

**The Mental Health Services Act:
Planning, Implementation and Analysis of Mental Health System Transformation in
California**

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ABSTRACT

In November 2004 California voters passed Proposition 63, which became the Mental Health Services Act (MHSA). This historic legislation places a one percent tax on adjusted gross income earnings over \$1 million that is earmarked to transform county-operated mental health services into more consumer/family-driven, culturally competent, recovery-oriented systems and reach previously unserved or underserved populations in need. The Petris Center received funding from the California HealthCare Foundation to study the implementation of the MHSA across the counties of California, and examine the changes in the financing and delivery of mental health services. The Petris Center study is using a multi-pronged approach to analyze this highly complex implementation process, including: 1) a county mental health director's survey; 2) an analysis of the Community Services and Supports plans submitted by the counties; 3) a qualitative analysis of the planning and implementation processes in 12 counties; and 4) an impact analysis of service delivery innovations. This paper summarizes the status of implementation of the MHSA, as well as preliminary results from the Petris Center's county mental health director's survey and Community Services and Supports plan analysis, and a status update on the remaining two study components.

BACKGROUND

The Mental Health Services Act

In November 2004 California voters passed Proposition 63, which became the Mental Health Services Act (MHSA). This historic legislation places a one percent tax on adjusted gross income earnings over \$1 million to create a fund that is earmarked to transform county-operated mental health services into more consumer/family-driven, culturally competent, recovery-oriented systems and reach previously unserved or underserved populations in need. The MHSA is grounded in the recognition that untreated mental illness is a leading cause of disability and imposes high costs on state and local government; that previous state budget cuts have left thousands of severely mentally ill individuals without necessary care and often homeless; and that with effective treatment and support, recovery from mental illness is possible for most people. By providing the resources and framework to expand programs and approaches that have demonstrated their effectiveness, the State of California hopes to reduce long-term adverse impacts of untreated mental illness on individuals, families, communities, as well as state and local budgets.

The MHSA provides funds for a broad spectrum of prevention, early intervention, and service initiatives, as well as money to enhance infrastructure, technology along with workforce development to support mental health system transformation.^{1,2} There are six components of MHSA which include: (1) Local Planning; (2) Education and Training; (3) Capital Facilities and Technological Needs; (4) Prevention and Early Intervention Programs; (5) Community Services and Supports for Children's, Adult, and Older Adult Systems of Care; and (6) Innovative Programs. The MHSA was initially projected to generate \$254 million in the first year (Fiscal Year 2004-05), \$683 million in FY 2005-06, \$690 million in FY 2006-07, and increasing in

subsequent years.³ Actual available funds have been much greater due in part to the health of the State's economy.

In its annual report to the legislature, the Department of Mental Health (DMH) highlighted the following accomplishments for the first year of implementation of the MHSA (FY 2005/06)³

- Initiation of an extensive transparent stakeholder advisory process;
- Development of the requirements for the statewide local planning process and distribution of funding to support those local processes;
- Development and issuance of the MHSA Community Services and Supports Three-Year Program and Expenditure Plan Requirements;
- Development of initial performance indicators to measure quality of services, productivity and positive outcomes;
- Statewide adoption of the Network of Care Web-based tool for program management, information and referral;
- Funding of the California Social Work Education Center program to recruit and train ethnically diverse students committed to working in public mental health;
- Implementation of a number of short-term strategies consistent with MHSA vision and values;
- Initiation of collaborative efforts with other state departments; and
- Establishment of the Mental Health Services Oversight and Accountability Commission.

Status of Implementation

The MHSA calls for three-year plans to be developed for each component. Each stage of implementation of the MHSA is occurring with extensive public input before the final plan is released, which has increased the original time estimates for the production of final guidelines. The Local Planning and implementation of Community Services and Supports (CSS) are well underway, and planning for the remaining four components of MHSA is currently in development. A timeline detailing the progress of planning and implementing the Act is shown in Table 1 at the end of this section.

The DMH has made the CSS component the first priority in the implementation of MHSA. Money for direct services, to be provided in a service model called Full Service Partnerships, will account for at least 50% of all MHSA funding requests. The final planning guidelines for CSS were released in August 2005, and the first county plan was submitted by Fresno in October 2005. As of March 2007, 56 counties and one city have turned in CSS plans, and 50 have been approved.⁴ The two smallest counties in the state, Alpine and Sierra, declined to participate in MHSA. Approved counties are currently in various stages of implementation. The DMH has also decided to extend the first three-year CSS plans to four years, possibly due to the lengthy plan development process.

