MHSOAC

Mental Health Services
Oversight and Accountability Commission

First Report to the Governor and Legislature
January 2011

Vision: Right care, right time, right place for all individuals, children and families at risk for or living with mental illness

MEMBERSHIP

The MHSOAC is composed of sixteen (16) voting members. In making appointments, the Governor seeks 12 individuals who have had personal or family experience with mental illness. The 4 seats not appointed by the Governor are the Attorney General or designee; the Superintendant of Public Instruction or designee; the Chairperson of the Senate Health and Human Services Committee or another Senator selected by the President Pro Tempore; and the Chairperson of the Assembly Health Committee or another Assembly member selected by the Speaker of the Assembly.

MISSION

Provide the vision and leadership, in collaboration with clients, their family members and underserved communities, to ensure Californians understand mental health is essential to overall health. The MHSOAC holds public mental health systems accountable and provides oversight for eliminating disparities, promoting mental wellness, recovery and resiliency, and ensuring positive outcomes for individuals living with serious mental illness and their families. The Commission recommends policies and strategies to further the vision of transformation and addresses barriers to system change, as well as provides oversight to ensure funds are spent true to the intent and purpose of the MHSA.

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Andrew Poat

Vice Chairman
Larry Poaster, Ph.D.

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MHSOAC Executive Director
Sherri L. Gauger

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Message from the Chair and Vice Chair

Governor and Members of the Legislature:

On behalf of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) we are pleased to present our first report to the Governor and Legislature. This report provides a detailed summary of the Commission's oversight and evaluation of the effective use of California's investment in improving quality and access to mental health services through the Mental Health Services Act (MHSA). In addition this report identifies some of the vast achievements being made in the implementation of new public MHSA mental health programs aimed at preventing mental illnesses from becoming severe and disabling, with an emphasis on improving timely access to services for unserved and underserved populations. These many accomplishments have been achieved through ongoing collaborative efforts at the State and local levels among the Commission, the Department of Mental Health, the California Mental Health Planning Council, the California Mental Health Director's Association, county mental health departments, and significant contributions throughout California from diverse citizens, including people struggling with mental illness and their family members.

The year of 2010 marked the five-year anniversary of the MHSA implementation, approved by voters in November 2004. We are pleased to note the accomplishment of several milestones:

- All California counties are receiving funding from the MHSA for programs developed through robust community stakeholder participation.
- All California counties have approved Prevention and Early Intervention plans and are in the process of implementing programs that will lead to early identification, diagnosis, and treatment of mental illness, with goals of wellness, recovery, and reduction of disability, suffering, and economic costs associated with untreated mental illness.
- Prevention and Early Intervention Statewide programs are being developed for suicide prevention, stigma and discrimination reduction, and mental health services for students; county-based prevention and early intervention programs are being implemented in all of these areas.
- As of November 2010, approximately $5.1 billion of MHSA funds have been distributed to counties. This includes the $734.9 million distributed for Prevention and Early Intervention and $175.5 million distributed for Innovation programs.
- Clients and taxpayers are seeing results. One evaluation by the UC Berkeley, Nicolas C. Petris Center, May 2010, demonstrated that after 12 months of participation in Full-Service Partnership (FSP) Programs, a key strategy of the MHSA, the proportion of mental health consumers living independently increases by approximately 20 percent, mental health-related emergency services are 67 percent lower, probability of being arrested drops by 56 percent, and employment outcomes are improved by 25 percent.

With five years of program experience now behind us, MHSOAC will be expanding its current evaluation efforts to ensure 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 the public.

Areas of measurement will include:

- Reduction rates in suicide, incarcerations, school failure or drop out, unemployment, prolonged suffering, homelessness, and removal of children from their homes.

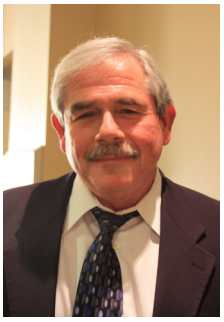
- The impact programs are making through new approaches to increase access to unserved and underserved groups, increase the quality of services, including better outcomes, promote interagency collaboration, and increase access to services.

- Per-person costs and financial analysis of outcomes and benefits of FSP Programs and the impact of selected services/strategies on outcomes specified in the MHSA.

Ongoing evaluations in these areas will be critically important in learning what is working at the county level and what can be modified to increase the positive impact these programs have on the public mental health system. In addition to evaluating Prevention and Early Intervention and Innovative programs, the Commission intends to utilize past evaluation efforts to build upon what has already been done and expand the scope to incorporate additional areas. This approach is an incremental process to learn from current research and identify additional components that could lead to a greater understanding of impact of the MHSA on the public mental health system. As referenced earlier, such past evaluations include the Petris Center, May 2010 evaluation titled "Evidence on the Effectiveness of FSP Programs in California's Public Mental Health System".

