	✓	✓	✓	NA	NA	NA	NA
Psychiatric Residents and Fellowships	Places medical residents and fellows in mental health settings with dedicated supervision.			✓	✓	✓	✓	NA	NA	NA	NA
Multidisciplinary Seminar	Seeks to increase the number of psychiatrists and other practitioners working in community mental health that are trained in specific service models.			✓	✓	✓	✓	NA	NA	NA	NA
Consumer Leadership Stipends	Provides clients and family members the opportunity to receive stipends for leadership or educational opportunities that increase knowledge, build skills, and further advocacy for clients on mental health issues.			✓	✓	✓	✓	NA	NA	NA	NA

PROGRAM/ ACTION TITLE	DESCRIPTION	FISCAL YEAR						AGE GROUP TARGETED			
		2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Workforce Education and Training											
Stipends for Individuals, Especially Consumers and Family Members, for Education Programs to Enter the Mental Health Field	Establishes a fund to allow individuals to apply for stipends to participate in educational opportunities that will lead to employment in Sacramento County's mental health system.			✓	✓	✓	✓	NA	NA	NA	NA
Capital Facilities and Technological Needs											
Technological Needs Project	Consists of five phases to build infrastructure to meet Sacramento County's goals in its Community Services and Supports plan and to achieve the federal objectives of meaningful use of electronic health records to improve client care.				✓	✓	✓	NA	NA	NA	NA

Sources: Mental Health Services Act component plans and annual updates prepared by the County of Sacramento Department of Health and Human Services.

NA = Not applicable. Workforce Education and Training and Capital Facilities and Technological Needs generally include efforts that focus on expanding, educating, and training the local public mental health workforce and improving infrastructure. Because programs within these components are not designed to provide direct mental health services, no age group is targeted.

✓ = Program appears in a plan applicable for the fiscal year.

● = County plan indicated that program targeted this age group.

* In fiscal year 2006–07, this program was titled Older Adult Intensive Services Program.

Table B.3
County of San Bernardino Department of Behavioral Health Administration: Mental Health Services Act Planned Programs by Component
Fiscal Years 2006–07 Through 2011–12

		FISCAL YEAR						AGE GROUP TARGETED			
PROGRAM TITLE	DESCRIPTION	2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Community Services and Supports ▼											
Comprehensive Child and Family Support System	Coordinate and access an array of county services for children who are challenged with emotional disturbances. Uses evidence-based practices and includes case management, flexible funding, family focus treatment, service coordination, child care, co-occurring treatment, psychiatric services, family advocacy, and parent partnerships.	✓	✓	✓	✓	✓	✓	●	●		
Integrated New Family Opportunities	Provides mental health services to children age 13 to 17 in custody and post-custody juvenile detention. Services seek to reduce out-of-home placements.			✓	✓	✓	✓	●			
One Stop Transition-Age Youth Center	Provides integrated mental health services to individuals age 16 to 25 at a drop-in center. Clients receive mental health services as well as short-term residential and educational/vocational services to help transition-age youth become independent, stay out of the hospital or a higher level of care, reduce involvement in the criminal justice system, and reduce homelessness.	✓	✓	✓	✓	✓	✓		●		
Consumer-Operated Peer Support System	Includes an independent program using clients hired as mental health specialists. Services include peer education and advocacy, employment support, and life skills development classes. Also expands existing clubhouse services to underserved adults.	✓	✓	✓	✓	✓	✓			●	
Forensic Integrated Mental Health Services	Consists of three programs that all target severely and persistently mentally ill individuals involved with the criminal justice system. The programs are the forensic assertive community treatment program, the supervised treatment after release program, and the crisis intervention training program.	✓	✓	✓	✓	✓	✓			●	

PROGRAM TITLE	DESCRIPTION	FISCAL YEAR						AGE GROUP TARGETED			
		2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Community Services and Supports ▼											
Assertive Community Treatment Team for High Users of Arrowhead Regional Center Behavioral Health Hospital	Provides support services 24 hours a day to clients who are frequent users of acute psychiatric hospitalization or are caught in the arrest cycle for minor crimes. The program includes peer support, clinical interventions, housing, and employment services.	✓	✓	✓	✓	✓	✓		●	●	●
Crisis Walk-In Center	Redesigns and expands current walk-in clinics to provide urgent mental health services. Provides integrated substance abuse treatment services for dually diagnosed clients.	✓	✓	✓	✓	✓	✓	●	●	●	●
Psychiatric Triage Diversion Team at Arrowhead Regional Medical Center	Creates a preliminary psychiatric screening program to better use mental health resources and reduce unnecessary hospitalizations.	✓	✓	✓	✓	✓	✓	●		●	●
Community Crisis Response Team	Combines the previously approved child's crisis response team and adult crisis response team, creating a community crisis response team, a seamless program that melds crisis intervention with outreach and education.			✓	✓	✓	✓	●	●	●	●
Homeless Intensive Case Management and Outreach	Provides case management services and linkage to community and county resources for mentally ill adults who are homeless or at risk of homelessness, incarceration, or hospitalization.			✓	✓	✓	✓		●	●	●
Alliance for Behavioral and Emotional Treatment	An alliance of organizations, private practitioners, and county departments that provide a variety of services to the mentally ill in the Big Bear Lake area.			✓	✓	✓	✓	●	●	●	●
System Transformation for Engaging Partners in Uplifting People	Develops Full-Service Partnership (Partnership) teams providing outpatient mental health and medication support services, community crisis intervention and case management services, and integrated treatment support.				✓					●	
Circle of Care: System Development	Provides mental health treatment and case management services to older adults age 60 and over to assist them in remaining independent and active in their communities.	✓	✓	✓	✓	✓	✓				●

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PROGRAM TITLE	DESCRIPTION	FISCAL YEAR						AGE GROUP TARGETED			
		2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Community Services and Supports ▼											
Circle of Care: Mobile Outreach and Intensive Case Management	Provides a mobile crisis team that provides services to older adults who are isolated in their homes, homeless, or in crisis. Also establishes a Partnership system of care initially in the High Desert.	✓	✓	✓	✓	✓	✓			●	●
Improving Information Systems	Purchases multiple software applications, such as electronic health records and geographic information system applications, designed to better track the success of the Mental Health Services Act (MHSA) implementation.	✓	✓					●	●	●	●
Department Training Program	Provides a comprehensive staff development program to train all staff and clients who are hired or participate in client activities in leadership roles.	✓	✓					●	●	●	●
Cultural Competence Program	Provides a comprehensive cultural competence program to better serve an ethnically and linguistically diverse population and eliminate disparities in access to services.	✓	✓					●	●	●	●
Housing and Employment Program	Provides housing and employment support services according to the appropriate level of care.	✓	✓						●	●	●
Capital Purchases	San Bernardino County is requesting $4,033,800 to be used for capital purchases for all 10 programs to be funded and implemented under the MHSA. Capital purchases include purchases such as cars, copiers, computers, furniture, and office rents that are required tools to operate the programs requested in the county's three-year Community Services and Supports plan.	✓						*	*	*	*
Prevention and Early Intervention ▼											
Student Assistance Program	Minimizes the barriers to learning and supports students in developing academic and personal success by training educators to identify students in need of additional interventions. Additionally, provides early intervention and counseling services.			✓	✓	✓	✓	●	●	●	
Resilience Promotion in African-American Children	Promotes resilience in African-American children in order to mediate the development of post-traumatic stress disorders, mood disorders, anxiety disorders, substance abuse, and psychotic disorders. The program consists of a 12-week intensive program followed by weekly counseling and mentoring.			✓	✓	✓	✓	●	●		

PROGRAM TITLE	DESCRIPTION	FISCAL YEAR						AGE GROUP TARGETED			
		2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Prevention and Early Intervention											
Preschool Project	Targets children (and their families) in Head Start programs who are displaying aggressive behavior or who have suffered traumatic loss. Includes programs to identify children needing referrals for more intensive mental health services, and provides direct services to children and their caregivers.			✓	✓	✓	✓	●	●	●	●
Family Resource Center	Attempts to reduce stigma and discrimination by providing a variety of prevention and early intervention services in a natural community setting. Each center implements programs that are culturally specific and community relevant.			✓	✓	✓	✓	●	●	●	●
Native American Resource Center	Provides culturally specific prevention and early intervention services to Native Americans.			✓	✓	✓	✓	●	●	●	●
National Curriculum and Training Institutes Crossroads Education Classes	Provides classes throughout the county in order to provide early intervention for children at risk of school failure and/or juvenile justice involvement. In addition, the program promotes communication between youth and family members.			✓	✓	✓	✓	●	●	●	
Promotores de Salud	Trains identified community leaders to become personal contacts or liaisons to mental health services and programs within the community. The goal of the program is to reduce stigma and make information regarding mental health resources more accessible.			✓	✓	✓	✓	●	●	●	●
Older Adult Community Services Program	Addresses needs of older adults by providing a mobile resource unit, wellness services, home safety programs, and suicide prevention through peer-to-peer counseling.			✓	✓	✓	✓			●	●
Child and Youth Connection	A collaborative effort with the San Bernardino County Department of Children's Services to screen children placed in foster care for mental health issues. Also provides funds for a mentoring specialist and a mental health liaison to the public defender's office.			✓	✓	✓	✓	●	●	●	●
Nurse Family Partnership/ LIFT	An evidence-based home visitation program in which nurses link families with needed health, mental health, and human social services.			✓	✓	✓	✓	●	●		

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PROGRAM TITLE	DESCRIPTION	FISCAL YEAR						AGE GROUP TARGETED			
		2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Prevention and Early Intervention											
Active Duty and Family Support	Provides in-home psychosocial assessments for returning military personnel and their families and provides prevention activities for children and families while a family member is deployed.			✓	✓	✓	✓	●	●	●	
Community Wholeness and Enrichment Project	Targets transition-age youth and adults and their families suffering early onset of mild mental health issues and identifies residents suffering from mild to moderate mental issues that can be addressed before hospitalization or incarceration.			✓	✓	✓	✓	●	●	●	●
Innovation											
On-Line Diverse Community Experiences	Creates pages on social networking sites such as Facebook and Twitter to disseminate news and information about mental health resources and increase connectivity. Also provides computer training to transition-age youth at community centers to aid access to online resources.					✓	✓	●	●	●	●
Coalition Against Sexual Exploitation	An interagency approach that includes government agencies, community organizations, parents, and other caretakers to develop a comprehensive model of interventions and services to address the issue of sexual exploitation of diverse children and youth.					✓	✓	●	●		
Community Resiliency Model	Adapts existing trauma training to a community-based model, offering training to diverse community members who in turn offer education and skills presentations to at-risk and underserved groups in their communities.					✓	✓	●	●	●	●
Holistic Campus	Creates a center that offers culturally appropriate and community-based mental health services for diverse and underserved populations outside of a clinical setting. Potential offerings include acupuncture, sweat lodges, pet therapy, yoga, and healing circles. Actual offerings are determined by a community advisory board.					✓	✓	●	●	●	●

PROGRAM TITLE	DESCRIPTION	FISCAL YEAR						AGE GROUP TARGETED			
		2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Innovation											
Interagency Youth Resiliency Team	Creates an interagency team to explore and test the implementation of innovative approaches that empower youth and their resource providers in the process of enhancing connections by resolving issues of grief and loss, resolving issues relating to exposure to violence, building coping skills, and assisting resource providers in navigating systems and services.					✓	✓	*	*	*	*
Transition-Age Youth Behavioral Health Hostel	Creates a youth hostel to allow transition-age youth to access peer-run services and linkages to the mental health system. Focuses on two groups of underserved transition-age youth: former foster youth/wards; and lesbian, gay, bisexual, transgender, and questioning youth.						✓		●		
Workforce Education and Training											
Expand Existing Training Program	Provides clients and family members, all levels of the diverse workforce, and contract agencies with education and training needed to advance the vision and business strategy adopted by the county, as well as fundamental MHSA concepts.		✓	✓	✓	✓	✓	NA	NA	NA	NA
Training to Support the Fundamental Concepts of the MHSA	Provides access for county staff, contract agencies, and clients and family members to training on wellness, recovery, and discovery models as well as evidence-based practices.		✓	✓	✓	✓	✓	NA	NA	NA	NA
Development of Core Competencies	Develops processes to ensure that staff receive training in topics central to their duties, and that the content of those trainings has been vetted.		✓	✓	✓	✓	✓	NA	NA	NA	NA
Outreach to High School, Adult Education, Community College, and Regional Occupational Program Students	In collaboration with California State University, San Bernardino, develop a career pathway from high school through graduation from university for careers in the mental health system. Also, develops agreements with adult schools throughout the county to provide federally mandated vocational training at county facilities and collaborate with other community colleges to develop certificate programs for careers in mental health.		✓	✓	✓	✓	✓	NA	NA	NA	NA
Leadership Development Program	Develops leaders from existing staff, begins succession planning for future county leadership, and builds leadership into supervisory training.		✓	✓	✓	✓	✓	NA	NA	NA	NA

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PROGRAM TITLE	DESCRIPTION	FISCAL YEAR						AGE GROUP TARGETED			
		2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Workforce Education and Training											
Peer and Family Advocate Workforce Support Initiatives	Expand the number and locations of trainings for the Peer and Family Advocate Certificate program from the city to the county.		✓	✓	✓	✓	✓	NA	NA	NA	NA
Expand Existing Internship Program	Increases internships within the Department of Behavioral Health as well as coordinates intern programs with contract agencies, thereby increasing the pool of potential future employees.		✓	✓	✓	✓	✓	NA	NA	NA	NA
Psychiatric Residency Program	Establishes a psychiatric residency program through the Arrowhead Regional Medical Center with specializations in child or geriatric psychiatry, public mental health, or multidisciplinary psychiatry.		✓	✓	✓	✓	✓	NA	NA	NA	NA
Scholarship Program	Creates a scholarship program that helps current county employees continue their education in the mental health field.		✓	✓	✓	✓	✓	NA	NA	NA	NA
Increase Eligibility for Federal Workforce Funding	Works to obtain federal designation for four additional county areas as areas with a shortage of mental health professionals, which would then open up additional federal funding opportunities.		✓	✓	✓	✓	✓	NA	NA	NA	NA
Capital Facilities and Technological Needs											
One-Stop Center/Crisis Residential Program	Converts a former medical facility into a one-stop center for transition-age youth. The center provides access to care and houses a crisis residential program.				✓			NA	NA	NA	NA
Integrated Information Systems Infrastructure	Incorporates multiple technology projects, such as a Charon-Vax server upgrade and improvements to data warehouse and electronic record keeping, with the intent of creating an integrated information systems infrastructure.				✓	✓		NA	NA	NA	NA
Integrated Healthcare Project	Develops, in conjunction with other county agencies, an integrated health care facility that combines medical and behavioral health services to address the whole person.					✓		NA	NA	NA	NA

Sources: MHSA plans and annual updates prepared by the County of San Bernardino Department of Behavioral Health Administration.