The Education and Training component of MHSA, which is intended to expand and develop the workforce required to fully implement the legislation, is still in the development stages. DMH has completed the required needs assessment through an analysis of workforce data, evaluation of the challenges identified in the CSS plans, and stakeholder input. DMH has also produced a draft of the workforce plan for public review.⁵ The final county guidelines should be completed in June 2007. Regional partnerships on consumer and family entry

programs, psychiatry residencies and mental health career pathway programs will also be funded in 2007.⁶

The Capital Facilities and Information Technology component has been divided into 3 areas: housing, capital facilities and information technologies. The MHSA Housing program was initiated by Executive order S-07-06, which was signed by the Governor in May 2006. The program provides up to \$75 million annually of MHSA monies to fund the development, acquisition, construction and/or rehabilitation of permanent supportive housing for people with mental illness and their families, with a particular focus on those who are homeless with a mental illness. The program may also use an additional \$40 million per year available for operating subsidies. The initiative will be jointly administered by DMH and the California Housing and Finance Agency (CalHFA).⁷ A Work Group that includes stakeholders in the mental health community, the Department of Housing and Community Development (HCD), county mental health departments, the California Mental Health Director's Association (CMHDA), the Governor's office, the Corporation for Supportive Housing (CSH), The Tax Credit Allocation Committee (TCAC), Housing California and a number of housing developers was convened to formulate the final program description and requirements. The first draft of the MHSA Housing program description was released in February 2007.

While the requirements for the Capital Facilities program is still in development, the current draft proposal calls for funds to be used for acquisition, improvement and development of land, construction or renovation of buildings or facilities and/or operating capital reserves with the goal of increased the number and variety of community-based facilities that support the mental health programs and services provided by the county in the CSS and PEI components of it's three-year plan.⁸ The types of facilities proposed include wellness and recovery centers, one-

stop service centers, administrative offices and co-location of mental health with physical health clinics. The draft guidelines became available in April 2007 for stakeholder input with the goal of finalizing the plan guidelines in June and approval of submitted county plans beginning in October 2007.

While the Technology program is still in development, one goal is to create electronic health records (EHR) for consumers of county mental health services that are interoperable across counties and other health systems, portable, flexible and secure.⁹ One-time funds for information technology have already been approved in 15 counties for 25 different projects, while 10 counties with 15 different projects were under review in March 2007. DMH plans to finalize county guidelines in June 2007 and begin to approve submitted county plans beginning October 2007.

Because the legislation specifically granted the MHSOAC approval authority on the Prevention and Early Intervention (PEI) monies and initiatives, the OAC has been actively involved in developing guiding principals and priorities for the DMH to use in drafting county guidelines.¹⁰ Some of the approved policy directions include: suggestion that 51% of funds be used for those who are 25 and under (children and transition-age youth), identification of five key community mental health needs, identification of six priority populations for PEI to focus on, and recommending programs, interventions and strategies that the state supports, while giving counties the option to select alternatives with justification. The MHSOAC has stated that county plans will be evaluated on the following principles: (1) transformational strategies and actions; (2) stigma and discrimination reduction; (3) leveraging resources; (4) disparity reduction; (5) recognition of early signs; (6) integrated and coordinated systems; (7) outcomes

and effectiveness; (8) optimal points of investment; (9) user-friendly plans; (10) non-traditional mental health settings; and (11) making PEI distinct from CSS plans.

The PEI component may also include three state administered projects on suicide prevention, stigma reduction, and training in prevention and early intervention.¹¹ The first project would provide \$14 million annually for four years for suicide prevention and \$500,000 per year for two years for statewide suicide prevention strategic planning. The second project would provide \$20 million annually for four years for stigma and discrimination reduction. Lastly, \$12 million per year for 4 years would fund training and technical assistance to partners outside of the mental health system to assist in prevention and early intervention. The local plan guidelines are expected to be completed by September 2007, after which counties will begin creating plans for these projects.

