

Mental Health Services Act Expenditure Report

Fiscal Year 2013-14



**EDMUND G. BROWN JR.
GOVERNOR
State of California**

**Diana S. Dooley
Secretary
California Health and Human Services Agency**

**Toby Douglas
Director
Department of Health Care Services**

January 2013

Mental Health Services Act Expenditure Report

Fiscal Year 2013-14

Table of Contents

Executive Summary	Page 1
Background	Page 2
Explanation of Estimated Revenues	Page 4
Overall Revenues	Page 5
Expenditures for MHSA Components	Page 6
MHSA Program Activities	Page 7
Community Services and Support	Page 7
MHSA Housing Program	Page 7
Capital Facilities and Technological Needs	Page 8
Workforce Education and Training	Page 8
Prevention and Early Intervention	Page 10
Innovation	Page 13
State Administrative Expenditures	Page 14
Judicial Branch	Page 14
State Controller's Office	Page 14
Office of Statewide Health Planning and Development	Page 15
Department of Health Care Services	Page 15
Department of Public Health	Page 16
Department of Developmental Services	Page 16
Mental Health Services Oversight and Accountability Commission ...	Page 16
California Department of Education	Page 17
Board of Governors of the California Community Colleges	Page 18
Financial Information System of California	Page 18
Military Department	Page 18
Department of Veterans Affairs	Page 18
Statewide General Administrative Expenditures (Pro Rata)	Page 19
MHSA Expenditures	Page 20

EXECUTIVE SUMMARY

The enactment of the Mental Health Services Act (MHSA) in November 2004 increased funding, personnel and other resources to support county mental health programs serving children, transition age youth, adults, older adults and families with mental health needs.

The 2012-13 Budget Act transferred the community mental health functions of the former Department of Mental Health (DMH) to other state departments, including the Department of Health Care Services (DHCS), Department of Social Services (DSS), Department of Public Health (DPH), Office of Statewide Health Planning and Development (OSHPD), and Department of Education (CDE). These changes require the entities charged with oversight of the fiscal and programmatic aspects of the MHSA to work closely with the State Controller's Office (SCO) as well as Department of Finance (DOF) in order to estimate and make projections of MHSA funds.

The total MHSA revenue for FY 2011-12 was approximately \$2.599 billion (\$1.191 billion generated in FY 2011-12). The 2013-14 Governor's Budget anticipates the total MHSA revenue for FY 2012-13 at \$2.108 billion (\$1.352 billion projected in the FY), and \$1.886 billion in FY 2013-14 (\$1.196 billion projected in the FY).

Approximately \$1.842 billion has been expended through FY 2011-12. Additionally, \$1.418 billion is estimated to be expended in FY 2012-13 and \$1.403 billion in FY 2013-14.

BACKGROUND

Pursuant to Welfare and Institutions Code (WIC) Section 5813.6(a) the Department of Health Care Services is required to submit annually two fiscal reports to the Legislature regarding the MHSA: one in January in conjunction with the proposed Governor's Budget; the other in May in conjunction with the May Revision of the Governor's Budget. This report contains information regarding the projected expenditures of MHSA funding for each state department and for each major program category specified in the MHSA for local assistance and support.

This report includes actual expenditures for FY 2011-12, estimated expenditures for FY 2012-13, and projected expenditures for FY 2013-14.

The MHSA addresses a broad continuum of prevention, early intervention and service needs while providing funding for infrastructure, technology and training elements that will effectively support the county mental health system. In addition to local planning, the MHSA specifies five components of the MHSA and the percentage of funds to be allocated to each of these components.

An overview of the five components is listed below:

Community Services and Supports (CSS) — This component refers to “System of Care Services” as required by the MHSA in WIC Sections 5813.5 and 5878.1-3. The MHSA requires that “each county mental health program shall prepare and submit a three-year plan which shall be updated at least annually.” Annual updates of this plan will be required pursuant to MHSA requirements.

CSS funds are used to implement the adult and older adult system of care model and the children's system of care model as well as the wraparound model. CSS funds may be used for Full Service Partnerships, General System Development, or Outreach and Engagement.

Full Service Partnerships are funds used to provide “whatever it takes”. Funding for the services and supports for Full Service Partnerships may include flexible funding to meet the goals of the individual services and supports plans. Under Full Service Partnerships the county works with the individual and his/her family to provide all necessary and desired appropriate services and supports to assist in achieving the goals identified in their plan. Individuals will have an individualized service plan that is person/child-centered. All fully served individuals will have a single point of responsibility or Personal Service Coordinator. Services also include linkage to all needed services or benefits.

