Mental Health Services Act Expenditure Report

Fiscal Year 2006 – 2007

ADDENDUM

A Report to the Legislature in Response to

AB 131, Omnibus Health Budget Trailer Bill
Chapter 80, Statutes of 2005

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Mental Health Services Act Expenditure Report

Fiscal Year 2006 – 2007

ADDENDUM

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EXECUTIVE SUMMARY

The passage of Proposition 63, the Mental Health Services Act (MHSA) in November 2004 provides an opportunity to increase 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. The MHSA addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support the local mental health system.

The MHSA imposes a 1 percent income tax on personal income in excess of $1 million. The MHSA was projected to generate approximately $254 million in FY 2004-05, $683 million in FY 2005-06, $690 million in FY 2006-07 and increasing amounts thereafter. These were initial estimates of revenue to come from the additional tax. Actual revenues to date have substantially exceeded these early estimates. The actual amount collected for FY 2005-06 is $1.34 billion. This includes cash transfers and interest income earned during FY 2005-06 and a portion of accruals posted in FY 2007-08. Table 1: MHSA Estimated Receipts displays revised estimates of available resources based on the Governor's proposed May Revise 2007 Budget.

The MHSA specifies six major components around which the Department of Mental Health (DMH) has created an extensive stakeholder process to consider input from all perspectives. Because of the complexity of each component, implementation of the six components is being staggered. Proposition 63 local assistance expenditures are estimated to be approximately $153.3 million in FY 2005-06, $475.8 million in FY 2006-07, and $1.5 billion in FY 2007-08 to continue a phased implementation of the MHSA components. During FY 2007-08, all of the MHSA components except Innovation will be fully implemented.

ISSUE STATEMENT

This report to the Legislature is required by Assembly Bill 131 (Chapter 80, Statutes of 2005), which specifies that the Director of the California DMH shall submit to the Legislature information regarding the projected expenditure of MHSA funding for each state department, and for each major program category specified in the measure for local assistance and support. The report includes actual past-year expenditures, estimated current-year expenditures and projected budget-year expenditures of local assistance funding.

The DMH is required to annually submit two fiscal reports on the MHSA, one in January in conjunction with the Governor's Budget and the other corresponding to the May Revision of the Governor's Budget. The DMH submitted its first fiscal report to the Legislature on the MHSA for FY 2005-06 in January 2006. As required by Assembly Bill 131, in May 2006 the DMH submitted an Addendum to the report to coincide with the Governor's Budget Revision. In addition to actual and projected expenditures of funds generated in FY 2006-07, this Addendum Report provides specific information regarding achievements to date and implementation activities planned for FY 2007-08.

BACKGROUND

A broad continuum of prevention, early intervention and service needs are addressed in the MHSA. The Act also provides for the necessary capital facilities, technology and training elements that will effectively support the local mental health system.

By imposing a 1 percent income tax on personal income in excess of $1 million, the MHSA was projected to generate approximately $254 million in FY 2004-05, $683 million in FY 2005-06, $690 million in FY 2006-07 and increasing amounts thereafter. These were the initial estimates of revenue to be generated by the additional tax. However, actual revenues to date have substantially exceeded these early estimates. The actual amount collected for FY 2005-06 is $1.34 billion. This includes cash transfers made and interest income earned during FY 2005-06 and a portion of accrued revenues posted in FY 2007-08.

Table 1 on the following two pages, entitled "MHSA Estimated Receipts," provides revised estimates of resources available by fiscal year based on the Governor's proposed May Revise 2007 Budget.

Table 1 - Mental Health Services Act Estimated Receipts
Estimated Based on Governor's 2007 May Revise Budget
(Dollars in Millions)

	Fiscal Year				
	2004-05	**2005-06**	**2006-07**	**2007-08**	**2008-09**
Total - All Components					
Original MHSA Estimate	**$254.0**	**$683.0**	**$690.0**	**$733.0**	**$784.3**
Revised Estimate					
Cash Transfers	$169.5	$894.6	$947.0	$998.0	$784.3
Accrued Revenue from Prior Years	$83.6	$0.0	$0.0	$423.7	$475.0
Interest Income	$0.7	$11.2	$49.2	$91.2	$89.1
Estimated Available Receipts	**$253.8**	**$905.8**	**$996.2**	**$1,512.9**	**$1,348.4**
Local Planning					
Original MHSA Estimate	**$12.7**				
Distribution Percentage from MHSA	5.00%	0.00%	0.00%	0.00%	0.00%
Revised Estimate					
Cash Transfers	$8.5				
Accrued Revenue from Prior Years	$4.2				
Interest Income	$0.0				
Estimated Available Receipts	**$12.7**				
Community Services and Supports (Excluding Innovation)					
Original MHSA Estimate		**$356.9**	**$360.5**	**$383.0**	**$558.8**
Distribution Percentage from MHSA	0.00%	52.25%	52.25%	52.25%	71.25%
Revised Estimate					
Cash Transfers		$467.4	$494.8	$521.5	$558.8
Accrued Revenue from Prior Years		$0.0	$0.0	$221.4	$338.4
Interest Income		$5.9	$25.7	$47.7	$63.5
Estimated Available Receipts		**$473.3**	**$520.5**	**$790.6**	**$960.7**
Workforce Education & Training					
Original MHSA Estimate	**$114.3**	**$68.3**	**$69.0**	**$73.3**	**$0.0**
Distribution Percentage from MHSA	45.00%	10.00%	10.00%	10.00%	0.00%
Revised Estimate					
Cash Transfers	$76.3	$89.5	$94.7	$99.8	$0.0
Accrued Revenue from Prior Years	$37.6	$0.0	$0.0	$42.4	$0.0
Interest Income	$0.3	$1.1	$4.9	$9.1	$0.0
Estimated Available Receipts	**$114.2**	**$90.6**	**$99.6**	**$151.3**	**$0.0**
Capital Facilities & Technological Needs					
Original MHSA Estimate	**$114.3**	**$68.3**	**$69.0**	**$73.3**	**$0.0**
Distribution Percentage from MHSA	45.00%	10.00%	10.00%	10.00%	0.00%
Revised Estimate					
Cash Transfers	$76.3	$89.5	$94.7	$99.8	$0.0
Accrued Revenue from Prior Years	$37.6	$0.0	$0.0	$42.4	$0.0
Interest Income	$0.3	$1.1	$4.9	$9.1	$0.0
Estimated Available Receipts	**$114.2**	**$90.6**	**$99.6**	**$151.3**	**$0.0**

