

Mental Health Services Act Expenditure Report

Fiscal Year 2011-12

ADDENDUM



CALIFORNIA DEPARTMENT OF
Mental Health

**Cliff Allenby
Acting Director**

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EXECUTIVE SUMMARY

This report to the Legislature is submitted as an addendum to the January 2012 Mental Health Services Act (MHSA) expenditure report and provides an update on revenues, expenditures and changes to the MHSA after the prior report was issued. This is the final report that will be produced by the Department of Mental Health (DMH).

The passage of Proposition 63, the MHSA, in November 2004 increased funding, personnel and other resources to support county mental health programs and monitor progress toward statewide goals for serving children, transition age youth, adults, older adults and families with mental health needs.

As part of the Fiscal Year (FY) 2011-12 budget process, on March 24, 2011, the Governor signed AB 100 (Committee on Budget, Chapter 29, Statutes of 2011). AB 100 redirected \$861.2 million in MHSA funds to support the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (\$579.0 million), Mental Health Managed Care (MHMC) (\$183.6 million) and AB 3632 Special Education (\$98.6 million) programs. AB 100 also reduced State Administrative expenditures, and streamlined State oversight of the MHSA.

The 2012-13 Governor's Budget proposes transferring the community mental health functions of DMH to other state departments, including the Department of Health Care Services, Department of Social Services, Department of Public Health, Office of Statewide Health Planning and Development, and Department of Education. These changes are reflected in this year's report and will require the entities proposed to be charged with oversight of the fiscal and programmatic aspects of the MHSA to work closely with the State Controller's Office as well as Department of Finance in order to estimate and make projections of MHSA funds.

The MHSA imposes a one percent income tax on personal income in excess of \$1 million. The tax has generated \$7.5 billion in additional revenues for mental health services from its inception through the end of FY 2010-11. The Governor's Budget expected the MHSA to generate an additional \$1.2 billion in FY 2011-12 and \$1.5 billion in FY 2012-13. At the May Revision, the estimate of the MHSA revenues is reduced to \$1.1 billion in FY 2011-12 and \$1.3 billion in FY 2012-13. On a cash basis, this equates to \$844 million in FY 2011-12 and \$1.1 billion in FY 2012-13.

Approximately \$6.4 billion has been expended through FY 2010-11. Additionally, \$1.9 billion is estimated to be expended in FY 2011-12 and \$1.4 billion in FY 2012-13.

BACKGROUND

The Director of DMH is required by Welfare and Institutions Code (WIC) Section 5813.6 to annually submit two fiscal reports to the Legislature on the MHSA; one in January in conjunction with the proposed Governor's Budget, and the other in conjunction with the May Revision of the Governor's Budget (May Revision). WIC Section 5813.6 specifies that the reports contain information regarding the projected expenditures of MHSA funding for each state department and for each major program category specified in the measure for local assistance and support. To meet this mandate, the report submitted to the Legislature in January 2012 included actual expenditures for FY 2010-11 and estimated expenditures for FY 2011-12. For FY 2012-13, projected expenditures were not made by DMH since, as the result of AB 100 (Committee on Budget, Chapter 29, Statutes of 2011), this responsibility will transfer to the counties and they will receive MHSA funds from the SCO on a monthly basis, effective July 1, 2012. This report reflects the changes in funding levels as proposed in the May Revision.

The MHSA addresses a broad continuum of prevention, early intervention and service needs and provides funding for the necessary infrastructure, technology and training elements that will effectively support the local mental health system. In addition to local planning, the MHSA specifies five major components of the MHSA program around which the DMH carried out an extensive stakeholder process to consider input from all perspectives. The MHSA specifies the percentage of funds to be devoted to each of these components and required DMH, in collaboration with the Mental Health Services Oversight and Accountability Commission (MHSOAC), to establish the requirements for use of the funds. Because of the complexity of each component, implementation of the five components was staggered.

An overview of the five components is listed below:

- **Community Services and Supports (CSS)** — This component refers to “System of Care Services” as required by the MHSA in WIC Sections 5813.5 and 5878.1-5878.3. The change in terminology differentiates MHSA Community Services and Supports from existing and previously existing System of Care programs funded at the federal, state and local levels. The MHSA requires that “each county mental health program shall prepare and submit a three-year plan which shall be updated at least annually.” Annual updates of this plan will be required pursuant to MHSA requirements.
- **Capital Facilities and Technological Needs (CFTN)** — This component addresses the capital infrastructure needed to support implementation of the CSS and Prevention and Early Intervention (PEI) programs. It includes funding to improve or replace existing technology systems and for capital projects to meet program infrastructure needs.
- **Workforce Education and Training (WET)** — This component targets workforce development programs to remedy the shortage of qualified individuals to provide services to address severe mental illnesses. It accomplishes this through stipend, loan assumption and training programs, as well as through direct workforce education and training services provided at the county level.

- **Prevention and Early Intervention (PEI)** —This component supports the design of programs to prevent mental illnesses from becoming severe and disabling, with an emphasis on improving timely access to services for unserved and underserved populations.
- **Innovation (INN)** —The goal of this component is to develop and implement promising practices designed to increase access to services by unserved and underserved groups, increase the quality of services, improve outcomes, and to promote interagency collaboration.