General System Development funds are funds used to improve programs, services and supports for the identified full service populations and to change the service delivery systems and build transformational programs and services. Examples of this kind of funding are client and family services such as peer support, education and advocacy services, mobile crisis teams, funds to promote interagency and community collaboration and services, and funds to develop the capacity to provide values-driven, evidence-based and promising clinical practices.

Outreach and Engagement funds are used to provide outreach and engagement services and activities to persons who are unserved or underserved.

Capital Facilities and Technological Needs (CFTN) —This component addresses the capital infrastructure needed to support implementation of the CSS and Prevention and Early Intervention (PEI) programs. It includes funding to improve or replace existing technology systems and for capital projects to meet program infrastructure needs.

Workforce Education and Training (WET) —This component targets workforce development programs to remedy the shortage of qualified individuals to provide services to address severe mental illnesses. It accomplishes this through stipend, loan assumption and training programs, as well as through direct workforce education and training services provided at the county level.

Prevention and Early Intervention (PEI) —This component supports the design of programs to prevent mental illnesses from becoming severe and disabling, with an emphasis on improving timely access to services for unserved and underserved populations.

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

In addition to funding the components listed above, MHSA allows up to 3.5 percent of the total annual revenues received in the Mental Health Services Fund (MHSF) to support state administrative costs. Refer to the section, State Administrative Expenditures, beginning on page 14 for detail on the agencies receiving a portion of the 3.5 percent administrative funding.

EXPLANATION OF ESTIMATED REVENUES

By imposing a one percent income tax on personal income in excess of \$1 million, the MHSA has generated approximately \$1.191 billion in FY 2011-12. This amount includes both income tax payments and interest income earned on the MHSF balance.

The amounts actually collected differ slightly from estimated MHSA revenues displayed in the Governor’s Budget. This is because the Governor’s Budget, prepared using generally accepted accounting principles, must show revenue as earned, and therefore, shows accruals for revenue not yet received by the close of the fiscal year. Table 1 displays estimated revenues for the 2013-14 Governor’s Budget.

As shown in Table 1, “Cash Transfers” amounts represent the net personal income tax receipts transferred into the MHSF in accordance with Revenue and Taxation Code Section 19602.5(b). Similarly, “interest income” is the interest earned.

“Annual Adjustment Amount”: An accrual adjustment. Due to the amount of time necessary to allow for the reconciliation of final tax receipts owed to or from the MHSF and the previous cash transfers, the Annual Adjustment shown in the Governor’s Budget will not actually be deposited into MHSF until two fiscal years after the revenue is earned.

**Table 1: Mental Health Services Act Estimated Receipts
(Dollars in Millions)**

	Fiscal Year		
	2011-12	2012-13	2013-14
Governor’s FY 2013-14 Budget ¹			
Cash Transfers	\$910.0	\$1,133.0	\$1,108.0
Interest Income Earned During Fiscal Year	2.7	2.6	1.9
Annual Adjustment Amount	278.0	216.0	86.0
Estimated Revenues	\$1,190.7	\$1,351.6	\$1,195.9

¹Source: Cash Transfers and Annual Adjustment Amount (DOF Financial Research Unit), Interest Income Earned (Schedule 10R).

OVERALL REVENUES

Table 2 below displays actual, estimated and projected receipts deposited into the MHSF. Actual receipts are shown for FY 2011-12, while estimated receipts are shown for FY 2012-13 and projected receipts for FY 2013-14.

Note: For FY 2011-12, the Legislature approved the Governor’s Budget proposal to achieve an \$861.2 million General Fund savings in FY 2011-12 based on amending the MHSA to allow the one-time use of MHSF for the Early and Periodic Screening, Diagnosis and Treatment program (EPSDT, \$579.0 million), Mental Health Managed Care (MHMC, \$183.6 million) and AB 3632, Special Education Pupils (\$98.6 million).

Table 2: Mental Health Services Act (MHSA) Revenues
Estimated By Component
(Dollars in Millions)

	Fiscal Year		
	Actual Receipts ²	Estimated Receipts	Projected Receipts
	2011-12	2012-13	2013-14
Community Services and Supports (Excluding Innovation)	\$873.2	\$991.2	\$877.0
Prevention and Early Intervention (Excluding Innovation)	218.3	247.9	219.3
Innovation	57.5	65.2	57.7
State Administration	41.7	47.3	41.9
Total Estimated Revenue Receipts³	\$1,190.7	\$1,351.6	\$1,195.9

² Actual receipts displayed are based upon the percentages specified in the MHSA for the components identified. Actual expenditures by component may vary.

