



## **Transition Plan**

Transfer of The Department of Mental Health's Community Mental Health Programs  
to Other State Departments and Organizations  
Effective July 1, 2012

Submitted by The Department of Mental Health  
Consistent with Provision 3, Item 4440-001 of the Budget of 2011

May 18, 2012



C A L I F O R N I A   D E P A R T M E N T   O F

# Mental Health

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May 18, 2012

To: All Community Mental Health Stakeholders

As California continues to redirect and realign community mental health services to the local level in a design to bring services closer to the people, we are thankful for your attentive, patient, persuasive, and persistent participation in our transition planning initiatives.

This 2012 Community Mental Health Transition Plan is designed to provide details about the specific functions formerly managed by the California Department of Mental Health's (DMH) Office of Community Services (OCS) and where they are proposed to be aligned in state government operations effective July 01, 2012.

In October 2011, a summary report about the 2011 Statewide Stakeholder Summer Themes and Issues was released by DMH. This summary was complimented by over 20 letters or papers that provided us with recommendations about ways to improve state and local administration of community mental health programs in a realigned environment. The Administration took these suggestions very seriously, and in this report, you will see that influence reflected in the transition proposals.

I want to once again convey our sincere appreciation to over 1,000 stakeholders who participated in our 2011 Statewide Stakeholder Summer. I am also grateful to the county mental health leaders who welcomed us and supported the meetings with consumer outreach, leadership participation, and logistical support.

With your continued engagement, we will make every effort to effectively implement a smooth transition of community mental health programs in these very difficult times.

Sincerely,

CLIFF ALLENBY  
Acting Director

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## EXECUTIVE SUMMARY

Governor Edmund G. Brown Jr., in both his 2011 and 2012 annual budgets, seeks, through administrative and programmatic decisions, to achieve efficiencies while at the same time maintaining the integrity of many critical programs. To this end, the Governor's 2011 May Revision to the FY 2011-12 Budget described his intent to propose a reorganization of the Departments of Mental Health (DMH) and Alcohol and Drug Programs (ADP) in his 2011 May Revision to the budget and proposed the creation of the Department of State Hospitals.

Presuming passage of the Administration's proposed trailer bill on July 1, 2012, many of the remaining community services functions, programs, responsibilities and resources would transfer out of DMH. This includes 58.0 DMH staff positions and state operations funding and local assistance contracts totaling \$104.7 million. These will transfer to the Department of Health Care Services (DHCS) under the leadership of the newly created Deputy Director of Mental Health and Substance Use Disorder Services, as well as the Department of Public Health (DPH), including its proposed Office of Health Equity, Department of Social Services (DSS), Office of Statewide Health Planning and Development (OSHPD), Department of Education (CDE) and the Mental Health Services Oversight and Accountability Commission (MHSOAC). The first part of this reorganization commenced with the September 2011 transfer of DMH's Medi-Cal programs and staff to DHCS, approved as a part of last year's budget process. This staff transfer was administrative only given that DHCS does not have legal authority to administer the program until July, 1 2012.

Under the direction of DMH Executive Management, the Office of Community Services is developing this transition plan in response to California Fiscal Year 2011-2012 Budget Line Item 4440-001-0001(3) SB 87, Chapter 33, Statutes of 2011 (Appendix A), requiring a transition plan to be presented to the Legislature. This transition plan describes how DMH conferred with stakeholders and the input they provided. The plan describes current DMH organization placement and descriptions of the transferring non-Medi-Cal DMH functions and staff. This plan is being released at May Revision to reflect the adjustments and most current information available.

Care will continue with the decision making process so that observations, comments and input from all stakeholders as well as program partners is considered to ensure that the transition is smooth and in keeping with the principle of realignment and effective State government. The Transition Plan will provide an overview of the proposed changes by program/function, department and funding.

## **Transition Activities**

### *MHSA Housing and Community Programs Support Unit*

The MHSA Housing and Community Programs Support Unit, in order to commence the transition process, is initiating a project management charter to capture and address the transition from DMH to DHCS and OSHPD. Staff is now participating in DHCS/OSHPD transition team meetings.