In addition to funding the components listed above, the MHSA allowed for up to five percent of the total annual revenues received in the Mental Health Services Fund (MHSF) for support activities administered by the DMH and other state departments and organizations, including the California Mental Health Planning Council (CMHPC) and MHSOAC. AB 100 reduced that amount to 3.5 percent of the total revenues received to support state level programs and administrative activities. Refer to the section, State Administrative Expenditures, beginning on page 16, for detail on the agencies receiving a portion of the 3.5 percent administrative funding.

EXPLANATION OF ESTIMATED REVENUES

By imposing a one percent income tax on personal income in excess of \$1 million, the MHSA has generated approximately \$7.5 billion through FY 2010-11. This includes both the income tax payments and interest income earned on the MHSF balance.

The amounts actually collected differ slightly from estimated MHSA revenues displayed in the Governor’s Budget. This is because the Governor’s Budget, prepared using generally accepted accounting principles, must show revenue as earned, and therefore shows estimates for revenue not yet received by the close of the fiscal year. The revenue information described in this report is presented on a cash basis to reflect funds actually received during the fiscal year. Table 1 below provides a comparison between estimated revenues versus cash deposits into the MHSF in each fiscal year.

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

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

**Table 1: Comparison between Mental Health Services Act Estimated Receipts
And Governor’s Budget May Revision
(Dollars in Millions)**

	Fiscal Year		
	2010-11	2011-12	2012-13
Governor’s Budget May Revision FY 2012-13 ¹			
Cash Transfers	\$905.4	\$906.0	\$981.0
Interest Income Earned During Fiscal Year	9.7	2.4	1.3
Annual Adjustment Amount	157.0	173.0	357.0
Estimated Revenues	\$1,072.1	\$1,081.4	\$1,339.3
Estimated Receipts-Cash Basis			
Cash Transfers	\$905.4	\$906.0	\$981.0
Interest Income Earned During Fiscal Year	9.7	2.4	1.3
Annual Adjustment Amount	225.0	-64.0	157.0
Estimated Available Receipts²	\$1,140.1	\$844.4	\$1,139.3

¹Source: FY 2012-13 MHSF (3085) Supplementary Schedule of Revenues and Transfers (Schedule 10R).

²Estimated available receipts do not include funds reverted under Welfare and Institutions Code (WIC) 5892(h) or administration funds not appropriated for use under WIC 5892(d).

OVERALL REVENUES

Table 2 below displays actual, estimated and projected receipts deposited into the MHSF. Prior to FY 2008-09, this revenue was distributed to the five major components: CSS, WET, CFTN, PEI and INN based on percentages specified in the MHSF. As of FY 2008-09, the MHSF no longer specified a percentage of funding for the CFTN and WET components. In FY 2008-09, 5 percent of MHSF revenue was allocated for State administrative support, 19 percent for PEI and the remaining 76 percent to CSS, with 5 percent of each of the funding streams from PEI and CSS used to support the INN component. Actual receipts are shown for FY 2010-11, while estimated receipts are shown for FY 2011-12 and projected receipts for FY 2012-13.

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

Table 2: Mental Health Services Act (MHSF) Revenues
Estimated By Component on a Cash Basis
(Dollars in Millions)

	Fiscal Year		
	Actual Receipts ³	Estimated Receipts	Projected Receipts
	2010-11	2011-12	2012-13
Community Services and Supports (Excluding Innovation)	\$823.2	\$619.2	\$835.5
Prevention and Early Intervention (Excluding Innovation)	205.8	154.8	208.9
Innovation	54.1	40.8	55.0
State Administration	57.0	29.6	39.9
Total Estimated Revenue Receipts⁴	\$1,140.1	\$844.4	\$1,139.3

³ Actual receipts displayed are based upon the percentages specified in the MHSF for the components identified. Actual 2010-11 expenditures by component may vary.

⁴ Estimated available receipts do not include funds reverted under the WIC 5892(h) or administration funds not appropriated for use under WIC 5892(d).

EXPENDITURES FOR MHSA COMPONENTS

Expenditures from the MHSF are estimated to be \$1.9 billion in FY 2011-12 and \$1.4 billion in FY 2012-13. The MHSA specifies funding for the major components, which form the basis of the county's MHSA program. Estimated expenditures for the five major MHSA components are \$993.5 million in FY 2011-12⁵ and \$1.3 billion in FY 2012-13. Implementation of each of the components was staggered partly due to the complexity of the requirement in the MHSA that local program and funding decisions be driven by a community stakeholder process at both the state and local levels and the requirement for mandated local hearings and comment periods.

To consider input from all perspectives when developing the guidelines for this program, DMH created an extensive stakeholder process at both the state and local levels. In addition, local planning efforts involve clients, families, caregivers and partner agencies in identifying community issues related to mental illness and resulting from lack of community services and supports. These efforts also serve to define the populations to be served and strategies that will be effective for providing the services, to assess capacity and to develop the work plan and funding requests necessary to effectively deliver the needed services.

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

- Redirect MHSA funds to support three programs proposed for realignment: 861.2 million for EPSDT, MHMC, AB 3632; and
- Authorize the SCO to distribute funds to the counties as specified.

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

⁵ Total local assistance expenditures from the MHSF for FY 2011-12 are \$1.9 billion which includes \$993.5 million for MHSA programs and \$861.2 million for other community mental health programs: EPSDT, MHMC, and AB 3632.