The Commission will face a variety of challenges in the upcoming years including the volatility of the MHSA revenues and the impending changes to the mental health system with the passage of Federal Healthcare Reform, the Federal Mental Health Parity and Addiction Equity Act and the approval of the new Medicaid 1115 Waiver. The Commission is eager to be a collaborative partner and leader during these times and as such will continue to meet its statutory role to provide oversight, review and evaluation of projects and programs supported with MHSA funds, review and/or approve local MHSA funding requests, and ensure oversight and accountability of the public community mental health system.

Sincerely,



Andrew Poat,
Commission Chair
Mental Health Services Oversight
and Accountability Commission

Larry Poaster, Ph.D.
Commission Vice-Chair
Mental Health Services Oversight
and Accountability Commission

Introduction

The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) is providing this report to inform the Governor and Legislature about the MHSOAC's activities, accomplishments and future endeavors for achieving the statutory mandates set forth within the Mental Health Services Act (MHSA). This is the Commission's first Report to the Governor and Legislature on MHSOAC activities. The fiscal information contained in this report includes the activities and fiscal accomplishments through June, 30 2010.

In November 2004, the voters of California passed Proposition 63, known as the MHSA. The MHSA is funded through a one percent income tax on personal income in excess of $1 million. As mandated by the MHSA, the MHSOAC was established to provide oversight and accountability for the MHSA, Adult and Older Adult System of Care Act and Children's Mental Health Services Act. The MHSOAC has three primary roles: 1) provide oversight, review and evaluation of projects and programs supported with MHSA funds; 2) review and/or approve local MHSA funding requests; and 3) ensure oversight and accountability of the public community mental health system.

In the role of reviewing and/or approving local MHSA funding requests, the MHSOAC is mandated to approve all funding for two of the MHSA's five components: Prevention and Early Intervention (PEI) programs and Innovation (INN) programs. The MHSOAC provides review and comment for the other three components: Community Services and Supports (CSS), Workforce Education and Training (WET) and Capital Facilities and Technological Needs (CFTN).

In addition to the Commission's three primary roles, the MHSOAC is charged with the following:

- Ensure that services provided, pursuant to the MHSA, are cost-effective and provided in accordance with recommended best practices subject to local and state oversight.
- Ensure that the perspective and participation of members and others suffering from severe mental illness and their family members are significant factors in all of its decisions and recommendations.
- Develop strategies to overcome stigma and discrimination, increase access to services for underserved populations and reduce the negative outcomes of untreated mental illness such as suicide, incarceration, homelessness, school failure, unemployment and prolonged suffering.

Background

MHSOAC Composition

The MHSOAC consists of sixteen members, twelve of whom are appointed by the Governor. The other four members are: 1) the Attorney General or designee; 2) the Superintendant of Public Instruction or designee; 3) the Chairperson of the Senate Health and Human Services Committee or another Senator selected by the President Pro Tempore; and 4) the Chairperson of the Assembly Health Committee or another Assembly member selected by the Speaker of the Assembly. The membership of this Commission contains diverse representation including that of law enforcement, educators, legislators, individuals with severe mental illness, and family members of individuals with severe mental illness, a mental health professional, a representative of a health care services plan, a physician, a representative of labor, and representatives of employers. This diversity allows for contributions of various ideas and perspectives and promotes better collaboration and accountability.

MHSOAC Collaboration with Partners and Stakeholders

State level responsibility for policy development, implementation, oversight and accountability are shared among three entities that have statutory responsibility set forth in the MHSA: the California Department of Mental Health (DMH), the California Mental Health Planning Council and the MHSOAC. In fulfilling its statutory responsibility, the MHSOAC works closely and collaboratively with the other statutory government entities as well as with stakeholders

including client and family members, representatives from unserved and underserved populations and the California Mental Health Directors Association (CMHDA). This collaboration is reflected in the MHSOAC's activities, accomplishments and initiatives, as stated in this report.

MHSOAC Priorities

During the first five years of its existence (2005-2010), the initial focus of the MHSOAC was on the responsible implementation of expanded services consistent with the values and intended outcomes included in the MHSA. During this time, critical initial state and local implementation steps were taken. The MHSOAC will now be broadening its focus from MHSA implementation to greater emphasis on program evaluation focusing on outcomes and the appropriate and effective use of MHSA funds.

In January 2010, the MHSOAC adopted the MHSOAC 2010 Work Plan with the following priorities:

- Fund and execute all MHSA components – this includes CSS, PEI, INN, WET and CFTN.
- Implement accountability framework – this includes both fiscal and evaluation activities to oversee the implementation of the MHSA.
- Address period of financial volatility – during fiscal year (FY) 2010-2014, MHSA revenues are projected to drop substantially, which will require careful planning to ensure sustainability and capacity of programs.
- Envision opportunities for restored financial growth – during FY 2014-2019, MHSA revenues are projected to rise again. In addition, the advent of the Federal Healthcare Reform, the Medicaid 1115 Waiver, and the federal Mental Health Parity law will also provide opportunities for growth.
- Five-Year Review of MHSOAC Processes – this includes reviewing the Commission's processes for stakeholder engagement and reviewing Commission procedures.