- 80% Community Services and Supports
- 20% Prevention and Early Intervention
- 5% Innovation
- 3.5% State Administration

³ Estimated available receipts do not include funds reverted under the WIC 5892(h) or administration funds not appropriated for use under WIC 5892(d).

EXPENDITURES FOR MHSA COMPONENTS

Expenditures from the MHSF are estimated to be \$1.418 billion in FY 2012-13 and \$1.403 billion in FY 2013-14. The MHSA specifies funding for the major components which form the basis of the county's MHSA program.

In March 2011, AB 100 amended the MHSA provisions in WIC Sections 5890 through 5893, addressing fiscal and administrative responsibilities. In part, AB 100 amended these provisions to:

- Redirect MHSA funds on a one-time basis to support three programs proposed for realignment: \$861.2 million for EPSDT, Mental Health Managed Care, AB 3632; and
- Authorize the SCO to distribute funds to the counties as specified.

This statutory change also aligns the administration of the MHSF to an accrual system used to develop the Governor's Budget beginning with FY 2011-12. AB 100 specifies that beginning no later than April 30, 2012, and on a monthly basis thereafter, the SCO is required to distribute the funds remaining in the FY 2011-12 MHSA Component allocations, consistent with specified provisions of the MHSA (WIC Sections 5847, 5891 and 5892(j)).

MHSA PROGRAM ACTIVITIES

Below is a description of the five MHSA components:

1. Community Services and Support (CSS)

This component refers to “System of Care Services” and differentiates the MHSA Community Services and Supports from existing and previously existing System of Care programs funded at the federal, state and local levels.

CSS funds are to be used for each service category (Full Service Partnerships, System Development, and Outreach and Engagement) and for each target age group (Children/Youth, Transition Aged Youth, Adult, Older Adult).

MHSA Housing Program

The MHSA Housing Program was created in August of 2007 and is a recognized service category under the CSS component (California Code of Regulations, Chapter 14, Title 9, Section 3615). A total of \$400 million of MHSA funds was set aside for initial funding of both capital funding and rental subsidy funding for the development of permanent supportive housing for individuals with serious mental illness and their families, who are homeless or at risk of homelessness. Counties may choose to assign additional CSS funds to the MHSA Housing Program.

Table 3 on the following page, provides data on the MHSA Housing Program as of September 30, 2012.

**Table 3: MHSA Housing Program
(As of September 30, 2012)**

MHSA Housing Program Funds Available	\$400,000,000
MHSA Housing Program Funds Assigned (San Francisco County assigned additional \$2.163 million) (Tri Cities assigned additional \$3.221 million)	\$404,137,919
Number of Counties that have submitted applications	37
Number of Counties that have assigned funds	52
Number of Counties Opting Out	8
Number of Counties who have not assigned funds	0
MHSA Applications Received	159
Shared Housing Projects	15
Rental Housing Projects	144

MHSA Loans Closed	94
Total Dollars	\$169,889,717
MHSA Units	1,416
Units Receiving Capitalized Operating Subsidy	1,012

MHSA Applications Approved and waiting to close	44
Total Dollars	\$77,220,542
MHSA Units	510
Units Receiving Capitalized Operating Subsidy	284

MHSA Applications in Process	21
Total Dollars	\$21,028,389
MHSA Units	234
Units Receiving Capitalized Operating Subsidy	49

2. Capital Facilities and Technological Needs (CFTN)

This component addresses the capital infrastructure needed to support implementation of the CSS and PEI programs. It includes funding to improve or replace existing technology systems and for capital projects to meet the needs of the community mental health system.

The MHSA required that a portion of the revenues collected from FY 2004-05 through FY 2007-08 be set aside for the CFTN component of the county plan. In subsequent fiscal years, counties may use a portion of funding from the CSS component to meet ongoing CFTN needs.

Funding for capital facilities is to be used to acquire, construct, and/or renovate facilities that provide services and/or treatment for those with severe mental illness, or that provide administrative support to MHSA funded programs. Funding for technological needs is used to fund county technology projects with the goal of improving access to and delivery of mental health services.

In March 2008, planning guidance was released for counties to access funds from the CFTN component. Because the MHSA limits the number of years MHSA funds are dedicated to this component, in the same year the guidance was released, a total amount of \$460.8 million was made available.

3. Workforce Education and Training (WET)

The Workforce Education and Training (WET) programs “remedy the shortage of qualified individuals to provide services to address severe mental illnesses” (Welfare and Institutions Code (WIC) Section 5820).

