

CALIFORNIA
DEPARTMENT OF MENTAL HEALTH
COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT MONITORING REPORT

August 18-20, 2009

EXECUTIVE SUMMARY

The Community Mental Health Services Block Grant (also known as the Mental Health Block Grant) monitoring visit of the California Department of Mental Health (DMH) occurred from August 18 through 20, 2009. The monitoring team was given the opportunity to review State and county documents and to meet with State and Placer County leadership and staff, consumers, family members, advocates, and members of the California Mental Health Planning Council (CMHPC), as well as with other key stakeholders.

In November 2004, the passage of Proposition 63, also known as the Mental Health Services Act (MHSA), gave DMH the opportunity to provide funding, personnel, and other resources to support State mental health programs. The MHSA establishes a 1-percent income tax on personal income in excess of \$1 million. The majority of the funding is given to county mental health programs to address a continuum of prevention, early intervention, and services; additionally, these funds are to provide for enhancing the system infrastructure, to include improved technology and training opportunities for persons working in the State mental health system.

The MHSA established a Mental Health Services Oversight and Accountability Commission (MHSOAC) to provide oversight for the MHSA. In 2007, the MHSOAC approved five prevention and early intervention projects to support the county mental health services. The five statewide projects are: Student Mental Health Initiative; Stigma and Discrimination Reduction; Suicide Prevention; Ethnically and Culturally Specific Programs and Interventions; and Training, Technical Assistance, and Capacity Building. In May 2008, the MHSOAC designated DMH to administer the Student Mental Health Initiative, Stigma and Discrimination Reduction, and Suicide Prevention.

Since 1997, DMH has required each county (as part of its mental health plan) to submit a cultural competency plan for review. The DMH will be issuing its third revision of the new cultural competency plan requirements in 2010. Each county system will be required to submit a new cultural competency plan to DMH for review. The new cultural competency plan requirements include the following criteria: (1) commitment to cultural competency, (2) updated assessment of service needs, (3) strategies and efforts for reducing racial, ethnic, cultural, and linguistic mental health disparities, (4) client/family member/community committee: integration of the community within the county mental health systems, (5) culturally competent training activities, (6) each county's commitment to growing a multicultural workforce by hiring and retaining culturally and linguistically competent staff, (7) language capacity, and (8) adaptation of services.

The DMH has a major initiative regarding workforce development. A plan is in place that covers the next 10 years. The goal is to increase the number of diverse and culturally competent staff who are trained in recovery and resilience and work in the public mental health system. This will occur through State and local efforts that include incentive programs, changes in educational systems, and licensing requirements.

The State is working with universities to research promising practices and practice-based evidence (PBE) to meet fidelity criteria to become best practices. Given the vast ethnic and geographic diversity of the State, programs that are created for one population may not be suited to all populations. Current best practice programs need to be evaluated for efficacy in minority communities to adapt programs to meet the unique needs of diverse populations. Financial resources have been allocated for this effort.

It was evident to the monitoring team that DMH is inclusive of key stakeholders in focus groups to assist DMH with its policy development concerning specific issues. The DMH has produced a number of studies and focus group reports on specific areas; the anti stigma campaign is one of these focused studies. The DMH is ready to publish a report on its findings. This document could serve as a model for other States that have antistigma programs.

A major challenge for DMH is adjusting to the retirement of many long-term employees. This situation has resulted in a loss of institutional knowledge. New staff hired must “get up to speed” quickly on DMH requirements. Additionally, due to budget reductions and staff turnover, there are fewer staff members to do more work.

The DMH Children’s Community Services Division manager reported that approximately 400 children are placed out-of-State by the county mental health programs for mental health services. There are insufficient residential programs instate that can meet the mental health needs of children in California.

The CMHPC fulfills its role of advocating for mental health services and monitoring the adequacy of the mental health system. The Planning Council and DMH have prepared a workbook (the Data Workbook) for mental health boards and commissions to help Council members and county boards understand how data are used for continuous quality improvement.

The DMH has designated staff members who staff the CMHPC and some subcommittees. The Council staff provide followup and research regarding specific system issues. A paper was written on recommendations to ensure that the county mental health programs and the Department of Veterans Affairs are partnering to provide services to veterans and their families. A number of other papers addressing issues in the mental health system have been published.

Every year, the counties are required to complete a renewal application for all State and Federal funds available to them. The application requires a plan and budget for the upcoming fiscal year and begins with the anticipation of base year allocations. The projected budget and plan are adjusted based on expected funding in accordance with directives from the State Budget Office. Some funding sources have their own allocation methodologies, and other funds are allocated in accordance with rules and guidelines established in the budgeting process. Programmatic data and prior year expenditure experience are considered in allocating funds in this process.

California is poised to demonstrate what a transformed system looks like in terms of embracing the concept of recovery, peer support, consumer-directed services, and use of research to inform practice. The MHSA has provided a significant incentive for improving service delivery; increasing the responsiveness of the system to improving clinical care; providing culturally

relevant and competent services; reducing stigma; introducing or expanding the use of evidence-based practices; and increasing the influence of PBE. There have been substantial investments in housing, integrating consumers into the system as advocates and direct service providers, addressing homelessness, reducing stigma, and particularly in developing the workforce—especially the creation of employment incentive programs, a high school-based health service academy, and other efforts to address capacity and diversity.

The Prevention and Early Intervention (PEI) statewide initiatives can inform a historically weak area for mental health policy. The PEI initiatives provide significant opportunities to strengthen the relationship with health in this area. The investment of MHSA funding in the PEI statewide initiatives will have a lasting impact. One area that requires additional attention is the need for State-level policy or statutory direction regarding coordination between criminal justice and mental health to specify actions needed to impact on the return of individuals with serious mental illness (SMI) from the prison system to the community.

The adult system has been confronted with a demand for services and new programmatic initiatives. It is a challenge for DMH to have access to information that allows it to know how the system is working on a day-to-day basis. The notion of county uniqueness, while having merit, is also making it much more difficult to defend the value of mental health services for the citizens of the State. There may be opportunities to develop partnerships and interventions for high-risk individuals (for example, women veterans), but the system's structure makes it difficult to speak with one voice. There is a difficult and extremely important need to balance the uniqueness argument with the need to emphasize common ground.

The enormity of California's mental health budget would likely create significant challenges for financial management operations of any entity. With the majority of DMH's fiscal staff having limited tenure in the Department, reduced experience with and historical knowledge of past practices and events can place additional obstacles in meeting those challenges. Although current staff appear to be ready to meet the challenges of providing efficient financial management for DMH, technical assistance from the Bureau of State Audits may expedite the learning curve in establishing the level of internal controls and accounting processes that auditors have cited. Several of the issues reviewed during this monitoring process suggest that an opportunity exists to improve the processes and procedures for managing State and Mental Health Block Grant (MHBG) funding.

The monitoring team would like to thank the staff of the California DMH for their help and assistance during the visit and to commend the staff for their diligent efforts in managing one of the largest mental health systems in the country.

Technical Assistance Recommendations

The work that has been done to develop a vision, goals, and strategies has been inclusive and comprehensive. The challenge, however, is in managing the business of operating as a purchaser and provider of services. It is recommended that technical assistance be obtained in the form of a comprehensive organizational assessment of the DMH central office in order to develop a blueprint for streamlining and improving business processes, tools, and structures to guide

consistent expectations. The intended outcome would be to improve the ability to make sound decisions and impact policy within the mental health system and across partner systems. Specific challenges include the issue of requirement setting for reporting and overcoming the current problem of huge amounts of data but little actionable information. Data systems design and a data strategic plan would be part of this effort and would assist in the ability of leadership to have needed decision support resources. There are an overwhelming number of expectations and a lack of specificity in how to determine if those expectations are being met. The organizational blueprint should address the lack of clear policies and procedures and the need for greater congruence among plans, contracts, data systems, and policy making.

It is clearly difficult to maintain a vision for the system while dealing with constant crises. A case can be made that there are not enough staff or support to provide training, education, and oversight needed to move the system forward. Another interpretation, however, is that there are not enough staff to conduct business the way it has been conducted in the past. Structures and processes generally seen in State systems (such as benchmarks that track system performance and conformance to both policy and accountability expectations) are challenging for several reasons. The functional realignment within DMH is a start at addressing this issue, but technical assistance can assist with developing a roadmap for improvements in processes and outcomes.

The monitoring team has recommended that DMH request specific technical assistance from the Substance Abuse and Mental Health Services Administration (SAMHSA) regarding the Department's utilization of data collected and development of a focus on the outcomes or benchmarks for the mental health system across counties. Given the challenges currently being experienced by the Department in terms of the State's financial situation, workforce development and upgraded management information systems at the county level (systems that can report the required data to DMH so that outcomes can be measured) are needed.

Current DMH staff are prepared to meet the challenges of providing efficient financial management of Department funding and contracting for those funds; however, an opportunity exists to expedite the improvement and refinement of DMH processes and procedures through technical assistance.

During the monitoring visit, the monitoring team went to Auburn in Placer County to review the delivery of mental health services to children and adults. The leadership of Placer County has concluded that the current and potential future funding reductions, coupled with the increased demand for services, mean that the service delivery model that has been used may be unsustainable in the future. Placer County leadership is launching efforts to become more actively engaged in the community in the development of services and strategies that will provide alternatives to the traditional mental health system. This will result in focusing existing resources on crisis services and little else. Placer County leadership has introduced the concept of a "learning collaborative" as a means to engage the community in problem solving and solution development. The ultimate goal is to utilize more natural supports and resources for the individual with serious mental illness (SMI) or a child with serious emotional disturbance (SED) as augmentation to the limited capacity of the county mental health system. There are proportionally fewer Medicaid-eligible individuals in the county, so the intended reductions of traditional mental health services will have a major impact and will require engaging the

community in new ways. This is an area where the leadership believes that technical assistance would be beneficial.

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CHAPTER I: INTRODUCTION

Mental Health Services Block Grant Monitoring

The passage of Public Law (P.L.) 102-321 afforded States the opportunity to receive Federal grants for the purpose of establishing or expanding comprehensive community mental health services to adults with serious mental illness (SMI) and children with serious emotional disturbance (SED). Under the statute, each State must submit a State Plan for Comprehensive Community Mental Health Services for the fiscal year involved. Each Federal grant can be used for the purpose of planning, administration, education, and evaluation activities related to carrying out and providing services under the State Plan.

The State Planning and Systems Development Branch, Division of State and Community Systems Development, within the Center for Mental Health Services (CMHS), is organizationally responsible for ensuring each State's compliance with the array of administrative and programmatic requirements under the law. P.L. 102-321, and as amended by P.L. 106-310, requires that "the Secretary [of HHS] shall in fiscal year 1994 and each subsequent fiscal year, conduct not less than 10 State investigations of the expenditures of grants received by the States under section 1911 . . . in order to evaluate compliance with the agreements required under the program involved" (Subpart III, Section 1945 (g)). The CMHS conducts these investigations in partnership with the States under the term "monitoring visit" to:

- Monitor the expenditures of Federal Block Grant funds.
- Assess compliance with the funding agreements and assurances required under the program.
- Identify strengths (e.g., best practices, exemplary efforts) of the State and local mental health systems.
- Focus on opportunities for improvement, i.e., ascertain/recommend priority needs for technical assistance, identify issues that need to be addressed, as well as policy challenges related to the mental health program and service delivery at the State and local levels.

The Monitoring Visit Process

The CMHS conducts the monitoring visits with the assistance of a team of three consultants with fiscal, management, and/or clinical expertise in providing services to adults with SMI and children with SED. One member of the team is designated as the Team Leader/Writer. A Federal Project Officer makes the final selection of the members and accompanies the team. The onsite visit of the State mental health system is usually 3 days in duration. The monitoring visit includes an assessment of the State Mental Health Agency, along with interviews with Mental Health Planning Council members, consumers, and family members, and a visit to a local

program (urban, rural, or suburban) that serves adults with SMI and/or children with SED and receives some portion of Federal Block Grant funds.

In addition to monitoring the Block Grant expenditures and compliance with the funding agreements and assurances, the monitoring process involves the assessment and analysis of a range of planning, management, clinical, and fiscal issues as they relate to the implementation of the five criteria. Guidelines have been developed to assist each consultant in reviewing related materials and in conducting focused interviews to obtain necessary information to prepare the report.

Before the monitoring visit, the State Mental Health Director and the Block Grant liaison receive notification of the visit. The liaison is also contacted to:

- Discuss the purpose of the monitoring visit.
- Identify materials to be reviewed before and during the monitoring visit.
- Request the selection of a local program to be visited by the monitoring team.
- Assist in identifying key personnel to be interviewed by the consultants.
- Develop the monitoring schedule.