MHSA PROGRAM ACTIVITIES

General MHSA Provisions

Prior to FY 2011-12, the MHSA required that “each county mental health program shall prepare and submit a three-year program and expenditure plan (county plan) which shall be updated at least annually and approved by DMH after review and comment by MHSOAC.” Since the passage of AB 100, the review and approval processes for both the MHSOAC and DMH have been removed, although the counties are still required to post their updates for public comment. Additionally, county mental health boards are still required to conduct a public hearing on draft plans and annual updates at the close of the 30 day public comment period. Further, the county mental health board must continue to review the adopted plan or update, and make recommendations to the mental health departments if there are to be any revisions.

The MHSA also required that “the department shall establish requirements for the content of the plans.” As of January 2009, DMH along with input from stakeholders, successfully implemented guidelines for all five MHSA county plan components. The guidelines for the content of county plans are available on the following DMH website: http://www.dmh.ca.gov/Prop_63/MHSA/default.asp

In accordance with the spirit of the MHSA to involve stakeholders, DMH committed to an extensive and transparent stakeholder process, beginning with its first general stakeholders meeting held in December 2004. Statute and regulations require the counties to seek and incorporate stakeholder input in the development of county plans and updates. Further, statute and regulations require all county plans and updates be circulated for 30 days to stakeholders for review and comment prior to submission.

Below is a description of the five MHSA components that comprise each county plan and efforts to date.

1. Community Services and Support (CSS)

CSS refers to “System of Care Services” as required by the MHSA in WIC sections 5813.5 and 5878.1-5878.3. The change in terminology differentiates MHSA Community Services and Supports from existing and previously existing System of Care programs funded at the federal, state and local levels.

In their MHSA three-year program and expenditure plan, counties are required to submit a listing of all programs for which MHSA funding is being requested that identifies the proposed expenditures for each type of funding (Full Service Partnership, System Development, and Outreach and Engagement) and for each target age group (Children and Youth, Transition Aged Youth, Adult, and Older Adult).

Through June 2012, approximately \$4.2 billion will have been distributed for the CSS component since inception of MHSA. Past county-specific information can be found at: http://www.dmh.ca.gov/Prop_63/MHSA/MHSA_Fiscal_References.asp

MHSA Housing Program

DMH adopted the MHSA Housing Program as one service category under the CSS component (California Code of Regulations, Chapter 14, Title 9, Section 3615). On August 6, 2007, DMH, the California Housing Finance Agency (CalHFA) and CMHDA announced the formation of the MHSA Housing Program. A total of \$400 million of MHSA funds were set aside for initial funding of the program. This new program provides both capital funding and rental subsidy funding for the development of permanent supportive housing for individuals with serious mental illness and their families, as appropriate, who are homeless or at risk of homelessness. This effort builds on the interagency collaboration established in 2005 with the Governor's Homeless Initiative (GHI) (see below). Table 3, on the following page, provides data on the MHSA Housing Program as of March 2012.

Governor's Homeless Initiative (GHI)

In August 2005, the Governor announced an initiative to address long-term homelessness in California. Part of the Initiative, known as the Governor's Homeless Initiative (GHI), directed an interagency effort to provide capital funding for housing projects to develop permanent supportive housing and serve a target population of persons who are chronically homeless and have severe mental illness. The interagency effort included the Department of Housing and Community Development (HCD), CalHFA and DMH. The GHI called for HCD to utilize approximately \$40 million of Proposition 46 funds as capital for the development of permanent supportive housing for homeless individuals with serious mental illnesses⁶. An additional \$3.15 million in MHSA funds were set aside to provide funding for capitalized rent subsidies and capacity building training in the counties.

Counties are an essential component of this effort as there is a long-term commitment to provide supportive services to developments that qualify for funding under the GHI. Through June 2011, GHI funds have been awarded to 11 developments located throughout the state, creating 378 units for the target population.

⁶ Proposition 46, the Housing and Emergency Shelter Trust Fund Act of 2002, authorized the sale of \$2.1 billion in general obligation bonds to finance state housing programs, including housing for individuals with mental illness.

**Table 3: MHSA Housing Program
(As of March 2012)**

MHSA Housing Program Funds Available	\$400,000,000
MHSA Housing Program Funds Assigned ⁷	\$404,137,919
Number of Counties with Approved Applications	
Number of Counties with Approved Applications	36
Number of Counties that have assigned funds	51
Number of Counties Opting Out	8
Number of Counties who have not assigned funds	0
MHSA Applications Received	
MHSA Applications Received	147
Shared Housing Projects	15
Rental Housing Projects	132
MHSA Loans Closed	
MHSA Loans Closed	79
Total Dollars	\$160,471,436
MHSA Units	1,242
Units Receiving Capitalized Operating Subsidy	911
MHSA Applications Approved and waiting to close	
MHSA Applications Approved and waiting to close	46
Total Dollars	\$74,642,236
MHSA Units	508
Units Receiving Capitalized Operating Subsidy	303
MHSA Applications in Process	
MHSA Applications in Process	22
Total Dollars	\$25,340,688
MHSA Units	261
Units Receiving Capitalized Operating Subsidy	80

⁷ Counties were allowed to assign additional funds beyond their Housing Plan planning estimate. This amount reflects additional funds assigned by San Francisco county and Tri-Cities.

2. Capital Facilities and Technological Needs (CFTN)

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

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

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

In March 2008, planning guidance was released for counties to access funds from the CFTN component. Because the MHPA limits the number of years MHPA funds are dedicated to this component, in the same year the guidance was released, a total amount of \$460.8 million was made available. As of July 2011, 48 counties have submitted their CFTN component of the county plan. As of July 2011, approximately \$235.9 million has been distributed for capital facilities projects and \$224.9 million has been distributed for technological needs projects since the inception of the MHPA. No further distributions have been made.

