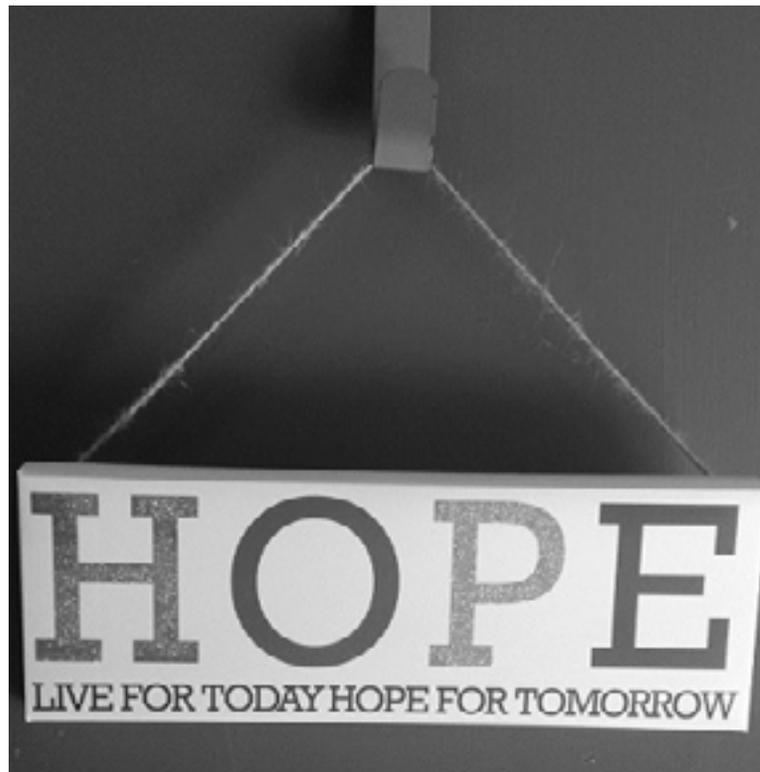


***PROMISES STILL TO KEEP: A SECOND LOOK
AT THE MENTAL HEALTH SERVICES ACT***

REPORT #233, SEPTEMBER 2016



A LITTLE HOOVER COMMISSION LETTER REPORT TO
THE GOVERNOR AND LEGISLATURE OF CALIFORNIA

To Promote Economy and Efficiency

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The Little Hoover Commission, formally known as the Milton Marks “Little Hoover” Commission on California State Government Organization and Economy, is an independent state oversight agency.

By statute, the Commission is a bipartisan board composed of five public members appointed by the governor, four public members appointed by the Legislature, two senators and two assemblymembers.

In creating the Commission in 1962, the Legislature declared its purpose:

...to secure assistance for the Governor and itself in promoting economy, efficiency and improved services in the transaction of the public business in the various departments, agencies and instrumentalities of the executive branch of the state government, and in making the operation of all state departments, agencies and instrumentalities, and all expenditures of public funds, more directly responsive to the wishes of the people as expressed by their elected representatives...

The Commission fulfills this charge by listening to the public, consulting with the experts and conferring with the wise. In the course of its investigations, the Commission typically empanels advisory committees, conducts public hearings and visits government operations in action.

Its conclusions are submitted to the Governor and the Legislature for their consideration. Recommendations often take the form of legislation, which the Commission supports through the legislative process.

Cover photo by Little Hoover Commission staff at Hacienda of Hope – Project Return Peer Support Network, Long Beach, California.

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LETTER FROM THE CHAIR

September 8, 2016

The Honorable Edmund G. Brown, Jr.
Governor of California



The Honorable Kevin de León
President pro Tempore of the Senate
and members of the Senate

The Honorable Jean Fuller
Senate Minority Leader

The Honorable Anthony Rendon
Speaker of the Assembly
and members of the Assembly

The Honorable Chad Mayes
Assembly Minority Leader

Dear Governor and Members of the Legislature:

More than a decade ago, California voters passed a landmark tax initiative that promised to expand access to mental health services and transform how people get help by providing services, when and where needed, at any stage of an illness.

For some Californians, the Mental Health Services Act (MHSA) has fulfilled this promise. Proposition 63-funded programs have helped individuals with mental illness recover and thrive. For some, the funding created programs that offer housing, healthcare, medication and help to become self-sufficient. For others at risk of developing mental illness, the funding provides safe, supportive local centers to stay and work through episodes of crisis. These are but two examples of the types of programs in which counties invest money from the Act. Throughout this report we offer a glimpse into nine programs the Commission visited this year and give voice to some who have benefited from these programs.

But these inspiring stories of success are shadowed by a continuing failure of the state to demonstrate what is collectively being accomplished. The state still can't provide conclusive data to show how it is keeping promises made to voters in 2004, or to wealthy taxpayers who fund Proposition 63 programs with a 1 percent surtax, and most importantly, to the individual Californians and their families who rely on these services for much-needed help. Others have shown this can be done. The County Behavioral Health Directors Association partnered with a non-profit public policy institute to release two reports showing successful outcome measures for county full-service partnership program participants.

In its January 2015 report, *Promises Still to Keep: A Decade of the Mental Health Services Act*, the Commission called on the state to better validate how money generated by the Act is used. The report cited a dispersed governance system with no definitive center of leadership. It also found a lack of meaningful data to account for expenditures or demonstrate outcomes to paint a picture of who is being served. In May 2016, the Commission revisited the topic, inviting relevant agencies, as well as stakeholders, to discuss progress in addressing shortcomings raised in the Commission's 2015 review.

Despite some encouraging developments, many of the same concerns remain. The Commission heard repeatedly from stakeholders desperate for more oversight of the Act and concerned about the lack of

consequences for bad behavior. Many said the processes to oversee the distribution and use of MHSA funds at the local and state levels are still woefully inadequate and leave those with questions or concerns confused about where to get answers. Others said that without more detailed demographic data, policymakers won't know whether more can or should be done to reach underserved communities.

The Commission admits to remaining somewhat baffled by the extreme complexity of interlaced agencies and data reporting systems that collectively still can't handily tell taxpayers how their money is being spent, who is being helped and what impact it is making. Though Proposition 63 created a new entity to oversee programs funded by the Act, the Little Hoover Commission has questioned why an oversight commission exists if it cannot deliver meaningful oversight. Additionally, though the Department of Health Care Services is empowered and funded to enforce the Act, this responsibility appears to be lost among others. Without strong leadership at the top, it is uncertain who is responsible to look out across the system to see what is working and make sure those lessons are being shared statewide. The state itself spends more than \$100 million from the MHSA and there is little oversight of that spending, beyond the regular budget process.

It is clearer than ever in the wake of the Commission's second review that the state must identify a well-defined leader to administer, oversee and enforce the MHSA or it will remain difficult to articulate a cohesive vision for the Act and ensure accountability to alleviate many of the visible statewide impacts of mental illness. This leader also should take charge to ensure counties are appropriately engaging stakeholders and that success stories are shared statewide.

Consequences of a long-standing inability to demonstrate the value of statewide Proposition 63-funded programs are already apparent. Lawmakers have begun chipping away at this lucrative funding source. Recently enacted legislation championed by the Steinberg Institute steers \$130 million in annual proceeds to finance a \$2 billion bond for supportive housing for homeless individuals with mental illness. This is one way to inject state priorities and accountability into how MHSA funds are used. Some, however, expressed concerns to the Commission that this may open a floodgate for setting additional priorities beyond those specified in the voter-approved ballot measure.

As lawmakers debate other possible diversions, the state's plans to finally provide data are tied up in a massive, multi-year technology project. Counties and others, at least in a partial way, are moving more quickly toward fiscal accountability and transparency of MHSA funds. The Commission believes the state must more rapidly develop its own data system to monitor and measure outcomes being delivered by MHSA funding. Proposition 63 backers in 2004 assured voters a high level of statewide oversight for this new revenue stream. Twelve years without definitive data to meet these assurances is hardly what voters expected, and if known, may well have provided a different outcome at the ballot box.

Despite some of these misgivings, the Commission remains hopeful that the many proposals it heard to improve fiscal transparency and accountability for outcomes will lead to necessary improvements. The Commission was most inspired by the stories shared during the site visits by those whose lives have been improved. With better accountability, the Commission also remains hopeful that many more Californians, rather than just some, will receive the help that they need. The Commission respectfully submits recommendations to strengthen the oversight of the Mental Health Services Act and stands ready to assist in this important initiative to improve the health of Californians.

Sincerely,



Pedro Nava
Chair, Little Hoover Commission

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INTRODUCTION

More than a year after the Little Hoover Commission's first look at the Mental Health Services Act, it decided to conduct a follow-up review and found that many concerns remain unheeded. The Commission launched its initial study of the Act in June 2014 to better understand what happens after voters say yes to a spending plan at the ballot box. Introduced to voters in 2004 as Proposition 63, the Act imposed a 1 percent surtax on the wealthiest Californians to directly fund specific types of mental health programs and services across the state and invigorate a faltering statewide mental health system. Since 2004, the Act has generated approximately \$17 billion for mental health programs and services throughout the state – currently at a rate of \$2 billion annually. These funds now comprise approximately 24 percent of the state's entire public mental health budget.¹

Proposition 63 allowed the Legislature to modify the Act without seeking voter approval for each reform. In the years since, the Legislature has exercised its authority to make significant amendments five times. Early reforms expedited distribution of money to on-the-ground service providers, eliminated the state's upfront review of spending plans and reoriented accountability for expenditures to the counties. Other reforms have expanded the variety of allowable programs or diverted funds for specific, one-time expenditures.

In its last review, the Commission heard many accounts of success, including programs and services for the state's mentally ill that likely would have been unaffordable without Proposition 63 funding. Often these anecdotal successes, however, lacked verifiable data. In its January 2015 report, *Promises Still to Keep: A Decade of the Mental Health Services Act*, the Commission voiced concern that as money comes through the MHSA pipeline each year, the state lacks an accountability mechanism to assure taxpayers, voters, and most importantly, mental health care consumers and advocates, that the money is being spent in ways voters intended.

The Commission also found overlapping and sometimes unaccountable bureaucracies and an oversight body lacking “teeth” for enforcement. Stakeholders, and ultimately the Commission, were concerned that the state lacks an organization that can effectively oversee the Mental Health Services Act. The mental health program within Department of Health Care Services is overshadowed by the state's massive Medi-Cal program and, without authority, the Mental Health Services Oversight and Accountability Commission (oversight commission) cannot help counties correct deficiencies in their plans or enforce changes to comply with the law. Recommendations from the Commission's January 2015 report are in Appendix B.