General Limitations

The fiscal observations contained in this report do not constitute audit findings. The fiscal information included in the report is based on the data provided by the agencies visited. Although the fiscal consultant attempts to verify key information during the visit, the fiscal interview is not conducted according to generally accepted auditing standards issued by the American Institute of Certified Public Accountants or Government Auditing Standards issued by the Comptroller General of the United States. Other limitations of the monitoring report are: (1) the limited time spent onsite, (2) the process of selecting staff interviewed and the program visited, (3) the process used to collect and review documents, (4) the sampling nature of the monitoring visit, and (5) the inherent limitations and biases of the team of consultants.

Exhibit 1: Monitoring Visit Data Sheet

Agency: California Department of Mental Health

Director: Stephen Mayberg

Date of Visit: August 18-20, 2009

Local Program Visited: Placer County – Auburn

Federal Project Officer: Deborah Baldwin

Team Assignments: Patricia Dorgan
Jim Stivers
Dave Wanser

Entrance Conference Participants: Federal Project Officer and Monitoring Team
Denise M. Arend
Ann Arneill-Py
Stan Bajorin
Denise Blair
Rachel Guererro
Rollin Ives
Barbara Marquez
Steve Mayberg
Cindy Radavsky
Vallery Walker
Sandra Zajkowski

Exit Conference Participants: Federal Project Officer and Monitoring Team
Ann Arneill-Py
Stan Bajorin
Denise Blair
Rachel Guererro
Don Kingdon
Heide Lange
Barbara Marquez
Vallery Walker
Kimberly Wimberly

CHAPTER II: STATE AGENCY SERVICE AND SYSTEM ASSESSMENT

State Mental Health Agency and Administration of Mental Health Services

The California Department of Mental Health (DMH) administers the delivery of public mental health services within the State. The DMH budget is approximately \$6.1 billion. The Department has 12,000 employees, including direct care and administrative staff at five State hospitals and two inpatient psychiatric programs.

The Director and the Chief Deputy Director of the agency are appointed by the Governor. The Director was appointed to his position in February 1993. Since his appointment, the Director has focused on shifting the mental health system from a State-based system to a county-based system. In 1991, legislation was passed that shifted the delivery of mental health services from the State to the 58 counties to allow for more integration of health and social services administered at the local county level.

The DMH comprises five major divisions: Administrative Services, Program Compliance, Community Services, Long Term Care Services, and Information Technology. Additional support functions include Legal Services, Office of Human Rights, Legislation, Office of External Affairs, Office of Multicultural Services, Strategic Planning, Internal Audits, Information Security, California Mental Health Planning Council, and Mental Health Services Oversight and Accountability Commission (MHSOAC).

California is a county-based system; therefore, the primary administrative role of the DMH as related to community-based services is entering into county contracts and providing policy direction and technical assistance. Some counties utilize county employees to deliver services, and others may subcontract up to three-quarters of their mental health services to local providers. In general, county employees and contractors are the primary providers of case management and crisis services. Given the county-based structure of the system and the direct allocation of funds from the State to the counties, counties have wide latitude in allocating funding and services. Each county develops its own plan individualized to local needs, which provides for optimal flexibility while creating challenges to consistent practice and the availability of performance-related information. Although some of the smaller counties have considered joint partnership agreements, county-centric attitudes are seen as a deterrent. Thirty-eight counties have consolidated their substance abuse and mental health operations, although the larger counties are more likely to have maintained separation of these operations.

The DMH also operates a system of five State hospitals that has evolved to be primarily populated by patients who are under forensic commitment. Less than 9 percent of the patients in the State-run hospitals are there by virtue of a civil commitment. In addition, DMH also operates two correction-system-based mental health programs. County mental health programs are responsible for providing local mental health hospitalization in lieu of State hospital placements. The average length of stay in these community-based facilities is currently 6–7 days.

The funding available through the Mental Health Services Act (MHSA) this fiscal year is approximately \$1.2 billion, \$900 million of which is directed to community services and supports for individuals with serious mental illness (SMI) and children with serious emotional disturbance (SED). The MHSA legislation directed that funding be used to reduce jail time and homelessness and increase employment. Current areas of focus include transition-age youth, especially those transitioning from the juvenile justice and foster care systems, and the mental health needs of older adults. Notably, an additional \$300 million has been made available for prevention and early intervention initiatives. Within the prevention and early intervention initiatives, five statewide priorities have been identified: suicide prevention and intervention; stigma and discrimination reduction; ethnically and culturally specific programs and interventions; training, technical assistance, and capacity building; and a Student Mental Health Initiative for K–12th grade and for higher education. All stakeholders across the State seemingly agree on a vision of recovery, hope, and resilience and on services based on needs of the client and family. The significance of the MHSA has generated a degree of tension about administration of the MHSA funds. The amount of funding and pressure for system change has created challenges (described below).

The other major driver of funding decisions (in addition to the MHSA) is the State Medicaid program, referred to as Medi-Cal. Although specific types of mental health services are proscribed by this funding stream, all other mental health services are county defined. Administration of the mental health benefit available through Medi-Cal has been delegated from the Department of Health Care Services to DMH and administered through a Medicaid waiver program. This means that, for mental health services, DMH is provided allocation that is subject to all the requirements of managed care, although there are some features of this arrangement that are not typically seen, such as funding counties through a cost reimbursement mechanism. There is also a requirement (based on a court settlement) that children's mental health services must be reimbursed through a fee-for-service arrangement without typical managed care controls on utilization. Although California benefited from the temporary adjustment to the Federal fiscal participation in Medicaid from 50 percent to 61.59 percent for the next 2 years, counties must use their own funds to match Medi-Cal, and financial crises in the counties have made this challenging now and in the future, as the ratio reverts back to 50 percent. Despite the significant Medicaid population in the State, California has a high proportion of uninsured individuals. Overall, individuals who are uninsured or covered through Medicaid total about 40 percent of the State population. The impact of the budget shortfall for State fiscal year (SFY) 2009-2010 was a \$60 million reduction in funding to DMH, although there was a billion in cost cuts across the entire Medicaid program and eligibility changes in the Temporary Assistance to Needy Families (TANF) program.

California has a long history of counties and stakeholders wanting to be on the cutting edge and embracing evidence-based practices (EBPs). There was widespread acceptance of the New Freedom Commission recommendations, and the MHSA and system values are aligned. At a conceptual level, there is a consensus on direction, but there is no roadmap for realizing the fundamental changes necessary to embrace recovery, implement EBPs, develop systems built around the individual and family, and reduce disparities. Thus, while counties claim to use EBPs, there is no way to determine if fidelity to the practices is being realized; there is not a

statutory requirement that counties utilize these practices. There is also concern that many EBPs are not tested on all populations being served, resulting in a reluctance to utilize them if there is not a population-specific research base. Specifically, there has been stakeholder concern about the appropriateness and effectiveness of EBPs by communities of color. Fortunately, the MHSA has allowed DMH to invest \$1.5 million to fund five historically underserved communities for planning activities: African American; Hispanic; Asian/Pacific Islander; lesbian, gay, and transgender; and Native American. There will be funding directed for projects with local organizations that have the intention of defining promising practices or community-defined evidence (CDE). To seek new solutions for ethnic and cultural disparities, the MHSA also targeted \$60 million over 5 years to implement new CDE in these historically underserved and unserved communities. The first expectation is that the above-listed five communities will have 2 years to identify community-based solutions (promising practices) and develop a comprehensive, inclusive strategic plan. Once the strategic plan is completed, the second expectation is that in 4–5 years, an evaluation of these efforts will be completed and the State will have created an investment in identifying new CDE that has been evaluated, comes from the communities, and can guide policy. There is also an effort to create a multicultural community collaborative. In addition, all counties are required to respond to priority areas regarding cultural competency in their local plans. Each county must identify disparities, indicate what funding is associated with addressing disparities, and define planned actions. In the past, these requirements were focused on the Medicaid population, but this year the requirements are expanded to incorporate all individuals served within the mental health system. The University of California Davis Center for Reducing Health Disparities (CRHD) has been contracted to develop assessment measures to assist the State in measuring progress.

State Agency Leadership Perspective

The State leadership is challenged by the tension between addressing immediate needs and making investments that will impact the system in the long term. The reality of system transformation is that it requires moving beyond immediate demands to making investments that permit the State to better use information technology, respond to changing workforce needs, and develop a meaningful research base to support planning and decisionmaking. The preferred way to achieve these goals, and leave a legacy for the future, is to obtain legislative support so that the vision is supported in statute.

Changing current practices and the existing values is something that requires constant leadership attention to educate consumers and advocates and maintain a level of pressure for system change. There are many priorities within DMH intended to achieve these goals, including improvements in administrative and business processes, increasing accountability, ensuring quality, addressing disparities, and embracing a public health model. These envisioned changes raise questions about whether DMH should implement complementary changes in measuring quality and outcomes within a public health framework that is more population based. A key feature of this model is interpreting the role of the State Mental Health Authority (SMHA) as one that addresses the mental health of all Californians, not just those in the formal mental health system.

The Workforce Education and Training component of MHSA addresses the shortage of mental health service providers in California. For occupations such as psychiatrists, psychologists, licensed clinical social workers, registered nurses, and psychiatric technicians, vacancy rates are approximately 20–25 percent statewide with vacancy rates far higher in rural areas. The California mental health system has historically suffered from a lack of diversity in the workforce, uneven distribution of existing mental health workers, and limited representation of individuals with client and family member experience in the provision of services and supports. A Five Year Workforce Education and Training Development Plan has been developed to provide a vision for State and local implementation; this plan identifies principles and projects for funding and governance at both the State and county levels and outlines performance indicators. The need for continual development of the workforce is being addressed by options ranging from stipend programs for universities' recruitment of minorities to contemplated efforts to acquaint young persons with a mental health career track starting in high school (specifically, Health Service Academies in Los Angeles high schools). In the State hospitals, there also is a 20/20 program with an employee working for 20 hours and allowed up to 20 hours for classes at community colleges to work toward a nursing degree, to receive psychiatric technician training or nurse practitioner training, or to enroll in other courses related to classifications needed by the institutions. The total investment being made to enhance workforce capacity in the system is \$240 million over 10 years. At the same time, counties are developing the means to increase the number of new professionals; they are finding that budget shortfalls leave them without the funding to hire these individuals. In addition, one aspect of DMH employment strategy was to hire consumers and family members to provide peer support and other services, but these hires are not materializing as quickly as hoped due to county budget constraints. Of an anticipated 4,000 new jobs, 1,000 were set aside for client and family support; however, there are indications that these positions may be the first to go in the face of local budget cuts, often because, per civil service rules, these new employees were the last hired.

The challenge to continuing to reach for the long-range transformation vision is the widely held mentality of the wish for immediate change and the need to respond to continual crises. The combination of budget shortfalls and insufficient workforce resources limits the ability to provide the training, education, and oversight needed to move the system forward. Although it is a worthwhile endeavor to rely on trust and commitment to value system, it is not quantifiable. Thus a major challenge for DMH is to find the balance between the demand for the immediate use of scarce resources to provide additional services and the needed system investments in information technology (IT) and workforce. Another major challenge is the system's reliance on Medicaid and the challenges of dealing with what is reimbursable versus what specific interventions an individual may need independent of the funding stream. The emerging reality is that the formal mental health system cannot take responsibility for the all-encompassing State issues, such as children transitioning from foster care and juvenile justice systems and needs of the growing elderly populations, as well as other issues that realistically require a broader coalition of State and local partners.

As all these issues and challenges are communicated to the broad range of stakeholders within the State, there is arguably too robust a planning and public input process to allow focusing on a manageable number of priorities. There were more than 120,000 individuals who provided input

and participated in the planning process around expending funds for populations targeted by the MHSA. This input was then vetted by each county board and posted for county-specific comments, which the counties then brought to the State for review and approval of a contract. The result is an extreme degree of variation coupled with an overly complex set of administrative processes that create difficulties for DMH in quantifying and replicating results.

One noteworthy strategy utilized by DMH to engage other State agency partners has been to invest State-appropriated administrative funds from MHSA across 16 different State departments for staff to participate in collaborative activities; the funding allows each of the agencies to ensure attention to mental health issues. The funding also allows each respective State agency to develop a county-level connection for collaboration. This approach has been criticized by local mental health administrators because these other agency partners are now reaching out for assistance in dealing with mental health issues in their respective populations and increasing the demand for services. The State leadership suggested that this is an area where the Substance Abuse and Mental Health Services Administration (SAMHSA) could assist at the Federal level by supporting collaborations with Federal partners that have encouraged a greater degree of integration across the entire health and human service system. For example, it is a routine occurrence that consumers and families participate in audits of local programs, whereas this is a foreign concept for other Departments to utilize someone who is a service recipient in reviewing the services that are provided.

