

**Jennifer Hoff
Ladera Ranch, CA**

Pedro Nava
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Little Hoover Commission
925 L Street, Suite 805
Sacramento, CA 95814
June 3, 2016

Full Written Testimony

My name is Jennifer Hoff

Thank you Commissioners for this meeting, I am grateful for an opportunity to share our families experiences with prop 63 services.

My seriously mentally ill son Matthew is serving 15 years in state prison...most of that time has been in solitary confinement...he threatened to blow up a bank = terrorist=felonies.

He had the protections of a contained facility from ages 12-18 funded by Orange County BHD and Irvine School District for "emotionally disturbed youth" and was on SSI.

Then our son turned 18 and fell off the cliff. This young man whom never a day in his life could keep himself safe was given his shoe laces and plane ticket home...managing his own life as a "client of MH services" within 6 weeks hit the revolving door.

Cycle lasted almost a year and included many things:

- Lots of police
- Helicopter
- Driving the streets of Santa Anna and calling the morgue nightly when his "right to be homeless" between jail sentences
- My husband picking up Matthew 3 days after coming home face down in his own vomit
- multiple ER visits
- overdoses on self medication
- pneumonia from being homeless in winter

This TAY kid was in control of his life now and his peer counselor encouraged him to stop taking his medication.

We were against...we made dozens of calls to his "team" about danger our son was in ...we sent over 400 pages of medical records to his case manager and every public defender insisting we be able to get him the help of a conservatorship... this fell on deaf ears...we were told our son was not "sick enough" for services. We were told by the health director they can help more "when he gets in trouble enough with the law" ...not satisfied I started to go to BOS meetings and Behavioral Health Dept. meetings to share our story of how we couldn't get our son into a hospital long term or on a conservatorship...many times I heard there is not enough "funding" for kids like him...this was confusing because I was aware of prop 63...we pay into it and believed it to be a good tax...I began to ask for them for help to see that these funds get utilized correctly and asking for their data to show treatment for the smi.

There would be no calibration...we were told "everything is working as intended" and that "many people are being saved" by prop 63....no reform needed...Matthew has the "right" to choose to live how he wants and they will not be spending money in programs for AOT, "forced drugging" or "corrosion". These words out of the mouth of individuals in charge of spending billions of tax dollars.

I also wanted to know why our son can get kicked out of 4 group homes in weeks of each other...and there is no data...its all his "choice" ...kicked OUT with no where to be "kicked to" ...then there was my confusion as to why the county would continually argument against AOT being part of a PEI program.....we were promoting Laura's Law at that time and our county fought us every step of the way including denying that funding could come form prop 63...gratefully that was cleared up the state level. Our son would have qualified for those services...not saying it would be enough just for some of these kids they have NEVER been able to show a prolonged time of being stable...and we treat them like they have moderate depression. So with no one to listen so I started going digging deeper into our funding stream...who's in charge and going to OAC meetings and found some very interesting results.

The meetings were stacked with recipients of grant recipients who proclaimed great success and showed great appreciation for the money...the last meeting in Oakland a couple years ago was of particular interest because the break out sessions were structured in such a way that the "family" group was actually facilitated by a consumer who took notes and at the end of the meeting shared a filtered version of our brainstorming session.... hospitalization came up and she said no AOT and I actually jumped up in my seat and said "yes" we want AOT...it was a bit twilight zone-ish.

I found that the "outside agencies" those grass roots organization I believed would be able to advocate for our loved ones were being forgotten under the bridge "everyone was awesome" as we were saving "thousands of lives" almost...the only individuals who were demanding a change were the families...I don't understand how a org can still be considered grass roots when 85% of funding comes from our tax.

So we started a foundation and began speaking more about the clear ways Prop 63 should be amended and reformed. We brought the suggestions from the LHC and wanted them implemented in our county...very quickly realizing that we are now viewed as “critics” simply for asking that there be comprehensive data collected and Evidence Based Programs funded.

Considering our family’s perspective both as funders of this tax and as parents of a child who was failed by our system I have a few ideas for you to consider:

A real whatever it takes approach...I cant tell you how many times I heard that in response to me sharing the reality of our situation...we “have a whatever it takes approach” the county told me in the same breath it said “we have to support his decision making” even if it meant being homeless??...well it wasn’t enough to save my son and his three school mates.

No more money for parties before we have a transparent system...after reading Steinbergs dismissive comments in response to the LHC reports areas of improvement and suggestions I am not convinced there is much willingness to face the FACTS as we see them too.

OAC meetings need reorganization

Data on more populations then the current system is calling “sick” my son wasn’t even considered “mentally ill” per the jail surveys.... even with CRAZY BOY tattooed across his face.

If you ask for the data on my child’s population you will not find it...those who we know won’t respond to current treatment are given the right to live in the street until they die in the gutter...where’s the data on kids who we know never stood a chance and had parents screaming for help all along the way?

For PEI:

Independent grievance process...the funding source is protected by our county...no one having their check paid through MSHA will agree with us that some things “might” need to change.

Contrary to Mr. Selixes opinions of my lines of criticism regarding PEI programs I don’t believe I am off base or lacking in appreciation of the value of prevention and early intervention programs nor have I ever suggested we use ALL the funds for the people who are already severely disabled...I am critical of the programs because they lack oversight, are not evidenced based nor are applied in a way that triages care for the sickest as a priority just like we do in the ER...everyone should get the care they need...but we must not deny a entire population of sick people care all while distracting the scene with pretty pie charts that are lacking my son in their data sample.

And

Eroding of public confidence...well

I don't like it when folks in charge of spending my tax money ignore my repeated requests for dialogue about our families tragedy nor take into consideration ideas we have for improving the lives of the SMI. I take personally when I am dismissed as an "angry mom" or as a "critic". This categorically painting families as dissidence and the dismissive attitude towards families who are critical of the broken parts of our system as "off base and lacking of appreciation of the value of prevention and early intervention" is dishonorable. We have lost children to a failed mental health system, its time our stories are listened to and we create a robust, measurable and transparent system of care for our SMI...fully realizing the promise to have a system "for all".

Until such a time is realized, I respectfully request a refund.

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Re: How to ensure the usage of of Prop 63/MHSA funds to serve those legislatively required to be served

Dear Mr. Nava:

Thank you for your desire to address the funding inconsistencies associated with Prop 63/MHSA.

Core Issue: MHSA funds are being systematically diverted from their legislatively required population, people with serious mental illness (SMI) and in the case of PEI funds, those who have a mental illness that is likely to become severe and disabling.¹ MHSA funds are being overly applied to individuals not diagnosed with SMI who have a wide variety of psychiatric “issues” (mental illness related or not). Current social service programs are overwhelmingly based on “feel good”, mindfulness and relaxation therapy’s and stigma reducing activities rather than comprehensive, peer reviewed or evidenced based programs. As part of the stakeholder process, tutoring, unemployment services, anti-bullying initiatives, crime reduction, stress in the marriage, prostitution, were all defined as mental health issues eligible for funding. Despite the requirements of the law² PEI funds are ostensibly going to “prevent mental illness” rather than fund services shown to prevent an individuals mental illness from progressing into a state of severe and disabling.

Individuals who were eligible, indeed the focus for services under the law as written (i.e. those eligible for Adult System of Care or CSS services) are found ineligible for the Full Service Partnerships (terminology never outlined in the law) and therefore are left untreated.

The Little Hoover Commission has been provided with outcome data, however some inconsistencies in outcome measures much be addressed such as use of “good” outcomes, when they are being achieved by limiting the actual number of seriously ill individuals . Serving only individuals closer to “wellness” is easier overall to show “successes”. There is no useful or independent data from within the MHSA, and all the data from outside the system shows MHSA is failing the same group of disabled individuals, repeatedly: homelessness, arrest, incarceration and suicide in individuals with SMI are all up in spite of positive only outcome measures provided by MHSA.² The core data we think is missing is not on outcomes, it is on who is being served. Some of that data, for instance on diagnosis, is available from Medi-Cal.

I respectfully disagree that one solution is to give MHSOAC more authority. MHSOAC has been a cheerleader for diverting the funds away from their intended purposes. For example, at a board meeting MHSOAC freed PEI programs from the requirement to measure outcomes and from using funds as described in their own plans.³

¹ In enacting MHSA, “The people of the State of California hereby declare their purpose and intent in enacting this act to be as follows: To define *serious mental illness* among children, adults and seniors as a condition deserving priority attention.” As Rusty Selix said, “And they didn’t want to fund all mental health, *only people that had severe mental illness.*”

² MHSA leadership points to reduced funding from other sources, but that is because they have allowed Counties to ignore the non supplantation provisions of MHSA.

³ Minutes show that MHSOAC review of counties was “based on what counties said they were going to do, rather than actual on the ground assessment”. The board also accepted a report stating there was no obligation to review outcomes. Minutes of September 22,

The severing of MHSA funds from the requirement they serve the seriously ill has been accomplished in several ways.

1. After the law was passed, authorities diverted MHSA funding from the Adult System of Care defined in the law and understood by all to something they invented and called “Full Service Partnerships (FSPs)” which were not mentioned in the law.⁴ FSPs are 100% voluntary and therefore by definition exclude the most seriously ill. “Whatever it takes” only applies to the higher functioning. Individuals who are eligible for the Adult System of Care that MHSA was supposed to fund are going untreated because they are ineligible for FSPs.⁵
2. County Behavioral Health Directors were encouraged by MHSOAC to allow the stakeholder process to trump the legislative requirement that MHSA funds serve people with serious mental illness. The issue is not, as Steinberg and Ewing tried to define it, whether a stakeholder process is taking place. The issue is, are the programs stakeholders are proposing eligible for funding. If stakeholders want a program, County Behavioral Health Directors fund it with MHSA funds, regardless of whether it serves seriously mentally ill or helps prevent people with mental illness from having it become severe and disabling. (See att.)
3. MHSOAC issued regulations that prevent PEI funds from serving people with mental illness that will become severe and disabling, which was the intent of PEI. They also issued regulations that divert funds away from evidence based practices and towards non-evidence based practices. (See att.)
4. Rather than working to solve the massive problems with MHSA, MHSOAC covers up the failure of MHSA to address the needs of those with serious mental illness and prevents solutions by commissioning self-serving reports to “prove” MHSA works and then hires public relations agencies to communicate the same to the public.⁶
5. Conflicts of Interest and Insider dealing. MHSOAC officials award MHSA funds to organizations they serve on the boards of, then commission reports to show they are doing a good job and then hire PR agencies to distribute the results of those reports to the public. There is a conflict of interest at every step. There is no *independent* oversight. (See att.)

The most important action that the Little Hoover Commission can take is to work to reform the MHSOAC which is the source of most of the problems. Help highlight that funds are not being used as legislatively required to help people with serious mental illness or to prevent those with mental illness from having it become severe and disabling. It is not enough to serve underserved communities, ethnic groups, members of LGBT

2011 MHSOAC Commissioners. Previously available at

http://www.mhsoac.ca.gov/meetings/docs/PriorMeetingMinutes/2011/MinutesApproved_Sept2011.pdf

⁴ “Subject to the availability of funds from the Mental Health Services Fund, the State Department of Mental Health shall distribute funds for the provision of services under Sections 5801, 5802 and 5806 to county mental health programs.” (5813.5) Those sections were pre-existing systems of care programs, they were not FSPs.

⁵ Statewide, FSPs are exclusively available to those who are well enough and high functioning enough to voluntarily accept services. All others are not being served. This is almost the opposite population that were served by the Adult System of care who are the ones the voter initiative required to be served. MHSA requires “Services *shall* be available to adults and seniors with severe illnesses who meet the eligibility criteria in subdivisions (b) and (c) of Section 5600.3 of the Welfare and Institutions Code” (5813.5) The 5600.3(c) criteria is “Adults or older adults *who require or are at risk* of requiring acute psychiatric inpatient care, residential treatment, or outpatient crisis intervention because of a **mental disorder with symptoms of psychosis, suicidality, or violence.**” (emphasis added) There is no evidence or even claim, that those being served by FSPs meet these criteria.