3. Workforce Education and Training (WET)

This component is intended to “remedy the shortage of qualified individuals to provide services to address severe mental illnesses (WIC Section 5820).” It requires that each county identify workforce shortages in both the county staff and contract provider staff.

The planning guidance for the WET component was released in July 2007 and as of July 2011, 51 counties had submitted their WET component of the county plan and annual update. An April 2009 analysis of WET plans submitted by 28 counties (representing 67.7 percent of California’s total population), found that counties identified psychiatrists, licensed clinical social workers, marriage and family therapists, and licensed supervising clinicians as the hardest positions to fill. The analysis also identified the need for proficiency in non-English languages; an estimated 7,800 additional staff are needed in California’s ten most common non-English languages: Spanish, Tagalog, Cantonese, Vietnamese, Mandarin, Farsi, Chinese, Korean, Russian and Cambodian.

In accordance with MHPA, DMH developed a five year plan for WET activities which was reviewed and approved by the CMHPC. This plan addressed specific areas and guides DMH’s statewide WET efforts. These efforts include expansion of postsecondary education to meet needs of occupational shortages; expansion of loan forgiveness and scholarship programs; establishment of stipend programs; and

establishment of regional partnerships among mental health and educational systems. The following summarizes major state-level activities to date.

Financial Incentive Programs

- Since its inception in 2005, approximately 1,286 second year students in Masters of Social Work Degree programs have received a stipend of \$18,500. Each year, over 56 percent of the students receiving stipends have proficiency in a non-English language and an average of 55 percent represents minorities.
- Since FY 2008-09, approximately 540 students obtaining Doctorates of Psychology, Masters Degrees in Marriage and Family Therapy and Psychiatric Mental Health Nurse Practitioners have received stipends of up to \$18,500 in exchange for one year's work in the public mental health system for each year a stipend was received. Over 60 percent of the students who received stipends are proficient in a language other than English.
- Through the Mental Health Loan Assumption Program (MHLAP), educational loans of up to \$10,000 are paid on behalf of mental health professionals who work in the public mental health system in hard to fill or hard to retain positions. From FY 2008-09 through FY 2010-11, over 1,000 individuals in 54 counties received awards under this program. Approximately half of the awardees were employed by community based organizations and 30 percent of the awardees self-identified as consumers and/or family members. This program is administered by the Office of Statewide Health Planning and Development (OSHPD). Beginning in FY 2012-13, an annual total of \$10 million will be available to support the MHLAP, consistent with the statewide WET plan. This represents an increase of \$5 million over FY 2011-12.

Other WET Programs/Activities

- DMH and OSHPD partnered to add a mental health track to the Song-Brown Residency Program for Physician Assistants. Since FY 2008-09, grants of \$100,000 each to five Physician Assistant training programs have resulted in 1,058 students being exposed to MHA principles and practices.
- DMH and OSHPD partnered to provide technical support to counties completing applications in order to obtain a federal designation as a "mental health professional shortage area." This designation allows the counties to compete for federal funding. For example, OSHPD approved 227 facilities for National Health Service Corps placement of mental health professionals, resulting in approximately \$6.8 million annually in new federal funds beginning October 2010.
- In FYs 2008-09 and 2009-10, DMH and the Board of Behavioral Sciences partnered to provide technical assistance to the federal National Health Service Corps (NHSC) regarding the rigor of the licensure examination taken by California's social workers. As a result, California-licensed social workers became eligible for the federal NHSC loan repayment program in October 2010.
- Three universities (University of California, Davis; University of California, Los Angeles-Kern and University of California, San Francisco-Fresno) have

expanded their psychiatric residency programs in areas of particular shortage, including specialists in Child Psychiatry, Integrated Psychiatry and Mental Health.

- Since their inception in FY 2008-09, the five Regional Partnerships throughout the State have brought public mental health employers and educators together to ensure that the education that mental health professionals receive addresses regional needs.
- The Superior Region has launched a distance learning (distributed education) Bachelor and Masters of Social Work (BSW-MSW) program through CSU Chico and Humboldt State University to ensure that more social workers are available to serve this rural area.
- The Greater Bay Area Regional Partnership launched a new school of social work at CSU Monterey, a Psycho-Social Rehabilitation program at Contra Costa College and a Mental Health Core Competencies Project.
- The Central Region helped fund a rural-focused, weekend MSW program at CSU Sacramento and an online psychiatric mental health nurse practitioner program through CSU Fresno. The Central Region also trained over 50 Mental Health First Aid instructors to provide stigma-reducing mental health trainings in the community.
- The Los Angeles Region has expanded its Peer Navigators Program and partnered with universities for training and research to children and youth, transition-aged youth, adults and older adults.
- The Southern Region has pursued federal designations as mental health professional shortage areas, begun a three-year project to train cultural competency skills in therapy sessions and collaborated with consumers and family members to develop core competencies for the Southern Region.
- A statewide Technical Assistance Center that supports incorporation of consumers and family members, and cultural and ethnic communities as leaders and employees throughout the public mental health system.