NA = Not applicable. Workforce Education and Training and Capital Facilities and Technological Needs generally include efforts that focus on expanding, educating, and training the local public mental health workforce and improving infrastructure. Because programs within these components are not designed to provide direct mental health services, no age group is targeted.

✓ = Program appears in a plan applicable for the fiscal year.

● = County plan indicated that program targeted this age group.

* Program description in county's plan did not contain specific age groups. We, therefore, could not determine which discrete age groups the program targeted.

Table B.4
Santa Clara County Mental Health Department: Mental Health Services Act Planned Programs by Component
Fiscal Years 2006–07 Through 2011–12

		FISCAL YEAR						AGE GROUP TARGETED			
PROGRAM TITLE	DESCRIPTION	2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Community Services and Supports ▼											
Child and Family System Improvement/ Full-Service Partnerships*	Provides a comprehensive program for youth age 0 to 15 that combines critical core services within a wraparound model that incorporates age-appropriate elements.	✓	✓	✓	✓	✓	✓	●			
Young Child System of Care Development	Creates a program, in cooperation with First Five Santa Clara and the Infant and Toddler Mental Health Collaborative, that addresses the full-service needs of children under the age of 6 in Santa Clara County who are experiencing significant mental health challenges.	✓	✓	✓	✓	✓	✓	●			
Child and Family System Improvement/ Behavioral Health Recovery Services*	Creates a strategic effort to improve the current Child and Family Behavioral Health outpatient system through the research, design, and implementation of systemwide level-of-care screening, assessment, and practice guidelines that incorporate core transformation principles and support selected evidence-based practices.	✓	✓	✓	✓	✓	✓	●			
Transition-Age Youth System of Care Development/ Full-Service Partnerships (Partnership)†	Combines critical core services and wraparound services designed for transition-age youth using a model called the Transition to Independence Process System.	✓	✓	✓	✓	✓	✓		●		
Transition-Age Youth Behavioral Health Services Outpatient System Redesign†	Creates a strategic effort to improve the current outpatient transition-age youth system through the research, design, and implementation of systemwide level-of-care screening, assessment, and practice guidelines that incorporate core transformation principles and support selected evidenced-based practices.	✓	✓	✓	✓	✓	✓		●		
Transition-Age Youth System of Care/Crisis and Drop-In Services and Supports†	Establishes a 24-hour drop-in center for transition-age youth that provides a safe place in a nonstigmatizing environment with access to mental health, other basic services, and crisis intervention during the day.	✓	✓	✓	✓	✓	✓		●		

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PROGRAM TITLE	DESCRIPTION	FISCAL YEAR						AGE GROUP TARGETED			
		2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Community Services and Supports ▼											
Transition-Age Youth System of Care Development/ Education Partnership†	Establishes a specialized recovery-through-education program through a partnership with a local community college, the California Department of Mental Health, the California Department of Rehabilitation and potential employers.	✓	✓	✓	✓	✓	✓		●		
Adult System Development/ Full-Service Partnerships‡	Establishes a Partnership program that provides all necessary services and supports that assist the client in achieving his or her personal recovery goals.	✓	✓	✓	✓	✓	✓			●	
Adult System Development/ Behavioral Health Recovery Services—Outpatient System Redesign‡	Establishes a strategic effort to shift the current mental health outpatient system to a behavioral health model, including stakeholder involvement and embracing a wellness and recovery model.	✓	✓	✓	✓	✓	✓			●	
Adult Criminal Justice System Development	Addresses the mental health needs of individuals with concurrent mental health and substance abuse problems who are also involved in the criminal justice system.	✓	✓	✓	✓	✓	✓			●	
Adult System Development /Urgent Care and Crisis Support‡	Establishes urgent care and mobile crisis support services near the Santa Clara County Valley Medical Center Emergency Psychiatric Service. These will respond to individuals who are in immediate need of medication management, crisis intervention, and linkage to community-based outpatient services.	✓	✓	✓	✓	✓	✓			●	
Adult System Development/ Consumer and Family Self Help‡	Hires program managers for Consumer Affairs and Family Support and Education to increase the engagement of family, significant others, and peers in supporting the individualized wellness and recovery plan for each client.	✓	✓	✓	✓	✓	✓			●	
Older Adult System of Care Development/ Full-Service Partnerships§	Establishes a Partnership program for individuals over the age of 60 who are seriously mentally ill. Clients receive necessary services and supports that assist them in achieving their personal recovery goals.	✓	✓	✓	✓	✓	✓				●

PROGRAM TITLE	DESCRIPTION	FISCAL YEAR						AGE GROUP TARGETED			
		2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Community Services and Supports ▼											
Older Adult System of Care Development/ Behavioral Health Recovery Services[§]	Represents a strategic effort to shift the current mental health outpatient system to a behavioral health model, including stakeholder involvement and embracing a wellness and recovery model.	✓	✓	✓	✓	✓	✓				●
Older Adult System of Care Development/ Mobile Assessment and Outreach[§]	Creates a mobile assessment and outreach team to provide for the mental health needs of older adults who are physically, linguistically, or culturally isolated.	✓	✓	✓	✓	✓	✓				●
Older Adult System of Care Development/ Family and Caregiver Support[§]	Provides counseling support and education to older adults, their families, and care providers on aging and mental health issues.	✓	✓	✓	✓	✓	✓				●
Housing Options Initiative	Provides permanent supportive and transitional housing.	✓	✓	✓	✓	✓	✓			●	
Community Family Outreach[‖]	Hires program managers for Consumer Affairs and Family Relations who will help the county move toward a more consumer-centered model of mental health recovery services.	✓	✓	✓	✓	✓	✓			●	
Behavioral and Primary Health Care Partnership	Creates a partnership with a local primary care provider to address a need for better access to basic health care for mental health clients.	✓	✓	✓	✓	✓	✓			●	
Behavioral Health Learning Partnership/ Education Employment, Self-Sufficiency Recovery Services[‖]	Creates a partnership with local community colleges to provide support for mental health clients to obtain their high school diploma and continue their education in community colleges or universities.	✓	✓	✓	✓	✓	✓			●	
Behavioral Health Learning Partnership	Creates a training center for stakeholders that include technical support, training, and consultation to ensure ongoing education in various healing practices.	✓	✓	✓	✓	✓	✓			●	
Adult System of Care Development/ Regional Survivors of Torture Treatment	Develops specialized services to assist refugees in Santa Clara County. Services will include psychiatric and psycho-social assessment and treatment, linkage to medical services, family support and education, and linkage to self-help through the Refugee and Immigrant Forum Ethnic Community Advisory Committee.	✓	✓	✓	✓	✓	✓			●	

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PROGRAM TITLE	DESCRIPTION	FISCAL YEAR						AGE GROUP TARGETED			
		2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Prevention and Early Intervention ▼											
Community Engagement and Capacity Building for Reducing Stigma and Discrimination	Reduces disparities in access to mental health interventions among underserved cultural populations due to sigma, discrimination, and lack of knowledge about mental health services. This goal is accomplished through four strategies: expanding outreach and engagement, enhancing mental health literacy, identifying programs to reduce stigma and discrimination, and building community capacity.				✓	✓	✓	●	●	●	●
Strengthening Families and Children	Prevents or intervenes early in the development of emotional and behavioral problems in young children by providing parents with outcome-based parenting strategies, support services, and access to screenings to identify developmental delays. In conjunction with other agencies, these strategies establish a foundational network of prevention and early intervention services to underserved cultural populations.				✓	✓	✓	●	●		
Prevention and Early Interventions for Individuals Experiencing Onset of Serious Psychiatric Illness with Psychotic Features	Implements a continuum of services targeting individuals experiencing an at-risk mental state or first onset. The services attempt to detect and treat serious mental illness early through community education, targeted multicultural outreach, community-based interventions, multifamily support groups, peer-support services, supported employment, and education and social services navigation.				✓	✓	✓	●	●	●	●
Primary Care/ Behavioral Health Integration for Adults and Older Adults	Provides a continuum of services targeting adults and older adults experiencing the onset of psychiatric illness. Some key strategies for this project will focus on improved coordination between primary care services and mental health services; improved capacity of primary care providers to identify, prevent, and treat mental health problems; improved mental health and social functioning of those with serious mental illness; and creating programs to prevent suicide.				✓	✓	✓		●	●	●

PROGRAM TITLE	DESCRIPTION	FISCAL YEAR						AGE GROUP TARGETED			
		2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Prevention and Early Intervention											
Suicide Prevention	Implements the five strategies of the county's suicide plan including coordinated suicide intervention programs and services, a community education and information campaign, improved media coverage and public dialogue, policy and governance advocacy to promote change, and it establishes robust data collection and monitoring to evaluate prevention efforts.						✓	●	●	●	●
Innovation											
Early Childhood Universal Screening Project	Creates online screening tools in primary health care settings in order to better detect mental illness in children, especially those speaking only Spanish.					✓	✓	●		●	
Peer-Run Transition-Age Youth Innovation	Develops a model to expand the leadership capacity of transition-age youth partners in the delivery of services in 24-hour care setting to improve access and outcomes for high-risk residents.					✓	✓		●		
Adults with Autism and Co-Occurring Mental Health Disorders	Determines whether a specialized assessment instrument will help clinicians more accurately diagnose co-occurring mental health disorders in adults with autism.						✓			●	●
Older Adults	Increases quality of services for isolated older adults from underserved cultural and ethnic groups through a 12-week interactive activity in which the older adult is elicited to reminisce, capture, and express his or her life story.					✓	✓				●
Multi-Cultural Center	Increases access to underserved and inappropriately served ethnic communities by creating a multicultural center where members of all ethnic communities can find a sense of cultural resonance, belonging, and support. Services are designed and delivered by peer and family partners.					✓	✓	#	#	#	#
Transitional Mental Health Services for Newly Released County Inmates	Creates a collaborative support group between the mental health department, faith-based organizations, and service providers for newly released inmates with mental health issues.					✓	✓	#	#	#	#

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PROGRAM TITLE	DESCRIPTION	FISCAL YEAR						AGE GROUP TARGETED			
		2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Innovation											
Mental Health/Law Enforcement Post-Crisis Intervention	Collects data on all suicide or mental health-related calls in the city of San Jose and creates a response team that will follow up on all incidents within 24 hours.					✓	✓	#	#	#	#
Interactive Video Simulator Training	Establishes a process whereby clients and family members, especially those from ethnic communities, can directly impart their perspectives and needs as they collaborate as equal partners in the creation of a training delivery system for law enforcement. The program also seeks to create a series of interactive video scenarios and lesson plans that impact the way law enforcement responds to mental health crisis situations.					✓	✓	**	**	**	**
Workforce Education and Training											
Workforce Education and Training Coordination	Hires staff to implement the county's Workforce Education and Training plan.				✓	✓	✓	NA	NA	NA	NA
Promising Practice-Based Training in Adult Recovery Principles and Child, Adolescent and Family Service Models	Expands a training program for staff, contract staff, and stakeholders that addresses child, adolescent, and family treatment models.				✓	✓	✓	NA	NA	NA	NA
Improved Services & Outreach to Unserved and Underserved Populations	Expands training for all staff to improve services to ethnic and cultural populations including marginalized populations.				✓	✓	✓	NA	NA	NA	NA
Welcoming Consumers and Family Members	Develops and implements training, workshops, and consultations that create an environment that welcomes consumers and family members as contributing members of the public health system, thereby reducing barriers to accepting and welcoming consumers into the workforce.				✓	✓	✓	NA	NA	NA	NA
Workforce Education and Training Collaboration With Key System Partners	Builds on the collaboration between the Mental Health Department and key system partners to develop and share training and education programs so consumers and family members receive more effective integrated services.				✓	✓	✓	NA	NA	NA	NA

PROGRAM TITLE	DESCRIPTION	FISCAL YEAR						AGE GROUP TARGETED			
		2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Workforce Education and Training											
Comprehensive Mental Health Career Pathway Model	Develops a career pathway model for consumers and family members that leads to participants becoming eligible for part- and full-time permanent positions with the county or community-based organizations.				✓	✓	✓	NA	NA	NA	NA
Stipends and Incentives to Support Mental Health Career Pathway	Provides financial support to attract and enable clients, family, and community partners to enroll in a full range of educational programs that are prerequisites for employment and advancement in public mental health.				✓	✓	✓	NA	NA	NA	NA
Capital Facilities and Technological Needs											
Electronic Health Record	Provides a comprehensive electronic medical record for consumers that can be shared in a secure and integrated environment across service providers.				✓	✓	✓	NA	NA	NA	NA
Enterprise Wide Data Warehouse	Creates a single data repository for all Mental Health Department service, administrative, financial, and provider information.				✓	✓		NA	NA	NA	NA
Consumer Portal and Web site Redesign Initiative	Provides additional services for consumers and their families by enhancing the current Mental Health Department Web site and developing a secure client portal.				✓	✓		NA	NA	NA	NA
Consumer Learning Centers	Sets up supervised computer labs and provides basic personal computer skills training to clients in Mental Health Services Act recovery programs and living in the community.				✓	✓		NA	NA	NA	NA
Bed and Housing Database Exchange	Creates a database that allows operators of inpatient/residential mental health facilities to post their open beds whenever they become available so that case managers, clinicians, and others authorized to act on behalf of Mental Health Department clients can quickly see what is available in housing and/or beds.				✓	✓		NA	NA	NA	NA
County Health Record Integration	Creates a system that provides secure, real-time combined countywide client health records that can be accessed across various service-providing agencies and provide a collaborative, cross-agency view of registered clients' demographic, services and care, medications, physical health services, insurance, employment, housing, and other information.						✓	NA	NA	NA	NA

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PROGRAM TITLE	DESCRIPTION	FISCAL YEAR						AGE GROUP TARGETED			
		2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	CHILD	TRANSITION-AGE YOUTH	ADULT	OLDER ADULT
Capital Facilities and Technological Needs											
Medi-Plex Health Center (Facility Renovation)	Redesigns and reconstructs space for children and transition-age youth that is large enough to accommodate both and offer privacy and space for each group.						✓	NA	NA	NA	NA
Downtown Mental Health Renovation	Renovates a portion of a building that will be used for a self-help center providing outpatient services and training.						✓	NA	NA	NA	NA

Sources: Mental Health Services Act plans and annual updates prepared by the Santa Clara County Mental Health Department.