Pursuant to Welfare and Institutions Code Section 5820, the former Department of Mental Health (DMH) developed a Five-Year Workforce, Education and Training Development Plan (April 2008 through April 2013) which was reviewed and approved by the California Mental Health Planning Council (CMHPC) in April 2008. This plan guides WET statewide efforts and includes the establishment of stipend programs, expansion of postsecondary education by expanding psychiatric residency programs to meet needs of occupational shortages; expansion of loan forgiveness and scholarship programs; technical assistance to promote the employment of consumers and family members in the community public mental health system; and establishment of regional partnerships among mental health and educational systems.

Effective July 1, 2012, OSHPD assumed responsibility for all WET-funded programs previously administered by the former DMH. The WET State-level programs transferred included \$27,150 million in budget authority related to:

- **Contracts with Institutions to Provide Stipends to Students in Mental Health Programs.** In exchange for a stipend, students perform their supervised hours in the community public mental health system (PMHS) and work for 12 months in the PMHS. (\$10 million)
- **Contracts with Psychiatric Residency Programs.** These programs add psychiatric residency rotations and fund psychiatric residency staff to co-locate in PMHS offices and conduct their rotations in the community. (\$1.35 million)
- **Contract with Statewide Technical Assistance Center.** The Center provides leadership, training, and technical assistance regarding recruitment, hiring, retention and support of employees; evaluates replicable model programs; and will disseminate information on the effectiveness of various strategies to stakeholders across the state. (\$800,000)
- **Contracts with Regional Partnerships.** To expand outreach to multicultural communities, increase diversity, reduce stigma associated with mental illness and promote the use of web-based technologies and distance learning techniques, counties have been grouped into five regional partnerships. (\$9 million)
- **Actions to be Determined by the WET Five-Year Plan.** The current Five-Year WET Plan is from April 2008 to April 2013. Currently, OSHPD is in the process of engaging stakeholders to develop a new plan to guide the next five years of WET activities and expenditures. The next Five-Year Plan is due April 1, 2014. (\$6 million)

Contracts for the stipend programs, psychiatric residency programs, statewide technical assistance center and regional partnerships are multi-year, have varying end dates and are funded through an annual appropriation.

One position transferred from the former DMH to OSHPD to support the WET programs transferred to OSHPD. In FY 2012-13, the cost of the 1.0 position is \$103,000; in FY 2013-14 the cost is projected to be \$108,000.

4. Prevention and Early Intervention (PEI)

This component supports the design of programs to prevent mental illnesses from becoming severe and disabling, with an emphasis on improving timely access to services for unserved and underserved populations.

The planning guidance for the PEI component was released in September 2007. As of March 2011, the MHSOAC, under its statutory authority for the PEI component, approved 58 county MHSAs. However, AB 100 removed the MHSOAC's statutory authority to review and approve PEI plans. Through June 2012, approximately \$1.26 billion will have been distributed since inception of the MHSAs.

The Administration's Participation in PEI State Level Efforts

There are four PEI Statewide Projects: Suicide Prevention, Stigma and Discrimination Reduction, Student Mental Health Initiative, and the California Reducing Disparities Project. This section summarizes the participation by the Administration (DHCS, Department of Public Health, and previously, the former DMH) to date in these projects.

Suicide Prevention

In 2007, the former DMH was directed, through a veto message to Senate Bill 1356 (Lowenthal), to convene a Suicide Prevention Plan Advisory Committee to advise the former DMH on the development of the *California Strategic Plan on Suicide Prevention: Every Californian is Part of the Solution*. The Plan was completed in 2008 and has been widely disseminated. The former DMH established the Office of Suicide Prevention (OSP) in February 2008 to serve as a statewide resource on suicide prevention and to assist state and local activities in support of implementation of the *California Strategic Plan on Suicide Prevention*. With the transfer to DHCS effective July 1, 2012, the Office of Suicide Prevention is now known as the Suicide Prevention Program (SPP).

Thirty-four counties submitted PEI plans containing suicide prevention activities that support recommendations in the State Strategic Plan. The SPP has established a website that links users to educational materials and resources about preventing suicide. To support building capacity of accredited suicide prevention hotlines, the SPP also convenes monthly conference calls among the 10 accredited suicide prevention hotlines in California.

SPP staff serve as the lead on veterans mental health issues including partnerships with the California National Guard (CNG) and the California Department of Veterans Affairs (CDVA). Staff also coordinate with the implementation of the Suicide Prevention Statewide Projects. Staff currently participate on the following coordination efforts:

- Suicide Prevention Network Program calls;
- Regional and local Suicide Prevention Capacity Building Program partner call; and
- PEI program partner monthly partner coordination call.