Through FY 2011-12, approximately \$273 million will have been distributed by DMH since inception of the MHSA. An additional \$17 million will have been expended by OSHPD for the MHSA WET programs under the purview of their administration. Beginning in FY 2012-13, all WET programs and functions administered by DMH will be transferred to OSHPD. Refer to Appendix A for a reconciliation of the statewide WET plan and estimated expenditures through FY 2011-12.

Prevention and Early Intervention (PEI)

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

The planning guidance for the PEI component was released in September 2007. As of March 2011, the MHSAOAC, under its statutory authority for the PEI component,

approved 58 county MHSA plans. However, AB 100 removed the MHSOAC's statutory authority to review and approve PEI plans. Through June 2012, approximately \$1.26 billion will have been distributed since inception of the MHSA.

DMH's PEI State Level Efforts

There are four PEI Statewide Projects: Suicide Prevention, Stigma and Discrimination Reduction, Student Mental Health Initiative, and the California Reducing Disparities Project. This section summarizes DMH's participation to date in these projects.

Suicide Prevention

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

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

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

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

Stigma and Discrimination Reduction

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

In June 2009, the 52 page Strategic Plan, consisting of 4 strategic directions, 26 recommended actions, and 134 next steps for local and statewide implementation

was adopted by the MHSOAC. Dissemination of the *California Strategic Plan on Reducing Mental Health Stigma and Discrimination* began in late Fall 2010.

Student Mental Health Initiative

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

California Reducing Disparities Project

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

- DMH funded five entities representing targeted populations to develop Strategic Planning Workgroups (SPWs) to identify population-focused, culturally competent recommendations to improve access and quality of care for underserved and underserved racial, ethnic and multicultural communities. The five target populations and established SPWs for these activities focus on the groups that demonstrate historic disparities in access to mental health services:
 - African Americans
 - Asian/Pacific Islanders
 - Latinos
 - Lesbian, Gay, Bi-Sexual, Transgender, Questioning (LGBTQ)
 - Native Americans
- The SPWs are comprised of community leaders, mental health providers, consumers and family members – all of whom are working together to identify new service delivery approaches for multicultural communities using community-defined evidence.
- Each of these five SPWs is currently in the process of developing specific Reducing Disparities Population Reports (RDPR). The final RDPRs will contain an inventory of community-defined strength based promising practices, models, and/or other resources. As of April 2012, four of five draft RDPRs are completed and available for public review and comment.
- The RDPRs will form the foundation of the comprehensive California Reducing Disparities Statewide Strategic Plan (CRDSSP) that will seek to identify new approaches toward reducing disparities.

- To further support the needs of the SPWs and development of CRDSSP, the following contracts were established:
 - California Mental Health Services Act Multicultural Coalition - responsible for sustaining a statewide multicultural coalition, establishing emerging community leader mentorships, ongoing collaboration and support of the five SPWs and guidance in the implementation of the CRDSSP.
 - CRDP Facilitator/Writer - responsible for collaboration with the five SPW's in meeting, reviewing, and providing input on draft RDPRs; in addition to writing the CRDSSP.

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

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

As part of the May Revision, the Administration proposed maintaining the \$60 million to fund Phase II of the CRDP over four years. Existing MHSA support funds and staff associated with the CRDP are proposed for transfer from DMH to the proposed Office of Health Equity at the Department of Public Health (DPH) as part of the 2012-13 Governor's Budget.

Innovation (INN)

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

The planning guidance for the INN component was released in January 2009. As of March 2011, the MHSAOAC has approved approximately \$182 million since the inception of the MHSA.

STATE ADMINISTRATIVE EXPENDITURES

As approved by voters in 2004, MHSA allowed up to 5 percent of the total annual revenues in each fiscal year for state administrative expenditures to support DMH, CMHPC, MHSOAC and other state entities. AB 100 amended the MHSA and reduced the maximum amount available for administrative expenditures from 5 percent to 3.5 percent. Additionally, the 2011-12 enacted budget eliminated the MHSA funding from a number of departments previously funded through the administrative cap, which are no longer referenced in this section of the report. The administrative expenditures below include the augmentations proposed in the May Revision for state entities receiving MHSA funding in 12-13:

Judicial Branch (JB)

FY 2010-11	FY 2011-12	FY 2012-13
\$1,003,000	\$1,054,000	\$1,048,000

Juvenile Court System

The JB Juvenile Court System receives funding and 4.0 positions to address the increased workload relating to mental health issues in the area of prevention and early intervention for juveniles with mental health illness in the juvenile court system or at risk for involvement in the juvenile court system.

FY 2011-12 Deliverables

- Develop a research component to identify and evaluate programs for juvenile offenders with mental illness to increase understanding and needs related to the juvenile system.
- Provide support for Judicial Officers who hear cases involving juvenile offenders with a mental illness.
- Provide support to mental health related programs in juvenile court
- Identify, develop and provide appropriate mental health and interdisciplinary training opportunities for those working with Juvenile Offenders with mental illness