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- Example 1. MHSOAC contracted with UCLA, itself a large recipient of MHSA funds for a report on FSPs “Full Service Partnerships: California’s Commitment to Support Children and Transition-Age Youth with Serious Emotional Disturbance and Adults and Older Adults with Serious Mental Illness” Before releasing the report, at the request of the commission and others, the UCLA authors amended the report to “focus on positive outcomes”. The report intentionally and knowingly overstated cost savings from incarceration by allocating fixed costs (which do not change due to number of people served) to each patient and calculating it as savings. See discussion by Commissioner Brown on page 16 of November 2012 Oversight Commission Board meeting minutes. He stated, “(T)hat that is not an accurate measure of cost savings and may taint the rest of the report in terms of what savings are achieved. This report will be open to criticism regarding the types of cost savings indicated. Additionally, there is a disparity where Los Angeles used a figure of over \$1,000 a day when every other county used a figure substantially lower.” The report was previously available at http://mhsoac.ca.gov/Meetings/docs/Meetings/2012/Nov/OAC_111512_Tab4_MHSA_CostOffset_Report_FSP.pdf
- Example 2. A recent highly publicized report commissioned by CalMHSA from RAND strained credulity. It claimed that watching an MHSA funded movie or hearing a tag line, cut costs to California taxpayers by \$1.5 billion! There is no research anywhere on earth that seeing a movie or listening to a tagline helps people with SMI. MHSOAC accomplished this slight of hand by imputing additional treatment with having seen the movie or tagline. However, as revealed in a footnote to the study, they don’t whether the treatment took place before or after seeing the movie, so they simply reported that anyone who was ever treated for anything had treatment that was caused by seeing the movie.

groups, or other special populations unless the funds are used for those within those communities who have SMI or in the case of PEI funds, a mental illness that is likely to become severe and disabling. The failure to stay within the law is what allows funds to go to things like Hmong gardens and hip-hop car washes. And the practice of using MHSA funds exclusively for FSPs which exclude the seriously ill, rather than the more extensive Adult System of Care they were required to fund and which do serve the seriously ill, must be ended.

The Little Hoover Commission is correct that better data is needed, but so is policing.

Structural Solutions

Massive media exposure of waste of MHSA funds, the State Auditors Report describing problems, and the Little Hoover Commission Report describing problems have not had any effect on MHSOAC. That is because the existing oversight mechanism is comprised of those with a vested interest in the status quo. It is well known that those in the mental health industry prefer to cherry pick the highest functioning for admission, and to turn the seriously ill over to police, sheriffs, shelters and morgues. The lack of independence and desire to maintain the status quo is so profound, that the Commission was forced to rely on data from the Steinberg Institute, the biggest promoter of the program.

Solving these issues is not going to be without challenges. Theoretically oversight bodies are in place, but because they are made up exclusively of mental health insiders, they have become part of the problem rather than the solution. Those who have highlighted the deficiencies within MHSA have been stymied. Replacing those mechanisms requires legislative action. Creating a body over the existing structure creates needless duplication. Within those limits, following are our suggestions. Admittedly, many of these are designed to cajole compliance, an approach that has failed in the past, so incorporating them into legislation may be necessary.

- Set up a process to refer instances of counties using funds for programs that are outside the scope of the act for criminal prosecution. Mr. Ewing's own submission noted, "Some local plans are not consistent with the law" and "Advocates who receive county funding or services can face retaliation if they speak up against priorities offered by county agencies." Those of us who want to improve the system have no independent place to do our whistleblowing.
- Require counties to report and monitor MHSA expenditures *by diagnosis or severity of illness in order to determine if funds are being used for eligible populations only.*
- Counties should be required to monitor and report *meaningful* metrics, not just any metric. For example, suicide reduction programs should measure rates of suicide, not just how many people clicked on a website. The former is "progress" measure, the later is a "process" measure. However care must be taken. It is not enough to monitor outcomes, as those can be improved simply by refusing to serve the seriously ill.
- Prohibit Insider Dealing: No funds should be allowed to go to programs associated with members of the Oversight Commission or that were associated with them in the prior three years. The members can choose whether they want to be a user of funds (stay on the board or staff of their organizations) or a distributor (stay on the board of the Oversight Commission). No one should be allowed to do both. It is not enough to recuse oneself from funding decisions, they should not be on the board.
- End conflicts of interest by putting outsiders on MHSOAC. The law defines the composition of MHSOAC, but in many cases it does not require those individuals to come from the mental health industry. For example, only two of the Governor's twelve appointees are required to be from the mental health industry, but almost all are. Mental health care industry executives, rather than business executives, fill the slots allocated to "a representative of an employer with less than 500 employees." The same is true for "a representative of an employer with more than 500 employees." There is no reason for those positions to be filled by industry insiders. Appointees who represent say, the Chamber of Commerce or downtown safety groups, are much more likely than industry insiders to return the

program to serving the seriously ill.

- While it would require legislation, increase representation from police, sheriffs, district attorneys, corrections, and inpatient psychiatric hospitals on oversight commission as they know what community services are needed to prevent incarceration and hospitalization of the most seriously ill.
- Make it clear to counties that the funds must be used to fund the Adult Systems of Care
- Conduct an outside review to identify and eliminate all regulations created by MHSOAC to divert MHSA funds to people without mental illness. (See att).
- Encourage MHSOAC and counties to take steps to eliminate funding of programs that falsely claim they prevent serious mental illness.
- Encourage MHSOAC to take steps to eliminate funding of programs that do not accept people with serious mental illness
- Define "Underserved Populations" by diagnosis and severity of their mental illness, rather than ethnicity, sexual identity, and other criteria not provided for in the law.
- Encourage MHSOAC to stop diverting funds to PR, TV shows, PSAs ("Universal Prevention Activities") and spend the money saved on helping people with mental illness from having it become severe and disabling.
- Eliminate the funding of political public relations that is self-serving and intended to communicate the benefits of Prop 63 and to suppress the problems.
- Eliminate funding of organizations that do not believe mental illness exists or lobby--even with non-MHSA funds--against treatment for those who are so sick they do not recognize their need for treatment.
- Eliminate the ability of County Behavioral Health Directors to lead or follow a stakeholder process that perverts and circumvents intent of legislation.

Mr. Ewing and Steinberg asked, "Where would be without MHSA" as if anyone is proposing elimination. The correct question is, "Where would be if all MHSA funds went where the voters were told they would go—to help the seriously mentally ill, rather than being siphoned off for irrelevant sideshows?"

Attached are fact sheets prepared by Mental Illness Policy Org. addressing some of the issues above. And thank you again for trying to right the wrong.

Sincerely,

Jennifer Hoff

Att.

FSP spending unaccounted for
MHSOAC regulations drove spending from intended recipients
The Failed Stakeholder process
Examples of statewide PEI misspending
Los Angeles Case History
Insider dealing by MHSOAC Commissioners

Mental Illness Policy Org.

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Full Service Partnerships: \$2.5 billion unaccounted for

Note: URLs are provided but may have expired

Background: MHSA was intended to expand successful existing programs.¹ Full Service Partnerships (FSP) were not an existing program and do not appear in California law or MHSA legislation. After Proposition 63 passed, the California Department of Mental Health created a broad definition of them:

“the collaborative relationship between the County and the client, and when appropriate the client’s family, through which the County plans for and provides the full spectrum of community services so that the client can achieve the identified goals.”²

FSPs are colloquially described as “doing whatever it takes,” albeit only for voluntary patients. As a result of direction to spend money on FSPs,³ \$2.5 billion went to FSPs instead of existing programs that had already proven their effectiveness.⁴ FSPs are serving some people with serious mental illness and doing a good job. FSPs are only voluntary, and therefore exclude many of the most seriously ill, like those who are psychotic. No information is collected or reported on the diagnosis of those being served. It is unclear how many of the individuals in FSPs have serious mental illnesses like schizophrenia or bipolar disorder or if FSPs are better than the existing programs that failed to receive funding as a result of the prioritization of FSPs.

Problems

1. Zero oversight to ensure people enrolled in FSPs have schizophrenia, bipolar disorder or other serious mental illness.

The Oversight Commission collects extensive information on age, ethnicity, sexual orientation of FSP enrollees, but not diagnosis.⁵ Thus, there is no way to know whether the \$2.5 billion FSP initiative is serving people with serious mental illness as required by the legislation.

Partially in response to growing public concerns, MHSOAC did contract with UCLA, a large recipient of MHSA funds for a report on FSPs.⁶

- Before releasing the report, at the request of the commission and others, the UCLA authors amended the supposedly independent report to “focus on positive outcomes”.⁷
- The report intentionally and knowingly overstated cost savings from incarceration by allocating fixed costs (which do not change due to number of people served) to each patient and calculating it as savings.⁸
- In order to “prove” FSPs save money, the UCLA authors added ‘physical health’ savings--a welcome, secondary, but not primary goal of MHSA, and a goal that can be readily achieved by serving people with physical illnesses rather than serious mental illnesses.

¹ “The legislature found “By expanding programs that have demonstrated their effectiveness, California can save lives and money” (Findings and Declarations (f)). The Purpose and Intent of the law was “To expand the kinds of successful, innovative service programs for children, adults and seniors begun in California”

² Emergency regulation in Cal. Admin. Code tit. 9, § 3200.130

³ Because FSPs were an unproven new program it might have been appropriate to spend Innovative Funds on them. 5% of MHSA funds are set aside for Innovative New Programs. Instead, massive general funding was mandated to be used. See direction at <http://www.dmh.ca.gov/DMHDocs/docs/letters05/05-05CSS.pdf>

⁴ MHSOAC allocated 51% of all CSS funds which are 50% of all MHSA funds to them, making FSPs the largest MHSA expenditure. If MHSA raised \$10 billion since inception, \$2.5 billion were spent on FSPs.

⁵ Diagnosis information would be available via MediCal or anonymized questionnaires.

⁶ “Full Service Partnerships: California’s Commitment to Support Children and Transition-Age Youth with Serious Emotional Disturbance and Adults and Older Adults with Serious Mental Illness” prepared by UCLA Center for Healthier Children, Youth and Families (10/31/12). Available at

http://mhsoac.ca.gov/Meetings/docs/Meetings/2012/Nov/OAC_111512_Tab4_MHSA_CostOffset_Report_FSP.pdf

⁷ See page 4 of UCLA Report.

⁸ See discussion by Commissioner Brown (who represents law enforcement on the commission) starting on page 16 of November 2012 Oversight Commission Board meeting minutes. Among other comments, Commissioner Brown noted the use of fixed versus variable costs and correctly stated, “(T)hat that is not an accurate measure of cost savings and may taint the rest of the report in terms of what savings are achieved. This report will be open to criticism regarding the types of cost savings indicated. Additionally, there is a disparity where Los Angeles used a figure of over \$1,000 a day when every other county used a figure substantially lower.”

“Available at http://mhsoac.ca.gov/Meetings/docs/Meetings/2013/OAC_012413_Tab1_Minutes111512.pdf

- The report recommended more studies be conducted the result of which would send more money to programs associated with the commissioners.
- The UCLA report did not include any information of diagnosis of participants.
- The UCLA report did not reveal the multiple regulations that make many of the most seriously mentally ill ineligible for FSP services or that FSPs were only serving those well enough to volunteer.

Oversight Commissioners used the UCLA report to declare their stewardship of FSP programs a success.

2. FSPs exclude many of the most seriously ill. They only serve those well enough to recognize they are ill.

Regulations were proposed that required MHSA funded programs to be designed for voluntary patients only.⁹ This made the most seriously ill ineligible for FSPs. Up to 40% of those with bipolar disorder and 50% of those with schizophrenia are so ill, they don't know they are ill (anosognosia).¹⁰ For example, a homeless person yelling they are the Messiah, or screaming the FBI planted a transmitter in their head would not likely be well enough to volunteer for services. These individuals are excluded from FSPs. Doing 'whatever it takes', should extend to helping people who lack awareness of their illness.¹¹ See Appendix D flow charts show the steps programs are skipping when determining if someone qualifies for MHSA-funded support.¹²

4. To fund FSPs, programs that help people with serious mental illness who are homeless were left unfunded.

Proponents of Full Service Partnerships claim FSPs are referred to in MHSA because the Finding and Declarations reference AB 34 programs.¹³ The population served by AB 34 Existing Systems of Care programs are “**severely mentally ill** adults who are **homeless, recently released from a county jail or state prison**, or otherwise at risk of homelessness or incarceration.”¹⁴ There is no indication FSPs are serving the same population as AB-34 programs. In fact, since 2007, “the proportion of prison inmates with mental illnesses has grown from 19 percent in 2007 to 26 percent now”.¹⁵

AB 34 programs reduced the number of consumers hospitalized, 42.3% number of hospital days, 55.8%; number of consumers incarcerated, 58.3% 45.9% barometers of success.¹⁶ They deserve equal or better funding than FSPs.

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4. The FSP model may help higher functioning get housing but is least successful at helping people with schizophrenia and bipolar disorder get housing—the two most serious mental illnesses.¹⁷

Conclusion:

\$2.5 billion is spent on FSPs without any oversight of whether they are serving eligible individuals. FSPs exclude many of the most seriously ill.

⁹ CCR Title 9 Regulation 3400(b)

(b) Programs and/or services provided with MHSA funds shall...(2) be designed for voluntary participation” While the regulation went on to state, “No person shall be denied access based solely on his/her voluntary or involuntary status” the use of MHSA funds to prevent implementation of Laura’s Law has obviated that option.

¹⁰ See anosognosia at <http://mentalillnesspolicy.org/medical/anosognosia-studies.html>

¹¹ One way around this conundrum would be for counties to implement Laura’s Law.