Below is the preliminary scope to complete the transition:

- Meet with DHCS/OSHPD facilities to determine space (logistical and infrastructure and respective system requirements);
- Meet with DHCS to clarify policy issues related to the MHSA Housing Program Interagency Agreement, disposition of funds currently held at CalHFA, and changes in requirements for small counties;
- Meet with DHCS to clarify fiscal policy issues related to Annual MHSA Revenue and Expenditure Report, Reversion, Component Allocations, and Prudent Reserve;
- Meet with DHCS to clarify program issues related to annual updates, Information Notices, Regulations;
- Meet with DHCS/OSHPD staff to determine integration of programs; and,
- Review and prepare contracts for transfer.

### *The Office of Suicide Prevention and State Level Prevention and Early Intervention Initiative Unit*

The Office of Suicide Prevention and State Level Prevention and Early Intervention Initiative Unit, in order to commence the transition process, is initiating a project management charter to capture and address the transition from DMH to DHCS. Staff have also participated in a meet and greet with DHCS' Chief Deputy Director and DHCS' Acting Deputy Director of Mental Health and Substance Use Disorder Services.

Below is the preliminary scope to complete the transition:

- Meet with DHCS staff to determine future of State Level Prevention Programs;
- Define the role of the State Level Prevention Unit in the implementation of the three Statewide Projects, Suicide Prevention, Stigma and Discrimination Reduction and Student Mental Health, being implemented by CalMHSA;
- Define the role of the Office of Suicide Prevention. When the Office was established, it was envisioned as having a role on program implementation, but with no funding and the current loss of positions, the Office has not been able to do the work as originally envisioned;
- Define the role DHCS has regarding the MHSA State Interagency MOUs and BCPs that DMH had developed with these agencies; and,

- Meet with DHCS facilities to determine space needs (logistical and infrastructure and respective system requirements).

### *The Office of Multicultural Services*

The Office of Multicultural Services, in order to commence the transition process, is initiating project management planning to capture and address the transition from DMH to DPH. OMS staff is now participating in DPH transition team meetings.

Below is the preliminary scope to complete the transition plan:

- Meet with DMH leadership regarding the future of the CRDP and the \$60 million for the implementation phase;
- Meet with DPH leadership to provide an overview of current OMS functions and activities, to learn more about the proposed Office of Health Equity's guiding principles, and the role of the Cultural Competence Advisory Committee;
- Meet with DPH and DHCS leadership to discuss the role OMS staff will have as subject matter experts in providing consultation and technical assistance to DHCS staff relative to the county Cultural Competence Plan Requirements;
- Meet with DPH facilities to determine space (logistical, infrastructure and respective system requirements);
- Maintain communication with contractors to ensure a successful transition of contracts by providing updated contact information and written notification of any deviation of contract oversight, terms, etc.; and,
- Keep stakeholders informed of transition activities via committee participation, emails and conference calls.

### *The Federal and State Grants and Data Management Unit*

The Federal and State Grants and Data Management Unit, in order to commence the transition process, is initiating a project management charter to capture and address the transition from DMH to DHCS. OCS staff is also participating in DHCS transition team meetings.

Below is the preliminary scope to complete the transition:

- Meet with DHCS to clarify policy issues and fiscal issues related to the administration and implementation of the Olmstead Grant, Community Mental Health Services Block Grant (MHBG) and Projects for Assistance in Transition from Homelessness (PATH) Grants, and changes in requirements for small counties;
- DMH shall review the retention requirements for Olmstead contract, County MHBG applications, County PATH applications, and any other fiscal-related reports;
- Meet with DHCS facilities to determine space for grant staff (logistical, infrastructure and respective system requirements);
- Meet with DHCS to clarify data issues related to current data systems and compatibility;

- Meet with DHCS to clarify program issues related to annual updates, Information Notices, and Regulations;
- Meet with DHCS facilities to determine space for research data staff (logistical, infrastructure and respective system requirements);
- Meet with DHCS to clarify policy issues related to the administration and implementation of the DIG and MHBG grants;
- Meet with DHCS to clarify fiscal policy issues related to the DIG and MHBG grants; and,
- Meet with DHCS regarding issues related to responsibility for the Consumer Perception Survey.