Oversight

Accountability

MHSOAC Accomplishments

Priority 1: Fund and Execute all MHSA Components

The MHSOAC's first priority is to ensure that all MHSA service components are fully funded and up and running. This is comprised of a variety of activities at both the local and state levels. Activities at the local level include counties submitting a county plan that has been vetted by local stakeholders and approved by the local mental health board. Activities at the State level include the review and approval of county plans through a collaborative plan review process. The MHSOAC approves the funding for PEI and INN plans and provides review and comment on CSS, WET and CFTN plans. DMH approves the funding for CSS, WET and CFTN plans and provides review and comment on PEI and INN plans.

The responsibility for ensuring that this priority is accomplished is shared by the MHSA's statutory partners, counties and stakeholders.

The table below identifies the funding approved to counties through county MHSA program plans as of June 30, 2010. This table also identifies the number of counties with approved MHSA plans within each of the five components. At this time, the CSS, WET, CFTN, and PEI components are launched and funded. INN was the last component to be launched and thus about half of counties have developed their INN plans. The MHSOAC anticipates that all counties will have approved INN plans during the 2011 calendar year.

MHSA Approved County Plans and Funding

Total County Plans and Funding Approvals are as of June 30, 2010[1]
(Amounts in the Millions)

MHSA Component	Counties with Approved Plans	Total Funding [2]
Community Services and Supports	59	$3,216.8 [3]
Prevention and Early Intervention	57	$631.2[4]
Innovation	16	$70.2[5]
Workforce Education and Training (includes state investments)	45	$163.8
Capital Facilities and Technological Needs	32	$193.9

[1] All totals are cumulative from beginning of implementation through June 30, 2010.
[2] DMH Summary Comparison Document, dated June 21, 2010, retrieved from the DMH website on July 1, 2010 at http://www.dmh.ca.gov/Prop_63/MHSA/MHSA_Fiscal_References.asp.
[3] Amount includes $392.6 million approved for the MHSA Housing Program. As of 6/30/2010, 86 housing applications have been submitted which will fund approximately 4660 units of affordable housing. Of these units, 1,344 are designated as MHSA units.
[4] Amount includes the approved funding for PEI Statewide Programs and Training and Technical Assistance (TA). As of November 2010, the Commission has approved 58 PEI plans and approximately $734.9 million for distribution.
[5] As of November 2010, the Commission has approved 26 INN plans and approximately $175.5 million for distribution.

Prevention and Early Intervention (PEI)

California has made an historic commitment to prevention and early intervention through the MHSA. PEI programs are intended to "prevent mental illnesses from becoming severe and disabling" and reduce the serious consequences that can result from untreated mental illness, including suicide, incarceration, school failure or drop out, unemployment, prolonged suffering, homelessness, and removal of children from their homes.[6] PEI strategies reach out to people who are in a position to recognize early signs of mental illness, offer programs in convenient and comfortable community locations, improve timely access for people currently unserved or underserved by the mental health system, and create partnerships with schools, justice systems, community groups, and a wide range of social services. PEI includes assessment and screening for early signs of psychosis, suicide prevention and efforts to reduce stigma and discrimination. PEI programs help identify individuals with severe mental illness or emotional disturbance and link them to treatment. While the majority of funds have been allocated to young adults under 25 years old, in recognition of the fact that half of all mental disorders start by age 14 and three-fourths start by age 24, PEI programs serve Californians of all ages. MHSA funding for PEI programs is subject to a three year reversion time, in which the funding allocated for each fiscal year must be requested and expended within three years. After three years the unexpended funds revert back to the Mental Health Services Fund (MHSF) for redistribution to all counties.

PEI Statewide Programs

The MHSOAC has primary responsibility for PEI Statewide Programs and has approved a total of $244 million of PEI funding for the five programs. This funding will fund each statewide program for four consecutive years.

- Training, Technical Assistance and Capacity Building (TTACB): $24 Million
- Suicide Prevention: $60 Million
- Student Mental Health Initiative (SMHI): $60 Million
- Stigma and Discrimination Reduction: $40 Million
- Reducing Disparities: $60 Million

The MHSOAC developed the criteria for the Training, Technical Assistance and Capacity Building Project in 2008. The primary goal of this project is to improve the capacity of local partners outside the mental health system (i.e., education, primary health care, law enforcement, older adult services, etc.) as well as county staff and partners who work on the development, implementation and evaluation of prevention and early intervention programs that will be funded through the PEI component of the county's plan.