Table 1. Timeline for MHSA Implementation

Timeline for MHSA implementation	
2004	
November 2, 2004	California Proposition 63 (now known as the Mental Health Services Act or MHSA) passed with 54% of the vote.
December 17, 2004	California Department of Mental Health (DMH) holds first general stakeholder meeting
2005	
January 1, 2005	MHSA becomes law
January 18, 2005	DMH released its guidelines for the County Funding Request for Mental Health Services Act (MHSA) Community Program Planning.
March 15, 2005	Deadline for counties to turn in funding requests for Community Program Planning
April 22, 2005	DMH releases funding for Community Program Planning to counties
June 1, 2005	Funding criteria for Community Services and Supports (CSS) released by DMH
July 7, 2005	First meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC)
July 18, 2005	DMH releases its policy on non-supplantation of MHSA funds
August 1, 2005	The Three Year Program and Expenditure Plan Requirements for CSS plans is released
August 22, 2005	MHSOAC holds two day retreat to outline vision and priorities
September 9, 2005	Performance Measurement Advisory Committee (PMAC) holds its first meeting
September 30, 2005	Fresno is the first county to turn in its CSS plan
October 25, 2005	Informational Technology (IT) workgroup holds its first meeting
2006	
January 24, 2006	Stanislaus is the first county to have its CSS plan approved
May 21, 2006	Governor Schwarzenegger signs executive order S-07-06, creating the MHSA housing program
October 2006	DMH completed workforce needs assessment
2007	
January 2007	1st MHSA expenditure report

PETRIS CENTER STUDY

Overview of the Study

The Petris Center received funding from the California HealthCare Foundation to study the implementation of the MHSA across the counties of California, and examine the changes in the financing and delivery of mental health services. The Petris Center study is using a multi-

pronged approach to analyze this highly complex implementation and transformational process. The four prongs of the Petris Center study include: 1) a county mental health director's survey; 2) an analysis of the Community Services and Supports plans submitted by the counties; 3) a qualitative analysis of the planning and implementation processes in 12 counties; and 4) an impact analysis of service delivery innovations. The county mental health director's survey provides a unique data set of baseline information to benchmark county performances in later years. The analysis of the CSS plans assesses the financial request data and planned resource allocation of all participating counties, and provides in-depth examination of planned programs and services in a subset of counties included in the Petris Center qualitative analysis. Through interviews with staff and stakeholders during two-day site visits, the qualitative analysis aims to compile detailed information about the management of the county mental health system and responses to the changing environment created by MHSA planning and implementation in the twelve participating counties. Lastly, the impact analysis of service delivery intends to document and uncover specific patterns of practice in the delivery of mental health services to different types of clients and thereby to learn what services funded by the MHSA work best, when, and for whom.

Director Survey Report – FY03-04 Baseline Findings

Significance

Implementation of the Mental Health Services Act (MHSA) is hoped to be a major lever of transformational change in California's public mental health system. However, in order to fully assess the impact of the changes brought about by MHSA implementation, it is necessary to have an understanding of each county's starting point. In California, each of the 58 counties is

designated as the local mental health authority responsible for providing mental health services.¹² Although the state's Department of Mental Health sets broad program and fiscal policy, the counties have significant flexibility and local control over the service delivery system resulting in significant differences in county programs across the state. Understanding these differences may prove to be key to understanding the counties' experience along with challenges and success in MHSA implementation.

Overview

In order to capture and describe at least some of the differences amongst the counties, county directors and their staff were asked to complete a written survey that would begin to address the paucity of baseline information on the state's county mental health programs from Fiscal Year 2003-2004 (FY03-04), the year prior to MHSA implementation.

The first survey was conducted in 2006, and was designed to elicit unique, specific, and detailed FY 03-04 baseline information about the county mental health departments. Survey topics included questions on:

- organizational structure, service scope, information technology
- budget/expenditures
- staffing patterns
- relationship with Mental Health Boards

Forty-four counties, accounting for 98% of California's population, returned completed surveys. Data were analyzed and descriptive summary statistics calculated for the entire state and by relevant subgroups. California is extremely diverse in multiple respects — ranging from racial and ethnic representation to differences in the size, populations, geography and wealth of counties. In order to reflect this diversity, statistics are reported by region (as established by the

California Mental Health Director's Association these include: Bay Area, Central, Southern, Superior), and by population size (small, medium, and large; corresponding to counties with populations under 200,000, between 200,000 and 800,000, and over 800,000 respectively). Los Angeles County (LA), which includes nearly one third of the state's population and has many unique program characteristics, is reported separately.