NA = Not applicable. Workforce Education and Training and Capital Facilities and Technological Needs generally include efforts that focus on expanding, educating, and training the local public mental health workforce and improving infrastructure. Because programs within these components are not designed to provide direct mental health services, no age group is targeted.

✓ = Program appears in a plan applicable for the fiscal year.

● = County plan indicated that program targeted this age group.

* Program combined into Child and Family System Improvement in fiscal year 2008–09.

† Program combined into Transition-Age Youth System of Care Development in fiscal year 2008–09.

‡ Program combined into Adult System Development in fiscal year 2008–09.

§ Program combined into Older Adult System of Care Development in fiscal year 2008–09.

ll Program combined into Behavioral Health Learning Partnership/Education Employment, Self-Sufficiency Recovery Services in fiscal year 2008–09.

\# The county's Innovation component plan did not identify specific age groups for the program. We, therefore, could not determine which discrete age groups the program targeted.

** This program is not designed to provide mental health services; rather, the purpose of the program is to create and present an effective mental health training delivery system for field law enforcement officers by adapting an existing technology in a new and innovative manner.

Appendix C

Mental Health Services Act Client Demographics and Diagnoses for the Four Counties Reviewed Fiscal Years 2006–07 Through 2011–12

The Joint Legislative Audit Committee directed the California State Auditor to identify the demographics of the populations receiving services funded by the Mental Health Services Act (MHSA) in each of the four counties we reviewed. To provide additional information about the population receiving MHSA services, where available we obtained from each of the four counties mental health diagnoses of their clients. We did not confirm the accuracy or completeness of the demographic or diagnostic data the counties provided.

County Client Demographics

We reviewed four county departments: Los Angeles County Department of Mental Health (Los Angeles), County of Sacramento Department of Health and Human Services (Sacramento), County of San Bernardino Department of Behavioral Health Administration (San Bernardino), and Santa Clara County Mental Health Department (Santa Clara). Tables C.1 through C.4 beginning on page 109 summarize client demographic data for those departments for the Community Services and Supports (Community Supports), Prevention and Early Intervention (Prevention), and Innovation (Innovation) components by fiscal year. If a county could not provide data for a given component for the audit period, which we established as fiscal years 2006–07 through 2011–12, we did not display data for that component. For example, Table C.2 does not include demographic data for clients receiving Innovation services because Sacramento had not provided Innovation services as of fiscal year 2011–12.[14] The tables do not include the Workforce Education and Training and Capital Facilities and Technological Needs components because these components do not provide direct services to clients.

We identified three state-defined demographic categories to use for this review: age, ethnicity, and primary language. The tables include the age group demographic because age group is a main focus of MHSA program design. Regulations define four age groups: children and youth, from birth, or age 0,

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

through age 17 and certain disabled individuals age 18 and over; transition-age youth, age 16 to 25; adults, age 18 through 59; and older adults, age 60 and older. To prevent unnecessary duplication of client counts, we requested that the counties provide information in non-overlapping age categories: children and youth, age 0-15; transition-age youth, age 16-25; adults, age 26-59; and older adults, age 60 and over. Also included are the ethnicity and primary language demographics because state regulations name both as contributing to a determination of being underserved, and the underserved are a focus of the MHSA. We limited the display of the primary language data that counties provided to the five most commonly reported primary languages for each county. For each county at least 95 percent of all clients who identified with a primary language, excluding those identified with "Other" or "Unknown," identified with one of the five most commonly reported languages.

Counties vary in the relative ethnic and linguistic makeup of their MHSA clients. For instance, tables C.1 and C.4 show that Hispanics and Latinos make up a significant number of MHSA clients in both Los Angeles and Santa Clara counties, respectively. Spanish and Vietnamese were common non-English primary languages among all counties' MHSA clients, although Los Angeles, Sacramento, San Bernardino, and Santa Clara counties reported Armenian, Russian, Farsi, and Chinese, respectively, as other major primary languages.

County Client Diagnoses

Tables C.5, C.6, and C.7 beginning on page 114 provide client diagnoses by fiscal year and county for the Community Supports, Prevention, and Innovation components, respectively. Not all counties tracked client diagnoses across these three components or for each year in our audit period. In some cases, this was because the counties had not yet implemented programs for a specific component, such as Innovation. To allow for comparison among counties, we summarized county-provided diagnoses into broader classifications as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV). According to the American Psychiatric Association, the DSM-IV is the standard classification of mental disorders used by mental health professionals in the United States. Each classification includes examples of the disorders that make up the classification.

Table C.1

Los Angeles County Department of Mental Health Client Counts for Age Group, Ethnicity, and Primary Language by Mental Health Services Act Component Fiscal Years 2006–07 Through 2011–12

		COMMUNITY SERVICES AND SUPPORTS						PREVENTION AND EARLY INTERVENTION			INNOVATION
		FISCAL YEAR 2006–07	FISCAL YEAR 2007–08	FISCAL YEAR 2008–09	FISCAL YEAR 2009–10	FISCAL YEAR 2010–11	FISCAL YEAR 2011–12	FISCAL YEAR 2009–10	FISCAL YEAR 2010–11	FISCAL YEAR 2011–12	FISCAL YEAR 2011–12
Age Group*	Children and Youth (0-15)	929	2,499	3,215	11,601	13,256	12,589	2,334	25,952	32,789	1
	Transition-Age Youth (16-25)	1,369	3,669	5,416	11,473	13,451	14,077	1,976	10,828	13,767	17
	Adult (26-59)	7,993	17,572	25,896	53,341	60,370	61,897	3,907	8,875	15,216	222
	Older Adult (60+)	1,105	3,184	4,745	9,051	10,134	10,695	340	725	1,565	34
Ethnicity	African-American	4,286	9,281	13,246	23,647	26,156	26,604	2,533	10,637	13,587	92
	American Native	35	137	199	540	580	555	61	203	279	19
	Asian/Pacific Islander	1,551	2,326	2,917	5,634	5,985	5,868	309	1,105	1,635	10
	Hispanic	3,026	7,927	11,990	29,994	35,461	36,770	3,627	26,167	35,780	60
	Other	527	1,095	1,370	3,247	3,687	4,141	283	1,335	2,078	13
	White	1,879	5,742	8,819	20,984	23,333	23,332	1,704	5,808	8,484	80
Primary Language†	Armenian	23	84	144	889	882	1,079	73	190	306	11
	Cambodian	731	792	768	978	964	950	7	84	97	2
	English	7,834	19,736	29,408	62,902	71,659	73,141	6,527	32,951	44,550	204
	Other	526	1,031	1,401	3,237	3,431	3,406	267	634	872	15
	Spanish	1,646	3,849	5,621	13,830	15,749	16,339	1,507	10,892	15,330	36
	Unknown/Not Reported	227	607	760	1,509	1,801	1,717	114	454	603	6
	Vietnamese	317	406	442	701	716	638	22	47	85	–

Source: Unaudited information provided by the Los Angeles County Department of Mental Health (Los Angeles).

* California Code of Regulations relating to the Mental Health Services Act defines the age groups as children and youth age 0 through 17 and certain disabled individuals age 18 and over, transition-age youth age 16 to 25, adult age 18 to 59, and older adult age 60 and over.

† Primary Language lists the five most commonly reported languages in data provided by Los Angeles for fiscal years 2006–07 through 2011–12. We combined all other languages in the category "Other."

Table C.2

County of Sacramento Department of Health and Human Services Client Counts for Age Group, Ethnicity, and Primary Language by Mental Health Services Act Component
Fiscal Years 2007–08 Through 2011–12

		COMMUNITY SERVICES AND SUPPORTS					PREVENTION AND EARLY INTERVENTION		
		FISCAL YEAR 2007–08	FISCAL YEAR 2008–09	FISCAL YEAR 2009–10	FISCAL YEAR 2010–11	FISCAL YEAR 2011–12	FISCAL YEAR 2009–10	FISCAL YEAR 2010–11	FISCAL YEAR 2011–12
Age Group*	Children and Youth (0-15)	65	117	153	238	280	1,083	2,470	2,939
	Transition-Age Youth (16-25)	148	354	579	928	1,155	2,596	1,587	3,692
	Adult (26-59)	556	1,967	4,591	6,763	7,592	9,575	8,172	6,194
	Older Adult (60+)	118	311	534	848	830	1,363	447	5,921
	Unknown	11	213	1,729	687	582	150	6,334	26,926
Ethnicity	African-American	166	498	1,058	1,695	1,984	1,403	320	1,021
	Asian	149	299	723	920	966	501	167	477
	Hispanic	110	220	546	962	1,178	1,292	462	1,501
	Multi	63	25	46	92	91	1,058	182	510
	Native	5	51	60	163	196	122	89	256
	Other	19	216	269	323	348	891	7	110
	Pacific Islander	11	42	47	66	76	–	92	118
	Unknown	28	273	2,113	1,062	1,040	3,554	4,138	23,506
	White	347	1,338	2,724	4,179	4,560	5,946	13,553	18,173
Primary Language†	English	763	2,433	4,743	7,572	8,640	14,767	18,805	42,497
	Hmong	27	78	215	266	284	–	2	32
	Other	36	114	456	483	421	–	45	918
	Russian	3	29	79	75	75	–	6	327
	Spanish	12	77	195	170	191	–	86	801
	Unknown	30	180	1,766	762	701	–	64	1,086
	Vietnamese	27	51	132	136	127	–	2	11

Source: Unaudited information provided by the County of Sacramento Department of Health and Human Services (Sacramento).

* California Code of Regulations relating to the Mental Health Services Act defines the age groups as children and youth age 0 through 17 and certain disabled individuals age 18 and over, transition-age youth age 16 to 25, adult age 18 to 59, and older adult age 60 and over.

† Primary Language lists the five most commonly reported languages in data provided by Sacramento for fiscal years 2007–08 through 2011–12. We combined all other languages in the category "Other."

Table C.3

County of San Bernardino Department of Behavioral Health Administration Client Counts for Age Group, Ethnicity, and Primary Language by Mental Health Services Act Component
Fiscal Years 2006–07 Through 2011–12

		COMMUNITY SERVICES AND SUPPORTS						PREVENTION AND EARLY INTERVENTION				INNOVATION	
		FISCAL YEAR 2006–07	FISCAL YEAR 2007–08	FISCAL YEAR 2008–09	FISCAL YEAR 2009–10	FISCAL YEAR 2010–11	FISCAL YEAR 2011–12	FISCAL YEAR 2008–09	FISCAL YEAR 2009–10	FISCAL YEAR 2010–11	FISCAL YEAR 2011–12	FISCAL YEAR 2010–11	FISCAL YEAR 2011–12
Age Group*	Children and Youth (0-15)	82	561	1,983	2,197	2,005	1,876	466	16,757	19,199	104,886	5	1,151
	Transition-Age Youth (16-25)	581	1,070	2,497	3,920	3,563	3,117	217	2,473	14,223	19,513	12	1,207
	Adult (26-59)	1,771	2,224	4,324	6,904	7,225	6,706	27	5,626	12,614	40,207	–	3,634
	Older Adult (60+)	78	216	387	572	577	593	1	5,571	4,942	12,578	–	953
	Unknown	–	–	–	4	–	–	–	–	–	–	–	1,062
Ethnicity†	African-American	452	612	1,456	2,257	2,175	2,082	114	4,128	5,611	17,385	12	709
	Asian/Pacific Islander	55	59	126	231	233	236	8	1,056	1,045	9,588	–	998
	Hispanic/Latino	779‡	1,214‡	2,914‡	4,253‡	4,138‡	3,678‡	385	12,008	16,049	73,640	3	3,632
	Native American	25	50	93	128	132	127	2	156	821	7,982	–	253
	Other	762	1,108	2,590	4,009	3,707	3,159	43	1,878	9,634	18,982	–	893
	White/Caucasian	1,218	2,242	4,926	6,972	7,123	6,688	159	11,201	15,249	42,380	2	1,522
Primary Language§	English	2,190	3,665	8,440	12,352	12,326	11,387	NAǁ	NAǁ	20,797	131,151	17	4,153
	Farsi	–	–	2	3	–	1			–	220	–	–
	Mandarin	–	–	–	3	–	–			–	729	–	–
	Other	92	64	144	294	249	230			2,140	2,142	–	33
	Spanish	126	136	332	555	455	416			1,720	17,104	–	1,413
	Unknown	103	203	268	379	329	248			3,400	5,239	–	2,408
	Vietnamese	1	3	5	11	11	10			13	80	–	–

Source: Unaudited information provided by the County of San Bernardino Department of Behavioral Health Administration (San Bernardino).

