Little Hoover Commission
September 23. 2014

Hearing on Oversight of the Mental Health Services Act (MHSA)
Testimony of David Pating, MD – Vice Chair, MHSOAC; Chair, Evaluation Committee

In response to questions from the Little Hoover Commission regarding the role of Evaluation in the oversight of the Mental Health Services Act, it is my privilege to offer the following testimony based on my experience as an active commissioner from 2007-2014.

Regarding MHSA oversight, I believe four general observations are relevant: 1) The MHSA is a very complicated Act with five mandated component programs, each administered by differing state agencies, 2) The MHSA imposed new structural and procedural requirements (for example, requirements for extensive community-based participatory needs assessment) made it difficult to immediately translate $1 Billion dollars annually into new mental health programs and services, 3) Once approved, MHSA programs needed to be operational for more than one cycle to produce measureable outcomes data and results, and 4) It is best to view the MHSA through a temporal lens to understand the evolution of its implementation and the development of oversight mechanisms, including oversight of the development of state and county administrative structures; the launching of new state and county therapeutic programs and services; and finally, the demonstration of processes leading to effective outcomes and evaluation. After, 10 years, it is fair to say that the MHSA has entered its mature phase—programs are running and outcomes can be demonstrated—but it wasn't easy getting here.

With respect to the temporal view of the MHSA, I believe there have been four unique phases in the evolution of oversight of the Act.

A. Launch: Following the 2004 approval of Proposition 63, the central task of the MHSOAC was to "get the money out." Challenges included hiring an Executive Director, building a staff and finding an office. Simultaneously, the Department of Mental Health (DMH) had the responsibility to implement the Act including authority to issue emergency regulations for all of the components. Due to the complex nature of the Act, DMH implemented each of the components in a sequential order instead of having the counties implement all of the components at the same time. For example, the first component to be rolled out was Community Supports and Services (CSS), then Prevention and Early Intervention and the last component was Innovation. The first guidelines provided a complicated implementation plan, which required the counties to account 'in detail' how dollars would be spent and programs implemented. DMH received considerable complaints about these plan requirements and its complexity resulted in some initial confusion and delay.
B. Targeting Inputs: In collaboration with DMH in 2007, the MHSOAC developed guidelines for the Prevention & Early Intervention (PEI) component and for the Innovation (INN) component in early 2009. At this time, there was shared

responsibility for the Act, but the MHSOAC was responsible for PEI and INN plan approval. In response, the MHSOAC developed a streamlined plan review process focused on "aiming the arrow" at credible county plan programs, while implementing an expedited 60 day review and plan approval process in response to previous county concerns. At this time, the MHSOAC was aware that the MHSA public investment in PEI was unique as it was the world's largest single investment in the public prevention of mental illness-- and our commission wanted to implement it well.

C. Transition through Recession: Beginning with the down turn in the economy, MHSOAC oversight and implementation activities were curtailed at both the state and county level by the enactment of Assembly Bill 100 in early 2011. Strategic partnerships, including partnership with DMH, were either curtailed or dissolved. General funding through realignment funds was also curtailed, resulting in greater reliance on MHSA funding at the county level. Despite these changes, the stability of the MHSA funds provided grounding for the state mental health system in MHSA values (wellness & recovery), forwarding MHSA goals. The stability of MHSA funding also allowed the MHSOAC to shift its oversight focus from "inputs" to "outputs," with the adoption of its policy of *Oversight through Evaluation in 2010* and its adoption of its *MHSA Evaluation Master Plan in 2013*.

D. Mature Oversight: Recently, the MHSOAC entered its mature phase of oversight in which, it is the commission's primary mission to drive oversight through systemic monitoring and program evaluation. To facilitate this, the commission hired a full time Evaluation staff, launched dozens of evaluation projects ranging from descriptive studies to complex services outcome studies for multiple components including CSS and PEI, and worked with DHCS to clean up its data system that was neglected during the recession and DMH transition. (See the Written Testimony of the MHSOAC Executive Director for details.) Early results have identified important findings: a) Full Service Partnerships (a major component of CSS programs) produce positive outcomes, especially for Transition Aged Youth, b) there is early evidence that Prevention and Early Intervention programs for Early Psychosis, Older Adult Depression and School-based trauma programs are extremely promising, and c) the incorporation of Peer-based Wellness and Recovery services lowers barriers to treatment.

At this juncture, the MHSOAC is committed to Evaluation as a primary tool for MHSA oversight, along with assuring fiscal accountability. With the assistance of the MHSOAC Evaluation Committee, which is advisory to the Commission and staff on all aspects of Evaluation, the MHSOAC has built a competent Evaluation unit. The Evaluation Committee, which is peopled by statewide research and evaluation experts, as well as, consumers, advocates, county representatives, and providers, cautions the MHSOAC about two concerns: 1) To effectively provide MHSA oversight through Evaluation, we need more MHSA evaluation and more evaluation dollars. Our experts feel the budgetary allocation for evaluation is significantly below industry standard for effective program evaluation. In general, they report that 5-15% of all service dollars should go for program evaluation. Currently, the MHSOAC is allocated about 0.1% of MHSA dollars for its state level Evaluation Activities (this does not include dollars allocated locally, which in total, still fall significantly below the recommended 5% funding); and 2)

We need reliable data that measures client level outcomes that can be scaled up to produce program, county and state results. Currently, the MHSOAC is working with Department of Health Care Services to clean its Data Collection Reporting (DCR) and Client Services Information (CSI) data systems, which are significantly corrupted (missing data, poor data). Despite this solution, it is thought that the usefulness of these legacy data systems is temporary. Ultimately, these data systems are unable to provide the detailed client, program or county results that we've deemed important in the MHSA Evaluation Master Plan. In the long term, a new statewide mental health data system will be needed. Unfortunately, the authority for this decision does not rest with the MHSOAC.

This concludes my comments. I welcome any questions the Little Hoover Commission has on any of these matters.

David Pating, MD (Vice Chair, MHSOAC)