Stigma and Discrimination Reduction

In the spring of 2007, the MHSOAC convened a committee to recommend strategies to reduce mental health stigma and discrimination. The committee recommended that a ten-year strategic plan be developed. At the request of the MHSOAC, the former DMH convened a fifty plus member stakeholder advisory committee to provide input on the development of the strategic plan. Public dialogue and subsequent feedback on a draft plan was obtained through two public workshops, a statewide conference call and written comments.

In June 2009, the 52 page Strategic Plan, consisting of 4 strategic directions, 26 recommended actions, and 134 next steps for local and statewide implementation was adopted by the MHSOAC. Dissemination of the *California Strategic Plan on Reducing Mental Health Stigma and Discrimination* began in late Fall 2010.

Student Mental Health Initiative

The overall purpose of the Student Mental Health Initiative (SMHI) is to provide an opportunity for California's public schools and higher education institutions to improve policies and programs in ways that strengthen student mental health. The SMHI was developed through a stakeholder process involving K-12 and higher education representatives who shaped the development of the *Student Mental Health Initiative Proposal* which outlines the basic components, criteria and funding amounts for the K-12 and Higher Education SMHI grants, evaluation and training and technical assistance.

California Reducing Disparities Project

In response to the call for national action to reduce mental health disparities and seek solutions for historically underserved communities in California, the former DMH, in partnership with MHSOAC, and in coordination with CMHDA and CMHPC, called for a key statewide policy initiative as a means to improve access, quality of care, and increase positive outcomes for racial, ethnic and cultural communities. In 2009, the former DMH launched a statewide PEI effort utilizing MHSAs state administrative funding. The project, entitled the California Reducing Disparities Project (CRDP), currently utilizes \$1.5 million in annual MHSAs state administrative funding to support Phase I of the project. As part of Phase I of the CRDP:

- The former DMH funded five entities representing targeted populations to develop Strategic Planning Workgroups (SPWs) to identify population-focused, culturally competent recommendations to improve access and quality of care for those not served and underserved racial, ethnic and multicultural communities. The five target populations and established SPWs for these activities focus on

the groups that demonstrate historic disparities in access to mental health services:

- African Americans
 - Asian/Pacific Islanders
 - Latinos
 - Lesbian, Gay, Bi-Sexual, Transgender, Questioning (LGBTQ)
 - Native Americans
- The SPWs are comprised of community leaders, mental health providers, consumers and family members – all of whom are working together to identify new service delivery approaches for multicultural communities using community - defined evidence.
 - Each of these five SPWs has developed specific Reducing Disparities Population Reports (RDPR). The final RDPRs contain an inventory of community-defined strength based promising practices, models, and/or other resources. As of December 2012, five of five RDPRs are completed.
 - The RDPRs will form the foundation of the comprehensive California Reducing Disparities Statewide Strategic Plan (CRDSSP) that will seek to identify new approaches toward reducing disparities.
 - To further support the needs of the SPWs and development of CRDSSP, the following contracts were established:
 - California Mental Health Services Act Multicultural Coalition - responsible for sustaining a statewide multicultural coalition, establishing emerging community leader mentorships, ongoing collaboration and support of the five SPWs and guidance in the implementation of the CRDSSP.
 - CRDP Facilitator/Writer - responsible for collaboration with the five SPWs in meeting, reviewing, and providing input on draft RDPRs; in addition to the writing of the CRDSSP.

The result of Phase I will be the development of a comprehensive statewide strategic plan that will provide the public mental health system with tools and information relevant to integrating meaningful culturally competent prevention and early intervention services and approaches to meet the unique needs of the communities in California.

Phase II of the CRDP will include implementation of the strategic plan (CRDPSSP) at the local level. The current implementation plan is to fund selected approaches across the five target communities for at least four years. Additionally, a strong community participatory evaluation component will be incorporated to demonstrate the effectiveness of the program models and establish evidence in reducing disparities. After successful completion of this six-plus year investment in community-defined evidence, California will be in a position to better serve these communities and to replicate the new strategies, approaches and knowledge across the state and nation.

Existing MHSA support funds and staff associated with the CRDP transferred from the former DMH to the Office of Health Equity at the Department of Public Health (DPH) July 1, 2012 as part of the 2012 Budget Act.

5. Innovation (INN)

The goals for the funding of the INN component are to develop new mental health approaches, increase access to unserved and underserved groups, increase the quality of services (including better outcomes), promote interagency collaboration and increase access to services. An INN project contributes to learning, as opposed to providing a service, by “trying out” new approaches that can inform current and future practices/approaches in communities.