* California Code of Regulations relating to the Mental Health Services Act defines the age groups as children and youth age 0 through 17 and certain disabled individuals age 18 and over, transition-age youth age 16 to 25, adult age 18 to 59, and older adult age 60 and over.

† San Bernardino provided detailed ethnicity data. We combined the data into six categories. Asian/Pacific Islander is composed of Amerasian, Asian/Pacific Islander, Asian Indian, Cambodian, Chinese, Filipino, Guamanian, Hmong, Japanese, Korean, Laotian, Samoan, Vietnamese, and Hawaiian Native. Hispanic is composed of Caribbean, Central American, Cuban, Dominican, Costa Rican, and Hispanic. Native American is composed of Native Alaskan and Native American. White includes White, Italian, and Armenian. Other is composed of Arab, Other Non-White, Unknown/Other, and Multiple.

‡ This includes persons of Hispanic origin, although those clients are also included in the category "Other."

§ Primary Language lists the five most commonly reported languages in data provided by San Bernardino for fiscal years 2006–07 through 2011–12. We combined all other languages in the category "Other."

ǁ NA = Not available as San Bernardino did not provide Prevention and Early Intervention primary language information for this year.

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Table C.4

Santa Clara County Mental Health Department Client Counts for Age Group, Ethnicity, and Primary Language by Mental Health Services Act Component Fiscal Years 2006–07 Through 2011–12

		COMMUNITY SERVICES AND SUPPORTS						PREVENTION AND EARLY INTERVENTION		INNOVATION
		FISCAL YEAR 2006–07	FISCAL YEAR 2007–08	FISCAL YEAR 2008–09	FISCAL YEAR 2009–10	FISCAL YEAR 2010–11	FISCAL YEAR 2011–12	FISCAL YEAR 2010–11	FISCAL YEAR 2011–12	FISCAL YEAR 2011–12
Age Group*	Children and Youth (0-15)	3,804	3,956	4,695	5,143	6,151	7,059	6	–	42
	Transition-Age Youth (16-25)	1,219	1,437	1,751	2,021	2,193	2,355	8	26	164
	Adult (26-59)	4,949	5,033	5,499	5,529	5,735	6,107	3	–	449
	Older Adult (60+)	880	907	979	968	1,027	1,045	–	–	17
	Unknown	–	–	–	–	–	–	–	–	127
Ethnicity	African-American	912	964	1,123	1,205	1,250	1,342	–	8	248
	American Indian	137	150	202	216	213	223	–	1	133
	Asian/Pacific Islander	1,892	1,829	1,884	1,918	2,007	1,979	–	1	347
	Latino	3,271	3,799	4,604	4,998	5,963	7,022	9	10	495
	Mixed	13	11	19	25	34	45	2	–	5
	Other	429	431	461	420	514	529	1	–	64
	Unknown	417	377	451	495	555	745	–	2	168
	White	3,781	3,772	4,180	4,384	4,570	4,681	5	4	262
Primary Language†	Cambodian	275	252	245	233	236	187	–	–	14
	Chinese	67	63	63	67	63	57	–	23	970
	English	8,684	8,983	10,341	11,040	12,036	12,998	10	–	23
	Other	407	406	427	443	465	447	5	3	472
	Spanish	743	987	1,186	1,215	1,630	2,140	2	–	1
	Vietnamese	519	530	556	558	551	550	–	–	31
	Unknown	157	112	106	105	125	187	–	–	8

Source: Unaudited information provided by the Santa Clara County Mental Health Department (Santa Clara).

* California Code of Regulations relating to the Mental Health Services Act defines the age groups as children and youth age 0 through 17 and certain disabled individuals age 18 and over, transition-age youth age 16 to 25, adult age 18 to 59, and older adult age 60 and over.

† Primary Language lists the five most commonly reported languages in data provided by Santa Clara for fiscal years 2006–07 through 2011–12. We combined all other languages in the category "Other."

Table C.5
Community Services and Supports Client Counts by Mental Health Diagnosis and County
Fiscal Years 2006–07 Through 2011–12

		FISCAL YEAR 2006–07				FISCAL YEAR 2007–08			
MENTAL HEALTH DIAGNOSIS*	DESCRIPTION	LOS ANGELES	SACRAMENTO	SAN BERNARDINO	SANTA CLARA	LOS ANGELES	SACRAMENTO	SAN BERNARDINO	SANTA CLARA
Adjustment disorders	Includes adjustment disorders with depression and with anxiety.	143	NA†	28	699	404	19	143	764
Anxiety disorders	Includes disorders such as panic disorders, obsessive-compulsive disorder, and agoraphobia.	807	NA†	57	988	1,662	12	246	1,122
Delirium, dementia, and amnestic and other cognitive disorders	Includes delirium, dementia, and disorders such as amnestic disorders.	NA‡	NA†	NA‡	5	NA‡	2	NA‡	12
Disorders usually first diagnosed in infancy, childhood, or adolescence	Includes disorders such as mental retardation, attention-deficit, and disruptive behavior disorders.	647	NA†	72	1,712	1,555	30	233	1,927
Mood disorders	Includes depressive and bipolar disorders.	5,668	NA†	1,499	3,841	14,013	257	2,544	3,773
Personality disorders	Includes disorders such as borderline personality disorder, narcissistic personality disorder, and paranoid personality disorder.	2	NA†	–	11	5	–	1	12
Schizophrenia and other psychotic disorders	Includes disorders such as schizophrenia, delusional disorder, and psychotic disorders.	3,812	NA†	810	3,185	8,198	145	826	3,261
Somatoform disorders	Includes somatoform disorder and disorders such as pain disorder and hypochondriasis.	2	NA†	–	6	5	NA‡	–	5
Substance-related disorders	Includes disorders such as alcohol-related, amphetamine-related, and cocaine-related disorders.	107	NA†	36	NA‡	265	3	60	NA‡
Other	Includes disorders counties diagnose irregularly such as dissociative disorders, sexual and gender identity disorders, eating disorders, and sleep disorders.	87	NA†	10	118	247	4	18	124
None/unknown	Includes clients who left services before being diagnosed, those whom counties determined not to have a Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) disorder, and clients reported as having an unknown diagnosis.	29	NA†	NA‡	287	153	18	NA‡	333

continued . . .

Sources: Unaudited diagnosis data provided by the Los Angeles County Department of Mental Health (Los Angeles), the County of Sacramento Department of Health and Human Services (Sacramento), the County of San Bernardino Department of Behavioral Health Administration (San Bernardino), and the Santa Clara County Mental Health Department (Santa Clara).

NA = Not applicable.

* Mental health diagnosis based on classifications from the DSM-IV.

† Sacramento did not provide client counts for Community Services and Supports programs; the county stated it implemented those programs in fiscal year 2007–08.

‡ The county did not provide client counts for this mental health diagnosis.

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FISCAL YEAR 2008–09				FISCAL YEAR 2009–10				FISCAL YEAR 2010–11				FISCAL YEAR 2011–12			
LOS ANGELES	SACRAMENTO	SAN BERNARDINO	SANTA CLARA	LOS ANGELES	SACRAMENTO	SAN BERNARDINO	SANTA CLARA	LOS ANGELES	SACRAMENTO	SAN BERNARDINO	SANTA CLARA	LOS ANGELES	SACRAMENTO	SAN BERNARDINO	SANTA CLARA
507	40	399	936	1,580	46	415	1,079	2,212	58	407	1,380	2,304	78	396	1,689
2,125	52	591	1,369	5,202	75	818	1,448	6,254	95	790	1,728	6,935	102	785	1,906
NA‡	–	NA‡	8	NA‡	2	NA‡	13	NA‡	1	NA‡	11	NA‡	1	NA‡	19
2,006	42	914	2,388	7,166	43	1,068	2,845	7,846	84	1,105	3,450	7,856	134	1,071	3,947
20,878	334	5,294	4,292	45,520	691	8,291	4,357	51,612	687	7,868	4,504	53,140	695	7,145	4,665
19	7	1	17	64	24	–	13	54	27	2	18	46	30	1	21
12,011	190	1,882	3,335	22,758	623	2,750	3,425	25,111	591	2,903	3,536	24,981	596	2,675	3,823
8	NA‡	1	3	33	NA‡	2	2	71	NA‡	3	4	71	NA‡	1	5
415	6	46	NA‡	617	1	32	NA‡	647	18	30	NA‡	640	20	26	NA‡
422	7	63	131	714	8	221	172	818	15	262	153	764	13	192	146
150	3	NA‡	445	392	9	NA‡	307	588	1	NA‡	322	532	10	NA‡	345

Table C.6
Prevention and Early Intervention Client Counts by Mental Health Diagnosis and County
Fiscal Years 2008–09 Through 2011–12

		FISCAL YEAR 2008–09				FISCAL YEAR 2009–10				FISCAL YEAR 2010–11				FISCAL YEAR 2011–12			
MENTAL HEALTH DIAGNOSIS*	DESCRIPTION	LOS ANGELES	SACRAMENTO	SAN BERNARDINO	SANTA CLARA	LOS ANGELES	SACRAMENTO	SAN BERNARDINO	SANTA CLARA	LOS ANGELES	SACRAMENTO	SAN BERNARDINO	SANTA CLARA	LOS ANGELES	SACRAMENTO	SAN BERNARDINO	SANTA CLARA
Adjustment disorders	Includes adjustment disorders with depression and with anxiety.	NA†	NA‡	16	NA§	291	NA‡	33	NA§	2,762	NA‡	71	2	4,601	1	196	107
Anxiety disorders	Includes disorders such as panic disorders, obsessive-compulsive disorder, and agoraphobia.	NA†	NA‡	17	NA§	563	NA‡	72	NA§	5,772	NA‡	49	4	8,512	3	96	157
Delirium, dementia, and amnestic and other cognitive disorders	Includes delirium, dementia, and disorders such as amnestic disorders.	NA†	NA‡	NA‖	NA§	NA‖	NA‡	NA‖	NA§	NA‖	NA‡	NA‖	–	NA‖	–	NA‖	–
Disorders usually first diagnosed in infancy, childhood, or adolescence	Includes disorders such as mental retardation, attention-deficit, and disruptive behavior disorders.	NA†	NA‡	1	NA§	955	NA‡	29	NA§	12,005	NA‡	34	2	15,295	3	110	12
Mood disorders	Includes depressive and bipolar disorders.	NA†	NA‡	33	NA§	4,949	NA‡	173	NA§	19,317	NA‡	68	3	26,831	7	86	322
Personality disorders	Includes disorders such as borderline personality disorder, narcissistic personality disorder, and paranoid personality disorder.	NA†	NA‡	–	NA§	–	NA‡	–	NA§	1	NA‡	–	–	2	–	–	2
Schizophrenia and other psychotic disorders	Includes disorders such as schizophrenia, delusional disorder, and psychotic disorders.	NA†	NA‡	8	NA§	1,531	NA‡	17	NA§	3,535	NA‡	–	4	4,364	71	2	25
Somatoform disorders	Includes somatoform disorder and disorders such as pain disorder and hypochondriasis.	NA†	NA‡	–	NA§	3	NA‡	–	NA§	17	NA‡	–	–	24	–	2	–
Substance-related disorders	Includes disorders such as alcohol-related, amphetamine-related, and cocaine-related disorders.	NA†	NA‡	2	NA§	44	NA‡	1	NA§	112	NA‡	3	NA‖	169	1	7	NA‖
Other	Includes disorders counties diagnose irregularly such as dissociative disorders, sexual and gender identity disorders, eating disorders, and sleep disorders.	NA†	NA‡	–	NA§	94	NA‡	28	NA§	313	NA‡	81	2	391	–	506	6
None/unknown	Includes clients who left services before being diagnosed, those whom counties determined not to have a Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) disorder and clients reported as having an unknown diagnosis.	NA†	NA‡	NA‖	NA§	87	NA‡	NA‖	NA§	1,422	NA‡	NA‖	–	1,653	–	NA‖	41

Sources: Unaudited diagnosis data provided by the Los Angeles County Department of Mental Health (Los Angeles), the County of Sacramento Department of Health and Human Services (Sacramento), the County of San Bernardino Department of Behavioral Health Administration (San Bernardino), and the Santa Clara County Mental Health Department (Santa Clara).

NA = Not applicable.

* Mental health diagnosis based on classifications from the DSM-IV.

† Los Angeles did not provide client counts for Prevention and Early Intervention (Prevention) programs; the county stated it began those programs in fiscal year 2009–10.

‡ Sacramento did not provide client counts for Prevention programs; the county stated it tracked one program beginning in fiscal year 2011–12.

§ Santa Clara did not provide client counts for Prevention programs; the county stated it implemented those programs in fiscal year 2010–11.

‖ The county did not provide client counts for this mental health diagnosis.