	Fiscal Year				
	2004-05	2005-06	2006-07	2007-08	2008-09
Prevention & Early Intervention (Excluding Innovation)					
Original MHSA Estimate		**$129.8**	**$131.1**	**$139.3**	**$149.0**
Distribution Percentage from MHSA	0.00%	19.00%	19.00%	19.00%	19.00%
Revised Estimate					
Cash Transfers		$170.0	$179.9	$189.6	$149.0
Accrued Revenue from Prior Years		$0.0	$0.0	$80.5	$90.3
Interest Income		$2.1	$9.3	$17.3	$16.9
Estimated Available Receipts		**$172.1**	**$189.2**	**$287.4**	**$256.2**
Innovation for Community Services and Supports					
Original MHSA Estimate		**$18.8**	**$19.0**	**$20.2**	**$29.4**
Distribution Percentage from MHSA	0.00%	2.75%	2.75%	2.75%	3.75%
Revised Estimate					
Cash Transfers		$24.6	$26.0	$27.4	$29.4
Accrued Revenue from Prior Years		$0.0	$0.0	$11.7	$17.8
Interest Income		$0.3	$1.4	$2.5	$3.3
Estimated Available Receipts		**$24.9**	**$27.4**	**$41.6**	**$50.5**
Innovation for Prevention & Early Intervention					
Original MHSA Estimate		**$6.8**	**$6.9**	**$7.3**	**$7.8**
Distribution Percentage from MHSA	0.00%	1.00%	1.00%	1.00%	1.00%
Revised Estimate					
Cash Transfers		$8.9	$9.5	$10.0	$7.8
Accrued Revenue from Prior Years		$0.0	$0.0	$4.2	$4.8
Interest Income		$0.1	$0.5	$0.9	$0.9
Estimated Available Receipts		**$9.0**	**$10.0**	**$15.1**	**$13.5**
State Administration					
Original MHSA Estimate	**$12.7**	**$34.2**	**$34.5**	**$36.7**	**$39.2**
Distribution Percentage from MHSA	5.00%	5.00%	5.00%	5.00%	5.00%
Revised Estimate					
Cash Transfers	$8.5	$44.7	$47.4	$49.9	$39.2
Accrued Revenue from Prior Years	$4.2	$0.0	$0.0	$21.2	$23.8
Interest Income	$0.0	$0.6	$2.5	$4.6	$4.5
Estimated Available Receipts	**$12.7**	**$45.3**	**$49.9**	**$75.7**	**$67.5**

Original MHS Fund estimated receipts are from the MHSA (Revenue and Taxation Code Section 19602.5(c)(3)(B)(i)). Revised revenue estimates are prepared twice a year in January and May by the California Department of Finance as part of the State Budget process. The revised estimated receipts encompass a two year period (current fiscal year and budget fiscal year) with subsequent fiscal year estimated receipts based on amounts in the MHS Fund. FY 2008-09 estimated receipts are based on a 7 percent growth rate over FY 2007-08 amounts in the MHS Fund in accordance with Revenue and Taxation Code Section 19602.5(c)(3)(B)(ii). The distribution percentage for each component is from the MHSA (Welfare and Institutions Code Section 5892).

Explanation of Estimated Receipts

The estimated receipts shown in the preceding Table 1 represent estimated deposits into the Mental Health Services (MHS) Fund anticipated to occur during the relevant fiscal year which reflects accounting for these receipts on a cash basis. Conversely, the Governor's Proposed May Revise Budget shows revenues when they are earned (regardless of when the funds are deposited) which reflects accounting for revenues on an accrual basis. The chart below provides a comparison between estimated revenues on an accrual basis as per the Governor's Proposed May Revise Budget versus anticipated deposits into the MHS Fund during each fiscal year on a cash basis. Since the DMH cannot make funds available until they are deposited into the MHS Fund, Table 1 shows estimated receipts by component on a cash basis.

As shown in the chart below, the cash transfers are the same under either accounting approach. These amounts represent the net personal income tax receipts transferred into the MHS Fund in accordance with Revenue and Taxation Code Section 19602.5(b). The accrued revenue shown in the Governor's Proposed May Revise Budget is not actually deposited into the MHS Fund until two fiscal years after the revenue was earned. Also, the interest earned on monies in the MHS Fund in the fourth quarter of each fiscal year is not deposited into the MHS Fund until the next fiscal year, so the interest income is slightly different on an accrual versus cash basis.

Mental Health Services Act Estimated Receipts
Compared to Governor's Proposed May Revise 2007 Budget
(Dollars in Millions)

	Fiscal Year			
	2004-05	**2005-06**	**2006-07**	**2007-08**
Original MHSA Estimate	**$254.0**	**$683.0**	**$690.0**	**$733.0**
Governor's Proposed January 2007 Budget				
Cash Transfers	$169.5	$895.0*	$947.0	$998.0
Accrued Revenue	$83.6	$423.7	$475.0	$591.0
Interest Income Earned During Fiscal Year	$0.7	$20.0	$59.2	$94.6
Estimated Revenues-Governor's Proposed Budget	**$253.8**	**$1,338.7**	**$1,481.2**	**$1,683.6**
Estimated Receipts-Cash Basis				
Cash Transfers	$169.5	$894.6*	$947.0	$998.0
Accrued Revenue from Prior Years	$83.6	$0.0	$0.0	$423.7
Interest Income Posted During Fiscal Year	$0.7	$11.2	$49.2	$91.2
Estimated Available Receipts	**$253.8**	**$905.8**	**$996.2**	**$1,512.9**

*The difference is due to rounding

Components of the MHSA

The MHSA specifies six major components around which DMH has created an extensive stakeholder process to consider input from all perspectives. Because of the complexity of each component, implementation of the six components is being staggered. The stakeholder process involves the development of discussion documents, a series of general stakeholder meetings and topic-specific workgroups to provide input on critical issues, and to advise on implementation policies and processes. Each component addresses critical needs and priorities to improve access to effective, comprehensive, culturally and linguistically competent expanded county mental health services and supports. Improvement in client outcomes is a fundamental expectation throughout the implementation process. The MHSA specifies the percentage of funds to be devoted to each of the components and requires the DMH to establish the requirements for use of the funds.