Taken together, the perspective of the State leadership is that the most pressing issue for technical assistance is to develop a comprehensive organizational blueprint for business process improvement. The assistance will include the development of strategies that streamline processes while allowing for a greater degree of integrating funding, long-term operational planning, IT planning, and development of analytic tools that allow DMH to analyze the return on investment of the service system. While pressures will remain around addressing immediate concerns, it is essential for DMH to have the tools to sustain its operational capacity and demonstrate accountability and positive outcomes in order to make the business case for resources in an increasingly constrained financial environment. It is also critical that internal business processes (such as claims payment) are engineered for improved timeliness and that a process is put in place to develop and manage policies and procedures because little in the way of expectations is formally promulgated. Because it is difficult to move regulations forward, less structured processes, such as notices and letters are used, which makes efforts to clearly identify current expectations challenging. Finally, there may be a need within this organizational assessment to evaluate the best utilization of staff and anticipate the ways that use of more advanced technologies may alter the number and assignments of staff.

Mental Health Planning Council

The California Mental Health Planning Council (CMHPC) is composed of 40 members, including consumers, family members, providers, and State agency representatives, all covering the various geographic areas of the State. The Council also has cultural diversity, which reflects the diversity of the residents of the State of California.

The Council has nine DMH staff positions assigned to working with the Council and staffing the subcommittees. The staff positions are funded through the Mental Health Block Grant (MHBG) and the MHSA. The Council's eight subcommittees are as follows:

- Cultural Competency
- Transition Age Youth
- Older Adults
- Adult System of Care
- Children and Youth System of Care
- Quality Improvement
- Policy and System
- Human Resources and Work Force Training

The CMHPC meets on a quarterly basis for 3-day meetings. Each quarterly meeting includes the meetings of the Council's subcommittees. A major effort of the Council and the subcommittees is the oversight and implementation of the MHSA focus on early intervention and prevention, which is reshaping the mental health system based on the principles of recovery and resiliency.

California State law charges the CMHPC with responsibilities beyond the Federal MHBG requirements. The scope of the Council's responsibilities is defined in the MHSA. The Council oversees system accountability with continued involvement of consumers and families. Council members are appointed by the DMH Services Commissioner. Nominations for Council vacancies come from diverse sources, including the county mental health directors or from other Council members to ensure that the geographic and cultural diversity of the CMHPC is maintained.

The Council subcommittees are active in producing reports that focus on system issues. A report on the coordination of care between the county mental health entities and the local Department of Veterans Affairs (VA) was to be published after the monitoring visit. This report includes recommendations to improve the coordination of mental health services for California's military personnel and veterans who have high suicide rates and for whom stigma is often a barrier for treatment. The Transition Age Youth Subcommittee has developed a resource paper to describe promising approaches to integrating fragmented services for transition-age youth 18 through 25 years.

The Adult System of Care Subcommittee produced a report on the use of seclusion and restraints in California's State-operated psychiatric hospitals. The Children and Youth System of Care Subcommittee is focusing on juvenile justice mental health courts and has recommended establishing juvenile justice mental health courts throughout the State. In October 2007, the Children and Youth Subcommittee also produced a report on the study of foster care.

The Older Adults Subcommittee is continuing to advocate for increasing the level of services available in all counties for older adults with mental health needs. The Quality Improvement Subcommittee and DMH staff created the Data Workbook, which was provided to assist Council members and county board members in understanding data for continuous quality improvement

(CQI). In April 2008, the Human Resources and Work Force Training Subcommittee reviewed and approved the Department’s Five Year Workforce Education and Training Development Plan.

During the monitoring visit, the monitoring team had the opportunity to meet with four of the Planning Council members (the current Chair, the past Chair, a consumer advocate, and a family member advocate who has also served on the National Association of State Mental Health Planning Councils (NASMPHC)) and two of the DMH Planning staff. The Council members shared their current concerns regarding the billions of dollars being cut from State government and the ways in which this will significantly impact the mental health system. The State hospitals’ mission has changed over time, and the hospitals are now primarily serving forensic patients.

The Council members also expressed concern that DMH does not currently have enough staff to continue to operate as in the past and impact system change, move the State system of recovery and resiliency forward, and implement best practices in mental health care throughout the county systems.

The Council members indicated that they are involved in the State transformation efforts and have assisted other boards and county board members in understanding the data reports and penetration rate reports provided by DMH. The Council members reported that DMH puts all reports and plans on its State Web site for consumer and family member review and input.

Council members reported concerns about workforce development, especially in recruiting psychiatrists and clinical staff to work in rural or linguistically diverse areas of the State. The DMH staff are currently in the process of recruiting additional psychiatrists and clinical professionals as part of the Workforce Development initiative.

Exhibit 2: Planning Council Composition by Type of Member

Type of Membership	Number	Percentage of Total Membership
TOTAL MEMBERSHIP	40	
Consumers/Survivors/Ex-patients (C/S/X)	7	
Family Members of Children Diagnosed with SED	3	
Family Members of Adults Diagnosed with SMI	3	
Vacancies (C/S/X and family members)	3	
Others (not State employees or providers)	4	
TOTAL C/S/X, Family Members and Others	20	50
State Employees	8	
Providers	11	
Vacancies	1	
TOTAL State Employees and Providers	20	50

Guidance for Membership:

- 1) The ratio of parents of children with SED to other members of the Council must be sufficient to provide adequate representation of such children in the deliberations of the Council.
- 2) Other representatives may include individuals with interest in children with SED or adults with SMI.
- 3) State employees and providers shall constitute no more than 50 percent of the total membership.

Quality Improvement and Decision Support

Quality management functions within DMH include licensing and certification, in the Licensing and Certification Branch (Program Compliance Division), of certain 24-hour facilities and residential programs, monitoring the delivery of community-based services, reviewing critical incidents, conducting criminal background checks on employees working in facilities licensed by the Department and those State employees working with criminal background check material in SDMH, conducting fiscal audits, and performing Pre-Admission Screening and Resident Review (PASRR) oversight and oversight of medical services. In addition, Medi-Cal oversight consists of clinical record reviews in designated community and hospital programs, clinic certification and recertification, investigation and referral of questionable billing to Medi-Cal, and management of treatment authorization requests and appeals. County mental health programs are reviewed at least every 3 years, licensing of specifically designated 24-hour programs is done annually, cost reports are reviewed annually, and recertification is done every 3 years. Generally, county-based programs are reviewed by four-member teams that usually include consumers and family members. The monitoring tool used for the Medi-Cal monitoring is an 88-page grid encompassing various State and Federal standards. The quality review reports are shared with the local county and internally but are not shared otherwise unless someone makes an open record request. A significant component of the local review process consists of client record reviews, with an average sample size of 20 records reviewed in larger counties and 10 reviewed in smaller counties. There is also a sampling process used for selecting 100 records to review for the children's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. Claims profiling can be done to identify trends, but there are no data mining tools currently in place. The analyses are done county by county and distributed through a secure interface. In some cases, counties are doing supplemental analyses of these data.

Two distinct organized groups are also involved in quality improvement (QI). A legislatively appointed Mental Health Services Oversight and Accountability Commission (MHSOAC) is charged with oversight of the MHSA program; the MHSOAC has several committees, including a consumer and family leadership committee. The MHSOAC provides feedback to the legislature on the activities subsumed under MHSA. In addition, the CMHPC has become active in identifying issues related to QI and has recently published the Data Workbook ("Using Data for Continuous Quality Improvement") to orient Council members to their role in evaluating the effectiveness of the mental health system.

A requirement of the Medicaid waiver is that the State contract with an External Quality Review Organization (EQRO) to review the quality and appropriateness of Medicaid-funded services. The mission of the EQRO is to conduct annual, external reviews of access, timeliness, quality,

and outcomes of the Medi-Cal specialty mental health services managed by the 56 California county mental health plans (MHPs). The contracted EQRO in California is APS Healthcare. To make this assessment, the EQRO conducts annual quality reviews that include an assessment of DMH-specified performance measures, assessment of local MHP-selected Performance Improvement Projects (PIPs), evaluation of selected aspects of each MHP's ongoing internal QI system, and a review of each MHP's health information system's capability to meet Medi-Cal requirements.

Although there are significant numbers of extremely detailed standards for Medi-Cal programs, there are many other areas where detailed standards guidance is lacking, which results in DMH being challenged to reduce data to a useful form. The lack of an overall data model that integrates the various DMH data systems creates challenges in measuring quality in a comparative way or in quantifying the costs and benefits of many of the State's highest-profile projects. The disparate data standards utilized by the counties limit the negotiating position of DMH in working within the larger and increasingly important State's Health Information Exchange. The DMH would like to use data to make decisions, but realizing this goal will be challenging, given the lack of timely, complete, and actionable data from the counties. In certain circumstances, service-level data being used for decisionmaking are 2 years old. There are significant gaps in what data must be reported and in the accuracy and completeness of reported data. An additional challenge is a burgeoning number of system oversight indicators, which produce more than 150 different measures to inform system oversight. If a fraction of this number of indicators were based on high-quality and timely data, it is likely that DMH leadership would have a better picture of system performance. The DMH has started posting performance data nonetheless, although there has been county resistance to public sharing of this information. The structure of the State's financing scheme is one that allocates funds to the counties directly, regardless of their performance levels or compliance with standards.

Two primary data systems are used for county mental health data. The Client and Service Information (CSI) system is a reporting system that includes client and service information on all persons served in county mental health programs. The Medi-Cal system is composed of several files that include all persons who are eligible for Medi-Cal and the Medi-Cal claims that have been paid for specialty mental health services. In addition to client-level data systems, there are two other systems that include county data. The County Financial Reporting System (CFRS) is a yearend cost report of all costs expended by county mental health programs. The Provider and Legal Entity File identifies the actual provider site as well as the legal or corporate entity, or county that is responsible for the provider. The CSI system is based on provider reporting, and the CFRS is based on legal entity reporting. Through the Provider and Legal Entity File, costs reported to the CFRS by a legal entity can be linked to services reported in the CSI by a provider. Through this linking process it is theoretically possible to estimate the cost of services provided to specific groups of individuals, such as youth, or persons with certain diagnoses. Not surprisingly, efforts to link the datasets have proven to be difficult. Among the other data systems utilized by DMH are the Web-Based Data Reporting System (WBDRS) used to collect data using a point-in-time method to target all adult and older adult consumers receiving face-to-face mental health services. The DMH Consumer Perception Survey, which assesses perceptions of quality and outcomes of care, is conducted twice yearly during a 2-week period. In addition,

MHSA Full Service Partnership (FSP) Outcomes Assessments are currently being submitted via the Data Collection and Reporting (DCR) system. At least five other separate data-reporting systems are utilized for specialized populations. Several automated systems at the State level contain client, service, and fiscal data from State hospitals. These systems include the Admission/Discharge/Transfer (ADT) system, an online system that captures demographic characteristics of patients, admission and discharge dates, types of legal class changes, and dates of ward changes. Data from the ADT system are linked with the Cost Recovery system to generate billing data. There has also been an initial deployment of the Wellness and Recovery Model Support System (WARMSS) that records each patient's assessed needs as derived during initial treatment team planning sessions, life goals, goals for each treatment session or class, types and providers of treatment, degree of patient achievement of each treatment goal, and measures of progress in treatment.

The Medicaid claims system, used by DMH for most non-Medicaid quality and outcome data, is also in transition and will further challenge the ability of DMH to know what is occurring in most aspects of mental health service delivery. The existence of several different data-reporting portals also makes it necessary to uniquely identify individuals without running data-linking programs, although up to 20 percent of the number of persons served may be lost through this process. As a result of the lack of a sufficient data infrastructure and the inability to ensure complete and accurate data reporting from the counties, DMH has had (and will likely continue to experience) difficulty in reporting National Outcome Measures (NOMs) data.

Perhaps the single most significant issue confronting DMH is the limited capacity of the CSI system. Although counties are responsible for collecting data and reporting back to DMH, there are significant shortcomings in data quality and completeness. In addition, the CSI is becoming antiquated, making it difficult for DMH to have timely information about or to respond to quality of care issues in the system. The DMH provided significant IT funding for counties to improve reporting (even in successful data system upgrades, of which there are reportedly few), but the transition to a new system slows the county's ability to report data to the State. Furthermore, these systems are all unique to county needs and there are no overall data standards to which they must comply.