Table C.7
Innovation Client Counts by Mental Health Diagnosis and County
Fiscal Year 2011–12

		FISCAL YEAR 2011–12			
MENTAL HEALTH DIAGNOSIS*	DESCRIPTION	LOS ANGELES	SACRAMENTO	SAN BERNARDINO	SANTA CLARA
Adjustment disorders	Includes adjustment disorders with depression and with anxiety.	13	NA†	NA§	1
Anxiety disorders	Includes disorders such as panic disorders, obsessive-compulsive disorder, and agoraphobia.	21	NA†	NA§	8
Delirium, dementia, and amnestic and other cognitive disorders	Includes delirium, dementia, and disorders such as amnestic disorders.	NA‡	NA†	NA§	–
Disorders usually first diagnosed in infancy, childhood, or adolescence	Includes disorders such as mental retardation, attention-deficit and disruptive behavior disorders.	2	NA†	NA§	1
Mood disorders	Includes depressive and bipolar disorders.	194	NA†	NA§	12
Personality disorders	Includes disorders such as borderline personality disorder, narcissistic personality disorder, and paranoid personality disorder.	–	NA†	NA§	–
Schizophrenia and other psychotic disorders	Includes disorders such as schizophrenia, delusional disorder, and psychotic disorders.	41	NA†	NA§	2
Somatoform disorders	Includes somatoform disorders and disorders such as pain disorder and hypochondriasis.	1	NA†	NA§	–
Substance-related disorders	Includes disorders such as alcohol-related, amphetamine-related, and cocaine-related disorders.	1	NA†	NA§	NA‡
Other	Includes disorders counties diagnose irregularly.‖	1	NA†	NA§	–
None/unknown	Includes clients who left services before being diagnosed, those whom counties determined not to have a Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) disorder, and clients reported as having an unknown diagnosis.	–	NA†	NA§	2

Sources: Unaudited diagnosis data provided by the Los Angeles County Department of Mental Health (Los Angeles), the County of Sacramento Department of Health and Human Services (Sacramento), the County of San Bernardino Department of Behavioral Health Administration (San Bernardino), and the Santa Clara County Mental Health Department (Santa Clara).

NA = Not applicable.

* Mental health diagnosis based on classifications from the DSM-IV.

† Sacramento did not provide client counts for Innovation programs; the county stated it did not offer services through Innovation programs until fiscal year 2012–13.

‡ The county did not provide client counts for this mental health diagnosis.

§ San Bernardino did not provide client counts for Innovation programs; the county stated it does not collect data in a usable format pending a software implementation.

‖ Los Angeles reported one client with an unspecified disorder affecting a medical condition.

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Appendix D

**Mental Health Services Act Revenues, Expenditures, and Prudent Reserves for the Four Counties Reviewed
Fiscal Years 2006–07 Through 2011–12**

The Joint Legislative Audit Committee directed the California State Auditor to compare counties' Mental Health Services Act (MHSA) planned expenditures to their actual expenditures for the last six fiscal years, which we established as 2006–07 through 2011–12. We reviewed four county departments: Los Angeles County Department of Mental Health, County of Sacramento Department of Health and Human Services, County of San Bernardino Department of Behavioral Health Administration, and Santa Clara County Mental Health Department. Tables D.1 through D.4 on the following pages summarize their revenues and expenditures using data obtained from the annual Revenue and Expenditure Report (RER) each county submitted to Mental Health. The RER ranged from fiscal years 2006–07 through 2010–11. In order to present MHSA revenues for years for which a county had not yet prepared an RER, we used the allocation amounts presented in Appendix A; for county expenditures, we obtained county accounting information. We did not confirm the accuracy or completeness of the counties' RERs or the accounting information they provided. Tables D.1, D.2, D.3, and D.4 generally show that, in total, the counties had growing positive ending balances in the earlier years of the time frame and that these peaked in fiscal year 2010–11.

To ensure that program service levels continue in the event of an MHSA revenue shortfall, counties are required to establish and maintain a prudent reserve. Tables D.1 through D.4 show the MHSA funds each county contributed to its prudent reserve as expenditures; the tables also summarize these funds in a stand-alone section. Because we obtained county contributions to the prudent reserve from the counties' RERs, we could not identify the amounts counties may have dedicated to their prudent reserves in fiscal years for which RERs were not available. Also, the stand-alone tables summarizing prudent reserve do not reflect funds the counties may have spent from these reserves. All expenditures are reflected in tables D.1 through D.4.

Table D.1

Los Angeles County Department of Mental Health: Mental Health Services Act Revenues and Expenditures by Component Fiscal Years 2006–07 Through 2011–12

Revenues and Expenditures by Component

	FISCAL YEAR					
COMPONENT	2006–07*	2007–08*	2008–09*	2009–10*	2010–11†	2011–12†
Community Services and Supports						
Unspent funds available	$69,580,600	$119,546,820	$128,669,270	$5,806,002	$34,791,908	$113,731,605
Revenues	107,787,977	158,076,638	182,714,073	260,798,561	319,091,506‡	210,077,200
Expenditures	57,821,757	148,954,188	177,999,591	231,812,655	240,151,809	249,898,868
Contributions to prudent reserve‖	–	–	127,577,750	–	–	–
Ending balance	119,546,820	128,669,270	5,806,002	34,791,908	113,731,605	73,909,937
Prevention and Early Intervention						
Unspent funds available	$–	$–	$6,220,352	$100,461,486	$143,979,291	$216,594,237
Revenues	–	7,074,500	97,522,000	87,648,558	122,608,254	67,946,000
Expenditures	–	854,148	3,280,866	10,983,101	49,993,308	81,599,995
Contributions to prudent reserve‖	–	–	–	33,147,652	–	–
Ending balance	–	6,220,352	100,461,486	143,979,291	216,594,237	202,940,242
Innovation						
Unspent funds available	$–	$–	$–	$20,294,900	$40,006,830	$89,687,855
Revenues	–	–	20,294,900	20,294,900	50,730,032	13,909,700
Expenditures	–	–	–	582,970	1,049,007	4,983,293
Ending balance	–	–	20,294,900	40,006,830	89,687,855	98,614,262
Workforce Education and Training						
Unspent funds available	$–	$–	$814,730	$20,981,138	$54,014,046	$87,956,208
Revenues	–	2,450,146	27,519,016	37,268,778	37,868,778	1,800,000
Expenditures	–	1,635,416	7,352,608	4,235,870	3,926,616	3,472,844
Ending balance	–	814,730	20,981,138	54,014,046	87,956,208	86,283,364
Capital Facilities and Technological Needs						
Unspent funds available	$–	$–	$–	$43,359,775	$70,204,026	$152,913,733
Revenues	–	–	43,359,775	28,576,585	88,232,464	–
Expenditures	–	–	–	1,732,334	5,522,757	14,322,812
Ending balance	–	–	43,359,775	70,204,026	152,913,733	138,590,921
Total ending balances	**$119,546,820**	**$135,704,352**	**$190,903,301**	**$342,996,101**	**$660,883,638**	**$600,338,726**

Mental Health Services Act Funds Dedicated to Local Prudent Reserve

COMPONENT	2006–07	2007–08	2008–09	2009–10	2010–11‖	2011–12‖	TOTAL
Community Services and Supports	$–	$–	$127,577,750	$–	$–	$–	$127,577,750
Prevention and Early Intervention	–	–	–	33,147,652	–	–	33,147,652
Totals	**$–**	**$–**	**$127,577,750**	**$33,147,652**	**$–**	**$–**	**$160,725,402**

Sources: Unaudited county Revenue and Expenditure Reports (RERs), unaudited internal county accounting data, and Appendix A allocation data.

* For fiscal years 2006–07 through 2009–10, revenues and expenditures are from the county's unaudited RERs. According to the director of finance for the county's Mental Health Department, revenues reflect cash received for the respective fiscal year and interest earned on those amounts.

† For fiscal years 2010–11 and 2011–12, revenues are based on state-allocated amounts the California Department of Mental Health reported and include some funds the county assigned to a Joint Powers Authority and, therefore, were not administered locally (see Appendix A). Expenditures are based on unaudited county accounting reports.

‡ According to the director of finance for the county's Mental Health Department, Community Services and Supports revenue for fiscal year 2010–11 was $210 million. Revenues are based on state-allocated amounts the California Department of Mental Health reported and are unaudited.

‖ The Mental Health Services Act requires a prudent reserve to ensure that the county can continue to provide Community Services and Supports and Prevention and Early Intervention programs to its current clients. The amounts shown are from the county's RERs and these documents were limited to fiscal years 2006–07 through 2009–10; thus, there may be contributions to the prudent reserve the table does not reflect.

Table D.2
County of Sacramento Department of Health and Human Services: Mental Health Services Act Revenues and Expenditures by Component
Fiscal Years 2006–07 Through 2011–12

Revenues and Expenditures by Component

	FISCAL YEAR					
COMPONENT	2006–07*	2007–08*	2008–09*	2009–10†	2010–11†	2011–12†
Community Services and Supports‡						
Unspent funds available	$1,231,301	$7,052,900	$11,285,593	$17,521,544	$15,366,689	$16,945,386
Revenues	13,769,665	16,507,375	30,857,863	27,976,100	33,141,107	23,754,100
Expenditures	7,948,066	9,622,947	15,501,500	30,130,955	31,562,410	24,661,208
Contributions to prudent reserve§	–	2,651,735	9,120,412	–	–	–
Ending balance	7,052,900	11,285,593	17,521,544	15,366,689	16,945,386	16,038,278
Prevention and Early Intervention						
Unspent funds available	$–	$–	$–	$1,232,942	$12,536,187	$30,703,357
Revenues	–	–	1,529,164	12,246,700	21,657,600	7,546,300
Expenditures	–	–	296,222	943,455	3,490,430	8,565,608
Contributions to prudent reserve§	–	–	–	–	–	–
Ending balance	–	–	1,232,942	12,536,187	30,703,357	29,684,049
Innovation‖						
Unspent funds available	$–	$–	$–	$–	$2,267,300	$10,504,242
Revenues	–	–	–	2,267,300	8,379,100	1,565,200
Expenditures	–	–	–	–	142,158	4,152,581
Ending balance	–	–	–	2,267,300	10,504,242	7,916,861
Workforce Education and Training						
Unspent funds available	$–	$–	$–	$402,178	$203,096	$(130,108)
Revenues	–	–	439,649	–	–	–
Expenditures	–	–	37,471	199,082	333,204	517,939
Ending balance	–	–	402,178	203,096	(130,108)	(648,047)
Capital Facilities and Technological Needs						
Unspent funds available	$–	$–	$–	$9,431	$884,431	$390,718
Revenues	–	–	642,371	875,000	1,797,290	–
Expenditures	–	–	632,940	–	2,291,003	2,110,071
Ending balance	–	–	9,431	884,431	390,718	(1,719,353)
Total ending balances	**$7,052,900**	**$11,285,593**	**$19,166,095**	**$31,257,703**	**$58,413,595**	**$51,271,788**

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Mental Health Services Act Funds Dedicated to Local Prudent Reserve

COMPONENT	FISCAL YEAR 2006–07	2007–08	2008–09	2009–10§	2010–11§	2011–12§	TOTAL
Community Services and Supports	$–	$2,651,735	$9,120,412	$–	$–	$–	$11,772,147
Prevention and Early Intervention	–	–	–	–	–	–	–
Totals	**$–**	**$2,651,735**	**$9,120,412**	**$–**	**$–**	**$–**	**$11,772,147**

Sources: Unaudited county Revenue and Expenditure Reports (RERs), unaudited internal county accounting data, and Appendix A allocation data.

* For fiscal years 2006–07 through 2008–09, revenues and expenditures are from the county's unaudited RERs. Revenues reflect deposits from state-allocated amounts and interest earned on those amounts.

† For fiscal years 2009–10 through 2011–12, revenues are based on state-allocated amounts the California Department of Mental Health reported and include some funds the county assigned to a Joint Powers Authority and, therefore, were not administered locally (see Appendix A). Expenditures are based on unaudited county accounting reports.

‡ Because of the nature of its accounting systems, Sacramento's Community Services and Supports expenditure totals for fiscal years 2009–10 and 2010–11 include amounts that may later be reimbursed by non-MHSA funds. As a result, Community Services and Supports total expenditures for those years may be overstated.

§ The Mental Health Services Act requires a prudent reserve to ensure that the county can continue to provide Community Services and Supports and Prevention and Early Intervention programs to its current clients. The amounts shown are from the county's RERs and these documents were limited to fiscal years 2006–07 through 2008–09; thus, there may be contributions to the prudent reserve the table does not reflect.

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

Table D.3

County of San Bernardino Department of Behavioral Health Administration: Mental Health Services Act Revenues and Expenditures by Component
Fiscal Years 2006–07 Through 2011–12

Revenues and Expenditures by Component

	FISCAL YEAR					
COMPONENT	2006–07*	2007–08*	2008–09*	2009–10*	2010–11*	2011–12†
Community Services and Supports						
Unspent funds available	$4,826,566	$22,658,065	$16,898,180‡	$14,213,315	$5,375,467	$14,528,329
Revenues	23,182,869	32,231,436	36,781,333	37,664,269	52,343,415	39,143,000
Expenditures	5,351,370	25,957,042	39,466,198	41,394,678	43,190,553	52,268,360
Contributions to prudent reserve§	–	11,989,911	–	5,107,439	–	–
Ending balance	22,658,065	16,942,548	14,213,315	5,375,467	14,528,329	1,402,969
Prevention and Early Intervention						
Unspent funds available	$–	$–	$676,619	$15,324,917	$14,521,032	$20,666,822
Revenues	–	881,387	17,511,603	13,628,096	16,407,441	12,213,200
Expenditures	–	204,768	2,863,305	9,376,968	10,261,651	13,199,134
Contributions to prudent reserve§	–	–	–	5,055,013	–	–
Ending balance	–	676,619	15,324,917	14,521,032	20,666,822	19,680,888
Innovation						
Unspent funds available	$–	$–	$–	$(6,167)	$6,467,016	$12,837,468
Revenues	–	–	–	6,794,246	7,110,599	2,570,200
Expenditures	–	–	6,167	321,063	740,147	5,979,698
Ending balance	–	–	(6,167)	6,467,016	12,837,468	9,427,970
Workforce Education and Training						
Unspent funds available	$–	$–	$130,654	$10,893,797	$9,730,507	$8,548,314
Revenues	–	754,600	11,856,500	204,765	120,145	1,800,000
Expenditures	–	623,946	1,093,357	1,368,055	1,302,338	1,993,020
Ending balance	–	130,654	10,893,797	9,730,507	8,548,314	8,355,294
Capital Facilities and Technological Needs						
Unspent funds available	$–	$–	$–	$–	$21,554,836	$19,589,365
Revenues	–	–	–	22,179,502	1,953,323	–
Expenditures	–	–	–	624,666	3,918,794	1,474,804
Ending balance	–	–	–	21,554,836	19,589,365	18,114,561
Total ending balances	**$22,658,065**	**$17,749,821**	**$40,425,862**	**$57,648,858**	**$76,170,298**	**$56,981,682**

Mental Health Services Act Funds Dedicated to Local Prudent Reserve

COMPONENT	2006–07	2007–08	2008–09	2009–10	2010–11	2011–12§	TOTAL
Community Services and Supports	$–	$11,989,911	$–	$5,107,439	$–	$–	$17,097,350
Prevention and Early Intervention	–	–	–	5,055,013	–	–	5,055,013
Totals	**$–**	**$11,989,911**	**$–**	**$10,162,452**	**$–**	**$–**	**$22,152,363**

Sources: Unaudited county Revenue and Expenditure Reports (RERs), unaudited internal county accounting data, and Appendix A allocation data.