Main Findings

There is a common saying in California: "If you've seen one county, you've seen one county." All in all, the survey findings indicated that there was extensive variation in California's counties across most measures examined for FY03-04. The differences and similarities are organized into the main topic areas of the survey and summarized below.

A. Organizational structure, service scope, information technology

- While all county mental health departments report to their Boards of Supervisors and individual county executive or administrative officers (CEO or CAO), they are housed in different agencies. One quarter are located within the county Health Department, while others are either stand-alone or part of other human service agencies.
- The scope of services and past experience with grant funded, demonstration or integrative service programs varied.

One goal of MHSA is to meet the needs of the historically un-served and under-served, and deliver services under a model referred to as a "Full-Service Partnership" (FSP). FSPs integrate the delivery of all necessary mental health and other services and consumers are provided with "whatever it takes" to sustain a high quality of life and independent functioning in the least restrictive setting.

- California Assembly Bill (AB) 2034 first introduced the FSP idea, and 68% of counties are part of that program. Information on participation in and funding of this and other programs such as Children’s System of Care (CSOC), California Senate Bill (SB) 163 Wraparound (a FSP-like model), and Mentally Ill Offender Crime Reduction Grants (MIOCR) are presented in the full report. Past experience in these programs may shape how easily a county can implement FSPs under MHSA.
- Trends in information technology revealed that nearly all counties (60-90%) relied on computers for conducting administrative tasks. In contrast, less than half of counties computerized any clinical functions, with a greater proportion of smaller counties computerizing clinical activities like charting and treatment planning.

B. Budget & Expenditures

- In FY03-04, the average total mental health budget (including all sources of revenues and expenditures, including grants and county-level funding) was \$77 million, but this figure varied widely by county size.
- Counties spent 90% of their budgets on staff and services, and an average of \$5,000 per client.
- Federal Financial Participation (FFP) and other state/federal funding accounted for half the counties’ revenue.
- One-third of county revenues came from realignment.¹³
- MHSA is expected to provide about a 10% budget increase to all counties.
- In FY03-04 counties spent one third of their budgets on child and family services.
- Counties spend on average 31% of their budgets on contracted services, with Bay Area region counties and LA in particular spending a larger share of their budget.

- Very small portions of county budgets were spent on state hospital (2%) or Institute for Mental Disease (IMD) beds (4%). One goal of MHSA is to reduce the need for institutionalization by consumers.

C. Staffing Patterns

Counties will need to hire more staff in the future to support all their new and expanded programs and services under MHSA. There has been speculation already that a shortage of trained staff will be a barrier to fully implementing planned services.

- Not including contract providers, in FY03-04 county staff was 71% clinical and 29% administrative.
- Very few counties tracked staff tenure and turnover information. Half the counties used temporary hires in FY03-04, primarily to meet non-medical staffing needs. Creating new staff positions in FY 03-04 took 3-5 months on average in all counties except for LA, where it took 12 months. Once positions were created, they were usually filled within 2-3 months, and counties were fairly satisfied with the quality and number of applicants.
- Southern counties were more satisfied and Superior counties were less satisfied about the applicant pool in FY 03-04 on a 1-10 scale (with 1=not at all satisfied, and 10=very satisfied).

Notably, counties seem to do a good job of accommodating consumers' different language and translation needs.

- Sixty-four percent (64%) provided mental health services in languages beyond the minimum threshold language¹⁴ requirements.

Increasing access to care and culturally competent providers are key issues in the mental health system, particularly in a state as culturally and linguistically diverse as California.

- Analysis of data from county cultural competency reports revealed that 25% of direct service and 14% of administrative staff were bilingual in one of the nine most common non-English languages.¹⁵

Additionally, increasing meaningful consumer involvement is central to MHSA.

- In FY03-04, seven counties (16%) had a consumer as a member of the management team; 32% had a program for hiring consumers as county employees and 52% had a program for employing them as part of community based organizations.

D. Relationship with Mental Health Boards

Mental Health Boards were empowered to hear public testimony and approve the Community Services and Support (CSS) Plans for MHSA before they were submitted to the state.

- Most Boards met 11-12 times per year and the county mental health Director or representative attended virtually all Board meetings.
- Most counties reported positive relationships with their Boards (93%) and used them as resources frequently (81%) in FY 03-04.
- Southern counties gave a much higher rating of the effectiveness of their Mental Health Boards than other counties (8 vs. 5 on a 1-10 scale).