¹² Flow charts: Impact of the Full Service Partnership Programs on Independent Living. Nicholas C. Petris Center on Health Care Markets and Consumer Welfare School of Public Health University of California, Berkeley May 2010

¹³ Findings and Declarations (b): A recent innovative approach, begun under Assembly Bill 34 in 1999, was recognized in 2003 as a model program by the President’s Commission on Mental Health¹³. This program combines prevention services with a full range of integrated services to treat the whole person, with the goal of self sufficiency for those who may have otherwise faced homelessness or dependence on the state for years to come.

¹⁴ Legislative analysis at http://www.leginfo.ca.gov/pub/99-00/bill/asm/ab_0001-0050/ab_34_cfa_19990816_185010_sen_comm.html

¹⁵ Associated Press. California Mental Health Dollars Bypass Mentally Ill , July 28, 2012 as published in Sacramento Bee.

¹⁶ <http://www.homebaseccc.org/PDFs/CATenYearPlan/CAHighlightOutreach.pdf>

¹⁷ Schizophrenia and bipolar disorder are two of the most serious mental illnesses. The housing initiatives funded by MHSA help people with those disorders the least. “The Impact of the Full Service Partnership Programs on Independent Living found “not having schizophrenia or bipolar disorder” led to increased likelihood of independent living.” Nicholas C. Petris Center on Health Care Markets and Consumer Welfare School of Public Health University of California, Berkeley . “The Impact of the Full Service Partnership Programs on Independent Living: A Markov Analysis of Residential Transitions” Petris Report # 2010-3. Available at http://www.dmh.ca.gov/Prop_63/MHSA/Publications/docs/3_Petris_Residential_Report_Final.pdf

Mental Illness Policy Org.

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HOW MHSOAC COMMISSIONERS USED THE REGULATORY PROCESS TO DRIVE MHSA FUNDING AWAY FROM WHAT IS STATUTORILY REQUIRED.

The California State Auditor found that, due to lack of oversight, “the State has little current assurance that the funds directed to counties for MHSA programs have been used effectively and appropriately.”¹⁸

Note: URLs are provided but may have expired

Overview

- The “Purpose and Intent” of the Mental Health Services Act is to “define serious mental illness among children, adults and seniors as a condition deserving priority attention”¹⁹. The regulations don’t do that.
- The purpose of Mental Health Services Oversight and Accountability Commission (MHSOAC) is “To ensure that all funds are expended in the most cost effective manner and services are provided in accordance with recommended best practices....”²⁰ The regulations don’t do that.
- The purpose of Prevention and Early Intervention funds specifically are to “prevent mental illnesses from becoming severe and disabling.” (5840(a)) Promulgated regulations fail to see that happens and drive funds away from that goal.
- Prevention and Early Intervention programs “shall include mental health services **similar to those provided under other programs** effective in preventing mental illnesses from becoming severe, and shall also include components **similar to programs that have been successful** in reducing the duration of untreated severe mental illnesses” (emphasis added)²¹ Regulations intentionally drive funds from “effective” “successful” programs to programs that are neither effective, nor successful.
- The regulators fail to “require reports on the achievement of performance outcomes”²² (i.e, measure ‘progress’, like number of suicides, number of people homeless, number incarcerated) and instead substitute “process” indicators (like how many people clicked on a web site, amount of money spent, etc.)
- The regulations redefined ‘evidence based’ to allow the funding of services that have popularity but no evidence of efficacy. This encourages the diversion of PEI funds to programs that should be funded with INN funds.
- The regulations allow more activities than the legislation does and seems to drive funding toward organizations associated with the MHSOAC Commissioners. (See “Examples of county social service programs masquerading as mental illness programs in order to receive MHSA PEI Funds”²³ and “Insider Dealing in MHSA PEI Programs.”²⁴)

Historical diversion of funds encouraged by MHSOAC

- In 2005, 2011 and at other times, DMH and MHSOAC repeatedly told counties to use PEI funds on people who don’t have mental illness, i.e, “prior to diagnosis”.²⁵ This was done in spite of the fact the

¹⁸ California State Auditor. “Mental Health Services Act” Available at <http://mentalillnesspolicy.org/states/california/mhsa/state-auditor-mhsa-report.pdf> (Accessed 6/14)

¹⁹ Purpose and Intent (a) available at http://www.mhsoac.ca.gov/docs/MHSA_AsRevisedSept2013_ForPosting_120613.pdf

²⁰ Uncodified Code Section 3, subdivision (e) “Purpose and Intent” of the MHSA) available at http://www.mhsoac.ca.gov/docs/MHSA_AsRevisedSept2013_ForPosting_120613.pdf

²¹ 5840(c)

²² 5848 (c)

²³ Available at <http://mentalillnesspolicy.org/states/california/mhsa/county-by-county-mhsa-missspending.pdf> and part of the “MHSA: 10 Year Bait and Switch” Report attached as an integral part of my comments.

²⁴ Available at http://mentalillnesspolicy.org/states/california/mhsa/mhsa_insider_dealing.html and part of the “MHSA: 10 Year Bait and Switch” Report attached as an integral part of my comments.

legislation requires the funds to serve people with mental illness not those without.

- Monterey attempted to use MHSA PEI funds as intended: to prevent those *with* mental illness from having it become “severe and disabling.” A letter was sent to them by regulators stating, “To be consistent with this [prevention] definition, MHSA-funded PEI programs *cannot serve people with a mental health diagnosis*. Several of Monterey County’s PEI programs currently target mental health consumers; however, to be consistent with the PEI Guidelines, please clarify that these programs include persons *without a mental health diagnosis*.” (emphasis added)²⁶
- Commissioner Van Horn and others intended to (may have) approved expenditures for substance abuse programs they knew were not allowable by law.”²⁷
- MHSOAC and/or DMH sent interim regulations to counties encouraging the diversion of MHSA funds²⁸

Some examples:

- 3400 (b) illegally separated PEI programs from having the statutory tie to serious mental illness. The first part of the regulation states “Programs and/or services provided with MHSA funds shall: (1) Offer mental health services and/or supports to individuals/clients **with** serious mental illness and/or serious emotional disturbance, and when appropriate their families. But it goes on to state “**The Prevention and Early Intervention component is exempt from this requirement.**” There is nothing in voter intent or legislative language that suggest PEI funds were ‘exempt’ from helping people *with* serious mental illness. This exempted \$2 billion in taxpayer Prevention and Early Intervention funds from serving people with mental illness.
- 3200.251 redefined the purpose of PEI programs from what voters intended (“preventing mental illness from becoming severe and disabling”) to “prevent serious mental illness” (we don’t know how); “promoting mental health” (making people happier) and “building the resilience of individuals”.
- 3200.305 encouraged counties to spend on so-called “Universal Prevention Activities.” That “*target the whole population or a subset of the population that does not have a higher risk for developing the symptoms of mental illness.*”²⁹ It takes the most tortured reading of Prop 63 to conclude that voters intended to fund PR campaigns, television shows, newspaper advertising, etc. for people without mental illness.
- CCR Title 9 3905 defined seven priority population groups as eligible for PEI funds. Only one group was “Individuals experiencing onset of a serious mental illness”. The other priority population were being prioritized for services based sexual orientation, employment status of parents, presence of parents, whether or not someone in the family ever died, age, criminal history and substance abuse—even in the absence of a mental illness.

Recent diversion of funds encouraged by MHSOAC

In June 2014, MHSOAC proposed regulations to encourage the use of MHSA funds for purposes inconsistent

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1. See Minutes of September 22, 2011 MHSOAC Commissioners. Previously available at http://www.mhsoac.ca.gov/meetings/docs/PriorMeetingMinutes/2011/MinutesApproved_Sept2011.pdf Accessed 6/24/13.
 2. See Regulation originally proposed by DMH to be included in CCR, Title 9. Rehabilitative and Developmental Services, Division 1. Department of Mental Health, Chapter 14. Mental Health Services Act Article 2. DEFINITIONS, Section 3200.251 which was shared with all counties
 3. See letters sent by DMH to counties in October 2005.) Both required counties to spend funds on those ‘prior to diagnosis’, i.e., without mental illness.

²⁶ Previously available at http://mhsoac.ca.gov/Counties/PEI/docs/PEIplans/PEI_Monterey.pdf (Accessed 6/22/13)

²⁷ Oversight Commission minutes show that the commissioners funded substance abuse programs specifically not included for funding in the final language of the legislation. “MHSOAC Vice-Chair Van Horn commented that ...the reason co-occurring disorders (substance abuse) were not mentioned in the MHSA was because during the Proposition 63 focus groups they were informed that using that language would lead to the defeat of the proposition.” He then went on to state, “**It is clear that co-occurring disorders need to be dealt with at the same level.**” Minutes of MHSOAC Board Meeting September 22, 2011. Previously available at http://www.mhsoac.ca.gov/meetings/docs/PriorMeetingMinutes/2011/MinutesApproved_Sept2011.pdf Accessed 6/24/12

²⁸ Some of these were promulgated, some not, some lapsed. But the direction to not use PEI funds for persons with mental illness was continually and forcefully communicated to counties and was defacto policy regardless of which regulations were in effect.

²⁹ <http://www.preventionearlyintervention.org/go/PromotingWellnessPrevention/UniversalPrevention.aspx> Not that the Institute of Medicine and SAMHSA both concluded Universal Prevention (public awareness) does not prevent serious mental illness

with the legislation and admitted what they were doing. *“The broad objective of these regulations is to facilitate the transformation of the mental health system from what has traditionally been seen as a fail first system to a help-first system.”*³⁰

There is no language in the legislation to support the claim that MHSA funds are to be used to “transform the system.” Using funds to transform the system does “alter, amend, and conflict” with statute. The legislation specifically states the purpose of the funding is to **expand already existing programs**, not to provide for “transformation of the mental health system.”³¹ The MHSOAC replaced the legislative requirement to fund existing programs with a requirement to fund FSPs. This alone accounts for much of the failure of MHSA to improve the lives of the seriously ill.

In 2015, MHSOAC promulgated the regulations diverting PEI funds from purposes enacted by voters. Following are just a few examples. Mental Illness Policy Org. can provide additional ones.

§CCR 3710 limits the receipt of PEI programs to 18 months. But individuals may need lifelong services to prevent their mental illness from becoming severe and disabling. This regulation intentionally prevents funds from serving their intended purpose.

§CCR 3710 encourages the use of PEI funds to address “ongoing stress” “experiences of racism” “social inequality”, and “isolation.” None of these are mental illnesses or causes of serious mental illness. The inclusion of this language legitimizes the diversion of funds meant to prevent mental illness from becoming severe and disabling to other social services.

§CCR 3710 encourages the use of “Universal Prevention” in spite of overwhelming evidence that Universal Prevention (often advertising, public relations) is not appropriate for serious mental illness.

§CCR 3740 circumvents the requirement that programs be evidence based and efficient by defining any program that is popular (has “community consensus over time, which may or may not have been measured empirically”) to be deemed evidence based.

³⁰ “Policy Statement Overview and Anticipated Benefits of Proposal” in the “Notice of Proposed Rulemaking” Previously available at http://www.mhsoac.ca.gov/Laws_Regs/docs/PEI_Notice.pdf. On Page 3 of 12 of Notice of Proposed Rulemaking. June 6, 2014.

³¹ 5840 (c).

Also see The Findings and Declaration Paragraph (e) which lists **pre-existing programs** the funds are supposed to expand. Findings and Declarations Paragraph (f) specifically states “By expanding programs **that have demonstrated** their effectiveness, California can save lives and money.” Findings and Declaration Paragraph (g) says the goal is “ To provide an equitable way to fund **these expanded services**”. There is no mention in the Findings and Declarations of ‘transformation’. There is extensive reference to funding programs that already exist.

Further support for the notion that funds are required to be used for existing systems of care are found in the “Purpose and Intent” of the Legislation which is “To expand the kinds of successful, innovative service programs for children, adults and seniors begun in California...”. It goes on to say “These programs have **already** demonstrated their effectiveness in providing outreach and integrated services, including medically necessary psychiatric services, and other services, to individuals **most severely affected by or at risk of serious mental illness.**” (emphasis added). Again, there is no call in the legislation to ‘transform’ the system. The clear goal of voters was to expand existing, proven systems of care.

The responsibility to use funds to expand existing programs is also stated explicitly within the PEI provisions of MHSA. “The (PEI) program shall include mental health services **similar to those provided under other programs effective** in preventing mental illnesses from becoming severe, and shall also include components **similar to programs that have been successful** in reducing the duration of untreated severe mental illnesses and assisting people in quickly regaining productive lives.”

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The Failed MHSA Stakeholder Process

Note: URLs are provided but may have expired

Background

MHSA legislation codifies a stakeholder process to provide input to county MHSA plans³²

Problems: In every county we looked into, we found the stakeholder process was fatally flawed and in most counties the process led by the county behavioral health director. The stakeholder groups were primarily composed of representatives and clients of social service and mental 'health' programs that do not serve people with serious mental illness and wanted funding for their own favored programs.