Oversight Hearing and Site Visits

The Commission initiated this follow-up review in May 2016 to gauge progress in addressing the serious concerns raised in its 2015 report. The Commission heard from state agencies responsible for overseeing the act, representatives from county mental health directors and local boards, as well as the Act's authors and numerous stakeholders, including clients, family members and advocates. Hearing participants are listed in Appendix A.

In May and June 2016, Commissioners also visited nine programs funded in part or entirely by the Mental Health Services Act in three counties: San Bernardino, Sacramento and Los Angeles. During these visits, the Commission saw how programs funded by the Act help Californians before they need intensive care, and others recover and reclaim their lives. These visits introduced the Commission to programs that give individuals short respites while getting needed help and others that help people transition from unstable living situations to permanent, supportive housing. Most significantly, the Commission heard directly from Californians whose lives and health are improving as a result of these programs.

Descriptions of programs visited, as well as the voices of some participants, are included throughout this report.

Based on its 2015 report, the information provided at its May 2016 hearing and visits to programs funded by the Mental Health Services Act, the Commission has identified several challenges that persist. Important questions remain unanswered: Who oversees MHSA spending, where does the money go and is the Act achieving its goals? Furthermore, though the Act built-in a stakeholder process for spending plans, Californians do not yet have a clear path for participating in, or question, spending decisions. And though the Act promised opportunities to transform the way mental health services are delivered in California by funding new and innovative programs, the state does not offer counties meaningful ways to share lessons learned. The Commission offers recommendations on pages to come to help the state keep its 2004 promise to Californians.



The Integrated Mobile Health Team, Los Angeles County

The Integrated Mobile Health Team helps clients transition from homelessness into permanent supportive housing, improving their mental health and substance use disorders. Mental health, physical health and substance abuse services are provided by multi-disciplinary staff working as one team, under one point of supervision and operating under one set of administrative and operational policies and procedures, using an integrated medical record/chart. Through a “street medicine” approach, the program staff bring care to its clients wherever they are – whether living in an encampment, a car or on the street. In July 2016, the team received the National Association of County’s Achievement Award. (CSS-funded, formerly INN)

One client explained he joined the program and came off the streets because “I didn’t like the feeling of being worthless.”



Photos by Little Hoover Commission staff and the Integrated Mobile Health Team, Mental Health America of Los Angeles in Long Beach, California.

A CONTINUING CHALLENGE: “MUDDLED” LEADERSHIP OVERSEES MHSA FUNDING

When voters approved Proposition 63 in 2004, they also approved a statewide governance system to administer and oversee new mental health programs funded by the Act. The Department of Mental Health was to take the lead state role in implementing most of the new programs created in the measure, as well as allocate funds for those programs through contracts with counties (The Department of Health Care Services picked up oversight responsibilities for the Act after the Governor and the Legislature dismantled the Department of Mental Health in 2012). A new Mental Health Services Oversight and Accountability Commission also would review county plans for mental health services and approve expenditures for certain programs. The measure layered these additional responsibilities within the existing mental health system and throughout the state’s Welfare and Institutions Code. As such, the Act left intact the responsibilities of other existing agencies, including the Mental Health Planning Council to review, to oversee and review the state’s mental health system.² (Examples of statutory roles and responsibilities for these agencies are included in Appendix C.)

In the years since, the Legislature has amended this system several times, but three state agencies continue to share responsibility for administering and overseeing aspects of the Act. At times, these three entities are required to work together to fulfill their roles – providing technical assistance, designing a comprehensive joint plan for a coordinated evaluation of client outcomes and developing regulations and other instructions to administer or implement the Act.³ State law also assigns specific oversight functions to each:

The Department of Health Care Services (DHCS). The department alone has the authority to enter into performance contracts with counties, enforce compliance and issue administrative sanctions if necessary.⁴ In fiscal year 2016-17, the department received funding from the Mental Health Services Act for 19 full-time equivalent staff for these and other functions related to the Act.⁵

State mental health leaders say the DHCS’ role in overseeing the Act is focused on monitoring and auditing for compliance and providing fiscal and program oversight. In practice, the department’s oversight of the Act appears minimal.

The annual performance contracts the department establishes with each county mental health program are its main tool for program oversight. Department leaders conduct onsite reviews of these contracts every three years, at a rate of about 15-18 counties per year – to ensure compliance with state and federal laws and the terms of the contract between the department and county mental health programs.⁶ The executive director of the oversight commission told Commissioners in May, “the DHCS has profound capacity through its performance contracts to shape these programs.”⁷ However, these performance contracts encompass a broad range of mental health programs and services,



El Hogar Guest House Homeless Clinic, Sacramento County

“The Home” is an entry point for mental health and homeless services in Sacramento County. The facility provides a clinic for homeless individuals and temporary housing for adults 18 and older. Services include comprehensive mental health assessments and evaluations, medications, links to housing and applications for benefits and services. The program used MHSA funds to expand services for client care, such as offering subsidies for housing and dental work. (CSS-funded)

One client, thankful for the help she received through El Hogar explained, “California has so many programs compared to [my experiences in] other states. I wish they could have even 10 percent of what California has. Being able to have housing, dental work and services has been awesome for me.”

of which those funded by the Mental Health Services Act are but one part – and a relatively new one. After the absorbing responsibilities from the Department of Mental Health in 2012, DHCS in fiscal year 2013-14 added questions specific to the Act in its reviews. Currently, the department’s review protocol includes only 17 questions related to the Mental Health Services Act – these take up just eight out of the protocol’s 121 pages.⁸ The department’s deputy director admitted to the Commission that these reviews of the Act are “not very robust.”⁹

To provide fiscal oversight, the department also performs “a desk review” of each county’s annual revenue and expenditure report to ensure accuracy and consistency from year to year. Counties are required to submit these annual reports, identifying MHSA revenues, expenditures and unexpended funds and providing information to evaluate programs funded.¹⁰ However, as of August 2016, 37 counties had submitted reports for fiscal year 2013-14 and just 26 counties had submitted reports for fiscal year 2014-15.¹¹ (A list of each county’s reporting status is included in Appendix D.) For those reports received, the department reviews the balance of unspent funds, reportable interest, revenue received and program expenditure levels, and compares the balance of unspent funds reported in the prior year’s report to ensure they match. The department also reviews the amount of revenue counties report receiving with what the State Controller’s Office says it distributed.¹² However, it does not analyze the data reported in these reports to determine whether counties spent the funds as they proposed.

The department alone holds power to address local shortcomings in implementation of the Act by imposing administrative sanctions such as withholding part or all of state mental health funds from the county and requiring the county to enter into negotiations to comply with state laws and regulations. The department also can refer issues to the courts. The Commission heard testimony from some stakeholders that it is appropriate for the department to serve as the enforcer of the Act. However, when Commissioners asked department officials how they might ensure that bad actors are not continuously getting funding, the deputy director said “there isn’t a requirement on the department that we can point to that says this is our role and responsibility.” Additionally, in a subsequent conversation with Commission staff, the deputy director said that if a county is found out of compliance with the Act, rather than initiating administrative sanctions she prefers to phone the county’s mental health director and prompt them for corrective action.¹³

The Mental Health Services Oversight and Accountability Commission. The Mental Health Services Act established the oversight commission to oversee programs funded by the Act, as well as the state’s systems of care for adults, older adults and children. As such, leaders from the oversight commission view its oversight responsibility broadly, to encompass the whole public mental health system, not just the Mental Health Services Act. “Because [the oversight commission] was created by Proposition 63, people think its role is just

KEY COMPONENTS OF THE MENTAL HEALTH SERVICES ACT

Community Services and Supports (CSS). 80 percent of county funding from the Mental Health Services Act treats severely mentally ill Californians through CSS. Within this component counties fund a variety of programs and services to help people recover and thrive, including full-service partnerships and outreach and engagement activities aimed at reaching unserved populations. Full-service partnerships provide “whatever it takes” services to support those with the most severe mental health challenges.

Prevention and Early Intervention (PEI). Counties may use up to 20 percent of their MHSA funds for PEI programs, which are designed to identify early mental illness before it becomes severe and disabling. PEI programs are intended to improve timely access to services for underserved populations and reduce negative outcomes from untreated mental illness.

Innovation. Counties may use up to 5 percent of the funding they receive for CSS and PEI to pay for new and innovative programs that develop, test and implement promising practices that have not yet demonstrated their effectiveness.

to oversee the Act. But it’s broader,” one senior official at the oversight commission explained.¹⁴ In addition, state law also assigns the oversight commission specific functions and responsibilities related to the Act, such as receiving all county plans for review, and for approving Innovation programs. In fiscal year 2016-17, the oversight commission received funding from the Mental Health Services Act for 30 full-time equivalent staff to carry out its responsibilities.¹⁵

In its 2015 report, concerned that the DHCS did not consistently exercise its enforcement authority over the Act in a timely fashion, the Commission recommended expanding the oversight commission’s authority to review and approve county MHSA Prevention and Early Intervention (PEI) plans, as it does with Innovation plans. The Commission also recommended the oversight commission be granted authority to respond to critical issues identified in county spending plans and clarify the process by which problems get solved. The intent of that recommendation was not punitive, but to expedite a review process that was, at times, taking DHCS up to two years. Some advocates and stakeholders still believe that the state should reinstate authority of the oversight commission to review and approve county spending plans, as well as statewide projects funded by the Act.¹⁶

In response to the Little Hoover Commission’s recommendation, the oversight commission executive director told Commissioners that he was working to “strengthen the local process, strengthen the boards of supervisors, and [the oversight commission’s] ability to do oversight based on the outcomes.” He said that giving the oversight commission “teeth” could potentially distract his commissioners and staff from other functions and would require them to “to really think differently about how we do our job.”¹⁷ The lack of progress of the oversight commission over the last year even to develop a response to the Commission’s previous recommendation indicates that something else must be done to improve accountability and facilitate achievement toward the Act’s goals.