The MHSOAC developed guidelines for three PEI Statewide Programs: Suicide Prevention, the SMHI and Stigma and Discrimination Reduction. PEI Statewide Programs are intended to build infrastructure and community capacity for sustainable statewide systems in these three areas. The PEI Suicide Prevention and Stigma and Discrimination Reduction Statewide Programs are expected to implement strategies in strategic plans, developed in June 2008 and June 2009. These strategic plans were the result of significant stakeholder processes that occurred over two years. SMHI programs are expected to implement the strategies within a SMHI policy paper developed in 2007. Counties may use PEI statewide funds to form multi-county collaboratives or assign funds to DMH or a joint powers authority such as California Mental Health Services Authority (CalMHSA) for implementation of PEI Statewide Programs that are consistent with the MHSOAC guidelines. The MHSOAC expects initial statewide program implementation in FY 2010/11.

DMH is overseeing the development of the Strategic Plan for the Reducing Disparities Statewide Project. It is anticipated that the Strategic Plan will be completed by June 30, 2012. Once completed the MHSOAC will approve the plan expenditure of $60 million and work with DMH, counties and other partners to identify the funding mechanism for the

[6] MHSA, Section 4, Welfare Institutions Code Sec 5840(d)

$60 million. The Commission will begin developing guidelines for the Reducing Disparities Statewide project during FY 2011/12.

Innovation (INN)

The INN component is the smallest MHSA component, deriving its funding from 5 percent of CSS and 5 percent of PEI funds. INN programs are intended to increase access, improve the quality and outcome of services, and promote interagency collaboration. Guidelines for this component require counties to design and test innovative approaches, including new or adapted programs and strategies with the potential to improve mental health delivery. Current INN programs include strategies to engage and support recovery for people who are homeless and mentally ill, expanded roles for mental health consumers and their family members, behavioral/physical healthcare integration, treatment and supports designed and delivered by and for diverse communities and integrated services and treatment for people with co-occurring mental health and substance use disorders. Consistent with PEI, INN funding is subject to a three year reversion time.

Community Services and Supports (CSS)

CSS refers to MHSA-funded services under the Adult and Older Adult Mental Health System of Care Act and the Children's Mental Health Services Act as required by the MHSA in Welfare and Institutions Code (WIC) Sections 5813.5 and 5878.1 et seq. CSS funds treatment and support for individuals with serious mental illness or children and youth with serious emotional disturbance and their families. MHSA provides CSS funding for the following types of programs:

- Full-Service Partnership (FSP) Programs – a broad spectrum of services and supports intended to do "whatever it takes" to help clients with serious mental illness meet their individual recovery goals. FSP Programs serve clients of all ages who have the greatest unmet needs, particularly individuals and families who are homeless or at risk of homelessness, children placed outside their homes, individuals involved with law enforcement, and people with multiple contacts with inpatient or emergency medical services.
- General System Development – improvements to services and infrastructure for FSP Program clients and other clients, and their families.
- Outreach and Engagement – activities to identify and reach unserved and underserved individuals to encourage them to participate in mental health programs, and reduce disparities in access to mental health services and supports.
- Housing – funding for capital costs and operating subsidies to develop permanent supportive housing for people of all ages with serious mental illness or emotional disturbance who are homeless, or at risk of homelessness. CSS Housing is a partnership between DMH, the California Housing Finance Authority (CalHFA) and county mental health departments.

MHSA funding for CSS programs is also subject to a three year reversion time, similar to both PEI and INN.

Workforce Education and Training (WET)

WET helps to remedy the shortage of qualified individuals to provide mental health services. California vacancy rates for core mental health occupations (psychiatrists, psychologists, licensed clinical social workers, registered nurses, and psychiatric technicians) are approximately 20–25 percent statewide[7], with much higher vacancy rates in rural parts of the State. WET also is intended to increase diversity and language capacity of the mental health workforce. Counties have up to ten years to spend WET funds before they revert to the Mental Health Services Fund (MHSF) for redistribution to all counties.

WET funding is available for individual counties for the purposes of workforce staffing support, training and technical assistance, mental health career pathways programs, residency and

[7] Workforce Education and Training Fact Sheet, retrieved on October 12, 2010 from the California Institute of Mental Health (CiMH) website at http://www.cimh.org/Services/MHSA/Workforce-Education-Training.aspx

internship programs and financial incentive programs. DMH also designated WET funds for statewide programs including loan assumption and stipends, expanded capacity of psychiatrist and physician assistant training programs, promotion of meaningful inclusion of clients and family members in the mental health workforce and technical assistance to counties, regional partnerships and a statewide technical Assistance Center.

Capital Facilities and Technological Needs (CFTN)

CFTN funding supports the technological needs and capital facilities that are necessary to provide services. Examples of capital facilities projects include acquiring, constructing, and renovating county-owned buildings. Examples of technological needs projects include modernizing and transforming clinical and information systems to ensure quality of care, parity, operational efficiency and cost-effectiveness. As in the case with WET, counties have up to ten years to spend CFTN funds before they revert to the MHSF for redistribution to all counties.