The planning guidance for the INN component was released in January 2009. As of March 2011, the MHSOAC had approved approximately \$182 million. Approval of this and other components is now subject to the Community Program Planning process with local stakeholders and approval by the County Board of Supervisors.

STATE ADMINISTRATIVE EXPENDITURES

As approved by voters in 2004, MHSA allowed up to 5 percent of the total annual revenues in each fiscal year for state administrative expenditures to support the former DMH, CMHPC, MHSOAC and other state entities. AB 100 amended the MHSA and reduced the maximum amount available for administrative expenditures from 5 percent to 3.5 percent. Additionally, the 2011-12 budget eliminated the MHSA funding from a number of departments previously funded for administrative expenditures; those departments are no longer referenced. Below, are the proposed administrative expenditures for state entities receiving MHSA funding in FY 2013-14 (whole dollars, rounded):

Judicial Branch

FY 2011-12	FY 2012-13	FY 2013-14
\$1,054,000	\$1,061,000	\$1,049,000

Juvenile Court System

The Judicial Branch, Juvenile Court System receives funding and 4.0 positions 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 juvenile court system.

Adult Court System

The Judicial Branch, Adult Court System also receives funding and 3.0 positions to address the increased workload relating to adults in the mental health and criminal justice systems.

State Controller's Office (SCO)

FY 2011-12	FY 2012-13	FY 2013-14
\$1,733,000	\$1,584,000	\$0

The SCO receives MHSA funds to support the 21st Century Project, the development of a new Human Resource Management System (HRMS) payroll system for use by state departments. The new HRMS/Payroll System, MyCalPAYS, will include Personnel Administration, Organizational Management, Time Management, Benefits Administration, Payroll and an Employee/Manager Self Service functionality.

Each year, the amount of funding expended on external contractors fluctuates. In FY 2010-11, approximately 70 percent of the total expenditures were expended on external contractors. In FY 2011-12, approximately 61 percent of the total expenditures were expended on external contractors.

Office of Statewide Health Planning and Development (OSHPD)

FY 2011-12	FY 2012-13	FY 2013-14
\$6,238,000	\$1,150,000	\$1,471,000
\$0 L/A	\$10,000,000 L/A	\$10,000,000 L/A

OSHPD has 7.6 full-time equivalent positions in WET programs including: 5.6 Mental Health Loan Assistance Program (MHLAP), 1.0 Mental Health Professional Shortage Area Designations, 1.0 to provide oversight and administration to the remaining WET programs. In FY 2012-13 the administrative cost is \$11,150,000; in FY 2013-14 the cost is projected to be \$11,471,000. Approximately \$10.0 million to be directed for loan assumptions (Workforce Education and Training State Level Projects/Local Assistance).

Department of Health Care Services (DHCS)

FY 2011-12	FY 2012-13	FY 2013-14
\$452,000	\$9,341,000	\$9,959,000

Primary responsibility for administering state-level MHPA functions transferred from the former DMH to DHCS beginning in FY 2012-13. 19.0 positions are funded by MHPA.

DHCS is responsible for overseeing the development and reporting of MHPA outcomes and the tracking, distribution, and reporting of MHPA funds. Currently, DHCS is developing county performance contracts; reviewing current allocation methodology for monthly distribution of MHPA funds; developing Annual Revenue and Expenditure Report (RER) forms and reviewing county RER submissions; reviewing issues submitted through the Issue Resolution Process; and, reviewing and amending MHPA regulations.

DHCS contracts with the California Institute for Mental Health (CiMH) to provide statewide training and technical assistance to county mental health departments for the implementation of the MHPA and MHPA-funded programs. This contract is funded at \$4.144 million per fiscal year.

DHCS contracts with Regents of University of California, Los Angeles to administer the California Health Information Survey (CHIS). Funding of \$800,000 is used for survey administration; data collection; publication development; and, questionnaire enhancement.

In FY 2012-13, funding and positions were provided to support a contract to develop and implement the interdepartmental California Mental Health Care Management Program (CalMEND). CalMEND staff continue to develop processes for tracking, evaluating, and improving psychotropic medication use and practices for those persons with serious mental illness (SMI), and severe emotional disturbance (SED) children and youth, and continues to provide overall guidance and technical assistance on data collection, analysis, and reporting for the pilots and other CalMEND partners.