The Mental Health Planning Council. Among other functions, the planning council reviews program performance of the overall mental health system, including programs funded by the Mental Health Services Act. Also, it annually reviews program performance outcome data to identify successful programs and make recommendations for replication in other areas.¹⁸

State law articulates a role for the planning council in developing plans to address the state’s mental health workforce needs and shortages.¹⁹ In fiscal year 2016-17, the planning council received funding from the Mental Health Services Act for five full-time equivalent staff.²⁰ Mental Health Planning Council officials say it lacks the data it says it needs to assess the strengths of the mental health system overall.



Hacienda of Hope, Los Angeles County

Hacienda of Hope is a short-term respite home run by “peers” – adults who are living with mental illness themselves. The respite program, operated by Project Return, The Peer Support Network, offers support and tools to foster wellness and manage crisis and recovery for up to eight guests in the program’s two-story home. Guests create individualized wellness and recovery plans and connect with local resources for employment, housing and mental and physical health care. Adults 18 and older who are experiencing distress or a life crisis, but who are not in immediate danger or in need of on-site medical treatment are eligible to stay. Typically, guests stay between one and three days. They may stay up to 14 days if additional help is needed. (CSS-funded, formerly INN)

A former client, now peer-advisor said of the program, “This is a hopeful place to go when you don’t have hope, when you are broken.”

Without Direction, Some Oversight Functions Haven't Happened

The state has laws requiring counties to provide a substantial amount of information about the Mental Health Services Act that could be used for evaluation. Counties, for example, submit three-year MHSA program and expenditure plans and annual updates to the oversight commission and the DHCS.²¹ These plans include descriptions of MHSA programs, that if compared with expenditure reports, could be used to ensure counties spent their MHSA dollars as they proposed. Yet, no state agency performs this type of review.

DHCS, when it implements recent legislative reforms, will post online county plans as well as revenue and expenditure reports.²² This reform should improve fiscal transparency, but falls short of ensuring accountability.

The oversight commission does not broadly review information contained in counties' program and expenditure plans to identify compliance issues or compile a statewide picture of implementation of the Act. Currently, oversight commission staff only read counties' plans within the context of reviewing Innovation programs. However, according to its deputy director, the oversight commission plans to build technology to make it easier to analyze the county-submitted reports and compare and contrast information across plans.²³



Palmer Apartments, Sacramento County

Run by Transforming Lives, Cultivating Success (TLCS), the Palmer Apartments offer short-term housing for up to 48 adults experiencing homelessness and psychiatric disability. The program provides a safe, hospitable alternative to shelters and access to permanent housing within 30 days once income is secured. Longer-term temporary housing also is available for those awaiting openings in MHSA-financed housing developments. Clients and staff work collaboratively to break the cycle of homelessness during average stays of six to eight months. (CSS-funded)

Reflecting on his experience, one client said "This is the first step for me being who I am. These people give us hope and from here, I'm learning how to live again."

State law does not require any state agency to review, analyze and summarize information contained in all of the county MHSA program plans and ensure the counties are spending the MHSA funds as they said they would. Perhaps it should.

Multiple Agencies, But Who is Accountable?

"Individually, each of the entities – the oversight commission and department of health care services – is very clear about their own responsibilities as set in law," Josephine Black, Chairperson, and Jane Adcock, Executive Officer, of the California Mental Health Planning Council wrote in testimony to the Commission. "However, when taking a global look, the roles are muddled resulting in divided (and weakened) leadership for key aspects of the public mental health system and no clear designation of authority. Who is to hold the system accountable? Who is to hold the oversight entities accountable?"²⁴

Advocates, stakeholders and others told the Commission they remain confused and dissatisfied with the diffusion and overlap of responsibilities at the state. They are still concerned that no one is accountable for overseeing the Act and systematically and comprehensively evaluating its outcomes. Questions remain about which agencies are ultimately responsible for ensuring the promises made to voters are kept:

- Is it the responsibility of the oversight commission to focus its oversight and evaluation efforts specifically on programs funded by the Mental Health Services Act, or on the broader public mental health system? And if the oversight commission's role is broad, how does that differ with the planning council?
- Is it the responsibility of the department to investigate whether county spending plans align with actual expenditures or is this a function of the oversight commission?
- Which agency is responsible for ensuring the state's progress toward achieving the transformational vision of mental health services proposed to and approved by voters in 2004?
- Which agency is ultimately responsible for determining how to evaluate the programs funded by the Act – is it the oversight commission, the department, counties or the Health and Human Services Agency?

- Which agency is best situated to enforce compliance with the Act and to hear and address concerns raised by consumers, family members, stakeholders and advocates if and when issues arise at the local level?
- When problems are identified by the oversight commission or the planning council, how do either of these entities ensure corrective action is taken by the department which has authority to act?

When looking for accountability to the Mental Health Services Act, it's difficult to see clearly because a tangled web of organizations with conflicting and overlapping oversight responsibilities is tasked with the job. Some argue that this diffusion makes sense: the Act is but one funding stream for a diverse and complex mental health system. But who is truly accountable? When asked by Commissioners, former State Senator Darrell Steinberg and co-author of the Mental Health Services Act, said ultimately, it's elected leaders – the Governor and the Legislature.²⁵ At some juncture, policymakers may question this division of responsibilities and consider whether California needs all three organizations. In the meantime, despite past clarifications, more must be done to further articulate the roles and responsibilities of the various state agencies that administer, oversee and enforce the Act. Voters enacted the measure with the expectation of oversight, putting a strong onus on the state to ensure that these dollars – specifically – are spent as voters intended and produce the outcomes promised. The state should notify any non-compliant county behavioral health department and board of supervisors with a written notice including a deadline and specific remedy to achieve compliance and these written notices should be prominently published on a state website. To ensure compliance, the state should withhold money from non-compliant counties – as current law allows – and redistribute this money to other counties that are complying with the Act. The Legislature should enhance current law to make this withholding mandatory after one or more formal written notices regarding non-compliance are sent to the county.

Recommendation 1: The Legislature should further clarify the roles and responsibilities of the state agencies responsible for administering, overseeing and enforcing the Mental Health Services Act.

Specifically it should:

- ***Clarify expectations for the scope of responsibilities of the department, oversight commission and planning council and define the separate roles of each in ensuring the Mental Health Services Act funds are used as voters intended.***
- ***Call on the entity charged with enforcement, currently the Department of Health Care Services, to identify the mechanism by which it will enforce the Act. The entity should identify metrics it will apply to evaluate county performance with potential consequences. Repeated poor performance should result in mandatory redistribution of money to compliant counties.***

THE QUESTION REMAINS: WHERE IS THE MONEY GOING?

To better answer basic questions about the statewide allocation and use of Mental Health Services Act funds, the Commission in 2015 recommended the Mental Health Services Oversight and Accountability Commission post meaningful financial information on its website. At a minimum, the Commission suggested, this should include a fiscal snapshot of overall and current year revenues and allocations by program component areas. It also should include information on how the state spends MHSA state administration funds.

Since the Commission’s last review, the oversight commission launched an updated website which includes some financial elements recommended by the Commission. Among them: a breakdown of the cumulative MHSA revenue reported since the Act passed in 2004.²⁶ The website also includes a placeholder page for county-submitted reports and financial evaluation reports. When posted, the public will find important information about the Act in one centralized location.²⁷ These, and planned improvements described below, are steps in the right direction. But, more can be done to help voters, taxpayers and mental health advocates, consumers and their families understand how money from the Act is used locally and statewide.

Though some counties make financial information about their MHSA expenditures readily available, the Commission heard from stakeholders and other members of the public that in some communities it is still difficult to track how MHSA funds are spent. (Counties receive about 95 percent of the dollars generated by the Act each year in amounts based on a formula established by the Department of Health Care Services. In fiscal year 2016-17, counties received approximately \$1.9 billion.²⁸)

“Mental health advocates, providers, and stakeholders alike, all want to know where the money is going. Most counties are not transparent with MHSA growth revenue and additional resources are not trickling down to the providers who offer mental health services,” Matthew

Gallagher, program director for the California Youth Empowerment Network, told the Commission. “So where is all the money going?”²⁹

New Tools Promise Easier Access to Local Financial Information

Some suggested a state entity should be made responsible for dispersing the information in a user-friendly format online. Also needed: a reporting process that quickly makes the information public.³⁰

A new fiscal transparency tool could show local MHSA expenditures online. According to its executive director, the oversight commission built the tool using data that counties must submit to the state in annual revenue and expenditure reports. The tool, he said, can show the distribution of MHSA funds to each county by component, identify how much has been spent and how much remains unspent, and show cumulative balances for each component of the MHSA. Plans to showcase the tool on the oversight commission’s website have stalled while addressing county



One Stop Transitional Age Youth Center, San Bernardino County

The one stop center – one of four in the county – provides a range of drop-in services for youth ages 16-25 with, or at risk of, mental and emotional issues. The goal of treatment: to offer employment assistance, educational opportunities, shelter housing, counseling and group activities to help clients become independent, stay out of the hospital or higher levels of care, reduce involvement in the criminal justice system and reduce homelessness. Because of disproportionate overrepresentation in the justice system and foster care system, the program specifically targets Latino and African-American youth. The county’s Probation and Children and Family Services, and other community groups, act as program partners. (CSS-funded)

concerns about the validity and reliability of the fiscal data on which it is built.³¹ Despite setbacks, plans are in place to launch the tool by October 2016.³²

The No Place Like Home initiative, a legislation package signed by Governor Brown in July 2016, established a new program for addressing homelessness and also included accountability measures. The legislation requires counties to certify the accuracy of their revenue and expenditure reports – and reiterates that the Department of Health Care Services may withhold Mental Health Services Funds for counties that fail to submit timely reports. Additionally, the legislation requires the department and the oversight commission to post county revenue and expenditure reports online.³³ When implemented, this will help fulfill one of the Commission’s previous recommendations.

The Department of Health Care Services intends to begin posting these reports online no later than mid-September 2016, beginning with reports from fiscal year 2014-15.³⁴ It is clear to the Commission that making reports publicly available will create additional pressure on noncompliant counties to submit their reports, as would, at a minimum, posting each county’s submission status.

“State level reporting does not allow for review of where the funding is going besides the full services partnerships, and also does not provide meaningful comparison of the relative costs and results of each FSP program. We don’t know who or what produces the best results and how the answers might vary based on age, sex or ethnicity.”