Priority 2: Implement Accountability Framework

The MHSOAC's second priority is to implement an accountability framework. This framework will apprise the Commission of the fiscal landscape for the MHSA and all public community mental health, which will help to evaluate the implementation of the MHSA. Both fiscal monitoring and evaluation efforts are critical for the MHSOAC to effectively oversee the implementation of the MHSA and its ongoing role within the public mental health system.

MHSOAC Financial Report

In April 2009, the Commission adopted a financial framework to guide the development of regular financial reports and identify key financial information relating to both the MHSA and public community mental health funding. This framework addresses the full cycle of public community mental health funding, which is comprised of revenue sources (money going in), the distribution of funding to counties (money going out) and MHSA expenditures (money utilized). The framework also identifies the timeframes in which information will be reported based on availability of financial updates throughout the year. This framework was used to guide the development of the MHSOAC's first financial report.

In January 2010, the MHSOAC published its first financial report containing the following information:

- MHSA revenues received on a cash basis through FY 2011/12 (actual, estimated and projected)
- Totals for the primary five public community mental health funding sources including State General Fund (SGF), Realignment, Federal Financial Participation (FFP), MHSA and other revenues (actual, estimated and projected)
- Totals for the primary five public community mental health funding sources adjusted for constant dollars and changes in population
- MHSA funding that has been committed, distributed, reverted and not yet requested
- MHSA State Administration funds

In May 2010, the Commission updated the January financial report, which incorporated updated MHSA revenue projections consistent with the Governor's FY 2010/11 May Revision as well as updates on MHSA funds committed and distributed to Counties. This report also displayed the progress being made in the implementation of the CSS Housing program through both approved housing projects and funding leveraged by MHSA housing funds.

See **Appendix A and B** for the January and May 2010 Financial Reports.

Evaluation

The MHSOAC has a statutory mandate to evaluate how funding for mental health has been used, what outcomes those investments have had and how to improve to maximize positive outcomes. The MHSOAC is committed to an approach of continuous evaluation, learning from and building upon each progressive evaluation that has been completed. In collaboration with its mental health system partners and stakeholders through its Evaluation

Committee, the MHSOAC has completed the following:

- **Phase 1** – the scope of an initial evaluation of the MHSA was completed on July 30, 2010. This phase included:
  - developing a concept paper
  - obtaining and compiling broad input on evaluation priorities and existing efforts
  - reviewing what data currently exist; and
  - recommending a design for the next evaluation to be completed with available resources.
- **Phase 2** – a Request for Proposal (RFP) was released on October 1, 2010, and was awarded in December 2010. This phase includes:
  - Document activities and costs for all MHSA Components.
  - Measure impact at client and system levels on priority indicators such as homelessness, employment, education and involvement in the justice system and provide periodic county-specific and statewide reports.
  - Summarize and synthesize existing evaluations and studies on impact of MHSA.
  - Provide final report and recommendations.
- **Phase 3** –During the May 2010 budget hearings, the Legislature approved one-time funding of an additional $1 million from FY 2010-2011 for continued evaluation efforts. This one-time funding was approved in the enacted FY 2010/11 budget. The MHSOAC released a RFP in December 2010 for this funding. This phase includes the following deliverables:
  - Determine per-person costs and provide a financial analysis of the achieved outcomes/benefits of full service partnerships.
  - Using participatory research, determine the impact of selected services/strategies on outcomes specified in the MHSA or system-of-care statutes.
  - Obtain recommendations for future evaluation activities/strategies.
- MHSOAC has collaborated with the California Mental Health Planning Council to prioritize a comprehensive set of performance indicators for the MHSA, with data from existing systems that include specific indicators and performance outcomes that are consistent with the MHSA.
- PEI Trends Report[8] – The PEI Trends Report was completed in early 2010. It reviews the extent to which California's first MHSA PEI component plans address the challenges of reducing the following seven negative outcomes, specified in the MHSA that may result from untreated mental illness: suicide, incarceration, school failure or drop out, unemployment, prolonged suffering, homelessness, and removal of children from their homes.[9] In addition, the report also addresses other priorities, such as reducing negative impact of trauma and co-occurring mental health and substance use disorders.
- UC Berkeley – The DMH contracted with the Nicholas C. Petris Center, UC Berkeley, to evaluate FSP Programs MHSA programs for adults.[10] This report provided outcome data that showed the FSP Programs have had significant success. The MHSOAC anticipates building from this data for future evaluation efforts.
- UC Davis, Center for Reducing Health Disparities – The MHSOAC has a contract with the Center for Reducing Health Disparities to provide the following deliverables by December 31, 2010:
  1. For three counties' pilot projects:

[8] The published PEI Trends Report can be found at http://www.dmh.ca.gov/MHSOAC/docs/Meetings/2010/May/Tab2_PEI_Trends_report.pdf

[9] MHSA, Section 4, WIC Sec 5840(d)

[10] Nicholas C. Petris Center. (2010) Evidence on the Effectiveness of Full Service Partnership Programs in California's Public Mental Health System. Retrieved from http://www.dmh.ca.gov/Prop_63/MHSA/Publications/docs/PetrisCenter_ExecSummaryReport_Final.pdf

a) Provide analysis of disparities in service access and delivery and explore merging databases to examine relationship between health and mental health.

b) Show local service use and areas underserved.

c) Examine disparities in type and frequency by race/ethnicity, gender and age.

d) In collaboration with counties, develop plans for tracking quality and cost-effectiveness of care.

e) In collaboration with counties, design knowledge transfer and build capacity.