* For fiscal years 2006–07 through 2010–11, revenues and expenditures are from the county's unaudited RERs. Revenues reflect deposits from state-allocated amounts and interest earned on those amounts.

† For fiscal year 2011–12, revenues are based on state-allocated amounts the California Department of Mental Health reported and include some funds the county assigned to a Joint Powers Authority and therefore were not administered locally (see Appendix A). Expenditures are based on unaudited county accounting reports.

‡ The unspent funds available as noted on the county's RER for fiscal year 2008–09 differed from the reported ending balance for fiscal year 2007–08 by over $44,000. The table reflects the difference.

§ The MHSA requires a prudent reserve to ensure that the county can continue to provide Community Services and Supports and Prevention and Early Intervention programs to its current clients. The amounts shown are from the county's RERs and these documents were limited to fiscal years 2006–07 through 2010–11; thus, there may be contributions to the prudent reserve the table does not reflect.

Table D.4

Santa Clara County Mental Health Department: Mental Health Services Act Revenues and Expenditures by Component Fiscal Years 2006–07 Through 2011–12

Revenues and Expenditures by Component

	FISCAL YEAR					
COMPONENT	2006–07*	2007–08*	2008–09*	2009–10*	2010–11†	2011–12†
Community Services and Supports						
Unspent funds available	$541,443	$17,502,332	$22,209,300	$21,513,979	$21,213,304	$35,842,965
Revenues	20,253,043	29,209,374	29,578,237	37,295,274	48,528,816	33,536,100
Expenditures	3,292,154	16,362,683	30,273,558	31,139,949	33,899,155	31,590,232
Contributions to prudent reserve‡	–	8,139,723	–	6,456,000	–	–
Ending balance	17,502,332	22,209,300	21,513,979	21,213,304	35,842,965	37,788,833
Prevention and Early Intervention						
Unspent funds available	$–	$–	$1,122,314	$790,434	$3,793,491	$35,344,648
Revenues	–	1,216,607	24,604	11,677,300	37,640,067	11,254,700
Expenditures	–	94,293	356,484	3,974,243	6,088,910	11,127,713
Contributions to prudent reserve‡	–	–	–	4,700,000	–	–
Ending balance	–	1,122,314	790,434	3,793,491	35,344,648	35,471,635
Innovation						
Unspent funds available	$–	$–	$–	$–	$240,772	$11,543,088
Revenues	–	–	–	310,919	11,720,900	2,238,600
Expenditures	–	–	–	70,147	418,584	2,553,459
Ending balance	–	–	–	240,772	11,543,088	11,228,229
Workforce Education and Training						
Unspent funds available	$–	$–	$695,073	$245,310	$7,921,404	$7,232,081
Revenues	–	743,304	18,419	9,294,049	2,000,000	–
Expenditures	–	48,231	468,182	1,617,955	2,689,323	1,851,704
Ending balance	–	695,073	245,310	7,921,404	7,232,081	5,380,377
Capital Facilities and Technological Needs						
Unspent funds available	$–	$–	$–	$–	$11,772,188	$19,488,405
Revenues	–	–	–	11,888,212	9,459,000	–
Expenditures	–	–	–	116,024	1,742,783	2,517,915
Ending balance	–	–	–	11,772,188	19,488,405	16,970,490
Total ending balances	**$17,502,332**	**$24,026,687**	**$22,549,723**	**$44,941,159**	**$109,451,187**	**$106,839,564**

Mental Health Services Act Funds Dedicated to Local Prudent Reserve

COMPONENT	2006–07	2007–08	2008–09	2009–10	2010–11‡	2011–12‡	TOTAL
Community Services and Supports	$–	$8,139,723	$–	$6,456,000	$–	$–	$14,595,723
Prevention and Early Intervention	–	–	–	4,700,000	–	–	4,700,000
Totals	**$–**	**$8,139,723**	**$–**	**$11,156,000**	**$–**	**$–**	**$19,295,723**

Sources: Unaudited county Revenue and Expenditure Reports (RERs), unaudited internal county accounting data, and Appendix A allocation data.

* For fiscal years 2006–07 through 2009–10, revenues and expenditures are from the county's unaudited RERs. Revenues reflect deposits from state-allocated amounts and interest earned on those amounts.

† For fiscal years 2010–11 and 2011–12, revenues are based on state-allocated amounts the California Department of Mental Health reported and include some funds the county assigned to a Joint Powers Authority and therefore were not administered locally (see Appendix A). Expenditures are based on unaudited county accounting reports.

‡ The Mental Health Services Act requires a prudent reserve to ensure that the county can continue to provide Community Services and Supports and Prevention and Early Intervention programs to its current clients. The amounts shown are from the county's RERs and these documents were limited to fiscal years 2006–07 through 2009–10; thus, there may be contributions to the prudent reserve the table does not reflect.

DHCS
TOBY DOUGLAS
DIRECTOR

State of California—Health and Human Services Agency
Department of Health Care Services

EDMUND G. BROWN JR.
GOVERNOR

JUL 17 2013

Ms. Elaine M. Howle, CPA*
State Auditor
California Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, CA 95814

Dear Ms. Howle:

The California Department of Health Care Services has prepared its response to the California State Auditor, Bureau of State Audits' (BSA) draft report, "Mental Health Services Act: The State's Oversight has Provided Little Assurance of the Act's Effectiveness [redacted]," report number 2012-122.

DHCS appreciates the work performed by BSA and the opportunity to respond to the draft report. Please contact Ms. Melanie Pascua, Audit Coordinator, at (916) 445-2410 if you have any questions.

Sincerely,

for Toby Douglas, Director

Enclosure

cc: See Next Page

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* California State Auditor's comment appears on page 133.

cc: Karen Johnson
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Department of Health Care Services'
Response to the Bureau of State Audits Draft Report Entitled
"Mental Health Services Act: The State's Oversight has Provided Little Assurance of the Act's Effectiveness [redacted]," Report Number 2012-122

Chapter 1: Despite the State's Historically Inadequate Oversight, Opportunity Exists to Demonstrate the Effectiveness of the Mental Health Services Act (MHSA)

Recommendation: To ensure that it monitors counties to the fullest extent including conducting the monitoring MHSA specifies as well as implementing best practices, the Department of Health Care Services (DHCS or Department) should draft and enter into a performance contract with each county that contains assurances that allow for effective oversight and further the intent of the MHSA, including counties demonstrating that each of their MHSA-funded programs are meeting its intent.

Response: DHCS agrees with the recommendation.

The current draft of the performance contract contains language that allows DHCS to monitor a county's performance according to the provisions of the Mental Health Services Act and related regulations. The draft performance contract also provides that a county may be required to develop a plan of correction regarding any findings. The draft performance contract also requires each county to annually certify that it is in compliance with all MHSA related laws and regulations.

To assist in demonstrating that counties meet the intent of the MHSA, the draft performance contract requires MHSA data reporting on full service partnerships, the achievement of performance outcomes, and revenues and expenditures. The Department will use this information for audits and reporting to the public and the Accountability Commission will be able to use it to support their evaluation activities according to the Oversight Commission Evaluation Master Plan.

DHCS will release the performance contract to counties in August 2013. It should be noted that DHCS must negotiate the terms of the performance contract with counties, and the release of this contract was delayed due to contract negotiations.

Recommendation: To ensure that it monitors counties to the fullest extent including conducting the monitoring MHSA specifies as well as implementing best practices, DHCS should conduct comprehensive onsite

reviews of counties' MHSA-funded programs including verifying county compliance with MHSA requirements.

Response: DHCS agrees with the recommendation.

Program Compliance Reviews:
DHCS performs a Medi-Cal Specialty Mental Health Services system review of each County Mental Health Plan on a triennial basis. Within the current limitation of program review resources, the Department has added questions specific to MHSA program requirements to the FY 2013-14 Annual Review Protocol for Consolidated Specialty Mental Health Services and Other Funded Services. The FY 2013-14 reviews will begin in October 2013.

The Department will require a county to submit a plan of correction for any items found to be out of compliance. The Department will follow up with the county to ensure it has implemented a plan of correction that is effective. For any significant compliance issues, the Department may conduct focused reviews and/or more frequent site reviews to assure corrective actions are clearly identified and implemented.

To the extent that it is able to do so with available staff resources, the Department will continue to develop MHSA programmatic review criteria to add to its compliance protocol with input from the Accountability Commission.

Fiscal Audits:

DHCS has three audit positions dedicated to completing comprehensive onsite reviews of counties' MHSA funded programs including verifying county compliance with MHSA requirements. DHCS will start the onsite reviews in the current production cycle.

Recommendation: To ensure that counties have needed guidance to implement and evaluate MHSA-funded programs, DHCS should issue regulations, as appropriate, for Prevention, Innovation, and Facilities programs and for other MHSA requirements such as a prudent reserve.

Response: DHCS agrees with the recommendation.

Due to the recent enactment of Assembly Bill 82 (Chapter 23, Statutes of 2013), the Accountability Commission is now responsible for developing regulations for Prevention and Early Intervention (PEI) and Innovation (INN) components while DHCS ①

continues to be responsible for developing regulations for the Community Services and Supports (CSS), Workforce Education and Training (WET), and Capital Facilities/Technological Needs (CF/TN) components.

DHCS will work in collaboration with the Accountability Commission beginning in July 2013 to review the current MHSA regulations and develop additional regulations. Work will begin with a review of the general MHSA requirements, including the local stakeholder process. The Department will review and revise CSS regulations followed by the development of CF/TN regulations. The Office of Statewide Health Planning and Development (OSHPD) is currently reviewing the WET regulations.

Recommendation: To ensure that counties have needed guidance to implement and evaluate MHSA-funded programs, DHCS should commence the regulatory process no later than January 2014.

Response: DHCS agrees with the recommendation.

DHCS will work in collaboration with the Accountability Commission beginning in July 2013 to review the current MHSA regulations and develop additional regulations. DHCS expects to have draft regulations available for public comment during Spring 2014. Assuming the standard regulations timeline, MHSA regulations will be adopted during Fall 2014.

Recommendation: To ensure that counties have needed guidance to implement and evaluate MHSA-funded programs, DHCS should collaborate with the Accountability Commission to develop and issue guidance to counties on how to effectively evaluate and report on the performance of their MHSA-funded programs.

Response: DHCS agrees with the recommendation.

DHCS will work collaboratively with the Accountability Commission to develop and issue guidance to counties on how to effectively evaluate and report on the performance of their MHSA-funded programs. This includes coordinated efforts on the performance outcomes indicators and measures, ongoing data reporting, and county training. DHCS will also continue to support and further the activities of the Accountability Commission's Evaluation Master Plan where appropriate.

Recommendation: To ensure that DHCS and other state entities can evaluate MHSA-funded programs and assist the Accountability Commission in its

efforts, DHCS should collect complete and relevant MHSA data from the counties.

Response: DHCS agrees with the recommendation.

Beginning in March 2013, the Department began a review of data submission completeness and accuracy. The Department has contacted all counties that are late in submitting Client and Service Information (CSI) and Data Collection and Reporting (DCR) data to assess their plans for submitting complete data and to assist where needed. The Department has also established a helpdesk to address county data reporting system questions and to escalate data reporting issues. DHCS will continue to assist counties to assure complete, accurate, and current data reporting; post monthly county submission status reports on the DHCS website; and coordinate with the California Mental Health Directors Association (CMHDA) and the counties for any needed system improvements and updates to data reporting requirements.

Recommendation: To ensure that DHCS and other state entities can evaluate MHSA-funded programs and assist the Accountability Commission in its efforts, DHCS should resolve all known technical issues with the partnership and client services databases and provide adequate resources with the necessary expertise to manage the databases going forward.

Response: DHCS agrees with the recommendation.

The Department has redirected Information Technology (IT) staff to manage and support the CSI and DCR reporting and database systems. These technical staff work directly with county staff and their system vendors to resolve county data submission issues. .

Through collaboration with the Accountability Commission, DHCS has recently received additional resources to assist with implementing system updates to the DCR data system. To further improve data reporting, the Department and the Accountability Commission have created a schedule of system updates to address priority system improvements to make the system more efficient for county use.

Recommendation: DHCS should, as soon as is feasible, revise or create a reasonable and justifiable allocation methodology to ensure that counties are appropriately funded based on their identified needs for mental health services. DHCS should ensure that it reviews the

methodology on a regular basis and updates it as necessary to ensure the factors and the weighting of the factors are appropriate.

Response: DHCS agrees with the recommendation.