The components and the required funding percentage specified in the MHSA for FY 2004-05 through FY 2007-08 are:

	Percentage Funding Distribution by Component			
	FY 2004/05	**FY 2005/06**	**FY 2006/07**	**FY 2007/08**
Local Planning*	5.00%	0.00%	0.00%	0.00%
Community Services & Supports	0.00%	52.25%	52.25%	52.25%
Workforce Education & Training	45.00%	10.00%	10.00%	10.00%
Capital Facilities & Technological Needs	45.00%	10.00%	10.00%	10.00%
Prevention & Early Intervention	0.00%	19.00%	19.00%	19.00%
Innovation:				
Community Services & Supports	0.00%	2.75%	2.75%	2.75%
Prevention & Early Intervention	0.00%	1.00%	1.00%	1.00%
State Administration	5.00%	5.00%	5.00%	5.00%
Total	100.00%	100.00%	100.00%	100.00%

** Local Planning is a maximum of 5 percent of the total amount distributed during a fiscal year*.

- **Local Planning (Community Program Planning Process)**—This is an inclusive local process involving clients, families, caregivers and partner agencies to identify community issues related to mental illness and resulting from lack of community services and supports. It also defines the populations to be served and the 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.

- **Community Services and Supports (CSS)**—"System of Care Services" described in the MHSA is now called “Community Services and Supports.” The CSS are the programs, services, and strategies that are being identified by each county through its stakeholder process to serve unserved and underserved populations, with an emphasis on eliminating disparity in access and mental health outcomes for racial/ethnic populations.

- **Workforce Education and Training**—This component targets workforce development programs to remedy the shortage of qualified individuals to provide services to address severe mental illnesses.

- **Capital Facilities and Technological Needs**—This component addresses the capital infrastructure needed to support implementation of the Community Services and Supports and Prevention and Early Intervention programs. It includes funding to improve or replace existing technology systems and for capital projects to meet program infrastructure needs.

- **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 (5 percent of CSS and 5 percent of PEI)**—The goal of this component is to develop and implement promising practices designed to increase access to services by underserved groups, increase the quality of services, improve outcomes and to promote interagency collaboration.

Table 2 on the following page displays actual expenditures for FY 2005-06, the estimated budget for FY 2006-07, and the proposed budget for FY 2007-08.

Table 2: Mental Health Services Act Expenditures
As of May 2007

	Actual Expenditures FY 05-06	Estimated Budget FY 06-07	Proposed Budget FY 07-08
State Support:*			
Department of Mental Health	$13,401,280	$19,918,000	$32,016,000
Mental Health Services Oversight and Accountability Commission	$496,797	$1,492,000	$2,352,000
Department of Rehabilitation	$119,564	$195,000	$214,000
Managed Risk Medical Insurance Board	-	$154,000	$156,000
State Controller's Office	-	$43,000	$48,000
Department of Social Services	$400,697	$508,000	$709,000
Department of Education	$125,282	$412,000	$1,011,000
Department of Alcohol & Drug Programs	$191,926	$258,000	$510,000
Department of Health Care Services	$39,966	$495,000	$580,000
Department of Consumer Affairs: Board of Behavioral Sciences	-	-	$105,000
Department of Aging	-	-	$93,000
Total Support	**$14,775,512**	**$23,475,000**	**$37,794,000**
Local Assistance:			
Local Planning	-	-	-
Community Services & Supports**	$153,308,253	$494,416,000	$980,700,000
Workforce Education & Training	-	-	$127,700,000
Capital Facilities & Technological Needs	-	-	$294,800,000
Prevention & Early Intervention**	-	-	$90,200,000
Total Local Assistance	**$153,308,253**	**$494,416,000**	**$1,493,400,000**
GRAND TOTAL	**$168,083,765**	**$517,891,000**	**$1,531,194,000**
Community Services & Supports	$153,308,253	$494,416,000	$954,600,000
Community Services & Supports Innovation**	-	-	$26,100,000
Total Community Services & Supports**	**$153,308,253**	**$494,416,000**	**$980,700,000**
Prevention & Early Intervention	-	-	$80,700,000
Prevention & Early Intervention Innovation**	-	-	$9,500,000
Total Prevention & Early Intervention**	-	-	**$90,200,000**
Community Services & Supports Innovation**	-	-	$26,100,000
Prevention & Early Intervention Innovation**	-	-	$9,500,000
Total Innovation**	-	-	**$35,600,000**

* The MHSA allows 5% of total annual revenues received for the Fund for state support activities.

** Includes funds available for innovative programs pursuant to Welfare and Institutions Code Section 5892(a)(6).

Table 3 below shows actual deposits, distributions and additional commitments as of April 30, 2007, for the three components that have been implemented: CSS and Supports; Workforce Education and Training; and Local Planning--as well as State Administration. Table 3 also shows actual deposits into the MHS Fund for the three components yet to be implemented, and the anticipated date funds will begin to be disbursed for the components. Overall, $1.95 billion has been deposited into the MHS Fund through April 30, 2007.