2. Provide detailed analysis of mental health component of the California Health Interview Survey 2007 data to assess need and design follow-up survey.

Priority 3: Address Period of Financial Volatility 2010 through 2014

The MHSOAC's third priority, addressing the period of financial volatility from 2010 through 2014, requires the Commission to be fully informed on financial projections and activities that will impact the MHSA as well as all public community mental health funding. This includes monitoring the declining MHSA revenues and understanding how this decline will impact community mental health; and ensuring the appropriate policies are in place to support counties as they identify fiscal strategies during this period of time. In order to ensure appropriate policies are in place, the MHSOAC has worked with DMH, California Mental Health Directors Association (CMHDA), CMHPC and other key stakeholder groups to assess overall financial declines, identify potential policy issues, analyze the implications of the issues and develop formal recommendations on solutions.

Monitoring Declining Revenues

The MHSOAC's January and May 2010 Financial Reports display a decline in MHSA revenues beginning in FY 2010/11. This is consistent with information provided in the FY 2010/11 Governor's Budget and the Governor's May Revise as well as personal income tax estimates from the Legislative Analyst's Office (LAO). This decline in MHSA revenues will impact the funding available to counties through component allocations for CSS, PEI and INN. The DMH, in consultation with the MHSOAC, CMHPC and CMHDA, has identified that there will be a decrease of $93.4 million in component allocations for FY 2011/12 due to revenue declines.

Prudent Reserve

The MHSA directs the establishment of a local prudent reserve in order to ensure that CSS programs can continue during years in which revenues are below recent averages. In February 2009, the MHSA was amended by Chapter 20, Statutes of 2009 Third Extraordinary Session (AB 5XXX). This legislation clarified and furthered the intent of the MHSA by adding new language that includes PEI services as services which could be maintained through the prudent reserve funds.

FY 2011/12 MHSA Component Allocations

The MHSA directs the DMH, in consultation with the MHSOAC, CMHPC and CMHDA, to inform counties of the amounts of funding that will be made available through component allocations. After consultation, these component allocations were adopted by the Commission in August 2010.

Priority 4: Envision Opportunities for Restored Financial Growth 2014 through 2019

The MHSOAC's fourth priority addresses significant coordination efforts in California, which will be needed due to the passage of the federal health care reform, federal Mental Health Parity law, and the approval of the Medicaid 1115 Waiver.

In April 2010, the MHSOAC began to examine the implications for behavioral health and the California public mental health system with the passage of these new mandates. MHSOAC believes that these extensive new mandates will require significant coordination efforts in California to ensure that individuals with mental illness and their families are provided all benefits

to which they are entitled in the most efficient and effective manner.

Federal Health Care Reform

On March 23, 2010, President Obama signed comprehensive health care reform, the Patient Protection and Affordable Care Act, into law. This reform focuses on provisions to expand coverage, control health care costs, and improve the health care delivery system. The new law will do four primary things: 1) Integrate the concept of shared responsibility into the United States health care system, 2) Implement significant health insurance market reforms, 3) Enact changes in the Medicare program, and 4) Enact other changes that support the health care safety net, and promote prevention and wellness.

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

On January 29, 2010, the Department of Health and Human Services (DHHS), Education, and Labor released an interim final rule (IFR) providing guidance on how the Mental Health Parity and Addiction Equity Act (MHPAEA) must be implemented. The MHPAEA of 2008 requires health insurers to offer mental health benefits equal in cost and scope to medical and surgical benefits. It will prevent insurers from requiring larger copayments or imposing lower reimbursement ceilings for mental health and addiction conditions.

Medicaid 1115 Waiver

The Department of Health Care Services submitted its waiver request to the federal government that restructures the organization and delivery of health care for populations that include the most medically vulnerable: high-cost Medicaid beneficiaries with complex chronic conditions, co-morbidities, and the highest needs for ongoing health care. Adults with serious mental illness have been identified as a target population for the new waiver. The U.S. DHHS approved the California Section 1115 Comprehensive Demonstration Project Waiver Proposal on November 2, 2010.