Adult Court System

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

FY 2011-12 Deliverables

- Increase understanding of mental health issues in adult courts

- Develop a research component to evaluate court programs for persons with mental illness in the Criminal Justice System
- Provide support to mental health-related programs in the courts
- Assist courts in their efforts to respond more effectively to individuals with mental illness in the courts
- Serve as a liaison between the Administrative Office of the Courts, DMH, Council on Mentally Ill Offenders and related executive branch Departments and community-based programs
- Assist courts in their efforts to respond more effectively to consumers by identifying best practices, conducting needs assessments, analyzing cost-benefit outcomes of court programs and collaborating with a variety of stakeholders for the mental health community.
- Drafted a Mental Health Court Research Brief based on findings related to long-term effectiveness of mental health programs in courts. Developed recommendations for the Task Force to improve outcomes for adults with mental illness in the criminal justice system.
- Establish of a reentry program liaison and collaborate with other MHSA partners in support of California Veteran Court projects.
- Disseminate locally-generated best and promising practices to trial courts. Develop and support educational programming for judicial officers working with offenders with a mental illness.
- Conduct regional symposia for judges and court personnel.
- Participate in both local and national conferences related to best practices for persons with mental illness in the court system.
- Collaborate with stakeholders, including local departments of mental health, treatment and service providers, court users and their families.
- Meet regularly with and provide technical assistance to drug and mental health court administrators. Hold discussions with the California Association of Drug Court Professionals to support their ability to provide referrals and promote increased integration between courts and mental health providers.

State Controller's Office (SCO)

FY 2010-11	FY 2011-12	FY 2012-13
\$714,000	\$1,733,000	\$1,584,000

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

Each year, the amount of funding expended on external contractors fluctuates. In FY 2009-10, approximately 44 percent of the project appropriation budget was expended on external contractors. In FY 2010-11, approximately 67 percent of the project appropriation budget is anticipated to be expended on external contractors. In FY 2011-12, approximately 59 percent of the project appropriation budget is anticipated to be expended on external contractors.

Office of Statewide Health Planning and Development (OSHPD)

FY 2010-11	FY 2011-12	FY 2012-13
\$5,681,000	\$500,000	\$924,000

As part of the Governor's Budget, funding for 1.0 position and \$12.15 million in local assistance will be transferred to OSHPD in FY 2012-13 to support the WET programs and functions currently administered by DMH. Also proposed for FY 2012-13: 1) an increase of \$5 million, for an annual local assistance appropriation of \$10 million, in support of the MHLAP program; and 2) \$15 million in local assistance to be held for distribution to Regional Partnerships (\$9 million) and other WET activities to be determined through a stakeholder process (\$6 million). The additional funds support the intent of the MHSa and the ten year spending plan approved by the DMH government partners (CMHDA, CMHPC, MHSOAC and DMH). Refer to Appendix A for a reconciliation of the WET spending plan and estimated expenditures through FY 2011-12.

Currently, OSHPD receives funding and 1.0 position to increase the number of California communities federally designated as mental health professional shortage areas and to expand Physician Assistants' mental health preparation to include training on cultural competency, recovery, resilience and community collaboration. OSHPD also receives funding and 4.0 positions to provide educational loan repayments for mental health professionals to encourage work in the public mental health system in positions the county mental health directors deem to be hard to fill or hard to retain.

FY 2011-12 Deliverables: Physician Assistant

- Since FY 2009-10, OSHPD awarded 15 Physician Assistant program applications from five programs. These five programs added a mental health track to the Song-Brown Residency Program for Physician Assistants (PAs). This has enabled 1,058 PA students to receive more than 30,000 hours of mental health clinical training. Upon graduation, these students will be able to

facilitate the integration of public mental health, substance abuse and primary care services.

FY 2011-12 Deliverables: Mental Health Professional Shortage Area (MHPSA)

- Together with the Board of Behavioral Sciences, provided technical assistance to National Health Service Corps (NHSC) that resulted in California’s LCSWs to be eligible for federal loan repayment.
- Provided technical assistance seminars/teleconferences to County Mental Health providers on benefits of, and how to apply for, the MHPSA designation.
- Recommended approval of 154 provider sites for NHSC placement of mental health professionals resulting in \$6.8 million in new federal funds per year.
- Reviewed and approved applications for designation as MHPSAs.
- Responded to over 500 requests for individual technical assistance on MHPSA applications and benefits.
- These activities have resulted to date in 167 federally designated mental health professional shortage areas.

FY 2009-10 through FY 2011-12 Deliverables (OSHPD-Health Professions Education Foundation Activities)

- From FY 2008-09 to FY 2010-11, a total of 1,077 individuals in 54 counties received Mental Health Loan Assumption Program (MHLAP) awards totaling \$10.3 million. Of these, 30 percent self-identified as consumers and/or family members; and 66 were bicultural and/or bilingual. The awards for FY 2011-12 are in the process of being finalized.
- Conducted Technical Assistance calls to help potential applicants.
- Inform county mental health directors, community based organizations and individual applicants of the new award cycle through e-mails, letters and conference calls.

Department of Health Care Services (DHCS)

FY 2010-11	FY 2011-12	FY 2012-13
\$1,107,000	\$863,000	\$7,803,000

Primary responsibility for administering state-level MHSA functions will be transferred from DMH to DHCS beginning in FY 2012-13. A total of 19.0 positions and \$7.8 million will be transferred. Prior to FY 2012-13, DHCS received funding and positions to support a contract to develop and implement the interdepartmental California Mental Health Care Management Program (CaMEND). CaMEND serves to improve mental

health care for Medi-Cal beneficiaries with severe mental illness or severe emotional disturbance (SED), while managing costs for this population.