In order to address some of its data quality issues, DMH is in the process of developing a Data Quality Improvement Strategy. What is proposed below are some of the areas of focus currently being considered by the Department.

1. Develop and disseminate useful information from the data the Department is collecting.
2. Develop a DMH-sponsored Statewide Data Quality and Analysis Users Group.
3. Participate in key technical committees, including the California Mental Health Directors Association (CMHDA) IT Committee, the MHSOAC Measurement and Outcomes Technical Resource Group, and the Mental Health Planning Council's Quality Improvement Committee.

4. Increase and strengthen language in the County Mental Health Plan that gives the Department the option of withholding funding should a county fail to comply with data reporting requirements.
5. Support the Development of Statewide Data Exchange Initiatives.

Consumer and Family Member Involvement

The DMH has demonstrated considerable support for consumer and family input into policy matters and makes every effort to be transparent about how decisions are made. One starting point for this was the existence of consumer positions on the executive team. A noteworthy effort to enhance the input of consumers and family members is the Client and Family Member Expert Pool, which was designed to develop a standing group of consumers and families to assist the State on compliance reviews or Medi-Cal oversight activities. Over time, the roles identified for this group have expanded; training was developed and the size of the group increased to 62 active members. Members continue to participate in program reviews, significantly, they work within the DMH Community Services Division to give input, review county MHSA plans, conduct workforce education, develop training plans, and work with counties as advocates or in peer support roles. It is often noted that family representatives in the Pool are divided into families with adult children and families with children under the age of majority. Pool members receive annual training and are involved in curriculum development. Expert Pool members are paid as intermittent part-time State employees.

The implementation of the MHSA has been a stakeholder-intensive process; across the State, public meetings have been conducted during which more than 120,000 individuals provided input. These general stakeholder meetings were conducted twice a year, and, at times, up to 500 individuals were in attendance at public meetings. In addition, as the MHSA was rolling out, DMH conducted statewide conference calls for each specific component plan in advance of initiation. Input collected from these calls was posted on the DMH Web site.

Specific outreach efforts to include consumers and family members who are cultural, ethnic, or linguistic minorities have become an area of increased attention, and DMH has entered into a contract with the University of California Davis Center for Reducing Health Disparities (CRHD) to provide recommendations regarding more effective outreach to minorities.

The DMH has launched an ambitious stigma reduction planning process, with efforts underway to create a strategic plan identifying strategies that can be implemented at the State and local levels to reduce stigma and discrimination. A broad-based stakeholder input process has begun with efforts to ensure input from stakeholders beyond those who are solely public-sector oriented. The intended outcome is a product designed to guide policy makers, program managers, and other interested parties. There are 74 advisory committee members guiding this process for DMH; in public hearings more than 1,000 comments were received from participants in two statewide workshops and a teleconference. The plan will emphasize applying research and using proven science to set the context for plan deployment. The stigma reduction plan was introduced to and adopted by the MHSAOAC. Current plans are to distribute \$60 million over 10

years on this effort, and counties can also spend some of the local prevention and early intervention funding on other stigma reduction efforts. The Client and Family Leadership Committee of the MHSOAC actively participated in the development of the final document. The plan also utilizes Behavioral Risk Factor Surveillance System (BRFSS) data collected by the California Department of Health. This Department and DMH collaborated to add additional elements to the annual surveys. These data will be used as a baseline to track changes in behavior as a result of the initiative.

The MHSA calls for the employment of consumers and family members within the service delivery system. To support this effort, DMH funds Working Well Together, which is a statewide technical assistance center formed as a collaborative venture among the California Network of Mental Health Clients, the National Alliance for Mental Illness (NAMI) California, United Advocates for Children and Families, and the California Institute for Mental Health. This technical assistance center targets efforts to develop consumer and family member employment opportunities within the public mental health workforce. In addition, approximately \$225 million over a 10-year period was allocated to counties for workforce and training, and the county mental health programs are strongly encouraged to hire consumers and family members. Currently, 6.8 percent of counties are reporting specifically designated consumer and family member positions. Each of the five State regions has \$180,000 for 3 years for workforce development activities, including activities targeting consumers and family members. A decade ago, California claimed to have the most consumer employee positions in the country. The county MHSA plans indicate 1,000 positions to be filled, although the budget situation may make this difficult to accomplish. There have been cuts to many positions around the State.

The DMH Consumer and Family Liaison, who sits on the DMH executive team, has responsibility for monitoring mental health contracts with the three consumer and family organizations and the projects on consumer and family member involvement funded through contracts with the California Mental Health Boards and Commissions. The DMH is also the recipient of a SAMHSA Peer Support and Recovery Grant. The 3 main consumer and family organizations funded by DMH are NAMI California, which supports efforts of 76 local affiliates in education, training, and technical assistance; the Network of Mental Health Clients, which seeks grassroots input for identifying and then implementing a diverse range of education, training, and support projects; and United Advocates for Children and Family, which supports statewide training efforts on the part of children and families, including leadership development for youth and transition-age youth and certification of family partners and trainers for the Equip curriculum. In total, the State invests more than \$4,700,000 in funding consumer and family support efforts.

Consumer and Family Rights

The DMH publishes consumer rights in Spanish and English and posts the information on its Web site. Consumer rights are given to clients when they are enrolled in a county mental health system. Consumer rights vary for clients, depending on whether they are receiving service in an inpatient facility or residing in a forensic facility. Children and adults have different rights. Typical grievances include those filed by consumers who are not satisfied with the service-

related decision or quality-of-care issues. Clients are given a notice of action when their services are reduced, changed, or suspended.

Consumers who receive services through the Medi-Cal system have a grievance process that is first reviewed at the county level. If the client issue is not resolved at that level, the consumer may file for a fair hearing by a State administrative law judge.

The counties have a grievance process for clients who do not have Medi-Cal and are served with non-Medicaid funding. These grievance processes vary from county to county. Counties have policies and procedures in place to ensure that consumer rights are protected and enforced by a combination of State and Federal laws and DMH contracts with the counties.

The State has an Ombudsman to respond to all client calls, regardless of insurance status. The ombudsman tries to resolve client problems and then refers the client to the appropriate agency for further resolution and assistance. The DMH Ombudsman tracks the number of calls received on a quarterly basis in a client database. If a trend is identified in a specific county, the trend is shared with the county quality management staff so that they can review the situation and make recommendations or note that staff at a provider level may need additional training.

ADULT MENTAL HEALTH SERVICES

Service Array for Adults

The MHSA envisions a Systems of Care approach to adult mental health service delivery. This approach is characterized by providing recovery-based comprehensive services, team models that rely heavily on interagency collaboration and cooperation to meet clients' needs, voluntary participation of clients in each service identified in a personal service plan, and provision of services on a 24-hour basis to meet all clients' needs, including housing, supported and competitive employment, socialization, education, rehabilitation, legal assistance, money management, mental health treatment, physical health care, and dental care. Some programs include information, counseling, respite, and other services for relatives of clients. Given the county-based structure of the mental health system, counties are largely responsible for service delivery and are also designated as the local mental health, managed care entity for Medi-Cal beneficiaries in their geographic areas. The way in which services are developed and implemented is a county-level process. There has been more attention paid to the activities conducted under the MHSA than to the services provided to Medi-Cal beneficiaries, and the existence of two major, but different, funding mechanisms creates different incentives and deterrents to effective service delivery in both systems.

Within DMH, there has been a functional realignment of staff with the goal of streamlining and simplifying interactions with counties, although another compelling reason for the realignment was to counter the impact of increasing percentages of staff retiring and the loss of institutional memory. The contract with counties for MHSA services specifies the services that are intended to be provided, documentation requirements, accessibility and access requirements, and the way in which EPSDT funds are distributed. Access standards regarding timelines for emergent,

urgent, and routine services utilize routine Medicaid managed care standards. There is no direct negotiation with counties about the contract requirements; rather, the county submits its MHSA Plan, and the contractual agreement reflects funding amounts for approved MHSA programs.

As stated earlier, the most significant need in the adult mental health system is an adequate number of professionals, particularly in rural areas, and also an adequate number of staff who are representative of cultural and racial minorities. Solutions to the staff shortage include loan assumption and stipend programs, an emphasis on peer counselors, and efforts to enhance workforce education and training. In many areas, the system cannot provide expected levels of service due to the lack of professionals.

The residential service array includes several levels of care. Community Residential Treatment Systems are residential homes of 16 beds or less. Within this type of program, there are short-term crisis residential stays with a 30-day limit, transitional residential stays with a yearlong limit, and long-term stays up to 18 months. There are 94 of these facilities serving more than 1,200 individuals. Other State mental health programs that operate a range of residential placements find that it becomes challenging to ensure that individuals move to the next level of care as soon as their condition merits, rather than after the maximum length of stay has been reached.

Special Treatment Programs are skilled nursing facilities; there are 28 of these facilities with 2,528 beds. Mental Health Rehabilitation Centers are residential programs that provide intensive support and rehabilitative services to adults who, without that level of service, would have been placed in a State hospital or another mental health facility. There are 23 of these facilities with 451 beds. Psychiatric Health Facilities are alternatives to acute hospitalization; there are 19 of these facilities with 451 beds (about half are privately operated and half are county operated). The DMH also has responsibility for conducting the PASRRs.

The MHSA also provides system development funds that can be used for housing. Although some counties wanted to use these funds for board-and-care type facilities, the housing-first model is guiding housing development in the State. There are two high-profile housing efforts underway, with the expected result of significant increases in the availability of safe, affordable housing. The MHSA Housing Program began in 2007 and is jointly administered by DMH and the California Housing Finance Agency. This program has been developed with the goal of providing funding for capital costs and operating subsidies to develop permanent supportive housing for persons with SMI who are homeless, or at risk of homelessness, and who are eligible for services under the MHSA. The application for these program funds must include a commitment for service funding from the county mental health department. A total of \$400 million of MHSA funds has been set aside for initial funding of the program, and each county mental health department in California received a portion of the funds that are available for capital costs and capitalized operating subsidies. Local collaboration between county mental health departments and housing developers is essential to the success of the program. Although this program makes a significant commitment of MHSA funds, additional resources such as grants, tax credits, and other loans are also necessary to support the program's continued growth. The most common model thus far seen in urban areas is mixed-use housing with a set-aside

number of units for the MHSA priority population. For example, Los Angeles funding is being used for new housing construction for older adults that will include mental-health-designated units. A few projects dedicated to transition-age youth have been approved, and these are only projects that utilize congregate living. Up to one-third of the MHSA funding will be used for rental subsidies, although the priority placed on new construction was to ensure permanent housing would be developed and sustained over time.

The Governor's Homeless Initiative (GHI) creates a housing finance model that ties together State Department of Housing and Community Development (HCD) capital funding and MHSA funds to encourage development of supportive housing projects that target chronically homeless individuals with SMI. This initiative offers a nontraditional, centralized loan and application approval process. Approximately \$3.15 million from MHSA funds in fiscal year (FY) 2005–2006 was targeted for this initiative. The DMH conducted a series of regional housing trainings throughout the State, with the goal of bringing together county mental health departments, county housing agencies, housing developers, and community-based service providers to share expertise and leverage resources to develop more housing opportunities for homeless individuals with SMI. County mental health department collaboration is a requirement for projects applying for funding under this program, and one of the conditions for approval is the county mental health department commitment to fund the supportive services. To date, five permanent supportive housing projects have been approved under this program.

Across the spectrum of mental health interventions, the MHSA has invested in both early intervention and prevention as well as extensive services and supports envisioned by the full-service partnerships. The full-service partnership is an approach that identifies high-need individuals, provides extensive services and supports, and closely tracks response to these interventions. In between these two points on the continuum of mental health services are services ranging from local crisis units in larger counties to funding availability for outreach and engagement, which includes the ability to pay for supports such as short-term rental subsidies. In rural areas, many of the county mental health programs are connected to the Federally Qualified Health Centers or Rural Health Centers.

Accessibility, Coordination, and Continuity

Access to services is not generalized across all funding streams. Although there are specific access requirements for beneficiaries in the Medi-Cal program, the same requirements do not translate to those served through other funding streams. The development of standard expectations for access and engagement regardless of funding streams would provide the basis for better performance and outcome tracking across all individuals served in the public mental health system.