Forthcoming Final Report

The Director Survey results will provide unique baseline data for the majority of California counties for FY03-04. The California Mental Health Directors Association is currently reviewing and providing feedback on the report. The final report is expected to be publicly released in fall 2007.

Analysis of County Community Services and Supports Plans

Objectives

The Petris Center is conducting an analysis of the content of the 3-year Community Services and Supports (CSS) plans submitted by the counties to receive funds under the MHSA. The objectives of this descriptive analysis are: (1) to summarize the priorities identified by the counties to improve their mental health services and reach previously under-served populations; and (2) for the 12 counties being studied more intensively by the Petris Center, to describe the most common and the most innovative strategies for transformation of the county mental health systems into more consumer- and family-driven, culturally competent, recovery-oriented systems.

Methods

County financial request data are being compiled by CSS program type (Full Service Partnership, System Development, and Outreach and Engagement) and age group (Children/Youth/Families, Transition Age Youth, Adults, and Older Adults). Programs are also identified as targeted to the homeless, users of the criminal justice system, and specific ethnic groups. This analysis will give a statewide view of which populations will be the primary beneficiaries of MHSA CSS funds, how funding will be allocated across programs and services, the expected costs per beneficiary for different programs and services, and the level and allocation of new staff across programs.

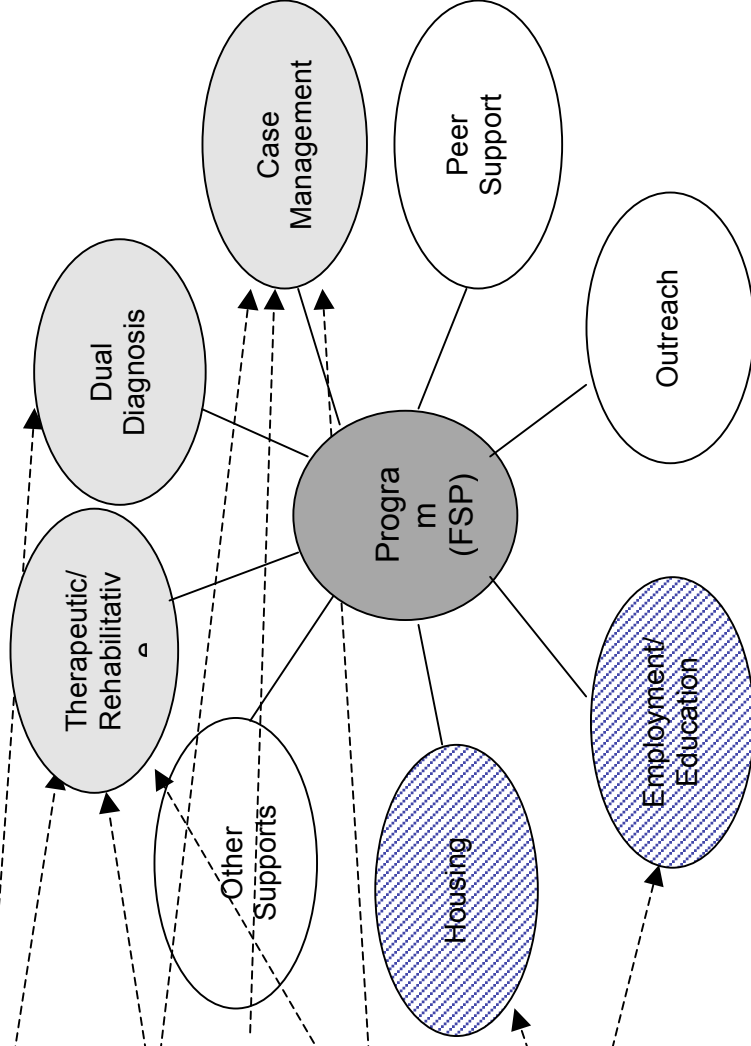
To analyze the allocation of MHSA funds to types of services, a set of 8 service categories was defined: therapeutic/rehabilitative; co-occurring disorders; case management; peer support; outreach; employment/education; housing; other supports. The 150 programs in the 12 case study plans were systematically coded to determine the array of services planned for

each program. After services in each plan were coded, the services were “mapped” to determine to what degree the programs will be comprehensive and which services are more or less likely to be provided. A sample of program mapping is shown in Figure 1.