Rusty Selix, Executive Director of Policy and Advocacy, Mental Health America of California³⁵

Additionally, proposed legislation, if signed by the Governor, would make it easier for Californians to understand how counties, alone and collectively, use MHSA funds. With this information, local decision-makers, advocates and stakeholders may be able to identify best practices in other counties and better inform their own spending decisions. Specifically, the measure, AB 2279 (Cooley), would require the DHCS, by July 1, 2018, to analyze data submitted by counties in their revenue and expenditure reports and annually produce a summary of revenues, expenditures and funds held in reserve. By requiring the department to make

readily-available data about revenues and expenditures by component, by county, the legislation also would implement Commission recommendations.

Accomplishments of State Administrative Funds are Still Difficult to Track

Though the bulk of Mental Health Services Act funds go directly to counties to spend on programs and services, 5 percent goes each year to state administration of the Act. As the tax base grows, so, too, does the state’s share. In fiscal year 2016-17, the Act is expected to generate approximately \$102 million for state administration, about \$15 million more than during the Commission’s last review.³⁶

State law guides how this portion of funds is spent. The Mental Health Services Act, as presented to voters in 2004, directed the California Mental Health Planning Council and the Mental Health Services Oversight and Accountability Commission to use the state administration funds “to implement all duties pursuant to the [MHSA] programs.” The Act further specified that the state administration funds be used for two purposes:

- “assist consumers and family members to ensure the appropriate state and county agencies give full consideration to concerns about quality, structure of service delivery or access to services” and
- “ensure adequate research and evaluation regarding the effectiveness of services being provided and achievement of the outcome measures set forth [in the Act].”³⁷

Current law gives these funds to five state agencies – the Department of Health Care Services, the California Mental Health Planning Council, the Mental Health Services Oversight and Accountability Commission, the Office of Statewide Health Planning and Development and the Department of Public Health – as well as any other state agency that implements MHSA programs. In fiscal year 2016-17, these five agencies received approximately \$22 million to support 72.5 positions and provide oversight of the Act. (Of this, the DHCS, planning council and oversight commission together received about \$15 million and 54 positions). Additionally, eight other agencies received funding for 23.5 positions and a myriad of programs ranging from supporting student mental health, conducting outreach to service members,

funding regional centers that develop innovative PEI projects and administering various grants.³⁸

The Commission, concerned that there is insufficient oversight of this large and growing pot of money, recommended in 2015 the oversight commission bolster its oversight of the state administration funds and provide policymakers with analysis, beyond the straightforward fiscal accounting provided by the Department of Health Care Services. The annual MHSA Expenditure Report, produced by the DHCS, provides a high-level overview of overall MHSA revenues and expenditures, as well as a brief description of how and where the state administration funds are disbursed. It does not offer an analysis, however, of how the various state entities use the funds to achieve MHSA goals.

Currently, decisions about the allocation of state administration funds are made through the regular budget process. The Department of Finance issues policies and procedures for departments to propose budget changes – including proposals for departments to access MHSA funds. Rules prevent the oversight commission from consulting on MHSA-related budget change proposals. However, the oversight commission does consult with the Department of Finance, the Legislative Analyst’s Office and legislative committees on specific budget proposals.³⁹ For example, the oversight commission currently is working with the Department of Finance and the Legislature to make it easier to understand how much is available in unspent state administrative funds.

The state needs to ensure that its 5 percent share of MHSA funds are spent appropriately. Someone must be responsible for asking: is it spent on purposes defined by the Act and what is it achieving?

During the Commission’s last review, the Mental Health Services Oversight and Accountability Commission’s financial oversight committee had begun inviting entities that receive part of the MHSA state administrative funds to report how the money is used. These presentations were helpful for decision-makers and stakeholders to better understand how these funds were being used and what they were accomplishing. However, the last time the committee heard a presentation from one of the state departments receiving funds was in November 2014.⁴⁰

The former Department of Mental Health coordinated interagency partnerships among the various entities that received MHSA state administration funds. It also established memorandums of understanding with receiving entities that clarified expectations and responsibilities for use of the MHSA funds.⁴¹ This type of oversight is needed again. To strengthen oversight of the ever-growing amount of state administrative funds and make it easier to analyze and evaluate their uses, the oversight commission should regularly analyze how state administrative funds are spent and what they achieve. Findings could help legislators and policy leaders better determine the successes of state programs funded with MHSA dollars, and make more informed decisions about spending increases or cuts as the fiscal climate demands.

Recommendation 2: The Governor should approve legislation, AB 2279 (Cooley), to make it easier for Californians to see how and where their Proposition 63 tax dollars are being spent.

Recommendation 3: The Department of Health Care Services should immediately begin posting online the MHSA Revenue and Expenditure reports it has available, instead of waiting for all counties to submit all reports.

Recommendation 4: The state must ensure MHSA state administrative funds are spent properly.

- ***The Mental Health Services Oversight and Accountability Commission’s financial oversight committee should reinstate presentations from departments receiving a portion of the state administrative funds, analyze expenditures and compile an annual report for consideration of the full oversight commission.***
- ***The oversight commission should share its findings with the Department of Finance, Legislators and the public.***

STILL UNKNOWN: IS THE ACT ACHIEVING ITS GOALS?

Despite compelling claims that the Mental Health Services Act has transformed mental health services in communities across California, the Commission noted in its 2015 report that the state cannot yet demonstrate meaningful, statewide outcomes across the range of programs and services supported by Proposition 63 dollars. In large part, this is due to the lack of robust data that can show policymakers and mental health leaders what interventions are working in specific populations.

“Data is not just esoteric. It provides necessary information to share with policymakers who may not believe that there is any real solution to the state’s homelessness crisis, or to help people stop cycling out of emergency rooms when they need immediate mental health assistance,” former state Senator Darrell Steinberg, co-author of the Act, told the Commission.⁴²

Josephine Black, Chairperson, and Jane Adcock, Executive Officer of the Mental Health Planning Council echoed a similar sentiment about the importance of mental health data: “We have many individual stories of success and they are extremely important and put a human face on the progress. However, data is the fundamental and universally-accepted evidence of progress.”⁴³

MHSA Data Effort Lost in Broader Mental Health Data System Fix

To tell a successful Proposition 63 story, the Commission in 2015 urged state mental health leaders to improve online access to existing MHSA information, plans and reports and showcase more model programs and best practices. The executive director of the oversight commission said he plans additional upgrades to the organization’s website over the next three to five years to map programs by type, geography and outcomes.⁴⁴ This is a promising vision.

The Commission also recommended the state develop a comprehensive, statewide mental health data collection system. As a first step, the Commission called on the

oversight commission and the Department of Health Care Services to develop a plan and timeline for a data collection system capable of blending information for MHSA programs and other state behavioral and mental health programs.

Since the Commission’s 2015 review, the state has continued with long-term plans to modernize legacy data systems for its mental health and alcohol and drug abuse programs. The proposal: a seven-year, multi-phase, multi-million dollar project to upgrade the state’s existing mental health data systems and streamline data collection. The oversight commission in 2015 funded the Department of Health Care Services to prepare a preliminary plan for this upgrade. As of July 2016, the department is awaiting approval from the Department of Technology to submit the preliminary plan to the federal

QUALITY DATA COULD THWART RAIDS ON MHSA FUNDING

At its May 2016 hearing, the Commission heard testimony from advocates and members of the public that recent legislative proposals to steer MHSA funds to new uses, while well-intended, may weaken the ability of counties to care for the mentally ill. Some said these proposals simply target the Mental Health Services Act as a “go to” funding source for ever-expanding programs and will lead to “theft” from the Act in future budget years.⁵⁶ During the 2015-16 legislative session, members proposed several bills to redirect Mental Health Service Act funds, including approximately \$130 million annually in bond interest payments and more than \$7 million dollars in one-time expenditures. These funds were proposed to construct permanent, supportive housing for chronically homeless people with mental illness, expand on-campus mental health services at colleges and provide funds for administration and technical assistance for specific programs.⁵⁷

Centers for Medicare and Medicaid Services.⁴⁵ Next steps include another plan to implement the project, then issue a bid for vendors to design, develop and build the new system by June 2021.⁴⁶ Cost estimates are not yet available. But the initial planning phase will cost nearly \$3 million, with the federal government picking up most of the tab.⁴⁷

While recognizing that a process to transition and modernize legacy data systems is complex, the Commission has strong reservations about the current data modernization proposal. It is unreasonable to wait nearly two decades for the state to collect and report data about the Proposition 63 funding stream. Government agencies across the nation – at the federal, state and local levels, are demonstrating that new approaches to data collection and sharing can cost less and be implemented faster than efforts to maintain outmoded technology. For example, the California Department of Social Services in 2015 partnered with Code for America and the federal government’s tech innovation team, 18F, to change its approach to procuring technology for a new Child Welfare System. Instead of issuing a massive contract for the project as a whole – traditionally a costly approach with low success rates – the department will build the new system in a series of projects focused on developing and delivering user-centered services and open source practices.⁴⁸ The Commission highlighted similar efforts in its 2015 report, *A Customer-Centric Upgrade for California Government*.

Meanwhile, Counties Initiate Their Own MHSA Data Collection Projects

Some counties individually have used MHSA money to develop local data systems to track outcomes. Los Angeles County built an application to measure MHSA outcomes and now produces a quarterly newsletter highlighting outcomes for participants in MHSA-funded programs. Debbie Innes-Gomberg, district chief of the Los Angeles County MHSA Implementation and Outcomes Division, also told the Commission the value of the data is “not just about saying that MHSA has made an impact. It’s about making decisions using that data, learning from that data and improving the quality of our services.”⁴⁹ These reporting practices should be a model for other counties that still lack capacity to report outcomes of MHSA-funded programs.

In the absence of a statewide mental health data system capable of reporting MHSA program outcomes, the County Behavioral Health Directors Association initiated its own data collection project in 2014, association executive director Kirsten Barlow told Commissioners in May. The Measurement, Outcomes and Quality Assessment (MOQA) project enables counties to report collective results of some MHSA programs using data counties already collect. Specifically, it aims to create uniformity in outcome reporting across different types of MHSA-funded programs.⁵⁰

MEASURING MHSA OUTCOMES: IT CAN BE DONE

Los Angeles County now has a decade worth of data for some MHSA-funded programs, which it uses to guide decisions about where to refine or expand services countywide. Using money from the Act, Los Angeles County in 2006 built a data system to capture outcomes of clients enrolled in full-service partnership (FSP) programs – one type of program funded under MHSA Community Services and Supports (CSS). In the years since the county has twice expanded the system to capture outcomes from field capable clinical services (FCCS), another CSS-funded program, as well as Prevention and Early Intervention (PEI) programs.