1. Professionals with experience treating and caring for the most seriously mentally ill were not part of the stakeholder process. i.e, police, sheriffs, corrections, district attorneys, inpatient doctors, inpatient nurses, doctors at homeless shelters, and others who treat the seriously ill individuals who are shunned by mental 'health' providers.
2. Stakeholders were allowed to prioritize programs that lacked evidence of efficacy or were known to be ineffective.
3. A billion dollar feeding frenzy erupted as programs tried to get MHSA funds for their own programs.
4. County behavioral health directors blindly accepted stakeholder input, even when inconsistent with the legislation.

Results:

1. Social Service programs that don't serve seriously mentally ill were prioritized for funding.
2. Programs received funding in spite of lack of evidence they work or known evidence they don't.
3. Programs that serve people with serious mental illness went unfunded.

Case Study: Fresno County allowed stakeholder input to trump helping people with serious mental illness:

The director of behavioral health services in Fresno County said "(H)e would like more of the Mental Health Services Act money to treat people with severe mental illness. With county budgets tight, he said, the priorities should be "crisis first, treatment and then early intervention, prevention. Evans said the county plan isn't perfect, but it is a compromise between what the community wants and what the staff sees as gaps in the system "It's all a compromise," she said.

(Fresno Bee, January 6, 2013)

Case Study: Sacramento County allowed stakeholder input to trump helping people with serious mental illness.

At a Sacramento County Mental Health Board Meeting in May 2013 attendants were told about PEI "Strengthening Families Project". Within this program are Quality Child Care Collaborative, HEARTS for Kids, Bullying Prevention Education and Training, Early Violence Intervention Begins With Education and Independent Living Program 2.0. Someone noted these were social services programs and ineligible for MHSA funding. They were told, "when the public hearing were held on these programs, the community wanted them"

Case Study: Butte County allowed stakeholder input to trump helping people with serious mental illness.

Butte County's failed stakeholder process led to the funding Hmong Gardens. Butte did a study of the need for housing for people of Hmong ancestry. Eight people participated. We do not know if any had serious mental illness or if any housing was ever built. But this 'study' found that two important services for this housing that is not limited to people with mental illness are "gardens" and a "community room". The researchers aggregated the two to conclude that if they built housing, 58% wanted "community room and garden" and therefore a garden was a service that prevents mental illness from becoming severe and disabling and was included in the PEI Plan (See discussion of Butte under county misspending chapter).

³² WIC 5848 (a)

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Examples of statewide misspending within PEI (and/or Innovation Funds)

Note: URLs are provided but may have expired.

Case Study: According to a reporter at the Orange County Register reported suicide in California is up and the MHSA suicide prevention program is not working:

“Jenny Qian, a manager in county behavioral services, says thanks to an injection of money from Proposition 63, Orange County has beefed up its suicide programs in the past two years and continues to roll out more programs. Qian tells me by calling what she describes as a local hotline number, 1-877-727-4747, people will find all the local help they need.”

“I called that number and asked for help for someone needing a counselor in the Mission Viejo area. I was informed the person who needs help should call. I pressed and was told they can’t help with local counselors because the service is nationwide.” <http://www.ocregister.com/articles/suicide-504805-county-gun.html>

Statewide Prevention and Early Intervention Initiatives (\$129 million)¹

MHSA PEI funds are generally given to counties to spend. However, there are two sources of statewide funds.

1. CalMHSA. CalMHSA is a Joint Power Authority created by counties to pool their MHSA funds to execute programs that are more efficiently executed by a statewide entity, rather than by individual counties. These expenditures must still comply with MHSA requirement to serve people with serious mental illness, “prevent mental illness from becoming severe and disabling” or “reduce the duration of untreated serious mental illness. They were still subject to approval by the Oversight Commission. CalMHSA bought 34 Ipads for County Behavioral Health Directors.²
2. Oversight Commission- The Oversight Commission has extensive funds of their own. These are generally used for reports, studies, and research, that create good press for the commission, jobs for those who get the contracts, but have very little to do with providing care to people with serious mental illness. While these come out of administrative funds (rather than PEI) we will discuss them here.

It is often difficult to determine which MHSA funded projects described below were funded from which buckets of money, but the fact that MHSA funds are being used is indisputable.

1. Suicide Prevention wastes up to \$32 million³

Background: Suicide is mentioned twice in MHSA. The “Findings and Declarations” declared, “Untreated mental illness is the leading cause of disability and suicide and imposes high costs on state and local government.” and “The (PEI) program shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness: (1) Suicide.”⁴ MHSA is only to reduce suicide that results from untreated mental illness. California previously created a “Strategic Plan on Suicide Prevention” (a/k/a “Schwarzenegger Plan⁵) that included data and strategies to prevent suicide and noted mental illness was a leading cause of suicide.⁶

¹ A description of some of the statewide programs with dollar amounts is at

http://www.mhsoac.ca.gov/Meetings/docs/Meetings/2011/Jul/OAC_072811_Tab3_CalMHSA_StatusReport.pdf. Some are annual expenditures. Others may be multi-year.

² See last page, last paragraph at <http://calmhsa.org/wp-content/uploads/2012/06/CalMHSA-Budget-Package-2012-2013-FINAL.pdf>

³ \$129 million was spent on CalMHSA on PEI of which 25% was allocated to suicide (\$32 million). Page three at <http://calmhsa.org/wp-content/uploads/2012/01/CalMHSA-Implementation-Work-Plan-FINAL-11-18-10-POSTED.pdf> \$3 million of this suicide prevention funding went to NAMI, whose former President Ralph Nelson was on MHSAOC Board. \$3 million of this went to MHA of SF, whose former Executive Director, Eduardo Vega was on MHSAOC board.

⁴ WIC 5840(d)(1)

⁵ <http://www.mhsoac.ca.gov/docs/Suicide-Prevention-Policy-Plan.pdf>

⁶ “(N)early half of suicide cases involve at least one documented mental health diagnosis. It is estimated that as many as 90 percent of individuals who died by suicide had a diagnosable mental illness or substance abuse disorder. Certain psychiatric diagnoses increase the risk of suicide substantially. Among individuals diagnosed with a major mood disorder (a spectrum that includes major depression and bipolar disorder), up to 20 percent die by suicide. The risk tends to be highest among those who have frequent and severe recurrences of symptoms.”

Problems: CalMHSA ignored the research included in the Schwarzenegger Plan and funded non evidenced based suicide programs instead. For example, the Schwarzenegger Plan found kids 10-15 are the lowest suicide risk but CalMHSA focused PEI suicide money on children. Adults, the group with the highest death rates—responsible for 50% of all suicides are not prioritized.

Prop 63 funding is funding ineffective, unproven, mistargeted TV, radio, billboard, print campaign to reduce suicide.⁷ There is no evidence that media campaigns reduce suicide and some evidence they increase it⁸. It is also inefficient because they reach the general public versus high risk populations like those with serious mental illness, those who have previously attempted suicide, or the first degree relatives of those who have attempted suicide.⁹

CalMHSA also uses MHSAs funds for anti-suicide websites like <http://www.yourvoicecounts.org> Your Voice Counts lets Californian's vote on what is effective at suicide prevention. It substitutes polling for science in deciding where MHSAs Suicide prevention money should go.

2. Stigma and Discrimination Reduction. up to \$48 million¹⁰

MHSA eloquently differentiated 'extremely common' mental illnesses from serious mental illnesses and stated the intent of the legislation to help the later and not the former.¹¹ In spite of this, stigma funds are being spent on those with common illnesses and not those with serious mental illnesses.

- A glossy four-color magazine insert was produced, printed, and distributed statewide in newspapers that is headlined, "Mental Illness Affects Everyone." That was clearly not designed to inform about the much smaller

⁷ The CalMHSA suicide prevention efforts have a \$32 million budget, but we don't know what percentage is being spent on this particular effort. <http://www.prweb.com/releases/prweb2012/12/prweb10229719.htm>

⁸ The theory behind these campaigns is that they educate people to see warning signs so they can intervene to prevent the suicide. But research shows it doesn't work mainly because suicide is exceedingly uncommon. Per the press release announcing the CalMHSA Suicide Prevention Media Campaign, of the 37.5 million Californians, 3,823 (.01%) took their own lives, and 16,425 (.04%) were hospitalized for self-inflicted injuries. To be effective, all experts agree that suicide prevention efforts should be highly targeted to those populations with higher rates of suicide or attempts. Populations with high rates of suicide include those who have previously attempted suicide and first degree relatives of those who have attempted suicide. It is simply a waste to fund TV campaigns when trying to reach less than 4,000 or 17,000 people.

We researched the professional literature and could not find any scientific evidence media campaigns reduce suicide. There are reputable sources that suggest (without proof) that these campaigns should be used, but in almost all cases they say the campaigns should be targeted at high-risk individuals.

The Suicide Prevention Resource Center does not list any public relations campaigns in their list of "Evidence Based Programs" They do list education and training, but these are targeted to 'gatekeepers', like nurses, doctors, and social workers so they can recognize symptoms. See <http://www.sprc.org/bpr/section-i-evidence-based-programs#sec1listings>

The Schwarzenegger Plan does suggest public education efforts (without citing any source or rationale) but immediately goes on to suggest that targeting gatekeepers is the most important strategy <http://mhsoac.ca.gov/docs/Suicide-Prevention-Policy-Plan.pdf>

There are many studies showing efforts targeted to the public are not supported by research. See *Suicide Prevention Strategies: A systematic review Journal of the American Medical Association* available at <http://jama.jamanetwork.com/article.aspx?articleid=201761> and *Why are we not getting any closer to preventing suicide? DIEGO DE LEO, FRANZCP BJ Psych* available at <http://bjp.rcpsych.org/content/181/5/372.short> *The later sates* "The conflict between political convenience and scientific adequacy in suicide prevention is usually resolved in favor of the former. Thus, strategies targeting the general population instead of high-risk groups (psychiatric patients recently discharged from hospital, suicide attempters, etc.) may be chosen"

We also contacted Dr. Alan Berman Executive Director of the American Association of Suicidology, to triple check our findings. He confirmed that there is no evidence PR campaigns reduce suicide and confirmed the research that they may in fact do harm (have 'untoward' effect).

⁹ Spending \$32 million to reach 3,832 (est.) individuals results in a per capita expenditure of \$8,370 per suicide prevented.

¹⁰ 37.5% of \$129 million per California Mental Health Services Authority Statewide Prevention and Early Intervention Implementation Work Plan page iii at <http://calmhsa.org/wp-content/uploads/2012/01/CalMHSA-Implementation-Work-Plan-FINAL-11-18-10-POSTED.pdf>

¹¹ After noting that mental illnesses are "extremely common" MHSA findings and declarations went on to state that these people with everyday common mental illnesses are not serious mental ill that MHSA was intended to help, "In any year, between 5 percent and 7 percent of adults have a serious mental illness as do a similar percentage of children— between 5 percent and 9 percent. "MHSA funds are intended to 'define *serious mental illness* as a condition deserving priority attention".

group with 'serious' mental illness¹².

- A TV commercial in five languages was produced¹³:

Title "One in Four"

Annrc: Every year, 1 in 4 Californians experience mental illness.

Mental illness does not discriminate.

It can happen to anyone of any ethnicity, income or gender.

It is a medical condition that affects thinking, feeling, mood, ability to relate to others, daily functioning.

There are many causes including life history particularly stress, trauma, abuse.

If you or someone you know is hurting, get help. Contact your county mental health or behavioral health department. (MHSOAC Logo)

This PSA does not even mention "serious" mental illness. The PSA misstates the science¹⁴ and proposes a solution that will not likely work for many of the most of the seriously ill.¹⁵

- Five "Mental Health Minutes" (sponsorships) were produced.¹⁶ Only one mentions serious mental illness.
- **\$11 million in stigma funding was given to a Sacramento public relations firm (Runyon Saltzman & Einhorn).**¹⁷ Among other tasks, they ran a Facebook group "Good News About Proposition 63". It did not provide any information to help people with mental illness, only puff pieces on how great Prop 63 is. When people started posting info about waste and fraud within Prop 63, rather than look at the site as useful tool to collect such information, they took the page down. The PR firm also writes op-eds extolling the virtues of MHSA¹⁸ and generates positive news stories.¹⁹ These efforts have made it very difficult for the truth about Prop 63 to get out to the public. Voters did not pass prop 63 because they felt a dearth of PR firms.
- **\$2.9 million in stigma funding is going to Disabilities Rights California (DRC)²⁰ and is being used to oppose Laura's Law²¹** a program that has been proven to help people who are so seriously ill they do not recognize their need for treatment²².
- **Approximately \$12 million in stigma funds were given directly to organizations headed by members of the Oversight Commission.** See Insider Dealing chapter for information on approximately \$3 million each in stigma funds given to NAMI, MHSA, and DRC all of which are headed by members of the Oversight Commission.
- **Stigma funds were used to tell newspaper reporters and editors how to write their stories.**²³

¹² Available at http://issuu.com/news_review/docs/2013-01-03_mentalillness

¹³ Available on right side at http://www.mhsoac.ca.gov/Prop63_Website/Prop63_NewWebsite.aspx

¹⁴ "Serious" mental illness is not caused by "stress, trauma, abuse" like the PSA says. Serious mental illness like schizophrenia is likely due to multiple interrelated genes somehow interacting with external influences like viruses. It may be a disorder incurred in-utero. Bipolar disorder, the other serious mental illness Prop 63 proceeds were intended to help is even more genetically related than schizophrenia. The "one in four" mental illnesses may not "affect...daily functioning" as the PSA says. It is the "serious" mental illnesses (that affect 5-9% of people) that are likely to "affect...daily functioning". Put another way, the author of this report has depression and takes Prozac. It doesn't affect his daily life at all. He's a "1 in 4" not a 5-9%. MHSA was not intended to serve me. The language of the legislation, and materials used to sell it to the public, clearly state Prop 63 is intended to serve the **seriously** ill.