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

FY 2011-12 Deliverables

- Modify selected change concepts to promote integration of publicly funded primary care and mental health services.
- Train primary care providers on mental health care principles and practices to improve their ability to provide care to persons with severe mental illness (SMI).
- Conduct medication therapy management service demonstration project.
- Continue pilot collaborative performance improvement projects with specialty county mental health services.
- Conduct Improving Client Service Capacity learning sessions geared toward improving transitions and recovery for clients with SMI.
- Continue research on the safety of medications for children/youth and develop an ongoing medication utilization review and management report.
- Implement a decision aid tool for use in the public mental health setting that will help people make specific, deliberate choices and provide information about options and outcomes relevant to the client’s health status and personal values.
- Contract with University of California, Los Angeles to plan and develop process for how to use decision aids within public mental health settings.
- Work with client and family members to gain input on decision aid tools.

Department of Public Health (DPH)

FY 2010-11	FY 2011-12	FY 2012-13
\$0	\$0	\$17,349,000

Beginning with FY 2012-13, core multicultural services in support of the MHSa will be transferred from DMH to the proposed Office of Health Equity at DPH. Most significantly, this includes the transfer of the administration of the California Reducing Disparities Project (CRDP). The existing 4.0 DMH positions supporting this effort will be transferred to DPH, as well as funding for the supporting contracts. Additionally, as part

of the May Revision, \$60 million has been proposed (\$15 million per year for 4 years) to implement Phase II of the CRDP (refer to pages 14-15 for additional information).

Department of Developmental Services (DDS)

FY 2010-11	FY 2011-12	FY 2012-13
\$1,131,000	\$1,133,000	\$1,129,000

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

FY 2011-12 Deliverables

Through a Request for Applications process, distributed funds to six Regional Centers throughout California, each of which created and implemented innovative training projects focusing on early intervention and treatment for children and families impacted by mental health issues and adults with a dual diagnosis.

Launched the following DDS mental health website:

http://www.dds.ca.gov/HealthDevelopment/MHSA_TrngRegProject.cfm

DDS is receiving MHSAs funds for regional centers to develop and oversee innovative training. Some training events focus on early intervention and treatment for children and families impacted by mental health issues. Additional training addresses treatment options for adults with developmental disabilities and mental illness. This 3-year cycle will fund Regional Centers to:

- Improve the care for persons with developmental disabilities and mental illness by training direct service providers and families;
- Expand community capacity by providing best practice training for clinicians & other professionals; and,
- Address opportunities and obstacles towards improving the delivery systems at the local level by conducting Regional Planning Summits statewide.

Department of Mental Health (DMH)

FY 2010-11	FY 2011-12	FY 2012-13
\$26,394,000	\$12,350,000	\$0

In FY 2010-11, DMH received funding and 147.0 positions to support the statutory requirements of the MHSAs. Actions taken by the 2011-12 Conference Committee on the Budget reduced the MHSAs expenditures for FY 2011-12 to \$12.3 million and 24.0 positions, which includes \$457,000 and 5.0 positions for the California Mental Health Planning Council (CMHPC), to fund key statewide projects including housing, suicide prevention, mitigation of stigma projects, focused data analysis, and some community-based contracts. With the elimination of DMH, these positions and related expenses

will be transferred to the Departments of Health Care Services, Social Services, Public Health and the Office of Statewide Health Planning and Development.

Mental Health Services Oversight and Accountability Commission (MHSOAC)

FY 2010-11	FY 2011-12	FY 2012-13
\$4,538,000	\$5,484,000	\$6,671,000

MHSOAC receives funding and 21.0 positions to support its statutory oversight and accountability for the MHSA. MHSOAC has three primary roles:

- Provide oversight, review and evaluation of projects and programs supported with MHSA funds;
- Ensure oversight and accountability of the public community mental health system; and,
- Advise the Governor and the Legislature regarding State actions to improve care and services for people with mental illness.

Statutory changes made as part of the 2011-12 budget process, no longer require MHSOAC to review and/or approve local MHSA funding requests. As proposed in the Governor's Budget, funds supporting client and family member activities will transfer to the MHSOAC beginning in FY 2012-13.

Department of Education

FY 2010-11	FY 2011-12	FY 2012-13
\$707,000	\$273,000	\$162,000

Action taken as a part of the budget process reduced the MHSA resources for the Department of Education to \$273,000 and 1.0 position. The funding supports county mental health programs' work with local education agencies, county offices of education, and special education local plan areas to provide necessary services.

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

FY 2010-11	FY 2011-12	FY 2012-13
\$213,000	\$125,000	\$105,000

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

FY 2009-10 through FY 2011-12 Deliverables

- Identify, develop and disseminate effective mental health practices for California Community Colleges (CCC) students and support the Chancellor's Office by convening and overseeing an inter-disciplinary, inter-agency Mental Health

Services Advisory Committee which includes student representatives. Status: Ongoing support for convening of the committee was eliminated and is now supported by a grant through 2014. The focus of the advisory committee, now called the Chancellor's Office Advisory Group on Student Mental Health (COAGSMH) is on activities related to the implementation of the CCC Student Mental Health Program (CCC SMHP), a grant funded by the California Mental Health Services Authority.