Currently DHCS is using an allocation methodology agreed upon by the Department and CMHDA. During FY 2013-14, DHCS will review the current allocation methodology in consultation with the Accountability Commission and CMHDA to determine the most appropriate criteria for funding mental health service needs. Annually in June, the Department may update county allocation ratios for the next fiscal year based on the funding criteria and any updated factors or weightings.

Chapter 2: Counties Should Improve Mental Health Services Act Performance Measurements and Documentation of Stakeholders Planning Efforts

Recommendation: To improve the quality of county processes related to measuring program performance, DHCS should use its performance contracts with counties to ensure they specify MHSA-funded program goals in their plans and annual updates and include those same goals in contracts with program providers

Response: DHCS agrees with the recommendation.

The current draft of the performance contract contains language specifying that counties must include MHSA-funded program goals in their three-year program and expenditure plans and annual updates and to include these same goals in their county contracts with program providers. The Department will also develop regulations to ensure MHSA-funded contract providers have contractual goals that are consistent with the approved three-year program and expenditure plans and annual updates.

Recommendation: To improve the quality of county processes related to measuring program performance, DHCS should use its performance contracts with counties to ensure they identify meaningful data to measure the achievement of all their goals, set specific objectives and require their program providers to capture those data and use that data to report on the effectiveness of each of the MHSA-funded programs in attaining their respective goals.

Response: DHCS agrees with the recommendation.

The current draft performance contract contains language specifying that counties must report required data for the purpose

of evaluating mental health outcomes. The counties must collect and report this data for services provided by county owned and operated providers and contract providers. The specific outcomes are established jointly by DHCS and the Accountability Commission, in collaboration with the CMHDA and in consultation with the California Mental Health Planning Council. The Department will also strive to develop consistent outcomes definitions and uniform, statewide data reporting requirements by leading and/or consulting with various performance outcomes committees and workgroups.

Recommendation: DHCS should develop standardized data collection guidelines or regulations, as appropriate that will address inconsistencies in the data counties report to the State. In developing the standardized data collection guidelines, DHCS should consult with the Accountability Commission to ensure data collected reasonably meets its needs for purposes of statewide evaluation.

Response: DHCS agrees with the recommendation.

DHCS will consult with the Accountability Commission to develop regulations necessary to ensure data are collected consistently for the purposes of statewide evaluation.

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

Response: DHCS agrees with the recommendation.

DHCS oversees the MHSA training and technical assistance contract that provides a variety of training options and technical assistance to county mental health plans and service providers. Utilizing this resource and available funding, the Department will work with the contractor and the Accountability Commission to develop training for counties on the MHSA local planning review process. This contract also provides training to Local Mental Health Boards on their role in implementing the MHSA. DHCS will address training and technical assistance contract changes needed for local planning review process as part of its next contract update, which is expected to be fully executed by August 2013.

Comment

CALIFORNIA STATE AUDITOR'S COMMENT ON THE RESPONSE FROM THE CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

To provide clarity and perspective, we are commenting on the California Department of Health Care Services' (Health Care Services) response to our audit. The number below corresponds to the number we have placed in the margin of Health Care Services' response.

Health Care Services correctly indicated in its response that the Mental Health Services Oversight and Accountability Commission (Accountability Commission) is now responsible for developing regulations for Prevention and Early Intervention and Innovation programs and that Health Care Services continues to have responsibility for developing regulations for Capital Facilities and Technological Needs (Facilities) programs. As a result, we modified the recommendation on page 41 to clarify that Health Care Services should coordinate with the Accountability Commission and issue regulations, as appropriate, for Facilities programs and other Mental Health Services Act requirements. (1)

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STATE OF CALIFORNIA
EDMUND G. BROWN JR., Governor

MHSOAC
Mental Health Services
Oversight & Accountability Commission

July 19, 2013

Elaine M. Howle, State Auditor*
Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, CA 95814

Re: Response to State Audit Report 2012-122

Dear Ms. Howle:

Please find enclosed the response of the Mental Health Services Oversight and Accountability Commission to the confidential redacted draft of the State Audit Report 2012-122.

Consistent with your request, we have submitted this written response in the envelope provided and the entire response, including this cover letter, on the enclosed CD using a PDF file.

On behalf of the Commission, we wish to express our appreciation for your audit team's hard work and professionalism.

Sincerely,

Sherri Gauger

SHERRI GAUGER
Executive Director
Mental Health Services Oversight & Accountability Commission

* California State Auditor's comments begin on page 139.

Overall Response

The Mental Health Services Oversight and Accountability Commission (MHSOAC) appreciates the Bureau of State Audit's (BSA) fundamental finding that the MHSOAC has generally satisfied the Mental Health Services Act's (MHSA) oversight requirements and joins the BSA in acknowledging that more can be, and is being, done. As the BSA report states, the MHSOAC's oversight authority changed overtime. During the first five years of its existence the initial focus of the MHSOAC's oversight was on the responsible implementation of expanded services and appropriate expenditure of MHSA funds. On November 8, 2010, the MHSOAC broadened its focus from "inputs" to "outputs" when it adopted "Accountability through Evaluative Efforts." Evaluation remains one of seven oversight strategies and the MHSOAC joins the BSA in its recommendations that, generally, the MHSOAC continue its current evaluation efforts.

BSA Recommendation

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

Response

The MHSOAC agrees with this recommendation.

The MHSOAC entered into its first evaluation of the Mental Health Services Act (MHSA) in 2009, the same year it was first statutorily authorized to evaluate the MHSA. Soon after in 2010, the Commission adopted an initial framework for evaluation. The Evaluation Master Plan continues and builds upon these past efforts and current MHSOAC evaluations to complete a comprehensive, cohesive look at community mental health. In the May Revision to the Fiscal Year (FY) 2013-14 budget, the Governor proposed and the Legislature supported beginning implementing the Evaluation Master Plan. For FY 2013-14 some highlights include continuing measuring priority indicators and transferring this function to the MHSOAC, developing a system to track outcomes for persons receiving services that are less intensive than a full service partnership, and determining the effectiveness of methods for engaging and serving transitional age youth clients. Highlights of future years include determining the effectiveness of selected programs for older adults, consumer run services, and services for children. (1)

The MHSOC appreciates the BSA's endorsement of the MHSOAC continuing these efforts.

BSA Recommendation

To ensure it can fulfill its responsibilities to evaluate MHSA-funded programs, the Accountability Commission should examine its prioritization of resources to ensure it is performing necessary evaluations.

Response

The MHSOAC agrees and will continue to examine its budget for potentially available resources to support evaluation efforts.

The Governor and Legislature provide the MHSOAC with specific resources to accomplish identified tasks in fulfilling statutory functions. The MHSOAC has followed standard state best management practices by utilizing resources given to it for those purposes, including evaluation. Evaluation is one of the MHSOAC's many statutory responsibilities and one of seven strategies for oversight adopted by the Commission in its Logic Model. While evaluation is a priority, it is not the sole priority, and the MHSOAC has balanced the resources it receives with its statutory responsibilities and strategies to oversee the community mental health system. (2)

While the MHSOAC's budget has increased over the past years, it has been for a specified purpose. For example, in FY 2012-13, the MHSOAC budget increased by approximately $1.6 million. That change was the result of contracts being reassigned from the former California Department of Mental Health to the MHSOAC to support specific organizations. These contracts and amounts are part of fulfilling the statutory responsibility that resources "assist consumers and family members to ensure the appropriate state and county agencies give full consideration to concerns about quality, structure of service delivery, or access to services." To redirect these resources to evaluation would be improper. (2) (2)

Even while managing within state practices, the MHSOAC spent more than the budgeted amounts on evaluation for the past three fiscal years due to year-end savings. Occasionally, a department can identify year-end, one-time savings in its budget. The MHSOAC was able to commit an additional $394,000 in FY 2010-11, $616,000 in FY 2011-12, and $285,000 in FY 2012-13 for a total of an additional $1.295 million that was prioritized for evaluation. (2)

Additionally, the MHSOAC leveraged an opportunity to redirect personnel to evaluation. When Assembly Bill 100 (Chapter 5, Statutes of 2011) eliminated plan review at the state level, the MHSOAC identified three vacant positions that were used for plan review and reclassified them to further support evaluation.

The MHSOAC agrees with the priority the BSA places on evaluation, appreciates the value the Governor and Legislature have placed on funding implementing the Evaluation Master Plan, and will continue to look for opportunities to identify additional resources from year-end, one-time funds for additional evaluations.

BSA Recommendation

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

Response

The MHSOAC agrees with this recommendation and one of the strategies the MHSOAC formally adopted in its Logic Model to oversee the community mental health system is to "utilize evaluation results for quality improvement."

The results of MHSOAC evaluations are already being used in this way. In January 2013, California Senate President Pro Tempore Darrell Steinberg advanced a National Framework for Investment in Mental Health to the Vice President of the United States Joseph Biden. This framework offered seven different MHSOAC evaluation results to support the national model.

These evaluations laid a foundation for supporting Senator Steinberg's "A Call for State Action: Invest in Mental Health Services for Community Wellness," a $206 million increase for items, including crisis residential treatment capacity, mobile crisis support teams, and triage personnel, which became the Investment in Mental Health Wellness Act of 2013.

Evaluation results have been used locally too. For example, the results of mapping disparities to access in services was then brought to select counties so this information could be used when developing service plans.

Each of the MHSOAC's Committees' charters include as a task to "receive regular updates on MHSOAC evaluation efforts, consider implications of pertinent results, and make plans to act on those that are relevant to Committee purpose and objectives." MHSOAC Committees are actively engaged in this task.

The MHSOAC will continue to use evaluation results to accomplish this recommendation.

BSA Recommendation

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

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

Response

The Commission agrees with this recommendation. The Commission first received regulatory authority in June 2013 and has begun the regulatory process for Prevention and Early Intervention and Innovation programs.

Comments

CALIFORNIA STATE AUDITOR'S COMMENTS ON THE RESPONSE FROM THE MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

To provide clarity and perspective, we are commenting on the Mental Health Services Oversight and Accountability Commission's (Accountability Commission) response to our audit. The numbers below correspond to the numbers we have placed in the margin of the Accountability Commission's response.

We disagree with the Accountability Commission's assertion that it was first statutorily authorized to evaluate the Mental Health Services Act (MHSA) in 2009. Although the Legislature expressly added evaluation to the list of the Accountability Commission's enumerated authorized activities in 2009, the Accountability Commission was established in 2004 by Proposition 63 to "oversee" the MHSA. Moreover, the California Department of Mental Health was required to allocate administrative funds, including funds specifically for the purpose of evaluation, to the Accountability Commission, among others. Accordingly, we believe that the Accountability Commission was charged with evaluating MHSA programs before 2009, and we located an Accountability Commission document dated April 2008 that supports that contention. Specifically, before the 2009 amendment expressly authorizing it to evaluate MHSA programs, the commission adopted a proposal that stated the Accountability Commission had an overarching responsibility for oversight and accountability and should be a lead entity for evaluating the extent to which the MHSA's objectives have been accomplished. (1)

The Accountability Commission states that evaluation is one of many of its statutory functions and, though it is one of seven strategies adopted to oversee the MHSA programs, it is not its sole priority. We never recommended that evaluations be its sole priority. Rather, as we state on page 42, we recommended that the Accountability Commission examine its prioritization of resources as it pertains to ensuring it is performing all necessary evaluations. We do believe, however, that for an entity established to oversee the accountability of MHSA programs, that evaluations to ensure those programs are achieving their intended outcomes and goals should be a top priority. (2)

We believe the recommendation to the Accountability Commission to prioritize its resources for evaluation is warranted and supported by the report's conclusions. The recommendation is based on our discussion and information in Table 4 on pages 32 and 33 where we summarize the Accountability Commission's expenditures and

amounts dedicated to evaluation. Table 4 includes the additional funds totaling $1.295 million that the Accountability Commission highlights in its response that it prioritized for evaluations in fiscal years 2010–11 through 2012–13. As we describe on page 33 in the report, with its reduction in duties following legislative change in March 2011, it seems reasonable that the Accountability Commission would have more of its existing resources to commit to evaluation efforts. The Accountability Commission maintains that its budget for fiscal year 2012–13 increased by $1.6 million to support specific organizations and that using these resources for evaluation would be improper. While we do not disagree, this does not explain why the amount it dedicated to evaluation in fiscal year 2012–13 decreased from the previous fiscal year as shown in Table 4. Specifically, when we reduce its fiscal year 2012–13 expenditures by the $1.6 million, the resulting amount is roughly equal to the Accountability Commission's expenditures for fiscal year 2011–12. Yet, as shown in Table 4, the amount it dedicated to evaluation decreased by roughly $800,000, from approximately $2.1 million in fiscal year 2011–12 to nearly $1.3 million in fiscal year 2012–13.

California Mental Health Planning Council

July 17, 2013

Elaine M. Howle, CPA
California State Auditor
555 Capitol Mall, Suite 300
Sacramento, CA 95814

Dear Ms. Howle,

- Advocacy
- Evaluation
- Inclusion

The California Mental Health Planning Council respectfully submits the following comment in response to the draft report for the audit of the Mental Health Services Act.

> The Council agrees with and is taking steps to address the recommendations. As the report has acknowledged, there are insufficient sources of performance outcomes or other data available for the Council's evaluation. Until they become available, the Council will seek alternative, innovative ways to fulfill its statutory responsibility while maintaining its advocacy efforts and identification of successful practices.
>
> Also, it should be noted that while the Council has not recently produced reports on performance outcomes related to the MHSA, the Council did develop and release the Performance Indicators in 2010 which have been subsequently adopted by the MHSOAC and are currently being used in their data analysis and evaluation activities.

Thank you for the opportunity to review and respond to the draft report. Please do not hesitate to contact our Executive Officer, Jane Adcock, at (916) 319-9343 or jane.adcock@cmhpc.ca.gov should you have any questions.