Table 3 – Mental Health Services Act Funding Status Report
Actual Deposits, Distributions and Commitments
January 1, 2005 Through April 30, 2007

	Fiscal Year			
	2004-05	2005-06	2006-07	Total
Local Planning				
Actual Deposits	$12,691,959	$0	$0	$12,691,959
Distributions	($12,624,260)			($12,624,260)
Commitments	($75,741)	$0	$0	($75,741)
Balance	($8,042)	$0	$0	($8,042)
Community Services and Supports				
Actual Deposits	$0	$473,266,890	$414,327,397	$887,594,287
Distributions		($236,112,568)	($299,734,155)	($535,846,723)
Commitments	$0	($237,154,322)	($114,593,242)	($351,747,564)
Balance	$0	$0	$0	$0
Workforce Education & Training				
Actual Deposits	$114,227,627	$90,577,395	$79,297,109	$284,102,131
Distributions				$0
Commitments	($114,227,627)	($85,772,373)	$0	($200,000,000)
Balance	$0	$4,805,022	$79,297,109	$84,102,131
State Administration				
Actual Deposits	$12,691,959	$45,288,698	$39,648,555	$97,629,212
Distributions	($4,318,950)	($14,775,512)		($19,094,462)
Commitments	$0	$0	($23,475,000)	($23,475,000)
Balance	$8,373,009	$30,513,186	$16,173,555	$55,059,750

Components With Future Disbursements

	Actual Deposits	Estimated Disbursement Date
Capital Facilities & Technological Needs	$284,102,131	Dec-07
Prevention & Early Intervention	$322,761,559	Jan-08
Innovation	$63,702,939	FY 08-09

Distributions under the CSS component are based on the fiscal year in which deposits were received rather than on a cash basis. For example, deposits in FY 2005-06 were used to fund CSS one-time expenditures in FY 2006-07, and these distributions are reflected in FY 2005-06 to correlate the distribution with the deposit. Commitments under the CSS component include funding for the MHSA Housing Program, a Prudent Reserve for each county, and funds committed to each county via the CSS Planning Estimates that have yet to be distributed to each county. Commitments under the Workforce Education and Training component include the state administered contracts and the flexible funding to be distributed to each county. Commitments under the Local Planning component primarily consist of funds for one county that has yet to participate in the program (Alpine). State Administrative commitments include funds budgeted for FY 2006-07 that have yet to be expended.

STATE SUPPORT EXPENDITURES

During FY 2005-06, FY 2006-07, and FY 2007-08, nine (9) state departments, the Managed Risk Medical Insurance Board, and the Mental Health Services Oversight and Accountability Commission (MHSOAC) are or will be allocated MHSA funding. Collaborative efforts are funded from state support. The nine departments are the DMH, the Department of Health Care Services (DHCS), the Department of Social Services (DSS), the Department of Education (CDE), the Department of Rehabilitation (DOR), the Department of Alcohol and Drug Programs (ADP), the Department of Consumer Affairs (DCA) Board of Behavioral Sciences, the Department of Aging (CDA), and the State Controller's Office (SCO). Refer to Table 2 on Page 10 for details on state support funding for FY 2005-06, FY 2006-07 and FY 2007-08.

Changes to state support expenditures since January 2007 include increases for the DMH, MHSOAC and CDE. Additional state departments funded since January 2007 include the DCA and CDA.

DMH: The DMH received a total increase of $16,930,000, including $9,269,000 for staff and associated operating costs and $7,661,000 for contract costs. The increase in DMH staff and related operating costs include the conversion of limited term positions to permanent, resources to absorb the increased workload, and the overall support for implementation of all MHSA components. Table 4, DMH State Support, details expenditures for FY 2006-07 and FY 2007-08.

MHSOAC: The MHSOAC received an increase of $884,000, which consists of $573,000 for support and operating costs and $311,000 for contracts.

CDE: The CDE reappropriated $289,000 to FY 2007-08, to provide training to local education agencies on various aspects of the MHSA, through a Spring Finance Letter. The reappropriation was requested and approved due to start up delays in contracting for the delivery of training.

DCA: Through a Spring Finance Letter the DCA, Board of Behavioral Sciences, was approved for $105,000 to fund one position to serve as a liaison to the DMH to help ensure that educational and examination requirements for licensure of various disciplines within the state's mental health workforce continue to be relevant within a transforming system. The DCA will also address workforce issues that limit consumer access to mental health services.

CDA: The CDA received $93,000 through a Spring Finance Letter to fund one position to coordinate efforts to improve access to mental health services for older adults with disabilities.

Table 4: Department of Mental Health State Support (Excludes MHSOAC)
Mental Health Services Act
Fiscal Years 2006-07 and 2007-08

Fiscal Year 2006-07	
Personal Services	$6,971,000
Operating Expenses	$1,717,000
Contracts	$10,616,000
Current Year Total at 2006-07 Budget Act	**$19,304,000**
The following adjustments were reflected in the 2007-08 Governor's Budget for FY 2006-07:	
Retirement Drill (Personal Services)	$59,000
Employee Compensation Drill (Personal Services)	$424,000
Operating Expenses Statewide Surcharge	$131,000
Current Year Total at Governor's Budget*	**$19,918,000**

Fiscal Year 2007-08	
The following adjustments were reflected in the Governor's Budget for FY 2007-08: (Apply adjustments to the Current Year Total at 2006-07 Budget Act to calculate Budget Year total)	
Less One-time costs eliminated from the FY 2007-08 Budget:	
Operating Expenses	-$36,000
Contracts	-$5,198,000
Subtotal one-time costs from FY 2007-08 Budget	-$5,234,000
Limited Term Positions Expired	-$1,595,000
Total Decreases	**-$6,829,000**
Increases:	
Personnel/Labor Relations BCP	$108,000
Retirement	$59,000
Employee Compensation	$379,000
Operating Expenses and Statewide Surcharge	$131,000
Pro Rata Adjustment	$1,740,000
Operating Expenses Price Increase	$194,000
Total Increases	**$2,611,000**
Budget Year Total at Governor's Budget	**$15,086,000**
The following adjustments are reflected in the May Revision for FY 2007-08:	
Increases:	
Personal Services	$7,270,000
Operating Expenses	$1,999,000
Contracts	$7,661,000
Total Increases	**$16,930,000**
Budget Year Total at May Revision	**$32,016,000**

*No additional adjustments were made to the current year total during the 2007-08 May Revision

CONTINUING IMPLEMENTATION ACTIVITIES IN FY 2006-07 and FY 2007-08

Stakeholders Process

Since passage of the MHSA in November 2004, the DMH has committed to an extensive and transparent stakeholder process, beginning with its first General Stakeholders Meeting held in December 2004. As of May 2007, the DMH has convened twenty-five (25) general and workgroup-specific stakeholders meetings and twenty-three (23) statewide conference calls. In addition, the DMH continues to encourage stakeholders to provide input on MHSA-related issues and policies through the general MHSA email address, the toll-free MHSA phone line and the MHSA Website.