- Monitor local, state and national data and information related to mental health and education to identify the extent of mental health issues and need at community colleges; the extent of current delivery systems; promising models and practices; resource opportunities; partnership opportunities; information and findings are shared with stakeholders through list serves, the CCC Chancellor's Office webpage, meetings, and conferences.
- Plan, implement and evaluate training for faculty and staff to raise awareness on the issues of Post Traumatic Stress Disorder, Traumatic Brain Injury and depression that impact student learning through the implementation of the Zellerbach Family Foundation Grant and selected CCCs.
- Enhance coordination of services and resources by fostering relationships with key system partners (Student Services administrators, Health Services staff and related organizations, Disabled Students Program and Services, CAPED, general counseling, etc.) who work on mental health or related issues, particularly partners working with students at higher risk of mental health issues (such as foster youth, returning veterans and underserved populations).
- Enhance established Mental Health Service webpage with mental health resources and information.
- Research and assess viability of other resource opportunities such as grant and foundation funding for CCC.
- Provide input, feedback and technical assistance to DMH, counties and other local and state entities on issues related to CCC student mental health.
- Assist community colleges seeking support or information to improve services and/or address current needs on their campus.

Financial Information System for California (FI\$CAL)

FY 2010-11	FY 2011-12	FY 2012-13
\$28,000	\$137,000	\$141,000

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

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

Military Department

FY 2010-11	FY 2011-12	FY 2012-13
\$366,000	\$540,000	\$549,000

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

FY 2009-10 through FY 2011-12 Deliverables

- Conduct education events to inform soldiers and their families about the ways to access mental health services.
- Present information about County mental health programs to CNG behavioral health providers and Guard members.
- Publish articles about suicide prevention and mental health resources in the “Grizzly,” the newsletter of the California National Guard.

Department of Veterans Affairs (DVA)

FY 2010-11	FY 2011-12	FY 2012-13
\$445,000	\$507,000	\$500,000

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

FY 2009-10 through FY 2011-12 Deliverables

- Coordinate DVA Referral Management Branch for Operation Welcome Home initiative.
- Obtain contact information for close to 20,000 veterans a month through a MOU with the Department of Motor Vehicles to include a question about military service on all driver’s licenses, identification cards and renewal applications.

MHSA Expenditures

Table 4, on the following page, summarizes MHSA expenditures for Local Assistance and State Administrative Costs by each state entity receiving a portion of MHSA funds. It displays actual expenditures for FY 2010-11, estimated expenditures for FY 2011-12, and the projected budget for FY 2012-13. Additionally, Appendix B offers a full reconciliation of estimated revenues, expenditures and resources that will transfer from DMH to other state departments in FY 2012-13.

Based upon estimated MHSF revenues, the 3.5 percent administrative cap is \$37.8 million and administrative expenditures are estimated at \$24.7 million for FY 2011-12. For FY 2012-13, the projected 3.5 percent administrative cap is \$46.9 million and the total projected expenditures are \$38.0 million.

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

	Actual FY 2010-11	Estimated FY 2011-12	Projected FY 2012-13
Local Assistance⁸			
2012-13 Total (breakdown TBD)			\$1,321,873
Community Services and Supports	853,572	741,000	TBD
Prevention and Early Intervention	256,040	185,200	TBD
Innovation	119,332	48,700	TBD
Workforce Education and Training State Level Projects ⁹	12,347	18,643	37,650
Capital Facilities and Technological Needs	2,295	0	TBD
Subtotal, Major Program Categories	\$1,243,586	\$993,543	\$1,359,523
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) ¹⁰	0	578,981	0
Mental Health Managed Care ¹⁰	0	183,590	0
AB 3632, Special Education Pupils ¹⁰	0	98,586	0
Total Local Assistance	\$1,243,586	\$1,854,700	\$1,359,523
State Administrative Costs¹¹			
Judicial Branch	\$1,003	\$1,054	\$1,048
State Controller's Office	714	1,733	1,584
Department of Consumer Affairs Regulatory Boards	94	0	0
Office of Statewide Health Planning and Development	5,681	500	924
Department of Aging	236	0	0
Department of Alcohol and Drug Programs	282	0	0
Department of Health Care Services	1,107	863	7,803
Department of Public Health	0	0	17,349
Managed Risk Medical Insurance Board	130	0	0
Department of Developmental Services	1,131	1,133	1,129
Department of Mental Health	26,394	12,350	0
Mental Health Svcs Oversight & Accountability Commission	4,538	5,484	6,671
Department of Rehabilitation	83	0	0
Department of Social Services	760	0	0
Department of Education	707	273	162
California State Library	128	0	0
Board of Governors of the California Community Colleges	213	125	105
Financial Information System for California	28	137	141
Military Department	366	540	549
Department of Veterans Affairs	445	507	500
Statewide General Admin Exp (Pro Rata)	0	24	13
Total Administration	\$44,040	\$24,723	\$37,978
Total Expenditures	\$1,287,626	\$1,879,423	\$1,397,501

⁸ Local Assistance expenditures reflect funds to the counties for CSS and PEI component allocations, as well as funds for Innovation which is a subset (5% each) of CSS and PEI funding. Allocation amounts for FY 2012-13 are not reflected since as the result of AB 100, this responsibility will transfer to the counties and they will receive MHSA funds from the State Controller's Office on a monthly basis.

⁹ Amounts displayed include all statewide programs administered under the WET component, including the MH Loan Assumption program and \$500,000 for the Song Brown program.

¹⁰ AB 100 allocated \$861.2 million from the MHSF to counties to meet the General Fund obligation for FY 2011-12. Total includes \$579.0 million to EPSDT, \$183.6 million to MHMC and \$98.6 million to Special Education Pupils (known as AB 3632).

¹¹ State entities listed in Table 4 receive funding for "State Administrative Costs" in accordance with the 3.5 percent authorized by Welfare and Institutions Code Section 5892(d).