### *California Mental Health Planning Council (CMHPC)*

The CMHPC, in order to commence the transition process, is initiating a project management charter to capture and address the transition from DMH to DHCS.

Below is the preliminary scope to complete the transition:

- Determine which documents to bring to DHCS, which documents to scan and store electronically, which documents to archive and which to discard;
- Meet with DHCS leadership to clarify roles, functions, procedures, lines of communication, etc.;
- Review existing advisory structures within DHCS to discern connections, intersections and applicable policies/procedures for operation;
- Meet with DHCS facilities staff to determine space and infrastructure needs;
- Meet with DHCS technology staff to discuss public access via technology, in order to notify and advise public in advance; and,
- Develop a plan to brief Planning Council members including a joint meeting with CMHPC membership and DHCS leadership; and,

### *Licensing and Certification (L&C) Branch*

The L&C Branch, in order to commence the transition process, is initiating a project management charter to capture and address the transition from DMH to DSS and DHCS.

Below is the preliminary scope to complete the transition:

- Determine which documents to bring to either DHCS and DSS, which documents to scan and store electronically, which documents to archive and which to discard;
- Meet with DHCS and DSS leaderships to clarify roles, functions, procedures, lines of communication, etc.;
- Review existing advisory structures within DHCS and DSS to discern connections, intersections and applicable policies/procedures for operation; and,
- Meet with DHCS and DSS facilities staff to determine space and infrastructure needs.

## **INTRODUCTION/BACKGROUND**

In January 2011, Governor Edmund G. Brown Jr. released his budget proposal designed to achieve state administrative efficiencies and bring services closer to the people through several state and local realignment proposals. As a part of last year's budget process, the Legislature approved the transfer of the Medi-Cal functions of the Department of Mental Health (DMH) and Department of Alcohol and Drug Programs (ADP) to the Department of Health Care Services (DHCS). DHCS will house these programs under the leadership of the new Deputy Director of Mental Health and Substance Use Disorders Services. Under the Governor's Budget for 2012-13, the remaining functions from DMH and ADP are proposed to transfer to DHCS and to other receiving departments on July 1, 2012.

In preparation for the transition of functions out of DMH, the Fiscal Year (FY) 2011-2012 State Budget Item 4440-001-0001(3), SB 87, Chapter 33, Statutes of 2011, called for a transition plan to be developed and presented to the Legislature. (Appendix B)

California's administration of community mental health programs is undergoing significant change. The FY 2011-2012 State Budget and associated trailer bills -- Assembly Bill 100, Chapter 5, Statutes of 2011 and 102, Chapter 29, Statutes of 2011-- significantly reduced the State's role in administering the Mental Health Services Act (MHSA) and authorized the transfer of all Medi-Cal Specialty Mental Health functions to DHCS. (Appendices C and D)

In addition to the transfer and realignment of specified DMH community programs, changes enacted in Assembly Bill 100, passed as a part of the budget process last year, include:

- Elimination of state level review and approval of county MHSA plans and expenditures by DMH and the Mental Health Services Oversight and Accountability Commission (MHSOAC);
- Replacement of DMH with the MHSOAC for providing technical assistance to counties on MHSA Plans;
- Reduction of the maximum amount available for state administration of the MHSA from 5 percent to 3.5 percent; and,
- Elimination of 123 DMH staff positions to conform to the State's reduced role in administration of the MHSA.

## REQUEST FOR STAKEHOLDER INPUT

In August 2011, DMH leaders launched a Statewide Stakeholder Summer process that was designed to hear the public's ideas, concerns, issues, and solutions about how to address the needs of community mental health clients in the restructured environment. Specific education sessions and presentations were developed to effectively inform the public about the options available and solicit ideas on the best approach to ensure better mental health program service delivery and more system efficiencies.