Through its Outcome Measure Application, the county records and monitors clients’ progress and response to services and reviews the impacts that programs have on clients’ welfare. For example, data from the system shows that while in FSP programs, clients experience fewer hospitalizations, less homelessness, reduced incarceration and fewer emergency events. Children improve their grades, more adults live independently and some gain employment for the first time. Clients in FCCS programs spend more time engaging in meaningful activities, such as working, volunteering or participating in community activities. PEI clients show dramatic reductions in symptoms; they are less depressed, less anxious, parents report fewer behavior problems and fewer symptoms related to trauma. Reports produced from the data also are shared with providers to encourage them to think about how they use and analyze outcome data in their own programs, county staff said.⁵¹

The project allows counties to report on outcomes through an online portal, supported and maintained by the California Institute for Behavioral Health Solutions. Currently, the database is set up only to collect outcome data from full-service partnership programs – one of the largest types of programs funded with MHS Community Services and Supports dollars. Common data elements for these programs include average percent of clients re-hospitalized within 30 days, reduction in homelessness, psychiatric hospitalizations and incarcerations for adults and reduction in trauma symptoms for children. The association is developing additional outcome measures for Prevention and Early Intervention programs.⁵² The MOQA database was built with funding from the Department of Health Care Services.

With compiled data, the California Behavioral Health Directors Association, in partnership with the Steinberg Institute, has released two easy-to-understand reports since 2015 showing that participants of county full-service partnership programs help people recover and get better when they have the right kind of support. (The Steinberg Institute is a statewide organization launched in 2015 to advance sound public policy and inspire leadership on mental health issues.) Among 25,418 children and adults served between 2013 and 2014, homelessness and emergency shelter use declined, as did arrests, psychiatric hospitalization and mental health emergencies. Most children did better in school and

some adults were able to find jobs after one year in a program.⁵³ The process also has improved data collection and reporting processes and increased use of data to inform best practices and administrative decisions.⁵⁴

Additionally, reports about the California Mental Health Services Authority's (CalMHSA) statewide Prevention and Early Intervention programs demonstrate reduced stigma and discrimination around mental illness. Investments also have educated many Californians about how to intervene with people at risk for suicide. CalMHSA, created by counties in 2010, uses MHS funds to implement statewide Prevention and Early Intervention services.⁵⁵

These reports and others demonstrate outcomes for portions of programs funded by the Mental Health Services Act. They begin to paint a statewide picture of what the Act has achieved and are critical for providing policymakers with evidence of how the programs are working. These types of reports demonstrate the type of statewide analysis and reporting that should be the norm for all programs funded by the Act. In the long term, it is not sustainable nor prudent to rely on other organizations to do the work that should be done by the state in its oversight capacity.

The State Still Needs to Improve MHS Data Collection

State leaders must immediately build on the counties' MOQA project to produce statewide MHS outcome reports.

IMPROVING DATA COLLECTION, PERFORMANCE MEASURES AND OUTCOMES FOR CALIFORNIA'S YOUTH OFFENDERS

California's juvenile justice data system has lingered without a significant state investment in data modernization for more than two decades. Among its challenges: outdated technology that cannot be upgraded, inability to track important case and outcome information and a lack of performance outcome measures, poor transparency and availability of statewide information, and, fractured data collection and reporting responsibilities among different state agencies and lack of integration with county-level data systems.⁵⁹

To address long-standing concerns about the state's lack of a juvenile justice data system, the Legislature in 2014 established a working group to help clarify what would be needed for the state to build capacity to collect and use juvenile justice data to support evidence-based practices and promote positive outcomes for the children and youth who move through the system. Staff from the Board of State and Community Corrections supported the working group by coordinating meetings, taking notes and drafting reports. After more than a year of meetings, research and deliberation, the working group released a report offering recommendations to improve and modernize the data system, while addressing concerns related to the cost of replacement technology as well as the need to create a system that leverages the infrastructure of existing county data systems.⁶⁰

State mental health leaders, with relevant stakeholders, should collectively identify indicators that will show progress toward reducing the negative outcomes from untreated mental illness. Defined by the Act, those include suicide, incarcerations, school failure or dropping out rate, unemployment, prolonged suffering, homelessness, and removal of children from their homes. Evaluation efforts by the counties show that reporting on these types of indicators is already possible for some components of the Act.

“We wonder whether mental health disparities are being reduced. But because of the lack of data, no one can really prove anything beyond anecdotal examples.”

Stacie Hiramoto, Director, REMHDCO⁵⁸

State leaders also should collect data to better understand who is being served. Throughout the Commission’s last review and again at its May 2016 hearing, advocates, stakeholders and members of the public voiced concerns that the state still cannot account for the number of people served by the Act, nor produce basic demographic data. Of particular importance, many said, is reporting data on racial, ethnic and other minority communities so the state can better understand how the Act is reducing disparities in services and guide future spending decisions. They said statewide outcome measures should include demographic information about who benefits from the Act, including their ages, gender, racial and ethnic background and language spoken.

Additionally, state mental health leaders should acknowledge the anxiety that the collection of outcome data can cause. They should emphasize the use of data to improve services and promote best practices, not to sanction poor performers. To ease the anxiety, representatives of those who will collect and use the data should be included in the process to clarify what the state must collect to oversee the Mental Health Services Act. The state’s work to build a juvenile justice data system offers a model to begin a conversation about building an appropriate outcome data system for MHSA-funded programs.

The Department of Health Care Services has started a workgroup to identify common ways counties measure and report MHSA and other behavioral health data to the state and to consider what doesn’t need to be provided

to the state. Membership includes key staff from the oversight commission, Mental Health Planning Council and counties. However, it is not clear from conversations with participants whether this group meets regularly, has an ultimate purpose for meeting, and whether the meetings or meeting materials are available to the public.

The state should leverage the momentum spurred by local data collection efforts, as well as burgeoning coordination among state agencies to review mental health data requirements in order to build a modern, Web-based data collection system to report outcomes from MHSA-funded programs.

Recommendation 5: Before proceeding further with the data modernization project, the Department of Health Care Services should immediately consult with civic technologists and data experts to refine and streamline its approach to modernizing the state’s mental health data collection system.

Recommendation 6: The Legislature should establish a Mental Health Services Act (MHSA) data workgroup within the Department of Health Care Services to build on existing county MHSA data collection efforts and develop and support a statewide MHSA database. The workgroup should:

- ***Be comprised of representatives from entities who collect and use mental health data at the state and local levels, stakeholders as well as technology experts and should be supported by department staff.***
- ***Define the statewide outcomes needed to evaluate the MHSA, identify whether existing data collection efforts are sufficient for reporting and articulate the technological needs for such a data collection system. If existing data is not sufficient, the workgroup should recommend how counties and providers might collect the additional data without creating undue work or redundancies for counties and providers.***
- ***Specify how demographic data will be collected, including age, gender, racial and ethnic background and language spoken.***

CALIFORNIANS STILL NEED MEANINGFUL WAYS TO PARTICIPATE IN SPENDING DECISIONS

The Mental Health Services Act established a process – and allocated resources – for stakeholders to participate in county decisions about how to spend MHSAs funds. The Act specifically calls for stakeholder involvement in developing counties’ three-year program and expenditure plans and annual updates. It also requires counties to “demonstrate a partnership with constituents and stakeholders through the process that includes meaningful stakeholder involvement on mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation and budget allocations.”⁶¹ These provisions codify a central and ongoing role for stakeholders in determining how and where counties should invest their MHSAs resources.

However, in this review and the last, the Commission heard that some counties fall short in including stakeholders in meaningful decisions. “Proposition 63 included specific requirements that county spending plans be developed through a stakeholder process.



Boulevard Court Apartments, Sacramento County

Operated by Mercy Housing California, the Boulevard Apartments offer a low-income housing program for homeless people with special needs. Using MHSAs funds, the program renovated a formerly dilapidated motel in a high-need neighborhood into a campus with 74 studio and one-bedroom units that offer residents supportive services such as health care education, financial literacy and community involvement. With stable housing in a supportive environment, residents can focus on successfully managing their individual disabilities. (CSS-funded)

“I like being here,” one participant said. “The best thing is that it is affordable for me and there’s a doctor onsite. Otherwise, it takes two to two and a half hours transportation time by the bus [to get to a doctor].”

Counties have complied with the state requirements,” Rusty Selix, MHSAs co-author told Commissioners. “Unfortunately that guidance has missed the mark by measuring how many people attended meetings and how many groups the counties reached out to.” He explained that counties are not required to describe how the funds are proposed to be spent compared to how they are actually spent. Nor are they required to have meaningful discussions that welcome stakeholder views before and after spending decisions are made.⁶² Some stakeholders say spending decisions seem to be made before they are asked to provide input, and that their input is “window dressing.”⁶³

“The approach to community engagement matters,” Stacie Hiramoto, director of the Racial and Ethnic Mental Health Disparities Coalition, told Commissioners. “A lot of times, counties have a big meeting at a big public place. For many people in underserved communities it’s not our culture to come out in public. And, in some of our communities, the stigma regarding mental health issues is actually more acute.” Ms. Hiramoto and others also explained there can be language or cultural barriers that impede participation, as well as scheduling barriers that make it difficult for workers to attend meetings during regular business hours.

To make it easier to participate in MHSAs planning efforts, stakeholders suggested counties partner with community groups or trusted leaders to figure out the best ways to approach certain cultural groups and show respect for their distinct values. With the help of these partners, counties could advertise meetings in different languages and hold discussions in smaller venues where people feel comfortable. Scheduling meetings in the evening or on weekends also could help working families participate.⁶⁴ Additionally, they suggested counties – as well as the state – establish advisory committees that involve consumers, family members and representatives of underserved communities in decisions. Many of these suggestions echo recommendations from various groups, including the Mental Health Planning Council,

the California Stakeholder Process Coalition and the oversight commission to fortify stakeholder engagement in implementation of the Act.⁶⁵

Additionally, clients and advocates suggested the state strengthen the process for stakeholders to report issues and concerns at the local and state levels. Several told Commissioners they are unsure where they should turn when they identify problems with the local planning process and program implementation. Some said they fear retaliation for speaking out against spending decisions or registering a complaint with the local process. Others said that even when local leaders articulate a plan of correction, there is no oversight by the state to ensure that what was promised is done.