Priority 5: Five-Year Review of MHSOAC Processes

Stakeholder Engagement

The MHSOAC's fifth priority is to solicit stakeholder input. The MHSOAC has had considerable success meeting the requirement of the MHSA for stakeholder engagement. The MHSA provides in Section 10, WIC Section 5846(e):

> The commission shall ensure that the perspective and participation of members and others suffering from severe mental illness and their family members is a significant factor in all of its decisions and recommendations.

The MHSOAC accomplished the following activities to ensure meaningful stakeholder involvement:

- Convened a Stakeholder Forum in January 2010 to determine how to solicit meaningful input from individuals and stakeholder groups and how to more effectively and efficiently collaborate.
- Contracted with three statewide entities to ensure participation in MHSOAC processes. These groups are the California Network of Mental Health Clients (CNMHC), the National Alliance on Mental Illness—California (NAMI-CA), and the United Advocates for Children and Families (UACF).
- Established five standing committees entirely comprised of stakeholders with two commissioners serving as Chair and Vice-Chair for each committee. These committees are made up of clients, family members, providers, professionals, government representatives and advocates.
- Created the MHSOAC website and Listserv to notify the public of Commission activities, including upcoming meetings.
- Ensured that all meetings of the Commission and Committees are open and accessible to the public, including providing teleconference access, disability accommodations and translation services upon request.

- Ensured that public comment is included on all action items on agendas in accordance with the Bagley-Keene Open Meeting Act.
- Changed the Commission's meeting agenda to include a stakeholder orientation at the beginning of each meeting and two general public comment opportunities during each meeting. The public comment cards are also offered in twelve different languages.
- Convened three public community forums held in Humboldt, Salinas, and Long Beach. A report on the outcome of these forums will be released in early 2011.

Commission Processes and Procedures

The MHSOAC has developed several internal processes and procedures to help the organization accomplish its mandates, including establishing Rules of Procedure and annual officer elections. In addition, the Commission has established five standing committees which vet issues relevant to the Commission and provide recommendations to the Commission for adoption.

The five MHSOAC standing committees are:

1. **Client and Family Leadership Committee (CFLC)** – ensures the perspective and participation of clients and family members are significant factors in all of the Commission's decisions and recommendations.
2. **Cultural and Linguistic Competence Committee (CLCC)** – ensures the perspective and participation of individuals and families who are members of unserved and underserved ethnic and cultural communities are significant factors in all of the Commission's decisions and recommendations.
3. **Mental Health Funding and Policy Committee** – ensures that all MHSA funds are expended in the most cost-effective manner and subject to local and state oversight to ensure accountability to taxpayers and to the public.
4. **Evaluation Committee** – ensures that the ongoing MHSA evaluations accurately depict the extent to which the objectives of the MHSA have been accomplished and to assure California taxpayers that their investment of mental health funds is producing efficient outcomes.
5. **MHSOAC Services Committee** – makes recommendations regarding MHSA implementation and sustainability of programs and services and ensures that all MHSA services are provided in accordance with recommended best practices.

In addition to the current five committees, the Commission also established a short-term Co-Occurring Disorders (COD) workgroup charged with developing comprehensive recommendations to address the needs of individuals with co-occurring mental illness and substance abuse. The workgroup convened multiple meetings, hearing briefings by state leaders and experts on the status of the treatment of co-occurring disorders in California. In November 2008 the Commission adopted the COD Report that summarized recommendations to improve the capacity of state and county policy makers and program administrators to address the needs of individuals with co-occurring disorders under the MHSA. The MHSOAC is continuing to implement many of the recommendations contained in the report. See **Appendix C** for the Report on Co-Occurring Disorders.

MHSOAC Next Steps

Broaden Evaluation Activities

Through its statewide evaluation efforts, the MHSOAC strives to assure to California taxpayers that the use of state public funds for mental health services will result in efficient investments at local and state levels, as well as demonstrate effective outcomes and impacts. The MHSOAC will evaluate how funding for mental health has been used, identify outcomes of those investments, and eventually recommend how to improve to maximize positive outcomes.

The MHSOAC is committed to continuous evaluation that learns from and builds on completed evaluations to promote quality improvement. In leading evaluation efforts, the MHSOAC will design studies that are based on achieving the outcomes specified in the MHSA.

The MHSOAC works with DMH, which collects and analyzes data, the CMHPC which approves outcomes, and counties, which collect the data and perform local evaluations. As in all aspects of the implementation of the MHSA, the MHSOAC values effective input from individuals with lived experience of serious mental illness and their families and other stakeholders in ensuring oversight and accountability.

PEI and INN Evaluations

The first three phases in the current evaluation efforts have focused primarily on the services offered through the CSS component. The next phase of MHSOAC evaluation activities will build upon the information collected during the initial evaluations and continue evaluating services offered through CSS as well as services offered through the PEI and INN components. The MHSOAC will begin developing a scope of work for a PEI evaluation during FY 2010/11 and anticipates awarding a contract for a PEI evaluator in FY 2011/12.