The county-based nature of the system makes efforts such as integrated funding exclusively the purview of county mental health programs, so while there are collaborative efforts across State-level entities they tend to be in areas of administrative oversight, such as licensing treatment programs or jointly funding social rehabilitation facilities and residential treatment facilities. There is a Co-occurring Disorder Joint Action Committee that meets quarterly and there are also

cross-functional finance, housing, and children's committees within the Department of Alcohol and Drug programs. The DMH has set aside \$8,059,000 of its annual SAMHSA Block Grant for allocation to counties to support existing efforts in providing integrated treatment services for adults with co-occurring disorders. There is also interagency coordination with the Department of Developmental Disability Services.

Addressing specific issues impacting the mental health system is also done through the California Mental Health Directors Association, informally among counties, or by each county on its own. Areas of service coordination currently being addressed include rural issues, development of mental health courts, telemedicine health information technology, and services to special populations. This approach allows local needs to drive priorities, but it also challenges the potential for systemic efforts to address special needs for which legislative support would be invaluable. Three notable areas are addressing the mental health needs of returning veterans, the drivers of forensic commitments to State facilities, and the needs of persons with mental illness in the criminal justice system. For example, MHBG funds are currently being used to partially fund services provided by the United States Veterans Initiative (U.S.VETS), New Directions, Inc., and the Salvation Army in Los Angeles. The funding provides emergency and transitional housing and comprehensive support services for homeless veterans with a history of substance abuse and/or mental illness. Having information about the effectiveness and potential costs and benefits of this program could assist DMH in promoting additional collaborations and seeking legislative funding support. The issue of forensic growth lacks data to quantify the growth drivers, and no State-level policies exist for coordination between the Department of Corrections and mental health providers to ensure successful reintegration of individuals with mental illness being released from prison.

Homeless Services

Point-in-time estimates of homelessness are conducted by counties, but, given the nature of the mental health system, DMH does not collect and summarize these data, thus creating difficulty in presenting a clear picture of the extent of the homelessness problem and impeding advocacy for resources. State staff indicated that the estimate of homelessness in the California MHBG plan is in error in stating that there are 50,000 individuals who are homeless on a given day. As a point of reference, these staff state that local homeless surveys confirm that there are an estimated 83,000 homeless individuals in Los Angeles alone on any given day. Of that number in Los Angeles (a number easily extrapolated to the rest of the State), a significant proportion is veterans.

Over the past 7 years, DMH has endeavored to expand the availability of safe, affordable housing with accessible services for individuals with SMI. This effort has involved collaboration among agencies (both public and private), State Departments, county departments, and many stakeholders. Beginning in January 2005, the MHSA provided a new funding source for services, and safe, affordable housing was recognized as a critical element for recovery. During the past 3 years, a range of housing services and supports has been included in the initial implementation of MHSA programs. In addition to housing services and supports that have been developed through the MHSA, there have also been the two statewide housing initiatives

(mentioned previously) that focus on expanding permanent supportive housing resources for persons with SMI.

The Projects to Assist in the Transition from Homelessness (PATH) grant funds community-based outreach, mental health and substance abuse referral, treatment, case management, and other support services, as well as a limited set of housing services for homeless persons who have mental illness. During SFY 2009–2010, a total of 47 counties elected to participate in the PATH program. County programs serve homeless persons with a variety of local revenue streams, but the PATH grant augments this effort by providing services to approximately 15,000 additional persons annually. Each county determines the use of PATH funds based on local priorities and needs, although all of the counties that receive PATH funds must establish one or more programs of outreach to, and/or services for, persons who are homeless and have mental illness.

CHILDREN’S MENTAL HEALTH SERVICES

Service Array for Children

Parents and children are viewed as essential partners and regarded as the best source of information when it comes to providing services for children, youth, and families. A wide range of services is available for children and youth with SED and their families through the 58 county departments of mental health and hundreds of certified community-based providers. California law requires the availability of a minimum array of services for children with SED to the extent that resources are available. Children with Medi-Cal are entitled to specific services that are covered under Medicaid. Non-Medicaid children and youth receive services based on funding at the county level for services.

Service issues identified by the DMH Community Services Division staff include the following:

- Services are hard to find or do not meet the need of the child and family, but children and youth remain in these services to continue to have services.
- Children and youth with SED are likely to have unsuccessful education experiences. Services are focused on behaviors and not on support of childhood development and intellectual growth.
- Children and youth with SED often exhibit violent or abusive behaviors toward their families and caregivers. Lack of services leaves the family with few options other than to call the police.
- Services need to be consistent with natural supportive environments that reflect client values and help-seeking behaviors.
- There are not enough supportive environments for transition-age youth.

- In the workforce, family and youth partners need to be developed as professions. There is a need to have statewide definition of roles, skill sets required, standards of care established, and training.
- Mental health programs for children and youth and their parents and caregivers need to incorporate an understanding of culture, traditions, beliefs, and culture-specific family interactions.
- There are not enough child psychiatrists in rural areas of the State.

Accessibility, Coordination, and Continuity

As noted in the Adult section of this report, children and families needing to access mental health services do so through the county-operated mental health systems. Because the counties are responsible not only for mental health services but also for juvenile courts, substance abuse treatment, child welfare, county education systems, and health services, the county-operated systems are able to collaborate and coordinate services for children, youth, and families.

School-based services are provided at some schools throughout California and are available at a few school health care centers or onsite at a community mental health service provider. County departments of mental health may also participate in the county's court schools or juvenile justice programs, which provide educational and treatment services for youth with educational needs, legal issues, and medical conditions.

A Federal grant supports a program of the California Workforce Investment Board to improve transition outcomes for youth with disabilities. Efforts focus on vocational and academic learning to assist youth in obtaining work experience while they are attending school. The projects are funded in three local workforce investment areas of the State. The Transitional Housing Placement plus Program (THP-Plus) provides services for former foster care youth and is administered by the California Department of Social Services. The THP-Plus provides affordable housing and support services to help former foster care and probation youth ages 18–24 to make the transition from out-of-home placements to independent living.

According to the DMH Community Services Division manager, approximately 70 percent of the children served by the mental health system are eligible for California's Medi-Cal program, which provides medical care for children and their families who receive public assistance or whose income is not sufficient to meet their medical needs. The Denti-Cal program provides for a comprehensive array of dental services. All Medi-Cal children and youth are screened for health, dental, mental health and substance abuse needs through the EPSDT screening tool. Primary care physicians and pediatricians are required to provide ongoing screening for children and youth enrolled in the Medi-Cal system.

Although the counties provide mental health services, a major challenge is that services can vary from county to county. Rural county areas may not have as extensive a service array or a choice of providers as in the urban and suburban areas of the State.

Out-of-State Placement

The DMH Community Services Division staff reported that the mental health system does sometimes send children out-of-State for treatment. There are not enough State resources that children may have to go out of the county for specialized residential care.

Only county mental health agencies place children and youth out-of-State when it is necessary to meet their individualized education plans (IEPs). These children must have a disability of emotional disturbance, and there must be no in-state placement available that will meet their needs. For example, children and youth who have a diagnosis of emotional disturbance and severe hearing impairment may be placed out-of-State for educational purposes in a specialized setting.

Homeless Services

The counties contract with local nonprofit organizations and homeless services for children, youth, and transition-age youth. Services include identifying and engaging homeless and runaway youth and linking them to mental health services. Services help to identify and link children and youth to providers for treatment. County programs use interagency case management teams to maintain an active followup for homeless youth known to the system. Case management teams make referrals for education, employment, and housing.

Many youth in California who are homeless are in this situation due to lack of an adequate transition system as the youth approach adulthood. Transition-age youth ages 16–25 are a discrete age group identified in county mental health service plans. The MHSA has allocated funding for youth programs to provide a variety of housing options, which includes the development of congregate living and studio apartments.

FINANCIAL MANAGEMENT

Fiscal Context of Community Mental Health Services

With a State population of more than 35 million individuals and a current DMH budget of \$6.1 billion, the scope of financial management for California's mental health service delivery system is enormous. Community mental health services are provided through a management system of 57 of the 58 counties (Sutter and Yuba consolidate efforts and funding) county governments and two city-operated mental health programs. The California DMH functions as the SMHA with programs and services contracted to the county and city provider entities functioning as Community Services Agencies (CSAs). The DMH is responsible for ongoing administration, program development, fiscal management, and policy direction of publicly funded community mental health services and State-operated mental health hospitals.

Within DMH, financial and administrative functions are managed by the Department's Administrative Services Division (ASD), one of five divisions in Department operations. This Division is responsible for budget development and management, allocation of appropriated

funding, information management, DMH personnel management, and contracting for and monitoring of community mental health services. The following offices are included in the ASD: Financial Services (Budgets, Accounting and Fiscal Systems {Disbursements, Financial Records, Reporting, Accounts Receivable, and Fiscal Systems}, and Fiscal Policy) and Human Resources (Staff Development, Labor Relations, Personnel, and Business Services). Other supporting Divisions include Information Technology (Application Development and Infrastructure Services), Program Compliance (Licensing and Certification, Medi-Cal Oversight, and Audits), and the Office of Health Insurance Portability and Accountability Act (HIPAA) Compliance within Legal Services. The ASD Deputy Director is supervised by the DMH Director and currently serves as Acting Chief Deputy Director.

Management of State mental health hospitals is an important responsibility for DMH in addition to functioning as the SMHA for community mental health services. The ASD provides financial and administrative support for State hospitals and for all other elements of the Department. The DMH also has responsibility for Medicaid services for statewide mental health programs and performs management oversight of the Medi-Cal program for mental health services.

Budgetary Planning

California's fiscal year extends from July 1 through June 30 of the following calendar year. Preparation for a fiscal year budget begins in July, 1 full year prior to the beginning of the fiscal year for which the budget is prepared. Budget development begins with the Governor's published instructions and guidelines issued through the State Director of Finance. Departmental staff begin the budget planning process utilizing the information provided by the Governor and other State offices. Information such as projected revenues and special funds, a projection of anticipated growth in government or level funding, and other factors is reviewed by DMH staff in preparing the preliminary DMH budget plan. The Department of Finance reviews the preliminary budget and works with departmental staff to make adjustments to refine the budget proposal. This process is expected to be completed by December 31 each year. The Governor is required to submit a balanced budget to the State legislature by January 10 each year.

Finalization of the proposed budget continues through the spring as the legislature conducts hearings and receives input from citizens and stakeholders. Subcommittee meetings and budget hearings are generally concluded by the end of March. Formal passage of the budget by both the State Senate and the State Assembly is expected by June 15 for presentation to the Governor for signature. A two-thirds majority of each legislative body is required for passage of the State budget.

Once the State budget is enacted by the legislature and signed by the Governor, Departments are expected to adhere to budgeted spending levels and to comply with policies and procedures contained in the budget document. The State has a process for requesting budget amendments with the State Controller's Office having authority over this process. Such requests are channeled through the State Director of Finance and are subject to review by the Governor and legislature.

The California community mental health system has benefited over the past 4 years by additional revenues generated from a new tax specifically designated for mental health services. This factor and strong support for mental health services enabled the DMH budget to grow from \$4.1 billion in SFY 2005–2006 to the current \$6.1 billion. Additionally, community mental health funding increased by 85 percent from SFY 2005–2006 through SFY 2007–2008. Factors affecting the State and national economies, however, have required California to reduce its current mental health budget and to plan for a reduction in its budget for the upcoming fiscal year. Significant in this scenario is the drop in property values and the consequential loss of real estate tax revenues, as well as investment losses by California citizens. Previously, California was experiencing significant housing development and a robust business climate.

Revenues and Expenditures for Mental Health

Revenues for mental health services provided in community mental health programs in the State of California are identified in the table below. The MHBG revenues for SFY 2007 and SFY 2008 are estimated. All dollar amounts are stated in thousands; for example, SFY 2008 revenues total \$3,489,904,000.

Table 1: California Community Mental Health Revenues

Revenue Source	SFY 2006	%	SFY 2007	%	SFY 2008	%
State General Revenue	\$342,591	11.1	\$1,048,194	25.2	\$784,189	16.3
Proposition 63 (MHSA)	167,206	5.4	515,826	12.4	1,509,954	31.5
Other State Funds	984	0.0	1,568	0.0	1,522	0.0
Medicaid Federal Financial Participation (FFP)	1,310,190	42.4	\$1,305,572	31.4	1,130,905	23.6
MHBG Funds	54,545	1.8	55,006	1.3	55,006	1.1
Other Federal Funds	7,984	0.3	8,286	0.2	8,328	0.2
<u>Realignment</u>	1,203,095	39.0	1,229,995	29.5	1,308,337	27.3
Grand Total	\$3,086,595	100	\$4,164,447	100	\$4,798,241	100

Source: DMH budget report, Health and Human Services Agency.