¹⁵ Up to 50% of those who have *schizophrenia or bipolar* and are not currently receiving treatment may be so ill they don't recognize they have it. It's called anosognosia. Lack of awareness of illness (a brain so sick it doesn't know it is not working) is the Number One reason people with serious mental illness won't accept treatment. So admonishments to "Get Help" will not work.

¹⁶ Available on left side at http://www.mhsoac.ca.gov/Prop63_Website/Prop63_NewWebsite.aspx

¹⁷ <http://www.californiahealthline.org/articles/2011/10/18/agency-doles-out-11-2m-for-mental-health-campaign.aspx>

¹⁸ <http://www.mhsoac.ca.gov/ArchivedOpinionEditorials.aspx>

¹⁹ <http://www.mhsoac.ca.gov/ArchivedInTheNews.aspx>

²⁰ Oversight Commissioner Eduardo Vega is on the DRC board.

http://www.mhsoac.ca.gov/Meetings/docs/Meetings/2011/Jul/OAC_072811_Tab3_CalMHSA_StatusReport.pdf

²¹ <http://lauras-law.org/states/california/llresultsin2counties.html>

²² According to Carla Jacobs of California Treatment Advocacy Coalition, DRC sued Los Angeles to prevent implementation of Laura's Law. For some 2005-2012 DRC anti-Laura's Law activity see <http://lauras-law.org/states/california/p&aopposition.pdf>

²³ At least one editor of one large California Daily was approached by MHSA funded stigma program which wanted her to use their "style guide" to change how she was writing about mental illness, i.e., downplay violence.

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Examples of county social service programs masquerading as mental illness programs in order to receive MHSA funds¹

Note: URLs are provided but may have expired

Many of the county programs below that came to our attention are admirable, worthy and even important social service programs. But they are not mental illness programs. They are therefore ineligible for MHSA funding. Diverting MHSA funds to these programs is not what voters intended, and leaves those with serious mental illness living untreated at home or homeless, living under lice infected clothing and eating out of dumpsters, while funds intended to help go elsewhere.

- **Butte County** uses MHSA funds for
 - A "Therapeutic Wilderness Experience".²
 - Hmong Gardens.³ This is a good example of a failed stakeholder process. Butte did a study of the need for housing for people of Hmong ancestry.⁴ Eight people participated. We do not know if any had serious mental illness or if any housing was ever built. But this focus group found that two important services for this housing that is not limited to people with mental illness are "gardens" and a "community room". The researchers aggregated the two to conclude that if they built housing, 58% wanted "community room and garden" and therefore a garden was a service that prevents mental illness from becoming severe and disabling.
 - African American Cultural Center.⁵
 - PR brochures that positioned the county behavioral health director as an effective steward of MHSA funds. They include no financial data on how the money is spent.⁶
- **Contra Costa County** is using MHSA funding
 - To teach parenting skills to parents(\$360,000)⁷
 - for a hip-hop carwash, family activity nights and a homework club.⁸
 - to help the elderly with or without mental illness.⁹
 - "New Leaf Collaborative."¹⁰ This works to improve grades.

¹ These are only the ones we have become aware of, and do not represent a complete list. We did not evaluate every county MHSA plan, only programs that came to our attention.

² We are not aware of any information that shows a Therapeutic Wilderness Experience will prevent mental illness from becoming severe and disabling http://www.mhsoac.ca.gov/Innovation/docs/InnovationPlans/Butte_INN_Approval_Summary.pdf

³ <http://www.fresnobee.com/2012/07/30/2929985/fresno-hmong-garden-praised.html#storylink=cpy>

⁴ <http://www.buttecounty.net/Behavioral%20Health/Mental%20Health%20Services%20Act%20-%20Old/~media/County%20Files/Behavioral%20Health/Public%20Internet/MHSA/Housing/HmongFocusGroupDataResults.ashx>

⁵ <http://www.buttecounty.net/Behavioral%20Health/~media/County%20Files/Behavioral%20Health/Public%20Internet/MHSA/Public%20Announcements/12-13%20Annual%20Update%20Narrative%20DRAFT%201.ashx>

and
<http://www.buttecounty.net/Behavioral%20Health/~media/County%20Files/Behavioral%20Health/Public%20Internet/MHSA/Public%20Announcements/BH1213MHSAPlanUpdateplan.ashx>

⁶ <http://www.buttecounty.net/Behavioral%20Health/~media/County%20Files/Behavioral%20Health/Public%20Internet/MHSA/Public%20Announcements/MHSA%20Benefits%20to%20Butte%20County.ashx>

⁷ http://64.166.146.155/agenda_publish.cfm?mt=ALL&get_month=10&get_year=2012&dsp=agm&seq=12398&rev=0&ag=238&ln=23705&nseq=12400&nrev=0&pseq=&prev=#ReturnTo23705

⁸ The "purpose" of the hip-hop car wash was to help at-risk children learn life skills that will make them productive citizens, by promoting educational and vocational opportunities any by providing training, support and other tools they need to overcome challenging circumstances." That may be worthy, but is outside the purpose and intent of MHSA which is to help people with serious mental illness. http://66.39.42.45/services/mental_health/prop63/pdf/pei_agencies_descriptions.pdf and http://www.contracostatimes.com/top-stories/ci_18356480

⁹ http://www.mhsoac.ca.gov/MHSAOC_Publications/docs/PressReleases/2011/PEITrendsReport_05-11-11.pdf

¹⁰ To "prove" it works the county notes, "Fifty-two students were enrolled in New Leaf last year. Of these, 71% of students improved their attendance; 78% earned the necessary academic credits at or above grade level; and 77% achieved at least 4 out of 6 individual goals." That is likely true. But improving school attendance, helping people get through high school are not the purpose of MHSA.

- Native American Health Center¹¹.
 - Lesbian, Gay and Transgender programs. Being lesbian gay or transgender are no longer considered mental illness. There is no evidence that being lesbian gay or transgender makes someone more likely to develop a serious mental illness like schizophrenia and bipolar.¹²
- **Fresno County** used MSHA funds for
 - What stakeholders wanted, even when inconsistent with the legislation and it prevents programs for seriously mentally ill from being funded.¹³
 - To expand outpatient services for children who are not seriously emotionally disturbed (\$750,000).
 - Community Garden (\$40,000)¹⁴
 - **Imperial County** used MSHA funds
 - For people experiencing trauma, child or domestic abuse, chronic neglect, enduring deprivation and poverty, homelessness, violence (personal or witnessed), racism and discrimination, intergenerational or historical trauma, the experience of refugees fleeing war and violence, loss of loved ones, and natural and human disasters.¹⁵
 - **King County** spends MSHA funds
 - on children in “stressed families”.¹⁶
 - on youth reading below grade level.¹⁷
 - RESTATE. This is an \$800,000 program operated jointly with Tulare County and alternatively describe as a stigma and discrimination reduction program or a suicide prevention program.¹⁸ It is basically an arts project that lets kids create a PSA. It is based on “Mental Health First Aid, a non-evidence based highly criticized approach.”¹⁹

http://library.constantcontact.com/download/get/file/1109615552347-349/CalMSHA_Contra_Costa_FINAL.pdf

¹¹ This is a social service program designed “to reverse the impact of discrimination, strengthen families and build community.” But the purpose of MSHA is to help people with mental illness. http://library.constantcontact.com/download/get/file/1109615552347-349/CalMSHA_Contra_Costa_FINAL.pdf

¹² It would, perhaps, arguably, be appropriate to have specialized (rather than mainstreamed) mental illness services for members of the LGBTG community, but there is no indication the services being provided by the county are for those with mental illness.

¹³ (Behavioral Health Director) "Thornton said he would like more of the Mental Health Services Act money to treat people with severe mental illness. With county budgets tight, he said, the priorities should be "crisis first, treatment and then early intervention, prevention. Evans said the county plan isn't perfect, but it is a compromise between what the community wants and what the staff sees as gaps in the system "It's all a compromise," she said. The quote appeared in the January 6, 2013 Fresno Bee formerly available at <http://www.fresnobee.com/2013/01/06/3124110/fresno-county-mental-health-projects.html> (accessed 1/7/13)

¹⁴ “The county would add a seventh community garden to six already in operation at a cost of about \$40,000.” The quote is believed to be from the January 6, 2013 Fresno Bee formerly available at <http://www.fresnobee.com/2013/01/06/3124110/fresno-county-mental-health-projects.html> (accessed 1/7/13) What is especially disturbing is that funding gardens in lieu of services for people with mental illness, had already come under public scrutiny at this time. However the commissioner was not worried about being audited. “Taylor said she wouldn't be concerned if the state audited the gardens. But that is unlikely to happen, because the state selected three counties to review, and Sacramento County was chosen in the Central Valley, she said.

¹⁵ “Trauma” is common. Everyone loses a loved one. Funds may not be spent to ‘reduce trauma’ however, they may be spent to treat PTSD if that occurs.

http://www.mhsoac.ca.gov/MHsoac_Publications/docs/PressReleases/2011/PEITrendsReport_05-11-11.pdf

¹⁶ http://www.co.kern.ca.us/artman2/kcmh/uploads/1/1MSHA_Update_Cover_12-13post3.pdf

¹⁷ This was funded with Innovative funds. Innovative Services funds must have a nexus to the overall intent of MSHA to help people with serious mental illness. Few who are reading below grade level will develop a “serious mental illness”. Improving reading does not “prevent mental illness from becoming severe and disabling.” It is a classic example of a worthy social service program masquerading as a mental illness program in order to access funds not intended for them.

http://mhsoac.ca.gov/Counties/Innovation/docs/InnovationPlans/INN_Kings_020911.pdf

¹⁸ <http://www.spif.org/english/index.cfm/programs/restate/> and http://www.hanfordsentinel.com/news/local/programs-target-teen-suicide-mental-health/article_bd82bf6e-63f4-11e2-9d10-001a4bcf887a.html

¹⁹ We have seen no evidence it helps persons with serious mental illness, although no doubt the kids enjoy creating the PSAs and the arts departments of the participating schools appreciate the additional funding. The website alludes to the fact that this is part of the Mental Health First Aid USA, a commercially available program distributed by various non-profits. Mental Health First Aid is non-evidence based. Thirty six of the 55 peer reviewed articles on Mental Health First Aid were authored or co-authored by the vendors of the approach. A 2005 study of Mental Health First Aid found “There has not yet been an evaluation of the effects on those who are the recipients of the first aid” and acknowledged, “Perhaps the most important unanswered question is the benefits of being a recipient of MHFA” Mental Health First Aid does not appear on SAMHSA’s National Registry of Evidence Based Practices.

• **Los Angeles** (Also see “The Failed Stakeholder Process: LA County as Case Study”²⁰) Los Angeles is using MHSA funds for

- Triple P Parenting Skills²¹ is being funded on Los Angeles, Shasta, and other counties. It is designed to reduce child abuse. In addition to not being a mental illness program, extensive research has been published showing Triple P is ineffective.²²
- "emotional recovery" centers, "stigma" campaigns, tuition reimbursement programs, market research, employment offices²³
- Student 'well-being' massage chairs, Zumba classes, a meditation room and a biofeedback lab (\$230,000)²⁴
- Populations that may or may not have mental illness such as Children/youth at risk for school failure and children/youth at risk of or experiencing juvenile justice involvement²⁵
- Free Your Mind Radio Show²⁶
- Unsuccessful employment training programs²⁷

• **Marin County** is using MHSA funds for

- Teen Screen.²⁸ Teen screen has proven to be ineffective at reducing teen suicide.²⁹
- Triple P Parenting.³⁰ See discussion under Los Angeles County for lack of evidence program is effective.