DHCS has regularly-scheduled planning, coordination and training conference calls/webinars with CalMEND team members. DHCS directed selection of and contracting with pilot sites throughout the state for CalMEND mental health/primary care integration activities. DHCS provides technical experts to support the pilot programs and is conducting two-day learning sessions (and providing technical assistance) for staff from pilot agencies (county primary care and mental health providers).

Department of Public Health (DPH)

FY 2011-12	FY 2012-13	FY 2013-14
\$0	\$17,342,000	\$17,195,000

Beginning with FY 2012-13, core multicultural services in support of the MHSA was transferred from the former DMH to the Office of Health Equity at DPH. Most significantly, this included the transfer of the administration of the California Reducing Disparities Project (CRDP). The existing 4.0 former DMH positions supporting this effort were transferred to DPH, as well as funding for the supporting contracts.

Additionally, as part of the Governor’s Final Budget Summary for FY 2012-13 (refer to page 363 for additional information) \$17.3 million was allocated in FY 2012-13. The intent of the Legislature is to make available a total of \$60 million over the course of four fiscal years beginning with the 2012-2013 fiscal year to implement Phase II of the CRDP.

Department of Developmental Services (DDS)

FY 2011-12	FY 2012-13	FY 2013-14
\$1,133,000	\$1,129,000	\$1,128,000

DDS receives funding and 1.0 position to coordinate a statewide community-based system of mental health services for Californians with developmental disabilities by distributing funds to Regional Centers throughout California.

Mental Health Services Oversight and Accountability Commission (MHSOAC)

FY 2011-12	FY 2012-13	FY 2013-14
\$5,340,000	\$6,925,000	\$6,916,000

MHSOAC receives funding and 21.0 positions to support its statutory oversight and accountability for the MHSA. The MHSOAC was established to provide oversight and accountability for the Mental Health Services Act (MHSA), Adult and Older Adult System of Care Act and Children's Mental Health Services Act. The MHSOAC's primary roles include: (1) provide oversight, review, accountability, and evaluation of projects and programs supported with MHSA funds, (2) ensure that services provided pursuant to the MHSA are cost-effective and in accordance with recommended best practices, (3) provide oversight and accountability of the public community mental health system, (4) review and approve county Innovation Program and Expenditure Plans, and (5) provide counties technical assistance in MHSA program plan development and to accomplish

the purposes of the MHSA. The MHSOAC also advises the Governor and the Legislature regarding state actions to improve care and services for people with mental illness.

California Department of Education (CDE)

FY 2011-12	FY 2012-13	FY 2013-14
\$251,000	\$159,000	\$179,000

The CDE receives funding and 1.0 position to support county mental health programs' work with local educational agencies, county offices of education, and special education local plan areas to provide necessary services. Staff in this position also participates in the Mental Health Services Oversight and Accountability Commission, the Cultural and Linguistic Competence Committee, and the California Mental Health Planning Council

In cooperation with the California Mental Health Services Authority (CalMHSA), two statewide projects have been developed to support stigma-free access for students and their families to appropriate mental health services to reduce the need for more intensive, costly interventions, and also to increase school success for students experiencing mental health issues.

- Collaborates with the Placer County Office of Education (PCOE) to provide professional development via Training Educators Through Recognition and Identification Strategies (TETRIS). Fully funded through the CalMHSA, this high-quality professional development training in student mental health for educators, administrators, and other school staff is coordinated and facilitated through a contract with the PCOE. The purpose of the TETRIS trainings is to increase knowledge and capacity among school staff to promote effective prevention and early intervention strategies for students experiencing mental health issues, including mental illness and suicide risk. TETRIS trainings are offered in each of the 11 service regions of the California County Superintendents Educational Service Association, and provided at no cost to the participants.
- Supports coordination of the Student Mental Health Policy Workgroup (SMHPW): The SMHPW meets for the purpose of developing policy recommendations on student mental health for the State Superintendent of Public Instruction and the California Legislature. This workgroup meets quarterly, and is comprised of a diverse group of educators and mental health professionals.
- Partners with other agencies throughout the country to find best practices for California public schools and to effectively collaborate with mental health agencies throughout the state.
- Provides ongoing technical assistance to the field and public regarding student mental health issues.

Board of Governors of the California Community Colleges (Board of Governors)

FY 2011-12	FY 2012-13	FY 2013-14
\$109,000	\$103,000	\$126,000

The Board of Governors receives funding that partially supports 1.0 position to assist in developing policies and practices that address the mental health needs of California community college students. Funding for the position has been reduced over the past two years and does not fully support the cost of one full time equivalent position. The Chancellor's Office has had to find other funding to support the full cost of this position.