In its triennial performance audit of counties, the Department of Health Care Services reviews whether counties have an issue resolution process for the Mental Health Services Act and that they maintain a log of all issues received and the dates they were resolved. The department does not, however, review the quality of these processes nor does it assess whether they are sufficient for capturing and responding to concerns.

In response to concerns about the adequacy of the issue resolution process, the oversight commission has begun a formal project to review the process and identify opportunities to clarify and strengthen ways for stakeholders to raise concerns and for those

concerns to be addressed, the oversight commission’s executive director told the Commission. The Commission commends this effort and encourages the oversight commission to develop tools and templates to improve the local issue resolution process, including making it easier for clients, advocates and others to learn how to engage and how and where to elevate their issue to the state, if necessary.

Recommendation 7: The Mental Health Services Oversight and Accountability Commission should provide guidance to counties on best practices in engaging stakeholders in MHSA planning processes, and offer training and technical assistance if necessary. Additionally, the oversight commission should develop standards and a template for counties to create consistency in reporting and responding to concerns about the Mental Health Services Act. The oversight commission and the Department of Health Care Services should clarify the process for elevating issues or concerns related to the Mental Health Services Act from the local level to the state.



Navigation Teams, Los Angeles County

Eight navigation teams work regionally across the county to help individuals and families access mental health and other supportive services. Navigation Team members help quickly identify available services tailored to a client’s cultural, ethnic, age and gender identity, and follow up with clients to ensure they received the help they need. Team members also build an active support network through partnerships with community organizations and service providers and map availability of local services and supports in the area. (CSS-funded)

A team member described the program as concierge mental health services – “navigators help people directly link to the services they need.”

COUNTIES NEED MORE WAYS TO SHARE SUCCESS

The Mental Health Services Act provides Innovation funds for counties to experiment with promising practices that have not yet proven effective. This financial commitment allows local communities throughout the state to become testing grounds for new and innovative mental health programs and practices. Brought to scale, successful programs could transform the way mental health services are delivered in the state. However, key to that transformation is the ability of local mental health leaders, providers and clients and their families to regularly share information and lessons learned about what’s working, what’s not and why.

Counties and providers currently have several venues to share best practices and lessons learned. For example, Mike Kennedy, Sonoma County’s Behavioral Health Division Director, told the Commission in September 2014 that counties can learn about successful approaches in other counties through the County Behavioral Health Directors Association and its subcommittees, conferences and forums.⁶⁶ The associations’ MHSa committee also holds monthly conference calls or meetings to share information about programs funded by the Mental Health Services Act.



The Transitional Age Youth Behavioral Health Hostel – The STAY, San Bernardino County

The hostel offers a short-term crisis residential program for up to 14 Transition Age Youth between ages 18 to 25 who are experiencing an acute psychiatric episode or crisis and is the first crisis residential treatment facility in the county. Services are culturally and linguistically appropriate, with a particular emphasis on diverse youth (African American, Latino, LGBTQ, etc.) as well as former foster youth or youthful offenders. The hostel is primarily peer run by individuals representing the county’s diverse ethnic communities and cultures. (INN-funded)

Additionally, the department, oversight commission and individual counties occasionally contract with the California Institute for Behavioral Health Solutions to develop training programs on evidence-based practices, hold conferences and policy forums, among other consultative activities. The nonprofit institute, established in 1993, helps health professionals and others improve the lives of people with mental health and substance use challenges. When the Mental Health Services Act was initially passed, the Department of Mental Health contracted with the institute to help counties develop and run full-service partnership programs. With input from state and local mental health leaders, providers, clients and family members, the institute developed toolkits to help providers implement full-service partnership programs, ensure ongoing quality improvement and improve access to care for unserved and underserved ethnic and cultural groups.⁶⁷ The institute has not yet been approached to coordinate similar training around successful MHSa Innovation programs.⁶⁸

Despite existing efforts to collaborate, the Commission heard from stakeholders that more is needed and suggested the state could play a key role in fostering information sharing and by providing additional technical assistance. At each county visited, the Commission heard providers say in various ways, “I’m not sure if other counties have a program like this.”

One member of an award-winning MHSa-funded Innovation program in Long Beach lamented, “I’ve been thinking about putting together a training program because no one seems to have anything like this. But I just haven’t found the time.”

Another provider – a “navigator” who links individuals and family members to appropriate mental health services, and provides referrals and responds to pleas for help – said she wishes for a way to “connect the connectors.” She explained that while she and the other “navigators” are familiar with the various programs in her

county, it would be helpful also to know what is available elsewhere. “It would be great to have conferences, more provider-to-provider learning opportunities,” she said. “If we don’t see anything outside our county, we’re not learning.”

The state could spread promising practices across communities and county boundaries by collecting information from successful Innovation programs and working with providers to develop training programs and share best practices.

The oversight commission has the statutory authority to establish technical advisory committees, employ technical assistance staff and other appropriate strategies as necessary to perform its duties.⁶⁹ But, according to its executive director, “the oversight commission does not currently have the staff to provide technical assistance and training on how innovation can be transformative.” Nor does it “currently have the capacity to fully disseminate information on the lessons learned through innovation investments.”

The oversight commission requested, and received in the 2016-17 budget funding for additional staff to better document how counties are innovating, what has worked and why. The oversight commission plans to develop tools and provide technical assistance around Innovation programs, as well as disseminate best practices. It also intends to reach out to partners in the business community, universities, foundations and federal

agencies, as well as counties and service providers, to leverage innovation as a strategy for transformational change, the executive director said.⁷⁰ Again, this is a promising vision, but more must be done to ensure that counties get the help they need to leverage best practices across the state, fulfilling one of the original intentions of the Mental Health Services Act.

To scale up promising MHPA-funded Innovation programs, mental health practitioners need more opportunities to learn from each other about what’s working well so that successful programs can be replicated. As part of its oversight responsibilities, the oversight commission should prioritize fostering the transformational potential of the Mental Health Services Act’s Innovation programs.

Recommendation 8: The Mental Health Services Oversight and Accountability Commission should identify best practices in counties achievements with MHPA programs, and provide training and technical assistance to disseminate these practices statewide. It also should develop regular opportunities to convene local mental health leaders and practitioners to spread lessons learned beyond county borders.



Crisis Respite Center, Sacramento County

Since opening in December 2013, the Crisis Respite Center provides crisis intervention services that reduce law enforcement calls and unnecessary emergency room visits. The program stabilizes adults experiencing mental health crises with 24/7 drop-in services in a warm and supportive setting. The program provides a stable, supportive environment to help “guests” explore their crises with a solution-oriented mindset. (CSS-funded, formerly INN)

A client reflected, “Here I had the chance to settle down and think straight *because* I felt safe. I had the chance to regroup coming here.”



Photo by Little Hoover Commission staff at the Crisis Respite Center – Transforming Lives, Cultivating Success in Sacramento, California.

APPENDICES**Appendix A: Public Hearing Witnesses**

***Public Hearing Revisiting the Mental Health Services Act
May 26, 2016***

Jane Adcock, Executive Officer, California Mental Health Planning Council

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition

Kirsten Barlow, Executive Director, County Behavioral Health Directors Association

Debbie Innes-Gomberg, District Chief, Los Angeles County MHSa Implementation and Outcomes Division

Karen Baylor, Deputy Executive Director of Mental Health and Substance Use Disorder Services, California Department of Health Care Services

Daphne Shaw, Councilmember, California Mental Health Planning Council

Phillip Deming, Chair, San Diego County Behavioral Health Advisory Board

Rusty Selix, MHSa Co-Author and Executive Director of Policy and Advocacy, Mental Health America of California

Toby Ewing, Executive Director, Mental Health Services Oversight & Accountability Commission

Darrell Steinberg, Former Senate President Pro Tem and Founder, Steinberg Institute

**Appendix B: Recommendations from the Little Hoover Commission's January 2015 report,
*Promises Still to Keep: A Decade of the Mental Health Services Act***

Recommendation 1: The Legislature should expand the authority of the Mental Health Services Oversight and Accountability Commission. Specifically, it should:

- Strengthen the ability of the state to conduct up-front reviews of the more controversial programs funded by the act before funds are expended by requiring the oversight commission to review and approve county Prevention and Early Intervention plans annually, as it currently does for Innovation plans.
- Refine the process by which the state responds to critical issues identified in county three-year plans or annual updates to ensure swift action. Empower the oversight commission to impose sanctions, including the ability to withhold part of the county's MHSAs funds, if and when it identifies deficiencies in a county's spending plan. Decisions of the oversight commission should become mandatory unless they are overturned by the Department of Health Care Services within a reasonable period, such as 60 days.

Recommendation 2: To provide greater oversight and evaluation of the state administrative funds, the oversight commission should annually develop recommendations for and consult with the Department of Finance before the funds are allocated.

Recommendation 3: To make MHSAs finances more transparent and make it easier for voters, taxpayers and mental health advocates, consumers and their families to see how and where the money is spent and who benefits from its services, the Mental Health Services Oversight and Accountability Commission should add to and update material on its website to include:

- MHSAs revenues, by component and annual allocations, and the cumulative total revenue since voters approved the act.
- Data about who benefits from the act, including the number of individuals served, their ages, gender, racial and ethnic background and language spoken.
- Data to demonstrate statewide trends on key indicators such as rates of homelessness and suicide that show how well the act's programs help those living with mental illness to function independently and successfully.
- A rotating showcase of model programs in each of the component areas to clearly demonstrate examples of what works.
- All county MHSAs plans and reports submitted to the state, including:
 - ✓ MHSAs annual revenue and expenditure reports.
 - ✓ Three-year program and expenditure plans and annual updates.
 - ✓ Other relevant mental health reports, such as county cultural competence plans that describe how a county intends to reduce mental health service disparities identified in racial, ethnic, cultural, linguistic and other unserved and underserved populations.