• **Merced County** is using MHSA funds for

²⁰ In other budget documents, LA County claims to have spent \$80 million on housing for seriously mentally ill. We would be interested in, but did not have time to determine, if any of the promised housing was built or- to ascertain the diagnosis of those provided housing. See <http://www.hacla.org/en/cms/7931/>

²¹ <http://www.redding.com/news/2012/nov/08/shasta-county-child-abuse-rate-climbs-twice-state/>

²² Thirty two of the thirty three studies purporting to show it works were by the same people who created the program. A meta study “found no convincing evidence that Triple P interventions work across the whole population or that any benefits are long-term. The ‘evidence’ for it turned out to lack validity. See “Triple P-Positive Parenting programs: the folly of basing social policy on underpowered flawed studies” published in BMC. Available via NIMH at <http://www.ncbi.nlm.nih.gov/pubmed/23324495>. Also see “How evidence-based is an 'evidence-based parenting program'? A PRISMA systematic review and meta-analysis of Triple P.” available via NIMH at <http://www.ncbi.nlm.nih.gov/pubmed/23121760>. See meta-study at <http://www.biomedcentral.com/content/pdf/1741-7015-10-130.pdf>

²³ These arguably benefit the least "severely" ill but inarguably don't benefit the most "severely" ill

http://ceo.lacounty.gov/ccp/mhsa_pei.htm#GI! And

<http://lacdmh.lacounty.gov/News/Publications/Enews/Documents/APR1411ENEWS.html>

²⁴ http://blogs.laweekly.com/informer/2012/07/california_tax_for_mentally_ill_massage_chairs_zumba_social.php and http://www.namicalifornia.org/uploads/eng/mhsa_full_report.pdf

²⁵ <http://www.freeyourmindprojects.com/static-pages/about-us/#.UDTo044Zy70>

²⁶ It allows recipients of MHSA funding to go on radio to say how important their work is. In the promo materials, they readily admit this is for the ‘one in four’ who have mental health issues, rather than the 5-9% with serious mental illness identified as being a priority population in MHSA legislation (who would be hard to reach by radio shows).

²⁷ At an MHSOAC board meeting a Los Angeles FSP Program Manager admitted the L.A. job training program had only increased employment days 4.2 percent and that was mainly due to government creating jobs versus any private sector jobs being created. See <http://lacdmh.lacounty.gov/News/Publications/Enews/Documents/APR1411ENEWS.html> and

http://www.mhsoac.ca.gov/meetings/docs/PriorMeetingMinutes/2011/MinutesApproved_Sept2011.pdf

²⁸

<http://www.co.marin.ca.us/depts/HH/main/mh/mhsa/MHSA%20PEI%20fund%20shift%20to%20Prudent%20Reserve%20June%202012.pdf>

²⁹ “On 15 November, TeenScreen, a program to detect depression in young people, announced on its website: “The National Center will be winding down its program at the end of this year. The center did not give a reason for the closure of its multimillion dollar project, nor did anyone from TeenScreen respond to inquiries by the BMJ. Critics of the program said that the test had not been proven to reduce suicides and that an analysis by its inventor, David Shaffer, showed that the computer based screening test had a positive predictive value of only 16%. Direct and indirect ties between the drug industry and TeenScreen fueled the concerns of critics that the program would inevitably cause more children, including preschoolers, to be treated with antidepressant drugs.”

<http://www.bmj.com/content/345/bmj.e8100>

³⁰

<http://www.co.marin.ca.us/depts/HH/main/mh/mhsa/MHSA%20PEI%20fund%20shift%20to%20Prudent%20Reserve%20June%202012.pdf>

Case Study: Laura’s Law a Good Program Being Funded with PEI Funds in Los Angeles. While this appendix lists inappropriate spending, we do note that Los Angeles has a tiny pseudo-Laura’s Law program being very appropriately funded with MHSA funds. LA should expand this program by cutting the misspending identified above. Using their version of Laura’s Law, Los Angeles reduced incarceration of people with the most serious mental illnesses 78%; reduced hospitalization 86%; and reduced hospitalization 77% even after discharge from Laura’s Law. (<http://lauras-law.org/states/california/lauraslawlosangelesstudy.html>)

- To host a Halloween event at Yosemite Lake, a Multicultural Celebration, Thanksgiving Lunch, Winter Celebration, Cinco de Mayo Celebration, Black History Month, the Hmong Harvest Celebration and... Mental Health Month Picnic at the Lake.³¹
- Caring Kids.³² It teaches skills to parents of children 0 – 5 years old. Funding the program with mental health dollars is almost offensive because it suggests parents cause mental illness and that by teaching parents skills they will not cause the mental illness.³³

- **Nevada County** uses MSHA funds for

Case Study: Laura’s Law: A good program in Nevada County By using MSHA funds to allow individuals under court orders access to existing programs Nevada County served the most seriously mentally ill and decreased number of Psychiatric Hospital Days 46.7%; number of Incarceration Days 65.1%, number of Homeless Days 61.9%; number of Emergency Interventions 44.1%. Laura’s Law implementation saved \$1.81-\$2.52 for ever dollar spent and “receiving services under Laura’s Law caused a reduction in *actual* hospital costs of \$213,300 and a reduction in *actual* incarceration costs of \$75,600 (<http://lauras-law.org/states/california/llresultsin2counties.html>)

- **Orange County** is using MSHA funds

- Wellness Centers specifically for those “who have achieved a high level of recovery,” Groups to improve “personalized socialization,” relationship building, and exploring educational opportunities.³⁴
- Teen Screen, an ineffective teen suicide program. See Marin County for a discussion of Teen Screen.
- High end annual report with no data on where the money went.³⁵

- **Placer County** received numerous critical comments about their use of MSHA funds for social services masquerading as mental illness programs. They did not address them.³⁶ MSHA uses MSHA funds for

- “Youth Council: What is Success Video Project”³⁷.
- “Ready for Success: Incredible Years”, and “Parent Project.”³⁸ These programs allegedly strengthen parenting competencies but are not related to mental illness. It is now well established that having bad parents does not cause serious mental illnesses like schizophrenia and bipolar disorder.
- “Positive Indian Parenting”³⁹
- “Native Youth Development Program”
- To “prevent mental illness”.⁴⁰ No one knows how to do that.
- Native Culture Camps

³¹ http://www.co.merced.ca.us/pdfs/mentalhealth/mhsa/mhsa_annual_update_2012_2013.pdf

³² <http://blogs.webmd.com/childrens-health/2012/08/study-links>

³³ The program claims to have made the following positive impacts, not having to do with preventing serious mental illness. “Parents, Child Care Providers, and Teachers have learned new ways to manage children’s behavior. Our support groups have helped parents learn new parenting skills. Parents have learned about how children grow. Parents have learned better ways to discipline their children. Parents have learned to share experiences and feelings with other parents. Parents have learned about information on community resources and services. Parents have learned to take better care of themselves. Parents have learned better ways to handle stress. Child Care Providers have learned new ways to promote attachment and bonding.”

³⁴ <http://ochealthinfo.com/docs/newsletters/recoveryconnection/2008-2010-RecoveryConnection.pdf>

³⁵ http://ochealthinfo.com/docs/behavioral/mhsa/Resources/Reports/MHSA_5_Year_Booklet_WEB.pdf

³⁶ Ex. Dr. Frank Lozano asked for “hard data” for number of individuals seen/program and the results of their time spent under the guidance of Placer Mental Health”. He also noted several programs were social services programs. Gayle Smullen of NAMI Placer County reported on the lack of programs for people with serious mental illness, and the preponderance of social service programs for non mentally ill being funded with Placer County MSHA funds. He did not receive an adequate response. Sharen Neal of Placer County NAMI noted that Placer county focused its PEI resources on children, when serious mental illness does not manifest itself until teens and twenties. Focusing on children left those most likely to develop mental illness least likely to be served. The response of Placer County authorities was inadequate, avoided the issue, and frequently blamed the Oversight Commission for the problems by saying they were due to their direction. See last pages of comments at <http://www.campaignforcommunitywellness.org/wp-content/uploads/2012/12/MHSA12-13AnnualUpdateFINALtoBOS.pdf>

³⁷ Page 11 at <http://www.campaignforcommunitywellness.org/wp-content/uploads/2012/12/MHSA12-13AnnualUpdateFINALtoBOS.pdf>

³⁸ Page 7 at <http://www.campaignforcommunitywellness.org/wp-content/uploads/2012/12/MHSA12-13AnnualUpdateFINALtoBOS.pdf>. Note that a large percentage of parents dropped out of the program.

³⁹ Page 8 at <http://www.campaignforcommunitywellness.org/wp-content/uploads/2012/12/MHSA12-13AnnualUpdateFINALtoBOS.pdf>

⁴⁰ <http://www.sierrasun.com/article/20120625/COMMUNITY/120629945/1066&ParentProfile=1051>

- “Life Skills Training”, a substance abuse prevention program⁴¹. Substance abuse programs (except for those with mental illness) were specifically excluded from the MHSA Legislation.⁴²
 - “Teaching Pro Social Skills” teaches kids about teasing, embarrassment, and expressing feelings.⁴³
 - Adventure Risk Challenge (ARC) a literacy program.⁴⁴
 - “What is Success” Video Project “to send the message to Middle and High School students that everyone has the ability to choose what success means to them and that it is never too late to start working towards your own goals.”⁴⁵
- **Riverside County** is using MHSA funds for
 - Parenting Program for Latina mothers (\$2,958,317).⁴⁶
 - **Sacramento** is using MHSA Innovation Funds to
 - Provide “culturally sensitive help to all generations” (United Lu-Mien)⁴⁷. Not a mental illness program.⁴⁸
 - Reduce Bullying⁴⁹
 - Reduce Violence⁵⁰
 - Increase Social Connectedness⁵¹
 - Help 12-26 year olds “to gain positive, proactive, successful life skills”⁵²
 - “To improve the well being of caregivers” (Del Oro Caregiver Resource Center⁵³). The caregivers being helped are caregivers for persons with dementia, not mental illness
 - Reduce stigma and promote mental health in population not identified by MHSA⁵⁴
 - Capital Adoptive Families⁵⁵. This organization supports adoptive parents and does not have the tight nexus to helping people with serious mental illness.
 - “Strengthening Families Project”. Within this program are “Quality Child Care Collaborative”, “HEARTS for Kids”, “Bullying Prevention Education and Training”, “Early Violence Intervention Begins With Education” and “Independent Living Program 2.0”. When presented at the May Mental Health Board meeting a participant correctly noted these were social services programs and ineligible for MHSA funding. They were told, “when the public hearing were held on these programs, the community wanted them”⁵⁶
 - **San Bernardino County** is using MHSA Funds to

⁴¹ <http://www.campaignforcommunitywellness.org/wp-content/uploads/2012/12/MHSA12-13AnnualUpdateFINALtoBOS.pdf>

⁴² September 22, 2012 MHSA Board Minutes, MHSA “Commissioner Horn commented that ...the reason co-occurring disorders were not mentioned in the MHSA was because during the Proposition 63 focus groups they were informed that using that language would lead to the defeat of the proposition” He then went on to express the importance of doing it anyway. This program is the result of that thought process. Minutes of MHSA Board Meeting September 22, 2011. Available at http://www.mhsoac.ca.gov/meetings/docs/PriorMeetingMinutes/2011/MinutesApproved_Sept2011.pdf Accessed 6/24/12

⁴³ Page 10 at <http://www.campaignforcommunitywellness.org/wp-content/uploads/2012/12/MHSA12-13AnnualUpdateFINALtoBOS.pdf>

⁴⁴ <http://www.namicalifornia.org/uploads/eng/mhsa%20full%20report.pdf>

⁴⁵ <http://www.campaignforcommunitywellness.org/wp-content/uploads/2012/12/MHSA12-13AnnualUpdateFINALtoBOS.pdf>

⁴⁶ While a worthy program, there is no evidence that serious mental illness is caused by parents (other than possibly genetically). Attaching the word ‘mood’ or “mental” to a program does not turn a program that helps people with mental illness. http://blogs.laweekly.com/informer/2012/07/california_tax_for_mentally_ill_massage_chairs_zumba_socal.php

⁴⁷ <http://www.sacbee.com/2012/11/30/5021702/grants-aid-four-sacramento-county.html>

⁴⁸ We could not find the term “mentally” or “mental” used once. This suggests to us the funds will not be used for mentally ill.

⁴⁹ Page 23 at <http://www.dhhs.saccounty.net/BHS/Documents/Reports--Workplans/MHSA-Reports-and-Workplans/RT-2013-14-MHSA-Annual-Update--Sacramento-County.pdf>

⁵⁰ Page 27 at <http://www.dhhs.saccounty.net/BHS/Documents/Reports--Workplans/MHSA-Reports-and-Workplans/RT-2013-14-MHSA-Annual-Update--Sacramento-County.pdf>

⁵¹ Page 24 at <http://www.dhhs.saccounty.net/BHS/Documents/Reports--Workplans/MHSA-Reports-and-Workplans/RT-2013-14-MHSA-Annual-Update--Sacramento-County.pdf>

⁵² Page 27 at <http://www.dhhs.saccounty.net/BHS/Documents/Reports--Workplans/MHSA-Reports-and-Workplans/RT-2013-14-MHSA-Annual-Update--Sacramento-County.pdf>

⁵³ <http://www.sacbee.com/2012/11/30/5021702/grants-aid-four-sacramento-county.html>

⁵⁴ Page 28 has a ‘mental health promotion’ project that features a web site <http://www.stopstigmiasacramento.org> Note that the site addresses the 1 in four with mental health issues. But MHSA has specific language saying it is not for one in four (25%) of population, it is only for the 9% with the most serious mental illnesses. It also includes info designed to minimize and confuse the public about the incidence of violence. <http://www.dhhs.saccounty.net/BHS/Documents/Reports--Workplans/MHSA-Reports-and-Workplans/RT-2013-14-MHSA-Annual-Update--Sacramento-County.pdf>

⁵⁵ <http://www.sacbee.com/2012/11/30/5021702/grants-aid-four-sacramento-county.html>

⁵⁶ Reported to us by an attendee who requested anonymity.