Figure 1. Example of Program Mapping

Full Service Partnership for Older Adults

- Mobile comprehensive assessment of mental health, substance abuse, and physical health
- Outcomes-based Treatment Planning System
- Services according to client/family-driven plan of care
- Multi-disciplinary team coordinated by Personal Service Coordinator
- Crisis services 24/7
- Linkages to employment/housing resources



Preliminary Results

Preliminary results of the analysis show that there is consistency across counties in planning Full Service Partnership programs that will provide the range of services to do “whatever it takes” to partner with consumers to meet their individual recovery goals. Nearly 20 percent of the programs plan to provide, contract for, or facilitate linkages to services in all eight of the service categories, and more than 50 percent of the programs plan services in at least six of the eight service categories. More than 80 percent of programs plan therapeutic/rehabilitative services and housing services. Employment/education and peer support services, which are also important components of recovery-oriented programs, are included in nearly 70 percent of the programs reviewed.

There is also consistency across counties in the targeting of expenditures to age groups and priority populations, such as the homeless and users of the criminal justice system. All counties have integrated a variety of strategies to reach under-served ethnic minorities in their counties with more culturally competent services and to increase the number of bilingual/bicultural professionals, paraprofessionals, consumers and family members providing outreach, education, and service delivery.

There is great consistency in the plans with respect to what the counties are trying to achieve with their programs. How the counties plan to achieve these objectives and the strategies and approaches that they plan to implement are as varied and diverse as the counties themselves. A wealth of innovation and creative approaches to transforming mental health services is found in the county plans. New approaches to involving consumers and family members in service planning and delivery are evident throughout

the plans. For example, in addition to the creation of paid staff positions for consumers and family members, several counties also specify a role for consumers and family members on policy boards, cultural competency committees, and other roles in program planning and management. Creative partnerships with other government agencies and institutions, such as the law enforcement and criminal justice system, physical health care providers, educational institutions, and the private sector will create new opportunities for bringing services to those in need who have been left out of the system, and new opportunities for consumers to meet their educational, employment, and housing goals.

Qualitative Analysis

As part of the study, the Petris Center is completing an extensive qualitative analysis of the experience of the counties planning and implementing new programs funded by the MHSA. Two-day site visits have been conducted in 12 counties, which have included interviews with 25-30 staff and stakeholders, including focus groups with consumers and family members. A variety of different mental health staff were interviewed, including individuals who are involved in cultural competency, quality assurance, finance, consumer affairs or patient advocacy, and data analysis, as well as line staff and managers, and contracted providers. A number of stakeholders outside of the mental health department were also interviewed, including CSS plan consultants, local NAMI representatives, board of supervisor representatives and union representatives.

The goal of the first set of site visits was to gather information about; 1) the history and background of the county prior to MHSA in order to learn what strengths and challenges the county might encounter in implementing MHSA; and 2) the stakeholder

planning process in each county to determine what lessons were learned about outreach, the needs of the communities, collaboration, and potential barriers to implementation. In-depth qualitative analysis of the interviews using Atlas.ti will be performed. Some of the emerging themes that may be examined include tensions between the inclusiveness and speed of the planning process, definitions of wellness and recovery, as well as baseline orientation, community needs, staffing issues, institutional or organizational barriers to change, and experience with innovative programs prior to MHSA.

Impact Analysis

After a lengthy and rigorous process, the Petris Center has obtained approval from the institutional review boards of both the University of California and the State of California to obtain state data on individuals who use the public mental health system, including new data being collected on recovery-oriented programs now being implemented in counties across the state. Our research will employ rigorous security controls to ensure the privacy of all individuals whose data we will be analyzing as required by both the University of California and the State of California. We plan to use this data to statistically model the effects of the Mental Health Services Act (MHSA), including a base-line analysis of the system before the implementation of MHSA, an analysis of the system during implementation, and an analysis of the system once MHSA is fully implemented.

The Petris Center has also obtained approval from the institutional review board of the University of California and is currently in the process of obtaining approval from the institutional review board of the county of Los Angeles to study data from the

Village, the innovative and successful program in Long Beach for seriously mentally ill adults. The success of the Village was influential in the design of the Mental Health Services Act. The Petris Center, in collaboration with senior staff from the Village, will use rigorous statistical methods to study the process by which the Village achieves its results.

The results of these studies will allow the Petris Center to release reports that will aid the State of California, individual counties, policy makers, consumers, and interested individuals in understanding the aspects of MHSA that are most successful.