Recommendation 4: To promote meaningful accountability of the MHSA, the state needs access to reliable, timely information that allows it to monitor effective progress toward the act's goals. The Mental Health Services Oversight and Accountability Commission and Department of Health Care Services should:

- Immediately develop a formal plan and timeline to implement a comprehensive, statewide mental health data collection system capable of incorporating data for all MHSA components, as well as other state behavioral and mental health programs.
 - ✓ This plan should address how the development of such a data collection system would be funded and should use a portion of the MHSA state administrative funds to support the effort.
- Regularly report to the Legislature on the progress made in developing this data system and identify challenges that arise.

Appendix C: Examples of Statutory Roles and Responsibilities Assigned to Mental Health Agencies

State law – California’s Welfare and Institutions Code – prescribes various roles and responsibilities for state and local agencies to implement the Mental Health Services Act. Examples of some of these roles and responsibilities are included below.

Code Section	Description	DHCS	MHSOAC	MHPC	Other	County	CBHDA
5655	DHCS shall, upon request and with available staff, provide consultation services to the local mental health directors, local governing bodies and local mental health advisory boards. If the director of DHCS considers any county to be failing, in a substantial manner, to comply with any provision of this code or any regulation, the director shall order the county to appear at a hearing, before the director or the director’s designee, to show cause why the department should not take action. If the director finds there has been a failure, the DHCS may withhold part or all of state mental health funds for the county, require the county to enter into negotiations for the purpose of ensuring county compliance with those laws and regulations and bring court action as appropriate to compel compliance.	✓					
5722	The MHPC shall have the powers and authority necessary to, among other duties, review, assess and make recommendations regarding all components of California’s mental health system, review program performance in delivering mental health services by annually reviewing performance outcome data, identify successful programs for recommendation and for consideration of replication in other areas, advise the DHCS if a county’s performance is failing, advise the Legislature, DHCS and county boards on mental health issues and the policies and priorities the state should be pursuing in developing its mental health system.			✓			
5845 (a)	MHSOAC established to oversee: Part 3: the Adult and Older Adult Mental Health System of Care, Part 3.1: Human Resources, Education and Training Programs, Part 3.2: Innovative Programs, Part 3.6: Prevention and Early Intervention Programs, Part 4: Children’s Mental Health Services Act		✓				
5845 (d) (6)	In carrying out its duties, the MHSOAC may, among other things, obtain data and information from DHCS, OSHPD or other state or local entities that receive MHSA funds for the commission to utilize in its oversight, review, training and technical assistance, accountability and evaluation capacity regarding projects and programs supported with the MHSA funds	✓	✓		✓		✓
5845 (d) (9)	Advise the Governor or Legislature regarding actions the state may take to improve care and services for people with mental illness.		✓				
5845 (d) (10)	If the commission identifies a critical issue related to the performance of a county mental health program, it may refer the issue to the DHCS.	✓	✓				
5845 (d) (11)	Assist in providing technical assistance to accomplish the purposes of Part 3, Part 4 in collaboration with the DHCS and in consultation with the CBHDA	✓	✓				✓

Code Section	Description	DHCS	MHSOAC	MHPC	Other	County	CBHDA
5845 (d) (12)	The MHSOAC may work in collaboration with DHCS and the Mental Health Planning Council, and in consultation with the CBHDA, in designing a comprehensive joint plan for a coordinated evaluation of client outcomes in the community-based mental health system, including but not limited to parts listed in 5845(a). The California Health and Human Services Agency shall lead this comprehensive joint plan effort.	✓	✓	✓	✓		✓
5897 (c)	The DHCS shall implement the provisions of Part 3, Part 3.2, Part 3.6 and Part 4 through the annual county mental health services performance contract.	✓				✓	
5897 (d)	The DHCS shall conduct program reviews of performance contracts to determine compliance. Each county performance contract shall be reviewed at least once every three years, subject to available funding.	✓				✓	
5897 (e)	When a county mental health program is not in compliance with its performance contract, the department may request a plan of correction with a specific timeline to achieve improvements. The department shall post on its website any plans of correction requested and the related findings.	✓				✓	
5898	The DHCS, in consultation with the MHSOAC, shall develop regulations, as necessary, for the DHCS, the MHSOAC, or designated state and local agencies to implement this act.	✓	✓		✓	✓	
5899 (b)	The DHCS, in consultation with the MHSOAC and CBHDA shall revise the instructions for the Annual Mental Health Services Act Revenue and Expenditure Report by July 1, 2017, and as needed thereafter, to improve the timely and accurate submission of county revenue and expenditure data.	✓	✓			✓	

Notes:

DHCS: California Department of Health Care Services

MHSOAC: Mental Health Services Oversight and Accountability Commission

MHPC: California Mental Health Planning Council

Other: A state agency, other than DHCS, MHSOAC, MHPC

CBHDA: County Behavioral Health Directors Association, formerly, County Mental Health Directors Association

Appendix D: County Submission Status of MHSA Annual Revenue and Expenditure Reports (as of August 26, 2016)

County	Fiscal Year	
	13-14	14-15
Alameda		
Alpine		
Amador		
Berkeley City	✓	✓
Butte	✓	✓
Calaveras	✓	✓
Colusa	✓	✓
Contra Costa	✓	✓
Del Norte	✓	✓
El Dorado	✓	✓
Fresno	✓	✓
Glenn	✓	✓
Humboldt	✓	
Imperial	✓	✓
Inyo	✓	✓
Kern	✓	
Kings	✓	✓
Lake		
Lassen	✓	
Los Angeles		
Madera		
Marin		
Mariposa		
Mendocino	✓	
Merced	✓	
Modoc	✓	✓
Mono	✓	✓
Monterey		
Napa		
Nevada	✓	

County	Fiscal Year	
	13-14	14-15
Orange	✓	✓
Placer		
Plumas		
Riverside	✓	
Sacramento		
San Benito	✓	
San Bernardino	✓	✓
San Diego	✓	✓
San Francisco	✓	✓
San Joaquin		
San Luis Obispo	✓	✓
San Mateo		
Santa Barbara		
Santa Clara		
Santa Cruz	✓	
Shasta	✓	
Sierra		
Siskiyou		
Solano	✓	✓
Sonoma		
Stanislaus	✓	✓
Sutter-Yuba		
Tehama	✓	✓
Tri-City	✓	✓
Trinity	✓	
Tulare	✓	✓
Tuolumne	✓	✓
Ventura	✓	✓
Yolo		

Source: Kendra Penner, Legislative Coordinator, Department of Health Care Services. August 30, 2016. Personal communication with Commission staff.

Total FY 13-14	37
Total FY 14-15	26

NOTES

- 1 Department of Health Care Services (DHCS). January 2016. Mental Health Services Act Expenditure Report: Fiscal year 2016-2017. Also, Mental Health Services Oversight and Accountability Commission (MHSOAC). "Proposition 63 History." Accessed August 5, 2016 at <http://mhsaac.ca.gov/history>
- 2 Secretary of State Kevin Shelley. November 2, 2004. Official Voter Information Guide. Page 34.
- 3 Welfare & Institutions Code, Sections 5845(d)(11), 5845(d)(12), 5898, 5899(a-b).
- 4 Welfare & Institutions Code, Section 5655.
- 5 DHCS. See Endnote 1.
- 6 Karen Baylor, Deputy Director of Mental Health and Substance Use Disorder Services, DHCS. July 12, 2016. Personal communication with Commission staff.
- 7 Toby Ewing, Executive Director, MHSOAC. May 26, 2016. Testimony to the Commission. Accessed September 8, 2016 at http://calchannel.granicus.com/MediaPlayer.php?view_id=7&clip_id=3752.
- 8 Department of Health Care Services. September 23, 2015. MHSUDS Information Notice: 15-042. Subject: Annual review protocol for consolidated Specialty mental health services and other funded services for fiscal year 2015-16.
- 9 Karen Baylor, Deputy Director of Mental Health and Substance Use Disorder Services, DHCS. May 26, 2016. Testimony to the Commission.
- 10 Welfare & Institutions Code, Section 5899.
- 11 Kendra Penner, Legislative Coordinator, Department of Health Care Services. August 30, 2016. Personal communication with Commission staff.
- 12 Karen Baylor, Deputy Director of Mental Health and Substance Use Disorder Services, DHCS. September 23, 2014 and May 26, 2016. Written testimony to the Commission.
- 13 Welfare & Institutions Code, Section 5655. Also, Karen Baylor. See Endnotes 6 and 12.
- 14 Brian Sala, Deputy Director, and Filomena Yeroshek, Chief Counsel, MHSOAC. July 8, 2016. Personal communication with Commission staff.
- 15 DHCS. See Endnote 1.
- 16 Rusty Selix, Executive Director of Policy and Advocacy, Mental Health America of California. May 26, 2016. Written testimony to the Commission.
- 17 Toby Ewing. See Endnote 7, hearing video at 1:50:04 to 1:51:37.
- 18 Welfare & Institutions Code, Section 5772(b) and (c).
- 19 Welfare & Institutions Code, Sections 5820 and 5821.
- 20 DHCS. See Endnote 1.
- 21 Welfare & Institutions Code, Sections 5847 and 5848.
- 22 AB 1618 (Committee on Budget). Chapter 43, Statutes of 2016. Also, Welfare & Institutions Code, Section 5848(e).
- 23 Brian Sala. See Endnote 14.
- 24 Josephine Black, Chairperson, and Jane Adcock, Executive Officer, California Mental Health Planning Council. May 26, 2016. Written testimony to the Commission.
- 25 Darrell Steinberg, former Senate Pro Tem and Founder, Steinberg Institute. May 26, 2016. Testimony to the Commission.
- 26 MHSOAC. See Endnote 1.
- 27 MHSOAC. "County Submitted Reports." Accessed August 5, 2016 at <http://mhsaac.ca.gov/county-submitted-reports>. Also, "Ensuring Fiscal Accountability" at <http://mhsaac.ca.gov/ensuring-fiscal-accountability>. Also, "Measuring Outcomes" at <http://mhsaac.ca.gov/measuring-outcomes>.
- 28 DHCS. See Endnote 1.
- 29 Matthew Gallagher, Program Director, California Youth Empowerment Network. May 5, 2016. Public comment to the Commission.
- 30 Sally Zinman, Executive Director, California Association of Mental Health Peer Run Organizations. May 25, 2016. Written testimony to the Commission.
- 31 Toby Ewing. See Endnote 7.
- 32 Brian Sala, Deputy Director, MHSOAC. July 29, 2016. Personal communication with Commission staff.
- 33 AB 1618. See Endnote 22. Also, Welfare & Institutions Code, Section 5899.
- 34 Kendra Penner. See Endnote 11.
- 35 Rusty Selix, Executive Director of Policy and Advocacy, Mental Health America of California. May 2016. Testimony to the Commission.
- 36 DHCS. See Endnote 1.
- 37 Kevin Shelley. See Endnote 2. Pages 107-108.
- 38 Welfare & Institutions Code, Section 5892(d). Also, DHCS. See Endnote 1.
- 39 Toby Ewing. See Endnote 7.
- 40 Financial Oversight Committee, MHSOAC. Minutes. March 27, 2015. Accessed July 18, 2016 at http://archive.mhsaac.ca.gov/Meetings/docs/Meetings/2015/March/FOC/FOC_032715_Agenda.pdf.
- 41 The WayBack Machine Internet Archive. Captured January 21, 2012,

http://www.dmh.ca.gov/Prop_63/MHSA/State_Interagency_Partners.asp.