Total revenues for community mental health programs increased by 85 percent from SFY 2006 through SFY 2008. During this same period, State General Revenue for community mental health increased by 128 percent. Additionally, the community mental health program in California has benefited greatly by the passage of the MHSA, also referred to as Proposition 63. This special tax, dedicated to mental health programs, increased by 800 percent from SFY 2006 to SFY 2008. During this 3-year period, the Federal portion of Medicaid for mental health services decreased by 14 percent.

The table below reflects expenditures for all State-supported mental health programs. An analysis of the SFY 2007–2008 maintenance of effort (MOE) schedule reflects a 45-percent share of total expenditures for children’s community programs and 55 percent for adult community programs. The Governor’s Budget Summary 2009–2010 (presented to the State legislature January 9, 2009) shows total Department of Alcohol and Drugs expenditures for SFY 2007–2008 at \$290,949,000 and the Health and Human Services Agency budget for SFY 2007–2008 at \$36,953,809,000. Expenditure amounts in the table below are stated in thousands; for example, the total budget for DMH for SFY 2008 is \$4,723,732,000.

Table 2: California Mental Health Expenditures

Program	SFY 2006	%	SFY 2007	%	SFY 2008	%
Community Mental Health Services (MHS)	\$1,883,500	46.0	\$2,934,452	55.0	\$3,489,904	58.0
Community MHS Realignment	1,203,095	29.0	1,229,995	23.0	1,308,337	22.0
Other Programs	120,000	3.0	66,000	1.0		
Inpatient Mental Health Services*	892,568	22.0	1,105,049	21.0	1,233,828	20.0
Total Mental Health Services	\$4,099,163	100	\$5,335,496	100	\$6,032,069	100

Source: DMH budget report, Health and Human Services Agency.

*Inpatient Mental Health Services are for State hospitals only. Ninety-two percent of the inpatients are judicially committed (i.e., Not Guilty by Reason of Insanity, Incompetent to Stand Trial, Sexually Violent Predator, etc.)

Total expenditures for DMH programs increased by 63 percent from SFY 2005 through SFY 2008, with an 85-percent increase in community programs and a 38-percent increase in State inpatient programs. The DMH staff report that the State’s accounting system allows up to 2 years paying obligations supported with State revenues. This provision may account for expenditure amounts being listed as “estimated” at a point when most States would have closed their accounts on the previous fiscal year.

Receipts from the MHSA have grown since SFY 2008 but may experience slower growth or some decline as national economic issues affect California. Property values and property taxes are being affected by these economic issues. The current DMH budget is approximately \$6.1 billion and will likely remain near that figure or slightly lower next year.

Other efforts by the SMHA to maximize funding and to develop new funding include educating county program staff about the availability of grants based on county-State partnerships for expanded mental health services and the potential of expanded Medicaid revenue with the use of additional FFP by the county. Management of MHSA funding includes a provision for reversion and redistribution of these funds when counties fail to spend their allotment in a given fiscal year. These funds can be rolled over to the next fiscal year or reallocated. The county-based community mental health service delivery system also creates the opportunity for the

development of county revenue through tax levies or special appropriations for county mental health services.

Contracts and Grants Management

Data Management

Data from all components of the State's management information system (MIS) are available to DMH financial management staff for the purpose of program evaluation from a fiscal perspective and analysis of client service costs. Staff are able to produce regular monthly and quarterly reports on system cost factors and ad hoc reports when desired. Client demographic and service encounter data are reported by the county programs on all clients served, including those services funded by Medi-Cal. The Department's Information Technology Division has produced several extensive reports on the Department's performance outcomes and on client service costs. The State's MIS program and ASD are capable of determining service unit costs and case rates in individual program areas. Available data are sufficient to meet the requirements of the Mental Health Statistics Improvement Project (MHSIP) as well as State projects for reporting on performance outcomes.

County programs submit data for billing contracted client services monthly. Service units are reported by individual client identification number and include all services provided for each client within the month billed. Services can be verified by tracking the events back to the client's individual medical record. Analysis of summary client billing information is used by Financial Management staff for budget development and allocation of funds.

Distribution of Funds to Community Service Agencies (CSAs)

California's community mental health system is designed as a county-based system with the 57 county governments responsible for managing or providing community mental health services. The DMH Director states that smaller counties provide as much as 100 percent of contracted services, and larger counties provide from 70 percent to 80 percent of the services contracted. Services not provided by the county are subcontracted to other local providers with county oversight. Based on this established system, funds are allocated to the 57 counties in accordance with rules and procedures governing State and Federal funds. The MHSA requires that funds collected from this tax shall be returned to the counties with State oversight.

Each year, counties are required to complete a renewal application for all MHBG funds available to them. The application requires a plan and budget for the upcoming fiscal year and begins with the anticipation of base year allocations. The projected budget and plan is adjusted based on expected funding in accordance with directives from the Budget Office. Some funding sources have their own allocation methodologies, and other funds are allocated in accordance with rules and guidelines established in the budgeting process. Programmatic data and prior year expenditure experience are considered in allocating funds in this process. If a county has not expended all its MHBG funds received in the current year, those funds are reallocated to the

county for expending in the first quarter of the new fiscal year. The California MHSA does not provide funding to for-profit entities.

Contracts between the SMHA and the county governments are thorough and explicit in including required contract items, such as prohibited expenditures, Federal Grant Catalog of Federal Domestic Assistance (CFDA) numbers, eligible expenditures in accordance with Office of Management and Budget (OMB) Circular A-87, caps on salaries, and limits on administration expenditures. The requirement for an OMB Circular A-133 audit is covered by reference, and ASD staff have agreed to include a more direct provision for this requirement in upcoming contracts. The Funding Agreement attachment to the contract includes the MHBG amount and the MHBG CFDA number and describes the eligible client populations and core services to be provided. The MHSA contract with the counties also requires the county to pass along the above stipulations in its subcontracts with local provider entities should they engage in such subcontracts.

The DMH monitoring process includes the review of subcontract entities. These providers are monitored by the DMH Program Compliance Division. Oversight of subcontracted services from a fiscal perspective is incorporated into the process used to manage the payment for services submitted by the county. Subcontracted services are reported to DMH by the county holding the subcontract.

State CSA, Subrecipient Awards/Contracts

As described above, contracts with county governments (and their subcontracts) are based on cost reimbursement with a fixed price per service determined through a negotiated rate process. This is not a sole source or competitive process, it is a process created by State legislation. All contracts contain narrative mandating that all MHSA contracts (and subcontracts) must be administered in accordance with State law, regulations, and procedures.

Fiscal Oversight, Monitoring, and Audits of CSAs

County providers are required to submit client encounter data and billings for services rendered monthly. In addition to OMB Circular A-133 audits, the counties are also required to submit an annual cost report, due by December 31 for the prior fiscal year. These cost reports reveal how the county determined the cost of each service type and service event. These audits and cost reports are required to adhere to cost principles included in OMB Circulars A-133 and A-87 regarding eligible expenditures and prohibited costs. Auditors forward their reports to ASD, identifying findings related to all funding sources, including MHBG funding.

County provider audit reports are sent to the State Controller's Office. Reports with findings relevant to DMH, such as MHBG findings, are forwarded to the DMH Program Compliance Division, Audits Branch. Followup is provided by the Audits Branch with assistance from ASD Financial Services as required. The Audits Branch has the responsibility for resolving the issue(s) with the involved provider entity.

Unspent funds are usually determined prior to the issuance of the annual audit report. There are different rules for addressing the issue of unspent funds, depending on the source of funding. The MHSA funds can be carried forward over a period of 3 years and can revert for redistribution or reallocation. When MHBG funds are unspent at the close of a State fiscal year, they can roll forward to the same contract entity to be spent during the first quarter of the next fiscal year. Other State funds and MHBG funds not spent within the mandated timeframes for each fund source revert to the State Treasury or are returned to the Federal Government in the case of MHBG funds. These issues are included in State Financial Services guidelines.

In the past, some of the State's smaller counties have not performed in accordance with contract requirements regarding the submission of an OMB Circular A-133 audit report. In March 2009, the California State Auditor notified DMH that the Department was not in compliance with the requirement for county submission of OMB Circular A-133 audit reports and followup requirements on this issue. The DMH Program Compliance Division, Audits Office accepted the State Auditor's recommendation and developed a process for ensuring compliance with this requirement effective March 30, 2009. The DMH Program Compliance Division is prepared to implement sanctions should this be required at the close of this calendar year. Other issues were also cited in the State Auditor's report and will be addressed in subsequent sections of this report.

Audit reports performed in accordance with OMB Circular A-133 and received by DMH contain a separate report titled "Reports Required by OMB Circular A-133." These reports list all Federal funds received by the community provider and include the respective Federal CFDA number and the amount of Federal funds expended by the agency/county. The SMHA can determine the amount of any unspent Federal funds by the provider by comparing the amounts reported in these audits with the amount of Federal funds contracted to the entity. One of the most recent county audits revealed an underspending of MHBG funds. The DMH has collected those funds from the involved county.

Additionally, the Financial Services-Fiscal Policy office includes a section called Grants Allocations and Rates, which tracks the allocation and expenditure of MHBG funds by fund recipient. This office provides a quarterly tracking log for the management of MHBG funds. This log identifies expenditures, payments, and underspent amounts that are to be rolled over to the provider's subsequent fiscal year contract.

California has a process for recovering and returning underspent Federal MHBG funds to SAMHSA and utilized this process in returning a portion of its Federal fiscal year (FFY) 2007 MHBG funding to SAMHSA. A Financial Status Report (dated December 16, 2008) was submitted to the Center for Mental Health Services (CMHS) detailing this transaction.

Additional fiscal oversight of State accounting procedures and processes is provided by the Bureau of State Audits under the direction of the California State Auditor. Findings developed by this office are included in the annual Single State Audit. Issues raised regarding DMH fiscal operations during the most recent Bureau of State Audits review are discussed in the section of this report relative to the Single State Audit.

In addition to the fiscal operations and accountability activities by the SMHA discussed above, the Assistant Deputy Director for Financial Services is responsible for the Accounting and Fiscal Systems section, which includes Accounting Disbursements. The Accounting Disbursements section provides additional accounting support for tracking MHBG funds. The activities of this office and the Grants Allocations and Rates section housed in the Fiscal Policy office work together to ensure that MHBG funds are expended within the 2-year grant period for which they are awarded. The MHBG funds are tracked by accounting codes that identify the funds as MHBG revenue and by award year. The 2008 Single State Audit contains a comment on expending MHBG funds within the 2-year eligibility period.

A review of the DMH Federal grant tracking process shows that the Department’s procedures and process are consistent with systems used by other States and should provide the accountability to ensure that funding is fully utilized. The DMH, however, did report unspent MHBG funds of \$4.5 million for FFY 2007. This payback resulted because of a difference in the methodology for capturing eligible MHBG expenditures as applied by two different accounting offices within DMH. An in-house audit of Financial Status Reports (FSRs) revealed errors over a period of years resulting in a cumulative overstatement of prior MHBG expenditures in the amount of \$4,597,465. This situation was remedied by reducing MHBG expenditures reported in the FFY 2008 FSR. This was a one-time occurrence, and the Fiscal Policy Office and the Accounting and Fiscal Systems Office are now using the same methodology for capturing MHBG expenditures. A review process has been implemented to ensure that such errors do not occur in the future.

The DMH complies with the requirements of the Federal Cash Management Act as it makes requests for MHBG funds quarterly based on eligible MHBG expenditures. All State and Federal funds are identified by specific accounting codes in the State’s financial system and in contracts with provider entities. Contracts also identify target populations and core services for which funding is allowable. The State and county accounting procedures enable the SMHA to ensure that funds are not “blended” and that prohibited costs are not covered by MHBG funds. The 2008 Single State Audit contains a comment on prohibited costs.

The Community Mental Health Services Block Grant Expenditures

The table below shows the amounts of MHBG awards and MHBG expenditures for the year under review and the 2 preceding years.

Table 3: California Mental Health Block Grant (MHBG) Awards and Expenditures

Item	2005–2006	2006–2007	2007–2008
Award (FFY)	\$54,955,073	\$55,061,465	\$53,728,412
Expenditures (SFY)	\$54,545,000	\$55,006,000	\$55,006,000

Source: FFYs 2006 and 2007 award information is from CMHS Block Grant Award Notices. The FFY 2008 amount is from the CMHS Web site. Expenditure amounts come from the State’s Supplementary Schedule–Federal Funds Reimbursements. (Expenditure amounts for SFYs 2007 and 2008 are estimated amounts.)