Community Services and Supports

CSS refers to "System of Care Services" as required by the MHSA in Welfare and Institutions Code Sections 5813.5 and 5878.1 to 5878.3. The change in terminology differentiates MHSA CSS 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 and approved by the DMH after review and comment by the Oversight and Accountability Commission." The MHSA further requires that "the department shall establish requirements for the content of the plans." Annual updates of the county three-year plan will be required pursuant to MHSA requirements. The requirements for the content of the plans and the emergency regulations can be located on the DMH Website at: **http://www.dmh.ca.gov/mhsa**.

The DMH developed plan requirements for the Program and Expenditure Plan for CSS with stakeholder participation in early 2005 and released them in final on August 1, 2005. No specific due date was provided for counties to submit their Program and Expenditure Plan and, as of May 3, 2007, fifty-six (56) county plans have been received and fifty-two (52) plans have been approved for funding (see MHSA Community Services and Supports Plan Approval Status Map on the following page).

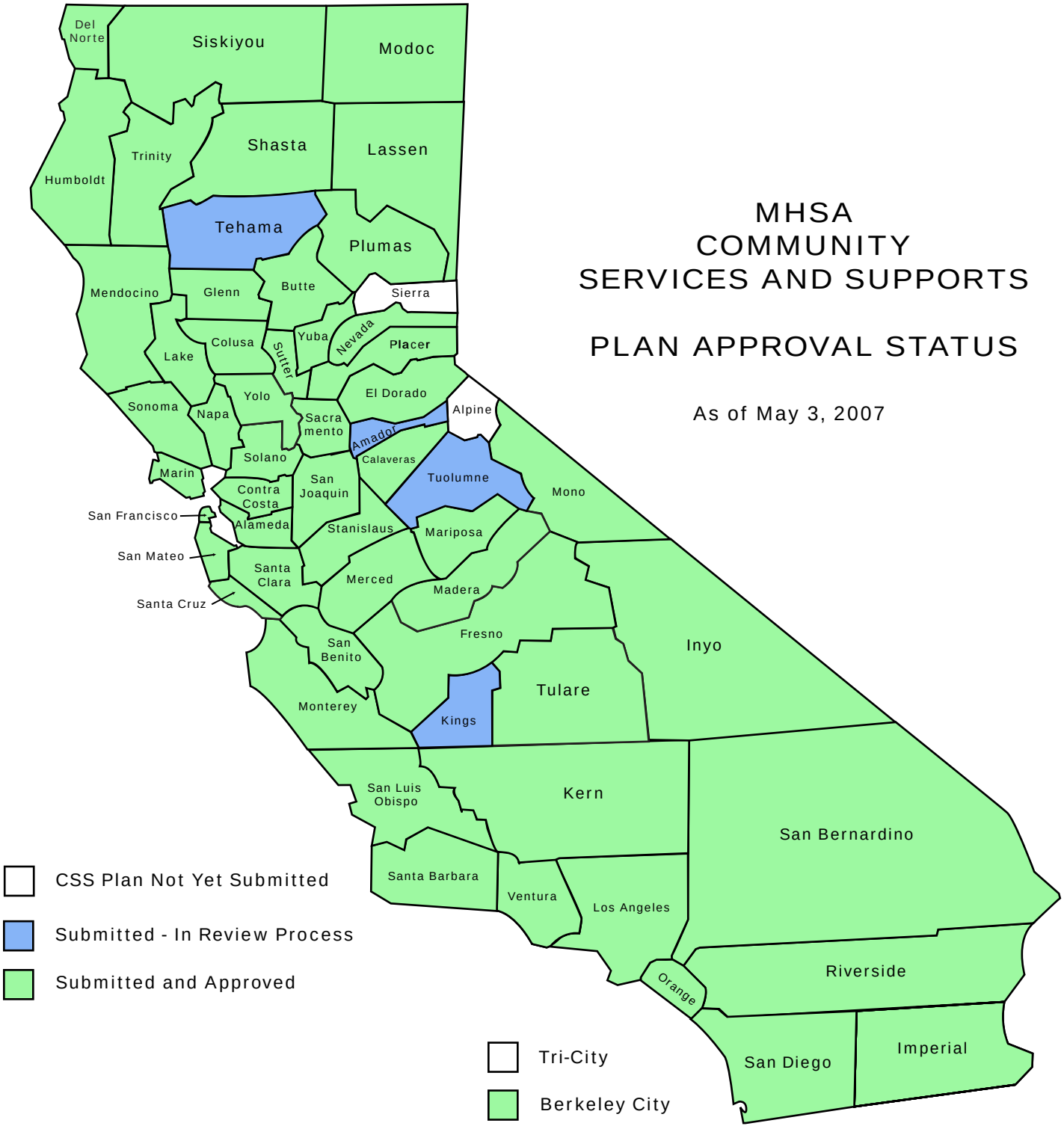
An estimated $1.78 billion[1] will be available over the three-year period from July 2005 through June 2008 to support the implementation of CSS, which includes $473.3 million for FY 2005-06 and $520.5 million for FY 2006-07. Uncommitted funds from FY 2005-06 and 2006-07 will be used to establish county prudent reserve accounts, as provided for in the MHSA, and future year service expansions.