Over the course of the DMH 2011 Stakeholder Summer, DMH heard from over 1,000 consumers, family members, private providers, county representatives, local and state level consumer groups, and county organizations. Each region was represented with the following cities hosting a Stakeholder Summer meeting:

- Sacramento (Kick-off Meeting) August 2, 2011
- Chico August 8, 2011
- Napa August 12, 2011
- Fresno August 16, 2011
- Sacramento (NAMI CA) August 18, 2011
- Los Angeles August 25, 2011
- San Bernardino August 26, 2011
- San Luis Obispo September 1, 2011
- City of Berkeley September 6, 2011
- Sacramento (CMHDA) September 7, 2011

The feedback collected by DMH was shared in the October 2011 Community Stakeholder Summer Final Summary Report. (Appendix E) This was an important factor in the Administration's decisions about the placement of state level program functions for mental health administration. The Stakeholder feedback is categorized into five overarching themes:

### 1. Concerns Regarding State Level Mental Health, including:

- A need for State level executive leadership for mental health;
- Continuing State oversight of programs;
- Maintaining the essential functions of program evaluation and quality improvement;
- Maintaining mental health's importance in the new "agency"; and,
- Ensuring mental health expertise is not lost.

### 2. Benefits and Challenges of Local Control, including:

- A larger role for local mental health board and commissions;
- Less bureaucracy;
- Improved data access;

- Local agencies may be challenged by having new financial responsibilities;
- A need to maintain local accountability; and,
- A challenge to continue “statewideness” of best practices and reporting.

3. Importance of Cultural Competence Leadership and Reducing Disparities Priorities, including:

- Keeping cultural competence and reducing disparities as high priorities; and,
- A need for State leadership of cultural competence at the highest level in a state department is a stakeholder preference.

4. Integrity of the Mental Health Services (MHSA) Act, including:

- Maintaining the achievements of the MHSA through realignment;
- Maintaining the focus on wellness and resiliency;
- Continuing to strive for an integrated service experience; and,
- Keeping focus on prevention and early intervention.

5. Role of Mental Health Consumers and their Families, including:

- Ensuring that stakeholders will not lose their existing power in realignment; and,
- A realization that this is an opportunity for new voices to be heard.

DMH is committed to and continues to hold an ongoing stakeholder process as the transition of mental health services progresses. Stakeholders are invited to participate in the stakeholder meetings that help guide the development of the Department’s transition plan. These stakeholder meetings provide government partners, advocacy organizations, consumers, family members, and community members with an opportunity to further explore and communicate on the transition of non-Medi-Cal mental health functions from DMH to the new “home” for community mental health services.

Since the Summer Stakeholder Meetings, DMH has held the following Stakeholder conference calls:

- October 27, 2011
- November 29, 2011
- December 21, 2011
- January 20, 2012

The minutes for these meetings and stakeholder correspondence regarding the transition (Appendix F) are located on the DMH website, and can be found in the DMH Stakeholder section at the link below:

[http://www.dmh.ca.gov/Services\\_and\\_Programs/Medi\\_Cal/Medi\\_Cal\\_Transfer.asp](http://www.dmh.ca.gov/Services_and_Programs/Medi_Cal/Medi_Cal_Transfer.asp)

## **GOVERNOR'S 2012 BUDGET PROPOSAL**

In January 2012, Governor Brown released his FY 2012-2013 Budget proposal that included the proposals for community mental health state administrative program transfer. Aligned with much of the input received by the 2011 Summer Stakeholder process, the Governor placed the majority of DMH community program administration within the Department of Healthcare Services (DHCS).

A principal benefit of this proposal is the consolidation of mental health and substance use disorder policy leadership under the new Deputy Director of Mental Health and Substance Use Disorders Services. The creation of an organization within DHCS dedicated to mental health and substance use disorder services will help to improve the overall health status of individuals with mental illnesses.