Sincerely,

John Ryan, Chairperson

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LAC DMH
LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
550 S. VERMONT AVE., LOS ANGELES, CA 90020 HTTP://DMH.LACOUNTY.GOV

MARVIN J. SOUTHARD, D.S.W.
Director
ROBIN KAY, Ph.D.
Chief Deputy Director
RODERICK SHANER, M.D.
Medical Director

July 17, 2013

Elaine M. Howle, CPA*
State Auditor
California State Auditor, Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, CA 95814

Dear Ms. Howle:

I am in receipt of the results of the Mental Health Services Act (MHSA) audit for Los Angeles County. Our Department has placed considerable resources into collecting, reporting, and using clinical outcomes, with an emphasis on improving services and client quality of life. We are pleased that the audit acknowledged our efforts in this area and no recommendations were issued for our County.

There are two sections we wish to provide clarification for your consideration. On page 24, your report states "Currently county boards of supervisors are tasked with reviewing and approving these documents." Our County Counsel has stipulated that the Board of Supervisors "adopts" MHSA Annual Updates and 3-Year Integrated Plans and that our Mental Health Commission is charged with "approving" those plans. (1)

Per our discussion with Sharon Fullner from your office, the second sentence of the first footnote from Appendix Table D.1 should be revised to state "Revenues reflect cash received for the respective fiscal year and interest earned on these amounts." (2)

Finally, we believe that Appendix Table D.1 has mis-stated Fiscal Year 2010-11 Community Services and Supports (CSS) planning estimates. Our CSS revenue was $210 million and not $319 million as stated in Table D.1. (3)

* California State Auditor's comments appear on page 145.

Elaine M. Howle, CPA
July 17, 2013
Page 2

Our Department plans to use your results to continue to improve the quality of our local planning processes and to enhance the scope and depth of our MHSA evaluation efforts.

Sincerely,

Marvin J. Southard, D.S.W.
Director

MJS:RK:DM:dig

c: Robin Kay, Ph.D.
Dennis Murata, M.S.W.
Debbie Innes-Gomberg, Ph.D.

Comments

CALIFORNIA STATE AUDITOR'S COMMENTS ON THE RESPONSE FROM THE LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

To provide clarity and perspective, we are commenting on the Los Angeles County Department of Mental Health's (Los Angeles) response to our audit. The numbers below correspond to the numbers we have placed in the margin of Los Angeles' response.

Los Angeles is concerned with our use of the word "approve" rather than "adopt." Under state law, county boards of supervisors are required to adopt county plans. However, because the plans are developed as a result of an ongoing stakeholder process and then acted upon by boards of supervisors, we used the word "approve" so that our readers would understand that those boards only act on what is presented to them after counties engage in the stakeholder process. The word "adopt" means "to accept formally and put into effect." Since "accept" is defined as, among other things "to give admittance or approval," we believe using the word "approve" accurately reflects the adoption of county plans as required by law. (1)

We have included Los Angeles' perspective in a footnote to Table D.1 on page 120. (2)

Audit evidence obtained from the California Department of State Hospitals supports the fiscal year 2010–11 Community Services and Supports revenue figure reflected in Table D.1. Nevertheless, we added a footnote to the table to present Los Angeles' perspective on the revenue amounts. Also, as we state in Appendix D on page 119 and again in Table D.1 on page 120 the figures are unaudited. (3)

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Health and Human Services
Sherri Z. Heller, Ed.D., Director

County of Sacramento

Divisions
Behavioral Health Services
Child Protective Services
Departmental Administration
Primary Health Services
Public Health
Senior and Adult Services

July 17, 2013

Ms. Elaine M. Howle, CPA
California State Auditor
555 Capitol Mall, Suite 300
Sacramento, CA 95814

RE: Response to Draft Audit Report – "Mental Health Services Act: [Redacted], and Select Counties Can Improve Measurement of Their Program Performance" (2012-122)

Dear Ms. Howle:

Enclosed please find Sacramento County's response to the draft audit report, titled "Mental Health Services Act: [redacted], and Select Counties Can Improve Measurement of Their Program Performance."

As instructed, we have included a hard copy of our response and also included this cover letter and our response on the CD provided.

Please contact Mary Ann Carrasco, Deputy Director, Division of Behavioral Health Services, at (916) 875-9904 if you have any questions or would like to discuss our response.

Sincerely,

Sherri Z. Heller

Enclosures (2)

c: Mary Ann Carrasco

Sacramento County – Response to Draft Audit Report 2012-122, titled "Mental Health Services Act: [redacted], and Select Counties Can Improve Measurement of Their Program Performance"

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

The Sacramento County Division of Behavioral Health Services (Division) is committed to addressing the recommendations contained in the audit report. To this end, the Division will conduct a complete review of the goals stated in the Mental Health Services Act (MHSA) plans as compared with the goals captured in the contracts for MHSA-funded programming. The Division will begin the internal review process immediately. Necessary revisions to contract scopes identified through the review process will be addressed with contracted service providers. These revisions will require review and approval by counsel/administration for both County and the provider agencies. Contracting authority is granted by the local Board of Supervisors. Due to the volume of contracts potentially impacted, the Division anticipates completion of this entire process with updated scopes capturing the plan goals prepared for inclusion in MHSA-funded contracts by June 30, 2014.

The Division looks forward to reading the audit report in its entirety upon release.

County of San Bernardino

Department of Behavioral Health Administration
268 W. Hospitality Lane, Suite 400, San Bernardino, CA 92415 • (909) 382-3133 • Fax (909) 382-3105

CaSONYA THOMAS, MPA, CHC
Director

July 17, 2013

Elaine M. Howle, CPA*
State Auditor
California State Auditor
555 Capitol Mall, Suite 300
Sacramento, CA 95814

Dear Ms. Howle:

Thank you for this opportunity to respond to the draft copy of the "Mental Health Services Act: Select Counties Can Improve Measurement of Their Program Performance" report. The County of San Bernardino Department of Behavioral Health (DBH) supports the use of performance audits as a tool to improve local mental health systems.

The behavioral health programs implemented by DBH strive to be recognized as a progressive system of seamless, accessible and effective services that promote prevention, intervention, recovery and resiliency for individuals, families and communities. The department values the inclusion of stakeholders in the community planning process and agrees that it is important to identify key performance measures and outcomes achieved and to assess the extent to which counties use performance measures and outcomes to improve their system of care.

The positive results of this audit demonstrate the commitment of DBH to the principles of openness and accountability. DBH is pleased that the audit report reflects no findings for DBH and appreciates the Auditor's acknowledgement that the department was in the process of improving its performance evaluation methods before the audit was undertaken. Specifically, the audit recognized DBH: (1)

- Complied with state regulations requiring that specific groups of stakeholders and community representatives be included throughout the Mental Health Services Act (MHSA) planning process and with community planning regulations that require staffing and training practices related to developing our plans.
- Demonstrated specific program outcomes and that outcomes were used to improve its mental health delivery system.
- Reviewed its Community Support provider contracts to strengthen the inclusion of desired goals.
- County expenditures were supported by program provider contracts and program descriptions in the county plans.

As requested, we have enclosed a written response to the report in the specified format.

DBH is invested in continuous improvement and will use this audit experience to further enhance our efforts to work with stakeholders to create a progressive, culturally competent system that promotes wellness and recovery for adults and older adults with serious mental illness and resiliency for children with serious emotional disorders and their families.

Sincerely,

CaSonya Thomas, MPA
Director

CT:rr

Enclosure
(Copies noted on the next page)

* California State Auditor's comment appears on page 153.

State Auditor Elaine M. Howle
July 17, 2013
Page 2

cc: Gregory C. Devereaux, County Chief Executive Officer
Linda Haugan, Assistant Executive Officer, Human Services
Frank Salazar, Deputy County Counsel
Sharon Fuller, Senior Auditor, California State Auditor

COUNTY OF SAN BERNARDINO RESPONSE TO MENTAL HEALTH SERVICES ACT: [REDACTED], AND SELECT COUNTIES CAN IMPROVE MEASUREMENT OF THEIR PROGRAM PERFORMANCE REPORT

July 17, 2013

This management response to the audit report received on July 11, 2013, is provided by the Department of Behavioral Health on behalf of the County of San Bernardino.

RECOMMENDATION: San Bernardino County should review its existing MHSA contracts and by December 31, 2013, amend them as necessary to include plan goals.

RESPONSE

The Department of Behavioral Health (DBH) includes plan goals in its Mental Health Services Act (MHSA) contract language, and goals are monitored on an ongoing basis. (1)

DBH has more than 60 MHSA contracts, and in the possible absence of specific contract language or collection of certain data favored by the audit, it should be not assumed or inferred that program goals are not being set, monitored, and accomplished, or that meaningful services are not being provided to the community. (1)

The department uses various performance measures to evaluate MHSA-funded programs and services. Continued monitoring provides the information necessary to make modifications, as needed, to ensure the efficiency and effectiveness of mental health services. (1)

The County of San Bernardino remains committed to continuous improvement, including developing/refining its approaches for evaluation of performance outcomes. DBH understands the value of this audit and the opportunity it offers to further enhance its programs and services to community members impacted by mental illness, and to continue to adhere to the spirit of MHSA.

Action Steps and Time Frame

DBH will review its existing MHSA contracts and amend as necessary.

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Comment

CALIFORNIA STATE AUDITOR'S COMMENT ON THE RESPONSE FROM THE COUNTY OF SAN BERNARDINO DEPARTMENT OF BEHAVIORAL HEALTH ADMINISTRATION

To provide clarity and perspective, we are commenting on the County of San Bernardino Department of Behavioral Health Administration's (San Bernardino) response to our audit. The number below corresponds to the number we have placed in the margin of San Bernardino's response.

San Bernardino has mischaracterized the information in the audit report. On pages 47 through 53 we discuss what we found in our review of county plans and nine San Bernardino provider contracts and our concerns with the plans and contracts including program goals, etc. In summary, we identified the following concerns regarding San Bernardino's plans and the nine contracts: (1)

- San Bernardino did not always state goals for its programs in its county plans. *(See page 47.)*
- For six contracts, San Bernardino did not include all program goals as stated in the county plans. *(See page 47.)*
- Eight contracts lacked requirements for collecting and providing information suitable for measuring the attainment of program goals. *(See page 48.)*
- None of the nine contracts contained specific objectives—meaning objectives that were well defined and measurable. *(See page 49.)*
- San Bernardino typically used ad-hoc approaches that were not always sufficient in identifying meaningful data to measure progress in meeting its programs' goals. Moreover, it often failed to collect meaningful data, which affected San Bernardino's ability to adequately analyze and report on whether program goals are being achieved. *(See pages 48 and 51.)*
- Even though San Bernardino reported to us specific program outcomes and the use of those outcomes to improve its mental health delivery systems, our review shows that this reporting may not be representative of the county's MHSA programs. *(See page 53.)*

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Dedicated to the Health of the Whole Community

SANTA CLARA VALLEY HEALTH & HOSPITAL SYSTEM
DEPARTMENT OF MENTAL HEALTH

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July 17, 2013

Elaine Howle, CPA
State Auditor
California State Auditor's Office
555 Capitol Mall, Suite 300
Sacramento, CA 95814

RE: 2012-122 Mental Health Services Act

Dear Ms. Howle:

Santa Clara County Mental Health Department ("County") is providing you with our written response to the redacted draft report, titled "Mental Health Services Act: [redacted], and Select Counties Can Improve Measurement of Their Program Performance," which we received on July 11, 2013 (the "Draft Report"). The following is the County's response to the State Auditor's two recommendations in the report for the County:

- **Recommendation #1**: The County should review its existing MHSA contracts and by December 31, 2013, or as soon as feasible, amend them as necessary to include plan goals.

  Response: The County will review its existing MHSA contracts with each mental health program division, Family and Children Services, Adult and Older Adult Services, Integrated Behavioral Health Services, and Learning Partnership. Each division will evaluate their specific MHSA contracts and will ensure plan goals are included for each program. Once the County has completed their evaluation of the contracts and defined the goals that need to be included, a timeline will be established to implement the contract amendments. This will be a multi-step process to be initiated immediately.

- **Recommendation #2**: The County should ensure that all MHSA invoices are adequately supported with information that demonstrates MHSA services were provided.

  Response: As part of the MHSA contract review process described above, the County will conduct a review of billing and invoicing procedures of each of the MHSA contracts. This process will include identifying documentation requirements for each category of invoices, i.e., direct services, flex funds, etc, and will establish invoicing requirements for each invoice category. Those requirements will be standardized and included in contract amendments.

Overall, the County agrees that a standardized system of performance measurement across all counties for MHSA and non-MHSA public mental health services is desired. We believe this can be accomplished by developing a broader performance measurement system that draws upon the findings and recommendations provided in various state and county evaluation reports that have been funded with MHSA resources over the past several years. To that end, the Full Service Partnership (FSP) data collected and reported to the State utilizes a common outcomes measurement methodology that provides important information on the outcomes yielded by MHSA funded programs for consumers across age-specific domains of functioning. Given that the MHSA funded FSP model of service is employed widely across the state, and the data collection system utilized to measure FSP outcomes has been developed with input from local and state stakeholders, we believe that this is an excellent foundation to build upon to establish a common set of measures that can be used across a variety of mental health service programs.

MHSA programs are critical to the provision of mental health services throughout the State. Thank you for your important review of the County's MHSA program, and for the opportunity to review and comment on the Draft Report.

Sincerely,

Nancy Peña, Ph.D

Nancy Peña, Ph.D., Director
Mental Health Department

cc: Laura Kearney, Project Manager
Sharon Fuller, Project Lead
Theresa Fuentes, Lead Deputy County Counsel
Jeanne Moral, MHSA Coordinator

cc: Members of the Legislature
Office of the Lieutenant Governor
Little Hoover Commission
Department of Finance
Attorney General
State Controller
State Treasurer
Legislative Analyst
Senate Office of Research
California Research Bureau
Capitol Press