- Reduce teen prostitution \$895,000.⁵⁷
 - Acupuncture and acupressure, teach art classes, equine therapy, tai-chi and zumba to the general public; and an LGBT prom.⁵⁸
 - Interagency Youth Resiliency Team.⁵⁹ It “employs former foster and probation youth to serve as mentors to “system involved” youth ages 13 - 21.”⁶⁰
- **San Diego** is using MHSA funds⁶¹
 - To reduce gang violence
 - Triple P Parenting Program, a program proven unsuccessful at reducing child abuse
 - “Reaching Out”, a program for those with Alzheimer’s
- **San Francisco** is using MHSA funds
 - for yoga, line dancing and drumming.⁶²
 - 90 minute movie about mental health (not mental illness).⁶³ It was shown at a community center and funded by MHA/SF, a large recipient of MHSA funds. MHA/SF Exec. Dir. Is on the Oversight Commission. While videos and movies are fun to make it is hard to see how making these movies should trump delivering services to people with mental illness.
- **San Luis Obispo County** uses MHSA funds for
 - employment programs⁶⁴
 - To help “Tens of thousands” rather than people with serious mental illness.⁶⁵
- **Shasta County** is using MHSA funds for
 - A Gatekeeper program to improve services for the elderly.⁶⁶
 - Triple P Parenting program. See “Los Angeles” County above for information showing Triple P has no scientific basis and is unproven. Shasta is a good example of how the stakeholder process was used to gain funding for this program in spite of its lack of efficacy.⁶⁷
 - Reducing “Adverse Childhood Experiences”⁶⁸
- **Stanislaus County** is using MHSA funds for
 - “Arts for Freedom”⁶⁹ an art show for people who want to display their art.

⁵⁷ <http://www.sbcounty.gov/dbh/Announcements/2010/Innovation%20Plan%20Final%20202-8-10.pdf>

⁵⁸ http://blogs.laweekly.com/informer/2012/07/california_tax_for_mentally_ill_massage_chairs_zumba_social.php

⁵⁹ <http://www.marketwatch.com/story/foster-youth-prepares-for-adulthood-with-help-from-new-mentor-program-from-emq-familiesfirst-2012-11-18>

⁶⁰ That is a worthy social service program, but it is not a program that reduces the duration of untreated mental illness or prevents mental illness from becoming severe and disabling. The PR announcement for it does not mention mental illness or mental health (except to state MHSA funds are being used for it) A PowerPoint explaining who IYRT serves is at http://emqff.org/about/docs/FY12_agency-wide_report_pp_final.pdf . Page 8, shows that only 2% of the population they serve have psychotic disorders (serious mental illness)

⁶¹ <http://sandiego.camhsa.org/files/PEI-Prg-Serv-Summ-Current.pdf>

⁶² http://www.sfdph.org/dph/comupg/oservices/mentalHlth/MHSA/FY11_12AnnualPlanUpdate_03012011.pdf

⁶³ <http://www.mentalhealthsf.org/programs/solve/>

⁶⁴ They are not for people who have mental illness, but are for “Transitional Age Youths” (TAYs) The County justifies the expenditures by claiming the groups are underserved in the County; they are likely to have experienced numerous traumatic events and be vulnerable to developing mental illness, substance abuse, *domestic violence, homelessness, criminal activity, and unemployment*. Trauma (losing a loved one, seeing something untoward) happens to many people and rarely ever results in a mental illness. http://www.mhsoac.ca.gov/MHSoAC_Publications/docs/PressReleases/2011/PEITrendsReport_05-11-11.pdf

⁶⁵ The director of Behavioral Health in SLO claims MHSA is helping tens of thousands in her county.

<http://www.sanluisobispo.com/2011/07/12/1680175/viewpoint-our-mentally-ill-deserve.html>

⁶⁶ <http://www.redding.com/news/2012/nov/07/senior-living-gatekeeper-program-keeps-eye-out/>

⁶⁷ Shasta County claims that Triple P got on the list of funded programs because “During MHSA’s stakeholder input process, community members ranked children and youth in stressed families as the #1 population to work with in preventing mental illness”. It is true that reducing stress in families of people with mental illness can improve the course of outcome. However, there is no science that says stress causes mental illness, or reducing stress in families of people without mental illness lowers the incidence of mental illness. This is a worthy social service program masquerading as a mental health program to access MHSA funds. http://media.redding.com/media/static/Annual_Report_7th_FINAL.pdf. See description of Triple P under LA County.

⁶⁸ <http://www.mhsoac.ca.gov/Counties/PEI/docs/PEIplans/ShastaPEIPlan.pdf> and http://media.redding.com/media/static/Annual_Report_7th_FINAL.pdf

- Stanislaus considered a good program, but we don't know if they ever followed through on it. "*Stanislaus County officials are talking with local hospitals about forming crisis teams to stabilize patients who are considering suicide or having psychotic symptoms. The units with staff able to prescribe medication would choose people with the best chances of being stabilized, so they can return home and not be admitted to Doctors Behavioral Health Center on Claus Road.*"⁷⁰
- **Tehema County is using MHSA funds for**
 - Teen Screen, an ineffective program designed to reduce teen suicide⁷¹
 - Drumming Circles⁷²
- **Tulare County** used MHSA funds for
 - farming webinar for dairy farmers who, due to the current economic state, are experiencing a downturn in milk prices.⁷³
 - RESTATE. This is an \$800,000 program operated jointly with King County and alternatively describe as a stigma and discrimination reduction program or a suicide prevention program. See discussion under King County on this being an ineffective non-evidenced school based program that seems to move MHSA funds from helping persons with mental illness to funding school art departments.

⁶⁹http://www.stanislausmhsa.com/pdf/public/INN%20Project%20Brief%20Descriptions%20Posted_8.25.11.pdf and <http://www.modbee.com/2012/04/25/2173965/county-promotes-mental-health.html>

⁷⁰<http://www.modbee.com/2012/11/11/2451993/stanislaus-county-mental-health.html> We don't know if this was ever implemented or if merely exists in press release form.

⁷¹http://www.mhsoac.ca.gov/Counties/PEI/docs/PEIplans/PEI_Tehama_Final_2-1-10.pdf. See Marin County for Teen Screen discussion.

⁷² <http://www.namicalifornia.org/uploads/eng/mhsa%20full%20report.pdf>

⁷³ http://www.mhsoac.ca.gov/MHSOAC_Publications/docs/PressReleases/2011/PEITrendsReport_05-11-11.pdf (Page 14)

Mental Illness Policy Org.

UNBIASED INFORMATION FOR POLICYMAKERS + MEDIA
OFFICE@MENTALILLNESSPOLICY.ORG MENTALILLNESSPOLICY.ORG

Los Angeles County as Case Study of Failed Stakeholder Process

Note: URLs are provided but may have expired

LA County stakeholders were primarily those who provide social services to people without serious mental illness LA conducted an extensive, expensive stakeholder input process that included social service and 'mental health' groups who were vying for MHSA funding for their social service programs.¹ The stakeholder process included a

- A 100 member "Stakeholder Delegate Group" representing various special interests seeking funding.
- A 29 member Ad hoc "Plan to Plan Advisory Group" that included representatives of those seeking funding;
- A 28 member Ad hoc "Guidelines Advisory Group" largely comprised of those seeking funding;
- A 25 member ad hoc "PEI Plan Development Advisory Group", largely comprised of those seeking funding; and
- A 150 member "Service Area PEI Ad Hoc Steering Committee" many representing programs seeking funding.

LA County excluded stakeholders with the most expertise in serious mental illness.

- There was no input from persons with mental illness who are in inpatient units
- There was no input from mentally ill patients who live in jails or prisons. About 30% of LA County prisoners have serious mental illness. LA County Jail is the largest psychiatric facility in the state. There are 3 times as many Californians with mental illness in jails than hospitals.²
- We are unaware of any attempts to seek input persons with mental illness who live in shelters or are homeless.

We believe the failure to solicit and prioritize input from the most seriously ill and those who know most about the population the legislation states "deserve priority attention" led to a plan that made eligible individuals ineligible and diverted the funds to other.

LA County Behavioral Health Department misinterpreted the legislation and failed to reject stakeholder recommendations that were outside the law.

The Home Page³ for the Los Angeles County Prevention and Early Intervention (PEI) Plan⁴ states

*The Los Angeles County Prevention and Early Intervention (PEI) Plan focuses on prevention and early intervention services, education, support, and outreach to help inform and identify individuals and their families who may be affected by **some level of mental health issue**" (emphasis added).*

¹ To develop their Community Support Service (CSS) plan, LA County conducted a needs and strengths assessment with over 2000 people, conducted workgroup, and community engagement meetings involving over 11,000 participants, and conducted 17 meetings with an average participation of over 200 people; in addition to the public hearing on September 20, 2005 which drew over 400 people. While community input is to be commended, the result of that input can not be allowed to supersede the law. (See 9/25/05 letter and attachments from Marvin Southard, LA County MH Director to Board of Supervisors) which set the framework for all future CSS spending. Available at http://lacdmh.lacounty.gov/News/Board_Correspondence/Adopted_Board_Letters/Documents/Approval%20for%20Submission%20of%20the%20MHSA%20Community%20Services%20and%20Supports%20to%20Plan%20to%20the%20State%20Dept%20of%20MH_101105.pdf.

² The doctors, social workers, parole and correction officials who work there are much more informed as to what persons with serious mental illness need, but in spite of that, were not consulted and prioritized.

³ http://dmh.lacounty.gov/wps/portal/dmh!/ut/p/b1/vZLdjoIwEIWfhQfYzJTys16ibUFjQaAu0huDycYoKJv9Y-Xpt9wZE_Fms52rzjmd801S0FASJNS3PUo82IA-V9-HffV5aM9VM9y1t-WIGCYit0MqApxzRIW8cscha2cZQXulJSJnRneVsKhzTpDD-uoByOowwLrxzAnyEUIAeiUHp3ug3kCGO68MSMA4YR-3pFUoD6t_DmEQeKNigs82PI7d5X_fZsU9_Pt6DTu14JxmnMYsXOX4RydYk78VK1W4Sq0wq3vVETsiLSHkg7IIIqfUozP_PMPdPwxag9027M5-vmMFJN8vLU51FHxkeqgss6xfMabNu/dl4/d5/L2dJQSEvUUt3QS80SmtFL1o2X0UwMDBHT0ZTMkczRkEwSUVEM1ROUDQxOTY0/

⁴ Described starting on Page 6 of Prevention and Early Intervention Plan for Los Angeles County, 8/17/2009. Available at http://lacdmh.lacounty.gov/News/Board_Correspondence/Adopted_Board_Letters/Documents/Approval%20for%20Submission%20of%20the%20MHSA%20Community%20Services%20and%20Supports%20to%20Plan%20to%20the%20State%20Dept%20of%20MH_101105.pdf

That is incorrect. PEI funding is limited to those with mental “illness” or “serious mental illness” not “some level of mental health issue.”⁵ This misinformation is repeated in the 2009-2010 Plan.⁶ This is not just nomenclature; there is a significant difference between those “who may be affected by some level of mental health issue” (i.e., can be made happier), and those who have serious mental illnesses like schizophrenia and treatment resistant bipolar disorder. The funds are legislatively required to help the later, not the former.⁷

LA County Mental Health Department Plan relied on guidance from the California Department of Mental Health and MHSOAC that was contrary to statute, rather than relying on the statute itself⁸

LA County justifies the part of their plan that uses funds to ‘encourage a state of well being’ and target a population group ‘not identified on the basis of risk’, by quoting direction from the Oversight Commission:

*Prevention in mental health involves reducing risk factors or stressors, building protective factors and skills, and increasing support. **Prevention promotes positive cognitive, social and emotional development and encourages a state of well-being that allows the individual to function well in the face of changing and sometimes challenging circumstances. Universal Prevention targets the general public or a whole population group that has not been identified on the basis of individual risks.***

MHSA is to help people with serious mental illness, not improve ‘well being’ or ‘target the general population’.

The LA County Plan justifies withdrawing services from people with serious mental illness by quoting direction from the Oversight Commission stating:

*Early Intervention is directed toward individuals and families for whom a **short duration** (usually less than one year), relatively **low-intensity intervention** is appropriate to measurably improve a **mental health problem** or concern very early in its manifestation, thereby avoiding the need for more extensive mental health treatment or services, or to prevent a mental health problem from getting worse.⁹*

The LA plan, seems to suggest that PEI funds must be withdrawn once a person is identified. This direction from the former California Dept. of Mental Health and Oversight Commission is not true. To prevent “mental illness from becoming severe and disabling” often requires on-going treatment. By limiting PEI funding to short term, low intensity programs, they have essentially excluded those who face lifelong disability.