[1] This figure does not include CSS Innovation.

MHSA COMMUNITY SERVICES AND SUPPORTS

PLAN APPROVAL STATUS

As of May 3, 2007



Governor's Homeless Initiative

The Governor's Homeless Initiative (GHI) created a housing finance model that ties together California Housing Finance Agency (CalHFA) debt financing, tax credits, and capital subsidies. The GHI was established as a result of the passage of Proposition 46 and leverages MHS funds to encourage development of supportive housing projects that target chronically homeless individuals with serious mental illness. This GHI offers a non-traditional centralized loan and application approval process. Approximately $3.15 million from MHS funds in FY 2005-06 were set aside for this GHI, with $2 million designated for rental subsidies, $750,000 designated for pre-development costs and $400,000 distributed to establish supportive housing development collaboration at the local level.

County mental health departments are a fundamental component of this effort to maximize housing options for individuals eligible for services under the MHSA, and they must provide a long-term commitment to fund supportive services for a project to qualify for approval under the GHI. As of April 2007, nine (9) applications have been submitted for funding under the GHI, five (5) of which have been approved for funding, and the remainder of which are under review.

Training and Technical Assistance

The MHSA requires the DMH to provide technical assistance and training to county mental health departments. Due to the aggressive timeline for conducting this process, it was critical that consultants with extensive background and knowledge of the DMH and county mental health program issues assist with the development of training principles and products. DMH issued a contract to the California Institute for Mental Health (CiMH) as they have this level of expertise and collaborative working relationship with the local county mental health departments.

In training and technical assistance content areas, CiMH has provided:

- Several rounds of regional trainings for counties on:
  - MHSA community planning process
  - Sources and uses of data for the CSS planning process
  - Project management for organizing and implementing CSS
  - Housing and building housing collaboratives with public and private resources
- Regional trainings for mental health boards and commissions to learn about the MHSA, identify the roles of boards and commissions in the planning and approval processes for implementing the MHSA.
- Dissemination of MHSA requirements for CSS.
- Training for medical directors and physicians to assist them in providing leadership in the MHSA implementation process.

- A series of Webcasts that focused on specific programmatic interventions for each of the four targeted age groups, including evidence-based, effective and promising practices.
- Regional meetings of County MHSA coordinators.

Technical assistance and trainings have targeted county and city mental health directors, MHSA coordinators, systems of care coordinators, supervisors and direct service staff from counties and community agencies, consumers, family members, Mental Health Board/Commission members, stakeholders from the community, and other agencies such as housing agencies and developers. For several trainings, including MHSA planning, building housing collaboratives and project management, counties were encouraged to bring teams of staff and stakeholders, including community agency providers, consumers and family members, to enable the team to develop strategies and action plans that could be implemented upon return to the counties.

To promote stakeholder involvement in training and technical assistance, CiMH has incorporated a wide range of interested stakeholders in planning the technical assistance and training events. First and foremost, consumers and family members were invited and participated in planning meetings and conference calls. Other stakeholders critical to the planning process included county MHSA staff and mental health directors, state DMH staff, and community providers. Expert consumers and family members were contracted to provide training and consultation. Expert county and state staff also assisted in providing technical assistance and training. CiMH staff and other expert consultants facilitated the meetings.

The emphasis has shifted from planning to implementation early this year, starting with the regional meetings of the MHSA Coordinators who meet face-to-face quarterly, and by phone in the intervening months. During the fall and winter, three two-day trainings on Full Service Partnerships (FSPs) for all ages were conducted throughout the state. A fourth training to be held in June will focus on the needs of small counties. CiMH is currently conducting a needs assessment of the counties to identify their training and technical assistance needs for implementing and maintaining FSPs. A Community Development Team involving four to six counties will provide technical assistance in implementation of Wraparound Programs. CiMH has provided technical assistance of some small counties in the planning process for developing CSS plans. Continuing technical assistance to the small counties will be provided, to include telemedicine, primary care collaborations, workforce development, and research on and implementation of evidence-based practices for rural areas.

In all, there were over thirty-five (35) face-to-face trainings serving over nineteen hundred (1,900) participants, and forty-one (41) Webcasts serving over three thousand (3,000) participants, for a total of seventy-six (76) trainings that served nearly five thousand (5,000) participants from fifty-six (56) local mental health authorities (counties and cities).

Workforce Education and Training

In the Workforce Education and Training component, the MHSA specifies that each county mental health program shall submit to the DMH a needs assessment identifying shortages in each professional and other occupational categories and a plan to increase the supply of professional and other staff that county mental health programs anticipate they will require. DMH is required to identify the total statewide needs for each professional and other occupational categories, and develop a five-year education and training development plan (Five-Year Plan).

DMH has continued to work with stakeholders in all policy and program formulations, to include the development of state and county responsibilities in the administration of workforce education and training funds, and the development of an initial budget and funding categories.

DMH has established a total funding level of $100 million through June 2009 for local workforce education and training. Of this total, $15 million has been allocated for planning and early implementation.

DMH has recently completed a five county pilot project that will enable the construction of a comprehensive statewide needs assessment methodology, to include workforce data forms that will accompany guidelines to counties for completing their respective county workforce education and training plans.

All elements of the Five-Year Plan have now been vetted through the stakeholder process, and will be submitted to the California Mental Health Planning Council (CMHPC) for consideration.

Statewide contracts with trainers and consultants are continuing through this fiscal year. These are entities that have a proven track record of providing training and technical assistance as envisioned by the Act. These include:

- **Organizational Change Support –** The California Institute for Mental Health (CiMH) continues its expanded statewide training and technical assistance mission of supporting county mental health programs. This expansion included ongoing technical assistance for organizational development toward consumer and family member-driven, evidence-based service delivery as envisioned by the Act, and to facilitate regional learning collaborative networks to plan and implement new practices.