42 Darrell Steinberg. May 5, 2016. Steinberg Institute and County Behavioral Health Directors Association press event. Sacramento, California.

43 Josephine Black and Jane Adcock. See Endnote 24.

44 Toby Ewing. See Endnote 7.

45 Karen Baylor. See Endnote 9.

46 Kendra Penner, Legislative Coordinator, DHCS. July 27, 2016. Personal communication to Commission staff. Also, Renay Bradley, Director of Research and Evaluation, MHSOAC. June 10, 2016. “MHSOAC Data Strengthening Efforts.”

47 Kendra Penner, Legislative Coordinator, DHCS. July 29, 2016. Personal communication to Commission staff.

48 Dan Hon. November 30, 2015. Code for America Blog Archive. “A New Approach to Procuring Government Technology in California.” Accessed July 28, 2016 at <https://www.codeforamerica.org/blog/2015/11/30/a-new-approach-to-procuring-government-technology-in-california/>. Also, V. David Zvenyach and Andre Francisco, 18F. March 22, 2016. “From 1,500 pages to 10: Helping California buy a new Child Welfare System.” Accessed July 28, 2016 at <https://18f.gsa.gov/2016/03/22/helping-california-buy-a-new-child-welfare-system/>.

49 Debbie Innes-Gomberg, District Chief, Los Angeles County MHSA Implementation and Outcomes Division. May 26, 2016. Testimony to the Commission.

50 Adrienne Shilton, Director of Intergovernmental Affairs, County Behavioral Health Directors Association of California. July 7, 2016. Personal communication to Commission staff.

51 Debbie Innes-Gomberg, District

Chief, and Kara Taguchi, Phys.D., Los Angeles County MHSA Implementation and Outcomes Division. June 16, 2016. Personal communication with Commission Staff. Long Beach, California. Also, Debbie Innes-Gomberg, See Endnote 49.

52 Kirsten Barlow, Executive Director, Mary Ader, Deputy Director of Legislative Affairs and Adrienne Shilton, Director of Intergovernmental Affairs, County Behavioral Health Directors Association. July 6, 2016. Sacramento, CA. Personal communication with Commission staff.

53 Steinberg Institute and County Behavioral Health Directors Association. May 5, 2016. Changes to Number of Clients After Entering Full Service Partnership Program.

54 Adrienne Shilton. See Endnote 50.

55 Wayne Clark, Executive Director, California Mental Health Services Authority. May 20, 2016. Written testimony to the Commission.

56 Josephine Black, Chairperson, Mental Health Planning Council (MHPC). June 8, 2016. “Letter to Honorable Kevin de Leon, President Pro Tempore, California State Senate RE: No Place Like Home Legislation – Oppose unless amended.” Also, Josephine Black, Chairperson, MHPC. June 24, 2016. “Letter to Assembly Member Kevin McCarty RE: AB 2017 College Mental Health Services Program – Oppose.”

57 AB 847 (Mullin and Ridley-Thomas), AB 1618 (Committee on Budget), AB 2017 (McCarty), SB 614 (Leno), SB 852 (Budget Trailer Bill).

58 Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition. May 26, 2016, Testimony to the Commission.

59 California Juvenile Justice Data Working Group. January 2016. “Rebuilding California’s Juvenile Justice Data System: Recommendations to

Improve Data Collection, Performance Measures and Outcomes for California Youth.”

60 California Juvenile Justice Data Working Group. See Endnote 59.

61 Welfare & Institutions Code, Section 5848(a).

62 Rusty Selix. See Endnote 16.

63 Racial and Ethnic Mental Health Disparities Coalition (REMHDCO). July 20, 2016. Survey on Proposition 63/Mental Health Services (MHSA) community planning process.

64 REMHDCO. See Endnote 63.

65 California Mental Health Planning Council. December 2015. “We’re Listening: A Community Dialogue on Mental Health.” Also, Resource Development Associates for the MHSOAC. August 8, 2014. “MHSA Community Program Planning Processes – Promising CPP Practices.” Also, the California Stakeholder Process Coalition. April 2012. “Transforming California Mental Health System through Consumer Engagement.”

66 Mike Kennedy, Director, Sonoma County Behavioral Health Division. September 23, 2014. Written testimony to the Commission.

67 California Institute for Behavioral Health Solutions. FSP Toolkits. Accessed July 21, 2016 at <http://www.cibhs.org/introduction/fsp-toolkits>.

68 Sandra Naylor Goodwin, President and CEO, California Institute for Behavioral Health Solutions. July 21, 2016. Personal communication with Commission staff.

69 Welfare & Institutions Code, Section 5845.

70 Toby Ewing. See Endnote 7. Also, California Enacted Budget. MHSOAC. Accessed July 21, 2016 at <http://www.ebudget.ca.gov/2016-17/pdf/Enacted/GovernorsBudget/4000/4560.pdf>.

Little Hoover Commission Members

CHAIRMAN PEDRO NAVA (*D-Santa Barbara*) Appointed to the Commission by Speaker of the Assembly John Pérez in April 2013. Advisor to telecommunications industry on environmental and regulatory issues and to nonprofit organizations. Former state Assemblymember. Former civil litigator, deputy district attorney and member of the state Coastal Commission. Elected chair of the Commission in March 2014.

VICE CHAIRMAN JACK FLANIGAN (*R-Granite Bay*) Appointed to the Commission by Governor Edmund G. Brown Jr. in April 2012. A member of the Flanigan Law Firm. Co-founded California Strategies, a public affairs consulting firm, in 1997.

SCOTT BARNETT (*R-San Diego*) Appointed to the Commission by former Speaker of the Assembly Toni Atkins in February 2016. Founder of Scott Barnett LLC, a public advocacy company, whose clients include local nonprofits, public charter schools, organized labor and local businesses. Former member of Del Mar City Council and San Diego Unified School District Board of Trustees.

DAVID BEIER (*D-San Francisco*) Appointed to the Commission by Governor Edmund G. Brown Jr. in June 2014. Managing director of Bay City Capital. Former senior officer of Genetech and Amgen. Former counsel to the U.S. House of Representatives Committee on the Judiciary. Serves on the board of directors for the Constitution Project.

SENATOR ANTHONY CANNELLA (*R-Ceres*) Appointed to the Commission by the Senate Rules Committee in January 2014. Elected in November 2010 and re-elected in 2014 to the 12th Senate District. Represents Merced and San Benito counties and a portion of Fresno, Madera, Monterey and Stanislaus counties.

ASSEMBLYMEMBER CHAD MAYES (*R-Yucca Valley*) Appointed to the Commission by former Speaker of the Assembly Toni Atkins in September 2015. Elected in November 2014 to the 42nd Assembly District. Represents Beaumont, Hemet, La Quinta, Palm Desert, Palm Springs, San Jacinto, Twentynine Palms, Yucaipa, Yucca Valley and surrounding areas.

DON PERATA (*D-Orinda*) Appointed to the Commission in February 2014 and reappointed in January 2015 by the Senate Rules Committee. Political consultant. Former president pro tempore of the state Senate, from 2004 to 2008. Former Assemblymember, Alameda County supervisor and high school teacher.

ASSEMBLYMEMBER SEBASTIAN RIDLEY-THOMAS (*D-Los Angeles*) Appointed to the Commission by former Speaker of the Assembly Toni Atkins in January 2015. Elected in December 2013 to represent the 54th Assembly District. Represents Century City, Culver City, Westwood, Mar Vista, Palms, Baldwin Hills, Windsor Hills, Ladera Heights, View Park, Crenshaw, Leimert Park, Mid City, and West Los Angeles.

SENATOR RICHARD ROTH (*D-Riverside*) Appointed to the Commission by the Senate Rules Committee in February 2013. Elected in November 2012 to the 31st Senate District. Represents Corona, Coronita, Eastvale, El Cerrito, Highgrove, Home Gardens, Jurupa Valley, March Air Reserve Base, Mead Valley, Moreno Valley, Norco, Perris and Riverside.

JONATHAN SHAPIRO (*D-Beverly Hills*) Appointed to the Commission in April 2010 and reappointed in January 2014 by the Senate Rules Committee. Writer and producer for FX, HBO and Warner Brothers. Of counsel to Kirkland & Ellis. Former chief of staff to Lt. Governor Cruz Bustamante, counsel for the law firm of O'Melveny & Myers, federal prosecutor for the U.S. Department of Justice Criminal Division in Washington, D.C., and the Central District of California.

JANNA SIDLEY (*D-Los Angeles*) Appointed to the Little Hoover Commission by Governor Edmund Brown Jr. in April 2016. General counsel at the Port of Los Angeles since 2013. Former deputy city attorney at the Los Angeles City Attorney's Office from 2003 to 2013.

HELEN TORRES (*NPP-San Bernardino*) Appointed to the Little Hoover Commission by Governor Edmund Brown Jr. in April 2016. Executive director of Hispanas Organized for Political Equality (HOPE), a women's leadership and advocacy organization.

SEAN VARNER (*R-Riverside*) Appointed to the Little Hoover Commission by Governor Edmund Brown Jr. in April 2016. Managing partner at Varner & Brandt LLP where he practices as a transactional attorney focusing on mergers and acquisitions, finance, real estate and general counsel work.

“Democracy itself is a process of change, and satisfaction and complacency are enemies of good government.”

*Governor Edmund G. “Pat” Brown,
addressing the inaugural meeting of the Little Hoover Commission,
April 24, 1962, Sacramento, California*