LA County Behavioral Health Department fails to report data by diagnosis or require a diagnosis so it can not know if it’s programs are serving people “with mental illness” or “serious mental illness” as required by law.

In order to know if a program is targeting those with mental illness or preventing mental illness from becoming severe and disabling, officials would have to collect data on the

- 1 diagnosis of people being served,
2. diagnosis of the mental illness the program is ‘preventing’
3. Diagnosis of the mental illness that they reduced duration of

⁵ WIC 5840.

⁶ “PEI focuses on evidence- based services, education, support, and outreach to help inform and identify those who may be affected by some level of mental health issue. Providing mental health education, outreach and early identification (prior to diagnosis) can mitigate costly negative long-term outcomes for mental health consumers and their families.”

http://file.lacounty.gov/dmh/cms1_159376.pdf

⁷ This distinction is very clear from the first “Findings and Declarations”. The legislation notes that “Mental illnesses are extremely common; they affect almost every family in California. They affect people from every background and occur at any age.” But then the legislation goes on to talk about “serious” mental illness: “In any year, between 5% and 7% of adults have a serious mental illness as do a similar percentage of children — between 5% and 9%. Therefore, more than two million children, adults and seniors in California are affected by a potentially disabling mental illness every year. People who become disabled by mental illness deserve the same guarantee of care already extended to those who face other kinds of disabilities.” The “Intent” of the legislation is then clearly defined: “To define serious mental illness among children, adults and seniors as a condition deserving priority attention, including prevention and early intervention services...” (emphasis added)

⁸ On page two of the LA County PEI Plan they note that “On September 25, 2007 SDMH (State Dept. of Mental Health) released the Prevention and Early Intervention Guidelines” Many of these guidelines and regulations were contrary to the legislation and had the effect of (a) preventing those the funds were intended to serve from gaining access and (b) diverting those funds to organizations that used them to provide services to ineligible populations.

⁹ Page five at http://file.lacounty.gov/dmh/cms1_179197.pdf

This information is not collected or provided by the county.

Los Angeles' failed stakeholder process led to a failed spending plan.

The failed stakeholder process led to failed spending. For example, while serious mental illnesses are most likely to strike in late teens early twenties, LA allocated 60% of funds to Transition Age Youth.¹⁰ Less than 3% of individuals in LA County PEI were the most seriously ill individuals with psychotic disorders.¹¹ Rather than focusing on the most seriously ill, LA focus is "clients at higher levels of recovery."¹² We could not find a single program that was designed specifically to help people with psychotic disorders or help the homeless who are at risk of becoming psychotic because they can't get medicine.

Incarceration of children went up.¹³ This is surprising because one of the programs, "Incredible Youth" (\$200K) is supposed to decrease incarceration.

\$2,393,926 of funding for "at risk" families is likely wasted.¹⁴ They are social service programs that purport to help people 'at risk' of mental illness. There are no known factors that put people at risk of "serious" mental illness (other than having a parent with it, which is a genetic issue). There are issues, like losing a family member or job that do put people at risk of being sad, being depressed, but not of the most serious mental illnesses like schizophrenia and bipolar disorder that MHSAs intended to prioritize.

\$2,899,231 of Trauma Recovery spending are likely wasted¹⁵. Trauma is not a mental illness. Almost everyone experiences trauma of some degree of severity (losing a loved one, having an accident, witnessing something horrible). PTSD is a mental illness. Severe traumatic events (being held prisoner, war, etc.) might cause trauma disorder. But these services are likely going to people who experienced the rights of passage we all experience: knowing someone who died, failing a grade in school, breaking up with a boy/girlfriend, not paying rent, etc. For example, "Incredible Years" is a crime prevention initiative aimed at aggressive youth.

Many of the other programs Los Angeles is spending on are social service programs masquerading as mental illness programs: Reflective Parenting, Strengthening Families, Positive Parenting, Brief Strategic Family Therapy, Loving Intervention for Family Enrichment Program, Multidimensional Family Therapy Program and Promoting Alternative Thinking Strategies.

CONCLUSION

Flawed process led to massive mission creep. A stakeholder driven "gold rush" that excluded experts who work with the seriously mentally ill resulted in funding programs not directly related to the purpose of PEI or MHSAs.

¹⁰ http://file.lacounty.gov/dmh/cms1_179197.pdf

¹¹ Page 101 Table 4 County Plan at http://file.lacounty.gov/dmh/cms1_179197.pdf

¹² Page 30. Also see page 88 for stats on how well this group "who are at higher levels of recovery" are doing.

¹³ Page 80. Authorities blamed a "coding error".

¹⁴ Page 120 column six of LA County Plan available at http://file.lacounty.gov/dmh/cms1_179197.pdf

¹⁵ Page 120 column seven of LA County Plan available at http://file.lacounty.gov/dmh/cms1_179197.pdf

Mental Illness Policy Org.

UNBIASED INFORMATION FOR POLICYMAKERS + MEDIA
OFFICE@MENTALILLNESSPOLICY.ORG MENTALILLNESSPOLICY.ORG

Insider Dealing: \$23 million diverted to organizations associated with Oversight Commissioners

Note: URLs are provided but may have expired

Summary

Over \$23 million in Mental Health Services Act (MHSA) funds are going to organizations currently or formerly run by those responsible for oversight of the expenditures. This may be a violation of California's conflict-of-interest laws and raises questions about whether MHSA funds are being spent appropriately. Some of the funds are being used to prevent people with serious mental illness from receiving treatment.

Background

Proposition 63 established the MHSA fund to provide services to individuals with "serious mental illness" and prevent those "with mental illness" from having it become "severe and disabling". Proposition 63 also established the Mental Health Services Oversight and Accountability Commission (Oversight Commission) to approve certain MHSA expenditures which are distributed by the Oversight Commission directly; or presented to them for approval as part of county mental health plans or via the California Mental Health Services Authority (CalMHSA), a Joint Power Authority that pools the resources of individual counties.

Methodology

We examined the 2011 "Prevention and Early Intervention" (PEI) component of MHSA which represents 20% of overall MHSA funds. We did not look for potential insider dealing in the other 80% or in prior years. To determine who received PEI funds we examined the 2011 CalMHSA Funding Report which includes PEI grants by dollar amounts¹ and a list of PEI programs funded by MHSA which does not include dollar amounts.² We then went to the websites of the organizations that received the funds to determine who sat on their boards of directors and in key staff positions. Finally, we compared the boards and staff of fund recipients with the names of those who serve the oversight commission.³

Findings

Rusty Selix - \$5.92 million

Mr. Selix is on the MHSOAC Mental Health Funding and Policy Committee and Evaluation Committee⁴. During the period of the study, he was Executive Director of Mental Health America of California (MHAC)⁵ MHSOAC commissioners approved one grant for \$3 million and another for \$2.92 million to MHA of San Francisco a chapter of MHAC. Other chapters of MHAC that had their grants approved by oversight commissioners include MHA Orange County (two grants); MHA LA (2 grants); MHA of SLO; and MHA Sutter-Yuba.

Mr. Selix is Executive Director of the California Council of Community Mental Health Agencies (CCCMHA).⁶ CCCMHA members receive MHSA funds. (See Richard Van Horn, below.) Mr. Selix received \$681,758 in compensation from CCCMHA (per CCCMHA 2010 990 IRS form).

Richard Van Horn - \$11 million

¹ http://www.mhsoac.ca.gov/Meetings/docs/Meetings/2011/Jul/OAC_072811_Tab3_CalMHSA_StatusReport.pdf Accessed 7/23/13

² http://www.namicalifornia.org/uploads/eng/mhsoac_full_report.pdf Accessed 7/23/13

³ While many of these grants were given out by counties and CalMHSA, all were required to be reviewed and approved by the Oversight Commissioners. In addition, counties and CalMHSA, are dependent on the commission to approve other grants they make which would give them an incentive to curry favor with the oversight commissioners.

⁴ http://www.mhsoac.ca.gov/Committees/docs/Charters/2012/MHFPC_Charter_2012.pdf

⁵ http://www.mhac.org/advocacy/key_leaders.cfm Accessed 7/23/13

⁶ <http://www.cccmha.org/aboutus.html> Accessed 7/23/13

During the period of our study, Mr. Van Horn was the MHSOAC Vice-Chair⁷ and on the board of California Council of Community Mental Health Agencies (CCCMHA) a trade association representing providers of community mental “health” services.⁸ Rusty Selix is Executive Director and received \$681,758 in compensation. MHSOAC commissioners approved \$2 million to go to CCCMHA member Didi Hirsch Psychiatric Services. They approved \$9 million to be split between CCCMHA members Transitions Mental Health Association, Kings View Corporation and others. The MHSOAC commissioners approved grants for the following CCCMHA members: Anka Behavioral Health; Bonita House (2 grants); Buckelew Programs; Chamberlain’s Mental Health Services; Edgewood Center for Children and Families; EMQ Families First (3 grants); Fred Finch Youth Center (2 grants); La Clinica de La Raza; Pacific Clinics (3 grants); Rubicon Programs; San Fernando Valley Community Mental Health Center; Seneca Center; Social Model Recovery Systems; and Tulare Youth Service Bureau.

Mr. Van Horn has also been President and Chief Executive Officer (CEO) of the Mental Health America of Los Angeles⁹ which received at least two grants. MHALA paid Mr. Van Horn \$111,175 (per 2009 990 IRS form) Mr. Van Horn is a member of the board of the Mental Health Association of California (See grants listed under Selix).

Eduardo Vega - \$2.9 million

During the period of this report, Mr. Vega was an MHSOAC Commissioner. He is on the board of directors of Disability Rights California¹⁰ a special interest law firm active in preventing counties from using Laura’s Law, to help persons with serious mental illness¹¹. DRC received a \$2.9 million grant approved by Mr. Vega and the other commissioners. Mr. Vega has served as the Executive Director of the Mental Health Association of San Francisco¹² that received two grants each in the \$3 million range for a total of almost \$6 million. Previously, he served as Associate Director of Project Return. Project Return received a MHA grant.

Ralph Nelson Jr., M.D. - \$3 million

Dr. Nelson is an MHSOAC Commissioner.¹³ During the period of this report, he was president of the National Alliance on Mental Illness in California. NAMI CA received a \$3 million grant of MHA funds. Local chapters of NAMI that received MHA funding include NAMI Sonoma and NAMI Orange County. Other NAMI chapters run programs benefiting from MHA funds including NAMI Butte; NAMI Riverside (2 programs); NAMI San Diego (3 projects); NAMI San Mateo (2 projects); NAMI Santa Cruz; NAMI Sonoma; NAMI Stanislaus (4 projects); NAMI Ventura (2 programs); and NAMI Amador (3 programs).

Delphine Brody and Sally Zinman - \$1.5 million

During the period of this report, Delphine Brody and Sally Zinman were on numerous Oversight Commission committees.¹⁴ Ms. Zinman founded and Ms. Brody was Director of Public Policy for the California Network of Mental Health Clients¹⁵. The Commissioners approved a grant of \$1.5 million to CNMHC.

Mr. Selix,¹⁶ Mr. Vega,¹⁷ Mr. Nelson, Ms. Brody, Ms. Zinman and their organizations have all lobbied or played a role in preventing counties from implementing Laura’s Law which helps prevent people with serious mental illness from becoming violent.

⁷ http://www.mhsoac.ca.gov/About_MHSOAC/Commissioner_Bios.aspx Accessed 7/23/13.

⁸ <http://www.cccmha.org/ourMembers.html>

⁹ <http://www.mhala.org/board-volunteers.htm> Accessed 7/23/13

¹⁰ http://www.disabilityrightsca.org/about/board_bios.htm Accessed 7/23/13.

¹¹ <http://www.disabilityrightsca.org/OPR/PRAT2012/AB1421.pdf> Accessed 7/23/13.

¹² <http://www.mentalhealthsf.org/about-us/staff/> Accessed 7/23/13.

¹³ http://www.mhsoac.ca.gov/About_MHSOAC/Commissioner_Bios.aspx. Accessed 7/23/13.

¹⁴

http://www.mhsoac.ca.gov/Announcements/docs/AnnouncementsEvents/OAC_2011MHSOACCommitteeMembers.pdf Accessed 7/23/13

¹⁵

http://www.mhsoac.ca.gov/Announcements/docs/AnnouncementsEvents/OAC_2011MHSOACCommitteeMembers.pdf Accessed 7/23/13

¹⁶ http://www.pbs.org/newshour/bb/health/july-dec12/lauraslaw_12-26.html Accessed 7/12/13

¹⁷ http://www.pbs.org/newshour/bb/health/july-dec12/lauraslaw_12-26.html Accessed 7/12/13