All MHBG funds, except for the portion used for DMH MHBG administration, are allocated to the 57 counties that provide community mental health services for the citizens of California. Contracts with the counties identify the client populations to be served with these funds and stipulate the core services to be provided.

The DMH defines an obligation as a commitment of funds for payment or support of services or products with payment to a specific entity. Obligations are supported by documents such as allocation schedules, contracts, or funding agreements. Expenditure of MHBG funds is tracked by grant award year to ensure that the funds are expended within the 2-year period pertinent to each award.

Maintenance of Effort (MOE) (Section 1915(b)1)

Expenditures included in the DMH MOE calculation are described in the DMH MOE schedule. This schedule includes directions for inclusion of specific expenditure categories and amounts and stipulates that only expenditures for adults with SMI and children with SED are to be included. Eligible expenditures for services provided to these two client populations are those paid with State General Fund revenues. No expenditures for inpatient services are included in the MOE computation. Expenditures connected to managed care services and to realignment funding are estimated based on a formula that allocates a portion of these expenditures to adults with SMI. The 2008 Single State Audit contains a comment on the MOE/SED calculation methodology.

The completion of the DMH MOE schedule is assigned to a staff member of the Budget Office within the Accounting and Fiscal Systems Office. The Assistant Deputy Director (ADD) for DMH is also the Chief Financial Officer and reviews and approves the MOE report prepared by DMH Budget Office staff. The MOE calculation methodology has not changed since it was originated. State matching funds for Medicaid services are not included. The following table provides a summary of DMH MOE expenditures. The SFY 2005–2006 amount is actual, and the SFYs 2007 and 2008 amounts are estimates based on current accounting data.

Table 4: California SFY 2008 Maintenance of Effort (MOE) Expenditures

Year	Expenditures	Average	Requirement
SFY 2005–2006	\$1,519,953,000		
SFY 2006–2007	\$1,988,473,000	\$1,754,213,000	
SFY 2007–2008	\$2,069,553,000		\$1,754,213,000

Source: DMH MOE/Set-Aside Report (SFYs 2007 and 2008 amounts are estimated.)

FFY 2008 MHBG Application.

The estimated amount listed in the Application for FFY 2008 is \$2,098,317,000. The difference in the two amounts is due to the subsequent recording of financial transactions pertinent to the fiscal year and to the fact that both amounts are estimates. The DMH FFY 2011 MHBG Application lists MOE actual expenditures for SFY 2008 as \$2,098,317,000, as well. It is

expected that the actual expenditure amount will vary from the estimated amount when final MOE calculations are determined. Based on a review of DMH expenditure reports, it is clear that California meets its MOE requirement for SFY 2008.

Children's Set-Aside (Section 1913(a))

Expenditures for community mental health services for children diagnosed as having SED are summarized in the following table. Only expenditures for community-based services paid with State General Revenue funds are included in this amount. No MHBG-funded expenditures are included in the DMH children's set-aside amount. The DMH, through its contracts with provider entities and service reporting procedures, ensures that expenditures for children with SED are reported accurately. Expenditures connected to managed care expenditures and to realignment funding are estimated based on a formula that allocates a portion of these expenditures to children with SED.

Table 5: California Children's Set-Aside Expenditures FY 2008

SFY 1993–1994 Base	SFY 2005–2006	SFY 2006–2007	SFY 2007–2008
\$160,683,000	\$281,863,000	\$291,296,000	\$301,890,000

Source: DMH MOE/Set-Aside Report.

The amount of set-aside expenditures for SFY 2005–2006 is actual expenditures, and the amounts for SFYs 2006–2007 and 2007–2008 are estimates based on current accounting information. The State of California continues to meet its children's set-aside requirement.

Administrative Expenditures (Section 1916(b))

The DMH charges eligible administrative expenditures to the MHBG based on an allocation methodology utilizing personnel assigned to MHBG activities. The methodology has not changed and the amount charged to the MHBG is always limited to the 5 percent allowed. An analysis of the State of California Supplementary Schedule–Federal Funds/Reimbursements for the past 3 State fiscal years indicates that administrative costs attributed to the MHBG are as follows:

SFY 2006=Actual 5.1 percent; SFY 2007=Estimated 5.9 percent; and SFY 2008=Proposed 5.9 percent. Administrative expenditures charged to the MHBG for SFY 2008 total \$2,686,421. This amount is less than the 5 percent allowed. If the allocation methodology is applied as stated above, the amount of administrative costs charged to the MHBG would be limited to 5 percent, irrespective of the actual amount of administrative expenditures attributed to this activity. The 2008 Single State Audit contains a comment on the allocation methodology for allocating administrative expenditures to the MHBG.

Annual Audit (Section 1942)

The most recent Single State Audit for California was conducted for SFY 2008. The DMH was notified of the audit findings March 26, 2009. Eight of the nine items reported in the audit are relevant to the MHBG, with one of the eight not a financial issue. None of the items identified any “questioned costs.” All eight items pertained to processes and procedures. The following table identifies issues related to the MHBG noted in the SFY 2008 Single State Audit.

Table 6: California Single State Audit Mental Health Block Grant (MHBG) Issues

Reference Number	Issue Description	Target Date
2008-1-12	Process for determining allowable costs	Sept. 2009
2008-3-13	Procedures for monitoring county advance payments	Sept. 2009
2008-7-13	Procedure for determining MHBG administration	Sept. 2009
2008-7-14	Methodology for documenting MOE & SED expenditures	Sept. 2009
2008-13-23	Subrecipient monitoring/CFDA number – OMB Circular A-133 audits	May 2009 Mar. 2009
2008-14-10	Peer Reviews	Oct. 2009
2008-8-11	Procedures ensuring expenditures within 2-year period	Mar. 2009
2008-9-2	Passing on requirement for suspensions & debarments	May 2009
2008-12-15	Segregation of duties, Financial Status Report	Mar. 2009

Source: California 2008 Single State Audit and DMH Corrective Action Plan.

The DMH submitted an updated Corrective Action Plan (CAP) to the California Department of Finance on August 6, 2009. All audit items were addressed with corrective action being completed on three MHBG issues by May 2009, and four MHBG issues were scheduled for completion by September 2009. The issue regarding peer reviews is scheduled for completion by October 2009. The DMH was advised by this reviewer to determine if these audit issues are subject to review by the Federal awarding agency.

The DMH processes and procedures examined during this review appear to be consistent with accounting processes and procedures reviewed in other State MHBG reviews. It is not clear if issues existed in the implementation of established processes and procedures or if the auditors identified weaknesses in the processes and procedures through a more detailed analysis of these issues. Given the number of DMH Financial Services staff who have limited tenure with the Department, it is recommended that the ASD Director request a followup review by the Bureau of State Audits.

Other Requirements not Covered Elsewhere

No funds were used by the SMHA to satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds.

CHAPTER III: SUBURBAN SYSTEM SNAPSHOT

Program Description

Placer County is located 36 miles from Sacramento. The county has a historic background and was established during the time of the gold rush during the 1840's. Auburn is the county seat. Other county towns include Roseville, Loomis, Newcastle, Penryn, Rocklin, Lincoln, Sheridan, Foresthill, Colfax, and Weimar. The county population is 341,945.

Placer County is a county-operated mental health, public health, substance abuse, and social services agency organized and operated as a fully integrated multiagency model that is noteworthy in the utilization of a team-based structure for both adult and children's services. The teams are staffed by professionals from several agencies and utilize a matrix supervision model that allows for oversight by both the team leader and the home agency of the individual team members. In addition, there are more than 100 contracted private providers, primarily utilized to serve the Medi-Cal program enrollees, although it should be noted that contracted providers have only recently been utilized to serve the adult population.

The leadership of Placer County has concluded that the current and potential future funding reductions, coupled with the increased demand for services, mean that the service delivery model it has used is unsustainable. Consequently, the leadership is launching efforts to more actively engage the community in the development of services and strategies that will provide an alternative to the traditional mental health system. This will result in focusing existing resources on crisis services and little else. Placer County has introduced the concept of a "learning collaborative" as a means to engage the community in problem solving and solution development. The ultimate goal is to utilize more natural supports and resources for the individual with serious mental illness (SMI) or a child with serious emotional disturbance (SED) as augmentation to the limited capacity of the county mental health system. There are proportionally fewer Medicaid eligible individuals in the county, so the intended reductions of traditional mental health services will have a major impact and will require engaging the community in new ways. This is an area where the leadership believes that technical assistance would be beneficial.

Another area where there are challenges is in the resources that must be dedicated to addressing oversight and data-reporting requirements. Within the various county Health and Human Services departments, different divisions have different requirements, reporting timeframes, and definitions for similar services. Placer County has experienced challenges in implementing its proprietary data system, as have other California counties; however, Placer County is adamant that it, and other counties, would not accept a State-hosted solution. The introduction of the integrated service delivery model will make data collection and reporting quite challenging. This integrated service delivery model represents the significant challenges confronting DMH in its efforts to quantify the value of the investment in mental health services in a system committed to complete county autonomy. Coming to a realistic compromise to develop a consensus data

strategy will be important for DMH and the county-based programs if they expect to keep pace with the rapid changes underway in health information technology.

Quality Improvement

The Quality Improvement (QI) plan is thorough, with performance indices for all of the services in the integrated framework, including but not limited to mental health. Performance data are collected, analyzed, and shared with the service teams. The QI plan also incorporates the agency's cultural competency plan and associated measures. One issue that the QI process has recently addressed is the assessment of wait times for services and the adequacy of the entry points into service. As a result of this effort, the access points into service were redesigned to be more efficient and welcoming. There also have been several county-specific studies conducted, one of which resulted in changes to the appeal and grievance forms, and another in changes to assessments so that the agency can be more effective at engaging the consumer and family. The quality oversight process includes annual site-based surveys of all contracted providers. Surveys are conducted by representatives from the QI Office, client rights, the designated ombudsman, and program staff. A combination of State-defined and local standards is used for these reviews. The QI Committee has broad representation, including community providers, and is linked with committees that have been created under the auspices of the Placer County Policy Council.

The Department of Mental Health (DMH) outcome reporting system regarding consumer and family perceptions of care consists of data collected during a 2-week period each year. Due to the lag time in obtaining results from this process, however, Placer County utilizes the free text responses to the DMH-conducted Consumer Perception surveys to obtain early feedback that it shares with stakeholders and utilizes in QI activities. Outcome data collection for the full-service partnership consumers presents a greater challenge, both in terms of the required data and in the ability to extract data from the State data system on county-specific clients.

Consumer and/or Family Involvement

The agency has recently developed relationships with local Latino and Native-American community organizations in an effort to better engage significant minority populations in the county and ensure that their services are known to those communities. The Substance Abuse and Mental Health Services Administration (SAMHSA) Recovery Support Grant funding was partially used to augment these efforts.

Placer County has funded a Welcome Center designed to be a point of engagement to individuals in the community who may be in need of mental health services or supports. Consumer navigator positions have recently been introduced, and these persons are stationed at the Welcome Center to assist consumers in getting connected with and obtaining needed community resources and services, particularly employment services. These positions are both volunteer and paid. Consumers are also assigned to the cross-functional teams that are responsible for service delivery. A consumer council guides the activities of the Welcome Center and serves as a communications vehicle with agency staff regarding agency programs and services. Consumers also serve on homeless outreach teams, and the agency supports a senior peer counseling

program. A consumer/family member is assigned to the crisis team, and his/her role is to offer early engagement and support services to both consumers and their families on first contact with the mental health system. Placer County reflects what was stated by DMH staff: funding reductions have impacted consumer-directed services and the hiring of consumers.

ADULT SERVICES

Coordination and Continuity

There are limited specific efforts or initiatives with special populations such as those with medical issues, minorities, older adults, and persons with disabilities, or with agencies serving them, although the multifunctional team structure integrates a number of social service agencies staff within the county health and human services umbrella. Although opportunities exist for additional outreach, budget issues and the financing structure will limit the county program's efforts to seek out additional service recipients.

When consumers who are known to the system are hospitalized, engagement is maintained with their caseworkers. Consumers who are new to the system are placed into an aftercare group postdischarge with nursing and psychiatric support, seen within 2 weeks, and then triaged into other services as needed. This process replaced scheduling appointments with a psychiatrist because it became more difficult to get an appointment scheduled within that timeframe given the limited amount of psychiatric time available. The local inpatient psychiatric facility is managed by a private company, but clinical services are under the direction of the agency's medical director. Individuals with private-pay insurance or Medicare are not triaged by this program but referred elsewhere. When individuals are discharged from forensic facilities on conditional release, they are served by a small specialty program for this group. There are no arrangements with the prisons to coordinate the referrals of inmates with mental illness who are being released back to the community.