- **Financial Incentive Program –** The California Social Work Educational Consortium (CalSWEC) expanded its existing stipend program to provide financial incentives for students in master's level social work programs committed to working in community public mental health. Ninety-five percent (95%) of the one hundred seventy-three (173) graduates available for employment this year are currently employed in the

public mental health system. One hundred eighty-eight (188) students are enrolled this academic year. This program provides a replicable model for development of additional financial incentive programs.

- **Statewide Constituency Partnership –** The statewide constituency organizations of the California Network of Mental Health Clients (CNMHC), United Advocates for Children and Families (UACF), and the National Alliance for the Mentally Ill – California (NAMI) have expanded their efforts to reach consumers and family members with self-help technical assistance and train-the-trainer curricula, such as Educate, Equip and Support – Building Hope, Peer-to-Peer, Family-to-Family, and Wellness Recovery Action Planning. These curricula will promote the meaningful inclusion and employment of consumers and family members at all levels of the public mental health system.

Additional state administered programs and activities are in the development stage and DMH is facilitating a stakeholder process to ensure these planned programs and activities adhere to the intent of the Act. Proposed county guidelines for developing county administered programs and activities is currently in draft form, and is posted on the DMH web site for public input.

Capital Facilities

A portion of the MHSA funds have been specifically set aside for Capital Facilities and Technological Needs in FY 2004-2005 through FY 2008-2009 to enable counties to support the goals of the MHSA in a manner which is consistent with the County's Three-Year Program and Expenditure Plan. In subsequent fiscal years, counties may continue to use a portion of their MHSA CSS funding for Capital Facilities and Technological Needs.

Each County's plan for the use of Capital Facilities funds should support the goals of the MHSA in a manner consistent with the County's Three-Year Program and Expenditure Plan. The County must clearly show how the planned use of the Capital Facilities funds will produce long-term impacts with lasting benefits that move the mental health system towards the goals of wellness, recovery, and expansion of opportunities for accessible community-based services for clients and their families. These efforts should include development of a variety of community-based facilities which support integrated service experiences and an increase in peer support and consumer run facilities.

The DMH recently made a policy change to designate housing as a service and/or support and an allowable expenditure under the CSS component funding rather than as a Capital Facility expenditure. As a result of this change, Capital Facilities funding will be utilized to purchase, construct, and/or rehabilitate facilities that provide services and/or treatment for those with severe mental illness, or to provide administrative support to MHSA funded programs. This change was reviewed and discussed through the stakeholder input process.

DMH recently released for stakeholder input draft proposed guidelines for Capital Facilities. The release of the proposed guidelines and regulations will each be followed by an opportunity for statewide stakeholder feedback and recommendations as part of the process for establishing the final requirements for the counties.

Mental Health Services Act Housing Program

In May 2006 Governor Schwarzenegger issued Executive Order S-07-06. This order states that up to $75 million per year of the MHSA funds will be dedicated to develop permanent supportive housing for individuals with mental illness and their families, with special emphasis on homeless individuals. This effort builds on the interagency collaboration established in November 2005 with the GHI. Proposed program guidelines will be released in mid 2007.

Technological Needs

The MHSA provides funding for county technology projects that will improve the access and delivery of mental health services to the public. DMH is responsible for ensuring that the MHSA funds are appropriated to county technology projects that are consistent with MHSA goals and objectives, and that are well-planned, well-managed and executed properly. In order to allocate funds appropriately, DMH created a process in which counties submit their technology funding requests for approval in accordance with established DMH guidelines. DMH then works directly with each county technology representative (usually the chief information officer) to develop a comprehensive understanding of the technology project and the anticipated results, and make any required modifications prior to approval. Once the approval is granted, funds are released to the county in support of the project. The DMH then continues to work in an oversight capacity with the county in order to ensure the project's success. From June 29, 2006 through March 30, 2007, the DMH approved technology funding requests from 17 counties for 31 projects totaling $11,089,396.

DMH evaluates and approves technology requests within the context of two goals: 1) modernize and transform clinical and administrative information systems to improve quality of care, operational efficiency and cost effectiveness, and 2) increase consumer and family empowerment by providing the tools for secure consumer and family access to health information within a wide variety of public and private settings.

The long-term technology goal of DMH is to develop an Integrated Information Systems Infrastructure where all counties have integrated information systems that can securely access and exchange information. This infrastructure will allow different county systems to share information across a secure network environment both inside and outside their respective counties. Counties and their contract providers, hospital emergency departments, laboratories, pharmacies and consumers and their families could all securely access and exchange information through the infrastructure. This long-term goal will be achieved as each county assesses their current state of technology readiness and moves through a continuum of improvements over time.

To facilitate the long-term technology transformation, DMH developed minimum statewide standards for mental health Electronic Health Record (EHR) systems. The EHR system is the foundation for the Integrated Information Systems Infrastructure. It is a secure, real-time, point-of-care, client centric, information resource for service providers. The ability to share timely, accurate and secure access to the client's health and healthcare information is possible through the use of uniform standards to transfer information from one source to another. To achieve statewide technology transformation, DMH will periodically specify increasingly complex minimum standards so that counties and their vendors will be able to adapt their systems while meeting their current business needs.

Prevention and Early Intervention

The MHSA authorizes the DMH to establish program requirements for PEI in California. In addition, the MHSA authorizes the MHSOAC to approve program expenditures for PEI. Because of this unique relationship, the DMH and the MHSOAC are working closely to craft the program and funding requirements. The MHSOAC approved its proposal for PEI principles and funding criteria in January 2007. This document was based on collaboration with the DMH, the California Mental Health Directors Association (CMHDA) and the CMHPC.

In addition to the collaboration of the government partners, the DMH is conducting statewide stakeholder meetings in April and June 2007 to solicit input on the draft PEI program guidelines. A parallel process for obtaining input from underserved and ethnic communities is being implemented through a contract with the U.C. Davis Center for Reducing Health Disparities. In addition, through a contract with Pacific News Services, the DMH is convening focus groups for transition-age youth (TAY) to obtain input from this population.