Financial Information System for California (FI\$CAL)

FY 2011-12	FY 2012-13	FY 2013-14
\$103,000	\$141,000	\$225,000

The FI\$Cal project receives funding to transform the State's systems and workforce to operate in an integrated financial management system environment. State agencies with accounting systems, including DHCS and the former DMH, will be required to use the system and, therefore, are required to fund it.

The system is being designed to include standardized accounting, budgeting and procurement features. Currently early in its development, FI\$Cal is headed by four partner agencies: DOF, SCO, the State Treasurer's Office and Department of General Services.

Military Department

FY 2011-12	FY 2012-13	FY 2013-14
\$539,000	\$561,000	\$1,351,000

The Military Department receives funding and 3.0 positions to support a pilot behavioral health outreach program to improve coordination between the California National Guard (CNG), local veterans' services and County mental health departments throughout the State. CNG educates Guard members about mental health issues and enhances the capacity of the local mental health system through education and training in military culture.

Department of Veterans Affairs (DVA)

FY 2011-12	FY 2012-13	FY 2013-14
\$433,000	\$496,000	\$505,000

The DVA receives funding and 2.0 positions to support a statewide administration to inform veterans and family members about federal benefits, local mental health departments and other services.

Statewide General Administrative Expenditures (Pro Rata)

FY 2011-12	FY 2012-13	FY 2013-14
\$24,000	\$13,000	\$0

The assessment to the MHSA for recovery of central service costs.

M H S A E X P E N D I T U R E S

Table 4, on the following page, summarizes MHSA expenditures for Local Assistance and State Administrative Costs by each state entity receiving a portion of MHSA funds. It displays actual expenditures for FY 2011-12, estimated expenditures for FY 2012-13, and the projected budget for FY 2013-14.

Based upon estimated MHSF revenues, the 3.5 percent administrative cap is \$47.3 million and administrative expenditures are estimated at \$40.0 million for FY 2012-13. For FY 2013-14, the projected 3.5 percent administrative cap is \$41.9 million and the total projected expenditures are \$40.1 million.

**Table 4: Mental Health Services Act Expenditures
May 2012
(Dollars in Thousands)**

	Actual FY 2011- 12	Estimated FY 2012- 13	Projected FY 2013- 14
Local Assistance⁴			
<i>Funding for MHSA Components Total</i>	\$1,812,375	\$1,340,000	\$1,340,000
Community Services and Supports	853,572	TBD	TBD
Prevention and Early Intervention	256,040	TBD	TBD
Innovation	119,332	TBD	TBD
Workforce Education and Training State Level Projects	17,381	37,775	22,650
Capital Facilities and Technological Needs	2,295	TBD	TBD
Subtotal, Major Program Categories	\$1,248,620	\$37,775	\$22,650
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) ⁵	379,029	0	0
Mental Health Managed Care ⁵	120,187	0	0
AB 3632, Special Education Pupils ⁵	64,539	0	0
Total Local Assistance	\$1,812,375	\$1,377,775	\$1,362,650
State Administrative Costs			
Judicial Branch	1,054	1,061	1,049
State Controller's Office	1,733	1,584	0
Office of Statewide Health Planning and Development ⁶	6,613	1,150	1,471
Department of Health Care Services	452	9,341	9,959
Department of Public Health	0	17,342	17,195
Department of Developmental Services	1,133	1,129	1,128
Department of State Hospitals	12,210	0	0
Mental Health Svcs Oversight & Accountability Commission	5,340	6,925	6,916
Department of Education	251	159	179
Board of Governors of the California Community Colleges	109	103	126
Financial Information System for California	103	141	225
Military Department	539	561	1,351
Department of Veterans Affairs	433	496	505
Statewide General Admin Exp (Pro Rata)	24	13	0
Total Administration	\$29,994	\$40,005	\$40,104
Total Expenditures	\$1,842,369	\$1,417,780	\$1,402,754

⁴ Allocation amounts for FY 2012-13 or FY 2013-14 are not reflected since the responsibility transfers to the counties. Counties will receive MHSA funds from the State Controller's Office on a monthly basis.

⁵ AB 100 allocated \$861.2 million from the MHSF to counties to meet the General Fund obligation for FY 2011-12. Total includes \$579.0 million to EPSDT, \$183.6 million to MHMC and \$98.6 million to Special Education Pupils (known as AB 3632). Actual expenditures based on a percent to total of the allocation. Follow-up with counties for actuals will need to be completed.

⁶ Approximately \$10.0 million funding is for loan assumptions under Workforce Education and Training State Level Projects/Local Assistance.