CONCLUSIONS

California is now early in the second year of implementation of the county programs funded by Community Services and Supports funds of the Mental Health Services Act. It is too early to draw any conclusions about the programs, their effectiveness, or whether they will indeed spark the intended transformation of the state mental health system. There are many lessons to be learned, however, from California's approach to laying the legislative and policy foundation and creating a process for an unprecedented synergy between top-down goals and over-arching principles and bottom-up stakeholder input. This process is already shaping a transformation that will truly reflect both the consensus on the values that should drive the mental health system and the tremendous diversity in the needs, priorities, and cultural values among California's mental health consumers, family members, and communities.

There are many obstacles to the successful implementation of these ambitious county plans. There is a challenge to maintain the participatory approach and open

dialogue of the planning process through program implementation. The success of the programs will also depend largely on the ability of the counties to recruit, hire, train and retain qualified staff, consumers and family members who reflect the cultural and linguistic diversity of the consumers and are committed to integrating recovery principles into all aspects of program implementation. The clear vision of the legislation and the Department of Mental Health together with the comprehensive, broad-based county planning processes give the counties clear roadmaps to proceed with implementation and a reason to be optimistic about managing the obstacles that may appear on the road ahead. The Petris Center hopes to contribute to understanding this complex transformation process by providing a multi-faceted objective analysis of the counties' plans and approaches, the strategies and challenges of the implementation process, and ultimately the outcomes for the intended beneficiaries of this historic legislation.

¹ State of California, Department of Mental Health. Program Expenditure Plan Requirements for Mental Health Services Act—Community Services and Supports. August 1, 2005.

² State of California. Mental Health Services Act. 2005.

³ State of California, Department of Mental Health. Mental Health Services Act Expenditure Report. Fiscal Year 2005-2006. January 2006.

⁴ Information compiled by the Petris Center from DMH's MHSAs Website:
<http://www.dmh.ca.gov/mhsa/CSS-Requirements.asp>. Last Accessed April, 20, 2007

⁵ MHSAs Legislative report

⁶ DMH estimated timeframe for implementation

⁷ California Department of Mental Health. Draft- Mental Health Service Act Housing Program. February 28, 2007. <http://www.dmh.ca.gov/mhsa/docs/DraftMHSAsHousingProgramDescription2-26-07.pdf>. Last Accessed April, 20, 2007

⁸ Mental Health Services Oversight and Accountability Commission. MHSAs Capital Facilities. Oversight and Accountability Commission Meeting March 22, 2007. PowerPoint presentation at MHSOAC meeting March 22, 2007

⁹ California Department of Mental Health. Mental Health Service Act Technology, Approach and Timeline. March 22, 2007. PowerPoint presentation at MHSOAC meeting on March 22, 2007.

¹⁰ Mental Health Services Oversight and Accountability Commission. Mental Health Services Act Prevention and Early Intervention: County and State Level Policy Direction.

<http://www.dmh.ca.gov/MHSOAC/docs/PolicyRecMHSAsPEI.pdf>. Last Accessed April, 20, 2007

¹¹ Mental Health Services Oversight and Accountability Commission. Prevention and Early Intervention (PEI) Stakeholder Workshops (PowerPoint).

http://www.dmh.ca.gov/MHSAs/docs/PEI_April_Stakeholder_Workshop_ppt_BW.pdf. Last Accessed April, 20, 2007

¹² For additional background information on the mental health system in California and MHSAs, see "History of Public Mental Health in California and the U.S." from the UC Berkeley Center for Mental Health Services Research. <http://ist-socrates.berkeley.edu/~cmhsr/history.html>. See also the UC Berkeley Petris Center 2006 Symposium briefing paper "Proposition 63/The Mental Health Services Act (MHSAs): A Research Agenda" at http://www.petris.org/Docs/PetrisBriefingPaper_MentalHealthServicesAct.pdf [Accessed 3/26/07].

¹³ Legislation that shifted administrative and fiscal responsibility for health, social and mental health services from the state to counties.

¹⁴ A *threshold language* is defined by a population of greater than 3,000 beneficiaries or 5% of the Medi-Cal (California's Medicaid) population (whichever is lower) that speaks a language other than English.

¹⁵ Spanish, Chinese, Vietnamese, Hmong, Lao, Mien, Cambodian, Farsi, or Russian.