The DMH plans to post the program guidelines in August 2007 at which time counties will begin their local planning process. The DMH anticipates that final county PEI plans will be submitted starting in November 2007, with contracts in place and funding flowing in early 2008.

The DMH is also convening a Statewide Advisory Committee to develop the California Strategic Plan for Suicide Prevention. The Strategic Plan will be completed by Summer 2008.

Innovation

The goals for the Innovation funding are to increase access to underserved groups; to increase the quality of services, including better outcomes; to promote interagency collaboration; and to increase access to services.

The MHSA authorizes the DMH to establish program requirements for the Innovation component. In addition, the MHSA authorizes the MHSOAC to approve the Innovation

program expenditures. Because of this unique relationship, the DMH and the MHSOAC are working closely to craft the program and funding requirements for the Innovation component. The MHSOAC has convened an Innovation Committee which is in its early stages of developing working definitions of Innovation, Innovation Need and Innovative Response. This work will culminate in the development of an Innovation Proposal to be presented and approved by the MHSOAC by September 2007. DMH has the responsibility for reviewing local plans; the MHSOAC will have primary responsibility for approving the plans for the Innovation component. It is anticipated that the Innovation component will be operational by FY 2008-09.

Outcomes Reporting

Counties that have received CSS plan approval are in various stages of implementing MHSA-funded programs and providing services, with a number of counties reporting FSP outcomes and other MHSA services information. In addition, all counties with approved CSS plans have begun submitting Quarterly Reports of targeted and actual numbers of persons outreached and served through the MHSA FSP, outreach and engagement, and system development funding sources. The DMH is creating streamlined data entry, consolidation and analytic processes for statewide aggregation and reporting of this information.

The Measurement and Outcomes Committee of the MHSOAC, which includes the Chief of the Evaluation, Statistics and Support branch within DMH, continues to work towards informing, guiding and assisting in the prioritization of performance measurement targets and methods for various aspects of MHSA implementation. During 2007, the Performance Measurement Advisory Committee (PMAC) continues to focus on furthering the development of measurement protocols for the mental health system's transformation targeting individual client, program/system and community level evaluations. The State Quality Improvement Council (SQIC) is also aligning its quality improvement goals and projects with the MHSA vision, and is coordinating its activities with the PMAC and other mental health quality endeavors, internal and external to DMH.

Because performance measures selection includes the consideration of technology options available to improve workflow processes, data quality and the feasibility of data collection, DMH information technology personnel, performance measurement personnel and numerous stakeholders statewide continue to collaborate towards enhancing information management infrastructures that support performance measurement and accountability reporting. To that end, the DMH is developing the Data Collection and Reporting system (DCR) and other Web-based data entry processes which streamline the data submission and reporting process for FSP programs and other MHSA strategies.

Mental Health Services Oversight and Accountability Commission

The MHSOAC was established in July 2005. The MHSOAC recommends policies and strategies to further the vision of transformation and address barriers to systems change, as well as providing oversight to ensure funds being spent are true to the intent and purpose of the MHSA. In this capacity the MHSOAC has been working collaboratively with the DMH, the CMHPC, the CMHDA and other key partners.

The MHSOAC has drafted an eighteen (18) month Work Plan covering the period January 1, 2007 through June 30, 2008, which spans FY 2006-07 and FY 2007-08. It is intended to be a blueprint to satisfy all of the above-stated objectives. It proposes an MHSOAC mission, defines the MHSOAC core roles and responsibilities as specified in the Act, identifies MHSOAC goals consistent with the Act, spells out long-term strategies and short-term activities, and suggests an organizational structure to fulfill the MHSOAC's responsibilities and implement its strategies. Information on the MHSOAC is available at its website: **http://www.dmh.ca.gov/MHSOAC/.**

The proposed mission statement of the MHSOAC is to provide the vision and leadership, in collaboration with clients, their family members and underserved communities to ensure Californians understand mental health is essential to overall health and to hold public systems accountable and provide oversight for eliminating disparities, promoting mental wellness, recovery and resiliency, and ensuring positive outcomes for individuals living with serious mental illness and their families.

The roles and responsibilities of the MHSOAC include:

- In collaboration with clients, family members and underserved communities, provide the vision, leadership and oversight necessary to prevent mental illness from becoming severe and disabling and transform the public and private systems charged with providing services, care and support to Californians living with mental illness.

- Oversee the implementation of MHSA Parts 3 and 4, CSS (Adults, Older Adults and Children's System of Care); Part 3.1, Human Resources; Part 3.2, Innovative Programs; and Part 3.6, PEI. Hold the State and county departments of mental health accountable for developing and implementing transformative programs.

    - Review and comment on the CSS, Capital Facilities and Technological Needs, and Workforce Education and Training components.

    - Review, comment and approve expenditures in MHSA county as well as statewide plans for PEI and Innovation.

- In collaboration with clients, family members and underserved communities, develop strategies to combat and overcome stigma.

- Advise the Governor and/or the Legislature regarding actions the State may take to improve care and services for individuals experiencing mental illness.

- Ensure transparency of the MHSA in planning, implementation and outcomes.

- Develop additional and necessary strategies to accomplish any objective or provision of the MHSA. Include clients, families and underserved communities in the development of strategies.

The MHSOAC will adopt four (4) key strategies to fulfill its roles and responsibilities and achieve its mission. Key strategies remain consistent from year to year. The four key MHSOAC strategies being proposed are:

1. Ensure transparency of the MHSA through communication with and education of the public.

2. Provide oversight over the MHS Fund and ensure accountability to the intent and purpose of the MHSA by:

    a. Reviewing and providing comment on CSS, Workforce Education and Training, and Capital Facilities and Technological Needs Plans. For these plans, provide transformation principles and implementation strategies to DMH to include in local plan requirements.

    b. Assisting the DMH in developing county and statewide plan requirements for PEI and Innovation; review, comment and provide final approval on county and statewide plan expenditures in PEI and Innovation Plans.

3. Establish expectations for statewide outcomes accountability.

4. Develop and advance a statewide policy agenda that promotes systems transformation.