California State Auditor FACT SHEET

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Mental Health Services Act

The State's Oversight Has Provided Little Assurance of the Act's Effectiveness, and Some Counties Can Improve Measurement of Their Program Performance

BACKGROUND

Because untreated mental illness is the leading cause of disability and suicide and affects state and local government, California voters approved in 2004 the Mental Health Services Act (MHSA), which levies a 1 percent income tax on individuals earning more than $1 million to provide funding for programs within five mental health service components. These funds expand services and programs that serve California's mentally ill and use innovative methods more likely to identify, mitigate, prevent, and treat mental illness. The responsibility of overseeing MHSA programs was primarily assigned to the California Department of Mental Health (Mental Health) and the Mental Health Services Oversight and Accountability Commission (Accountability Commission). However, changes in law effective June 2012 transferred nearly all remaining MHSA functions from Mental Health to the California Department of Health Care Services (Health Care Services), the Accountability Commission, or the Office of Statewide Health Planning and Development.

KEY FINDINGS

During our review of the MHSA, we noted the following:

- Although the MHSA has funded many programs and served numerous individuals, Mental Health and the Accountability Commission did not provide the oversight needed to demonstrate whether the MHSA is effective.
  - ✓ We found no evidence that Mental Health conducted systematic monitoring to ensure that counties appropriately implemented their state-approved MHSA plans.
  - ✓ Mental Health did not provide explicit direction to counties on how to effectively evaluate their programs and did not issue regulations for three of the five MHSA components.
  - ✓ Despite its charge to evaluate the MHSA, the Accountability Commission has been slow to establish a necessary framework and did not believe it had a clear responsibility to evaluate until 2009, even though its purpose has not changed since 2004 when the MHSA was approved.
- Mental Health required counties to report extensive MHSA data, but the data was incomplete and of limited value in measuring MHSA program effectiveness.
- The counties' MHSA funding allocations may not be appropriate—the methodology used to calculate the funding levels was developed in 2005 and the demographic factors used to calculate the funding have not been updated since 2008.
- Each of the four county departments we reviewed used different and inconsistent approaches in assessing and reporting on their MHSA programs, and the county departments rarely developed specific objectives to assess the effectiveness of the programs.
- Although each of the four county departments we visited included stakeholders and community representatives throughout the MHSA planning process, some counties did not document or describe in their plans of the MHSA programs certain aspects of the public review process.

KEY RECOMMENDATIONS

We made several recommendations to Health Care Services—the new oversight entity—to monitor counties to the fullest extent, including that it conduct comprehensive on-site reviews, draft performance contracts with counties that assure effective oversight, and adopt best practices when possible. We also recommended that performance contracts with counties specify program goals and data to measure performance. Further, Health Care Services should collaborate with the Accountability Commission to develop needed guidance or regulations on evaluating and reporting on county program performance. Also, we recommended that certain counties review and amend their current contracts as needed to include plan goals.

Date: August 15, 2013 **Report: 2012-122**