In addition the MHSOAC believes the following are important next steps to begin measuring PEI and INN:

- Develop PEI performance indicators – The California Mental Health Planning Council developed state and county-level priority indicators for CSS. A high priority for the MHSOAC is to ensure that comparable priority indicators are developed for PEI.
- PEI Trends Report – In December 2009, the MHSOAC published a PEI Trends Report that assessed areas of emphasis and other trends in 223 PEI programs from 32 counties. The MHSOAC plans to build on this work by assessing trends in PEI programs implemented throughout California.
- PEI Annual Update Data – Counties currently report data about their PEI programs through annual updates. The MHSOAC will ensure that the data that counties report are useful and feed into PEI evaluation efforts as well as quality improvement.
- INN Learning Chart – An assessment conducted on the approved 74 INN programs identified the development of new mental health practices in the following program areas: peer services (including crisis response), transitional-age youth (TAY), integrated behavioral services, diverse community partnerships, justice/law enforcement, community funding, WET, collaboration, co-occurring disorders, employment, evaluation, treatment models, faith communities, LGBTQ, parenting, trauma, wellness/holistic and mobile services. See **Appendix D** for the INN Learning Chart.
- INN Trends Report – The MHSOAC expects to prepare a report on trends in Innovation programs to highlight the areas in which new mental health models are being designed and tested with the hope that they will be incorporated into service delivery and replicated.

Integrated Plan (2011-2014)

In addition to ongoing evaluation activities, the MHSOAC anticipates working with DMH, CMHDA, CMHPC and stakeholders to prepare for an Integrated Plan which the MHSA requires be developed. The MHSA states that DMH shall not issue guidelines for an Integrated Plan before January 1, 2012.

Mental Health stakeholders have a variety of expectations for an Integrated Plan, ranging from integration of the component parts of the MHSA (CSS, PEI, etc.) to integration of the mental health system as a whole, based on MHSA values.

There are many questions that will need to be answered in the development of an Integrated Plan. These include:

- What are the goals of an Integrated Plan?
- What are the strategies to achieve those goals?
- Should the State continue to provide expectations for local planning processes?
- What will be the program policies of an Integrated Plan?
- What are the accountability consequences if standards are not met?

Deliberate and Recommend Policies on Fiscal Issues

The MHSOAC must continue to monitor the fiscal environment including both the volatility of the MHSF and other sources of funding for community mental health programs as both play a role in the successful implementation of the MHSA and integration into the public mental health system. This information is essential to understand how policy changes will impact counties and if desired outcomes will be obtained. The MHSOAC will continue to work with its partners to develop recommendations on fiscal issues related to the MHSA.

Determine Implications of Federal Healthcare Reform, Medicaid 1115 Waiver, Mental Health Parity

Another task before the MHSOAC is understanding the implications for behavioral health and the California public mental health system of Federal Healthcare Reform, the Medicaid 1115 Waiver and Mental Health Parity.

The MHSOAC will need to keep apprised of all implementation efforts in order to ensure that individuals with mental illness who are served by California's public mental health system benefit from these changes. These major initiatives have the potential to increase access to mental health care. The Medicaid 1115 Waiver is designed to provide integrated care for individuals with co-occurring conditions – a major issue in the public mental health system because individuals with mental illness have significant health conditions which are often untreated or undertreated.

Federal Healthcare Reform will make changes to the health care safety net that will benefit individuals with mental illness. The Mental Health Parity Act will provide for mental health coverage in health insurance. Conversely, however, these initiatives could also substantially reduce the role of public mental health as mental health care is integrated into primary health care, which could negatively impact individuals with mental illness and the public mental health system. The MHSOAC will evaluate the extent to which this may occur and make recommendations accordingly.

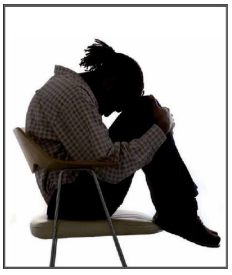
Continue Stakeholder Engagement

The MHSOAC Work Plan states that the Commission is committed to ongoing, effective stakeholder participation and input. The MHSOAC will continue to engage and involve all stakeholders in its deliberations, as mandated in WIC Section 5846(e).

Conclusion

Chapter 20, Statutes of 2009 of the Third Extraordinary Session (AB 5XXX) established the MHSOAC as separate and apart from the DMH. The Legislature clearly intended that the MHSOAC operate as an independent entity in order to ensure independent oversight and accountability by strengthening the MHSOAC's role in carrying out its responsibilities. The MHSOAC will continue to carry out its mandate with respect to oversight and accountability of the MHSA and the public mental health system. The Commission is committed to ensuring that Californians are receiving what they voted for and will continue as stewards of the MHSA throughout its implementation and into the future.

More than 2 million children, adults, and seniors are affected by potentially disabling mental illnesses every year in California.



MHSA Benefits All Californians