The budget crisis has impacted adult services to a greater degree than children's services due to the financing for adult services being supported less by Medicaid. This situation has impacted funding for the consumer support positions, particularly those involved in supported employment. There is also concern on the part of the program's staff about individuals receiving Supplemental Security Income (SSI) becoming employed and losing their benefits. Despite this, it would appear that there are opportunities for the county to better develop outreach efforts with local employers regarding employment opportunities for consumers. Similarly, the county housing authority and the mental health program have not been involved to any significant degree in cross-agency coordination efforts. Placer County has enjoyed an 8-year-long collaboration with the local chapter of the National Alliance for Mental Illness (NAMI) for the development of housing resources for consumers. The program has created 13 housing units targeted to individuals who are at risk of homelessness. More recently, NAMI has created a separate corporation to focus on creating additional housing resources. Some of these resources are funded through the Department of Housing and Urban Development (HUD). There are additional plans to develop shared housing, which will serve more in the capacity of assisted living for individuals who require individualized supports.

Delivery Strategies

Crisis services are provided using a team-based model with consumer members on the team. There is also a 24-hour crisis phone line. Most of the individuals who are evaluated for dangerousness and the need for inpatient hospitalization are seen at local emergency departments, primarily the one located in Roseville, which also has 16 dedicated psychiatric beds. More than half of the referrals for adult mental health services are made by police, and there has been a good working relationship with law enforcement, including the provision of annual Crisis Intervention Team (CIT) training to local police departments. Psychiatric services availability has also been reduced; the county-employed psychiatrist is rotated around various areas in the county.

CHILDREN'S SERVICES

Coordination and Continuity

Placer County has implemented Systems Management, Advocacy and Resource Teams (SMART) to promote system change and expand services to at-risk children and families. The countywide Systems of Care approach is overseen by the SMART Policy Board, which integrates funding from Child Welfare Services, Mental Health, Alcohol and Other Drugs, and other county services targeting children, youth, and families.

The organizational structure of SMART comprises a Policy Board and the SMART Management Team (SMT). The Board is composed of the Department leaders of Placer County Probation; Health and Human Services; Children's System of Care; and Adult, Child and Community Emergency Services Support, as well as county Health Officers, the Placer County Superintendent of Schools, and the Placer County Juvenile Court Judge and Commissioner. The Juvenile Court Judge serves as the Chair for the Policy Board meetings. The SMT is made up of the managers from Children's System of Care, Education, Probation, and Public Health Nursing. The SMT's purpose is to assess and intervene and to authorize the use of SMART resources for children, youth, and their families who have complex personal, family, or social problems and who have multiagency need and involvement.

This system was created in 1988 to combine and coordinate county probation, education, child welfare, mental health, and juvenile court resources. The SMART advocates for providing early intervention and intensive multisystem services for Placer County's most troubled youth and their families. In 1994, SMART reorganized (through funding from DMH) through Assembly Bill 3015 Children's System of Care to establish multidisciplinary services and staff in a single co-located administrative and services unit.

The strength of the Children's System of Care is the multidisciplinary approach to case management and service delivery. The SMART staff develop cross-functional responsibilities related to family preservation, mental health, probation, child protective services, sexual abuse treatment, special education, public health, substance abuse, and foster care placement and

evaluation. Service delivery in the Placer County system is not handled by a single worker but by cross-functional interdisciplinary teams,

Delivery Strategies

Placer County Children's System of Care is based upon the concept of family involvement and participation at every level from service planning through parents and youth participation on community advisory and decisionmaking boards.

Placer County has a Parent Involvement Coordinator, who provides consultation, training, and policy guidance on involvement of consumers and families in the areas of child welfare, probation, special education, behavioral health, and substance abuse treatment programs. The success of the program in encouraging parent participation has led to requests by staff and parents for expansion of this approach to engaging families and staff in a change process. In addition to the paid staff position of a Parent Involvement Coordinator, the Placer County SMART Children's System of Care also employs one Parent Partner Director, one Parent Partner Supervisor, nine Family Advocates, one Youth Coordinator, and one Youth Advocate. The Parent Partner Program is provided under contract with United Advocates for Children and Families.

Parent and consumer participation starts with the involvement in a family team process for the determination of services. The family team uses a family-centered approach to encourage the parent partner's active involvement in the development of his/her child's services plan. The family team process is also included in the team decisionmaking process, which is to help reduce out-of-home placement when possible and help support early family reunification in the event of an out-of-homecare placement. Placer County provides wraparound services where children and families have a great deal of input into the child's care plan.

Children who are homeless receive shelter through the Koinonia Group Home, which is a Christian-run group home. The facility has six beds and provides shelter to children and youth who are in crisis situations. Children are linked up with services with the goal of getting permanent placement.

FINANCIAL MANAGEMENT

Fiscal Context of Community Mental Health Services

The county's annual financial statement does not identify the mental health program budget as a separate schedule. Mental health programs are included in a larger budget category labeled Health and Sanitation. The annual report's organization chart shows the Health and Human Services Department under the heading of Health and Welfare. The mental health program has two divisions, one for adults and one for children. Both are organizationally included in the Health and Human Services Department. The county's Fiscal and Budget Operations Manager supervises financial activities related to the mental health program. This position works with the Directors of the Adult System of Care and the Director of the Children's System of Care, both of

whom are supervised by the Health Officer and the Director of Health and Human Services. In the county's more detailed organization chart, the Fiscal and Budget Operations Manager is supervised by the county's Director of Administrative Services while also reporting to the mental health directors on financial issues pertaining to adult and children's mental health programs. The County Executive Officer is the top executive position of the county, working under the direction of the County Board of Supervisors.

The Director of Administrative Services attends monthly meetings of the State association of mental health and substance abuse providers, where information is shared regarding community mental health programs and financial issues. Staff from DMH attend these meetings to discuss important issues in their respective area of responsibility. Other avenues of direct communication are also available for addressing financial issues between State and county fiscal and administrative staff.

Despite issues negatively affecting the State and national economy, support for community mental health services in Placer County has experienced a reasonable degree of stability. Funds from the Mental Health Services Act (MHSA) continue to grow, Mental Health Block Grant (MHBG) funds have remained constant, HUD assistance for housing programs is stable, and the Federal match for Medicaid has been temporarily increased through the national Stimulus Act. According to Placer County financial staff, the county's economic situation has not suffered to the same extent as other areas of the State. Staff are aware, however, of the need to operate more efficiently and to prepare for the possibility of funding reductions in future budgets.

Revenue and Expenditures for Mental Health Services

As stated above, Placer County's annual audit report does not include a detailed schedule of mental health revenues and expenditures. The county does prepare annual cost reports for submission to the State Mental Health Authority (SMHA); these reports would have more detailed financial data relative to individual programs and services. A request was made for copies of these annual cost reports, and assurance was given that the reports would be forwarded to this reviewer. However, no information was forthcoming from the Placer County staff despite followup requests.

Additional financial information was obtained from the Placer County Web site in the Budget and Financial Documents, Final County Budgets 2003–2009 section. At this site, revenue and expenditure information for the Adult System of Care and the Children's System of Care was available for State fiscal years (SFYs) 2006, 2007, and 2008. The Placer County annual audit report also provided a supplemental report relative to the Office of Management and Budget (OMB) Circular A-133 requirements. That report confirmed the expenditure of MHBG funds for SFY 2008.

The following tables provide a summary of revenues and expenses for the county's Adult System of Care and Children's System of Care. Due to the construction of financial reports on the county's Web site, it is not possible to ascertain the specific revenues and expenditures pertinent solely to mental health programs. It is apparent from the nature of the revenue sources that these

reports cover mental health, substance abuse, and some child welfare services. The figures contained in the tables below are the result of an analysis of county financial and budget reports and reflect the reviewer’s classification of expense and revenue items, based on experience with behavioral health budgeting and accounting.

Table 7: Placer County Adult/Children’s Program Revenues

Source	County Fiscal Year (CFY) 2006	%	CFY 2007	%	CFY 2008	%
State Funds	\$10,698,882	19.2	\$12,501,352	20.5	\$11,137,407	17.7
Federal Funds	25,381,438	45.5	26,885,435	44.1	28,930,350	46.0
Other Intergovernmental Funds	1,447,617	2.6	1,342,254	2.2	1,090,595	1.8
Fees	757,519	1.4	738,966	1.2	461,598	0.7
Donations	35,250	0	265	0	0	0
Other	90,330	0.1	1,000,243	1.6	94,064	0.1
Placer County Funds	17,392,972	31.2	18,539,128	30.4	\$21,186,806	33.7
Total	\$55,804,008	100	\$61,007,643	100	\$62,900,820	100

Source: Placer County Web site, budget reports, and Annual Financial Report.

Total revenues for adult and children’s programs have increased by 12.7 percent over the 3-year period represented above. State and Federal funds are 64 percent of the total budget for these programs, and county funds make up almost 34 percent of the county fiscal year (CFY) 2008 budget.

Table 8: Placer County Adult/Children’s Program Expenditures

Program	CFY 2005	%	CFY 2007	%	CFY 2008	%
Adult System of Care	\$26,226,760	47.0	\$27,735,715	45.5	\$29,319,584	46.6
Children’s System of Care	29,577,248	53.0	33,271,928	54.5	33,581,236	53.4
Total	\$55,804,008	100	\$61,007,643	100	\$62,900,820	100

Source: Placer County Web site, budget reports, and Annual Financial Report.

For context and comparison, the total Placer County Health and Human Services budget for CFY 2008 was \$147,313,981. The combined Adult System of Care and Children’s System of Care budgets represent 43 percent of the county’s Health and Human Services budget. Over the past 3 years, the ratio of adult program expenditures and children’s program expenditures to total expenditures has remained constant. The adult program budget has increased by almost 12 percent over the 3-year period, and children’s program expenditures have increased by more than 13.5 percent over the same period. Total expenditures have increased by 12.7 percent.

Community Mental Health Services Block Grant Expenditures

The amount of MHBG funds received by Placer County for community mental health services is not identified in the budget documents reviewed. The agency is aware of the amount of MHBG funds it receives and the Catalog of Federal Domestic Assistance (CFDA) number identifying those funds. The amount of MHBG funding the agency receives is identified in an attachment to the County's Annual Audit, which is performed in accordance with OMB Circular A-133. The MHBG CFDA number is included in this audit schedule.

The county used \$420,929 of its MHBG funds to provide eligible mental health services to adults diagnosed in its own programs as having serious mental illness (SMI) and children diagnosed as having serious emotional disturbance (SED). During CFY 2008, the county used \$315,016 of its MHBG funds to contract for the purchase of eligible services from a community provider. The county is able to expend its MHBG funds within the required timeframe and has used the State's rollover provision to accomplish this.

The DMH contract with Placer County addresses the issue of prohibited costs, and the county's financial staff are aware of these costs. County staff are also aware of the requirement to obtain an OMB Circular A-133 audit and made these audits available for the 3 years under review. There were no audit findings relative to the MHBG.

As stated above, the county subcontracts a portion of its MHBG funds to a community provider. The contract for these services did not contain the amount of MHBG funds contracted and also did not include the MHBG CFDA number. A review of the contract revealed that the provisions required by DMH to be passed on in subrecipient contracts were not present in this subcontract. County staff were advised of this compliance issue. A subsequent review of the subrecipients' annual audit reports revealed that the agency audit did not identify the CFDA number for MHBG funds and did not recognize the amount of the MHBG funds received.

Placer County staff stated that they monitor community agencies with which they subcontract on an annual basis. They also verify the agency's required certification. If the agency is an out-of-county agency, the staff may review the agency's monitoring report from the county in which the agency has its base of operations.

Placer County communicates its use of MHBG funding through its annual MHBG Application to the State, which is reviewed by the Advisory Committee to the Board of County Supervisors. This Application and the county's annual audit report are public documents and can be obtained by stakeholders or other interested parties.

NOTES OF APPRECIATION

The monitoring team wishes to thank the Placer County staff for their time and effort preparing for the local program visit. The local visit to Placer County in Auburn allowed the team to observe how State policies and plans are implemented on the local county level.

The Center for Mental Health Services (CMHS) and the monitoring team wish to thank the California Department of Mental Health staff for their time and effort preparing for this monitoring visit.