This will also align California with its partners at the county and federal levels, as other states have already done. Currently, more than 50 of the 58 counties, the federal Substance Abuse and Mental Health Services Administration (SAMHSA), and over 30 states and territories have already moved to administratively integrate these critical areas of health.

Specifically, the Governor's FY 2012-2013 Budget proposes the state administration reorganization for personnel, contracts and resources currently administered by DMH. (Appendix G)

## **PART A – ADMINISTRATIVE TRANSITION**

### **Consumer Group/Stakeholder/California Institute for Mental Health Contracts**

The MHSA Housing and Community Program Support unit provides support to the Director's office for reviewing and approving invoices from seven contracts and the Office of Multicultural Services provide supports for the remaining contract as identified in the two charts that follow. Additionally, the Unit is responsible for the oversight and contract development of the California Institute for Mental Health (CIMH) contract in the current fiscal year.

**MHSA Housing & Community Programs  
Consumer Group/Stakeholder/California Institute for Mental Health Contracts**

<b>Contractor</b>	<b>Amount</b>	<b>Term</b>	<b>Deliverable</b>
1. CA Association of Local Mental Health Boards and Commissions	\$166,500	FY 2010/11 – 2012/13	4 meetings per year on Support, Education, Training and Technical Assistance
2. California Mental Health Services Authority	\$160,000,000	FY 2009/10 – 2013/14	Develop Prevention and Early Intervention (PEI) statewide projects for MHSA
3. National Alliance on Mental Health	\$1,909,197	FY 2009/10 – 2012/13	Peer to Peer Education and Training – Family to Family Education and Training and Self-Help Web site project
4. California Client Network	\$1,643,850	FY 2009/10 – 2012/13	Self-help, peer support, public education on policy for clients, cultural competency training, outreach, employment and career development
5. California Institute for Mental Health	\$4,144,000	FY 2011/12-2012-13	For MHSA: General Information Dissemination, Technical Assistance, Monitoring and Evaluation
6. United Advocates for Children and Families	\$581,485	FY 2011/12-2013-14	To increase meaningful participation of parents and caregivers in the development and maintenance of local mental health service systems.
7. United Advocates for Children and Families	\$630,000	FY 2011/12-2013/14	To develop a multi-media, multi-language “Gateway to Hope” project that connects broad band technology and traditional service delivery systems.

**Office of Multicultural Services  
California Reducing Disparities Project (CRDP)**

<b>Contractor</b>	<b>Amount</b>	<b>Term</b>	<b>Deliverable</b>
1. Mental Health Association in California	\$1,000,000	FY 2009/10 – 2014/15	Statewide Coalition on Reducing Disparities for Racial, Ethnic and Multicultural Communities
2. California Pan-Ethnic Health Network, Inc.	\$262,713	FY 2009/10 – 2011/12	Statewide Strategic Plan for Reducing Disparities
3. African American Health Institute of San Bernardino County	\$411,052	FY 2009/10 – 2011/12	Reducing Disparities Population Report for the African American Community
4. Pacific Clinics	\$470,000	FY 2009/10 – 2011/12	Reducing Disparities Population Report for the Asian Pacific Islander Community
5. Native American Health Center Inc.	\$470,000	FY 2009/10 – 2011/12	Reducing Disparities Population Report for the Native American Community
6. The Regents of the University of California	\$469,736	FY 2009/10 – 2011/12	Reducing Disparities Population Report for the Latino Community
7. Equality California Institute, Inc.	\$444,000	FY 2009/10 – 2011/12	Reducing Disparities Report for the Lesbian, Gay, Bisexual and Transgender (LGBT) Community.

For a complete list of contracts, see Appendix G.

## TIMELINE for Transition Plan Development

March 2011	AB 100 Chaptered
June 2011	AB 102 Chaptered
June – August 2011	DMH prepares to transition staff working primarily on Medi-Cal functions to DHCS
August – September 2011	DMH convenes a series of stakeholder meetings to discuss the proposed elimination of DMH
September 2011	DMH/Medi-Cal staff transfer to DHCS payroll
September – December 2011	DMH External Workgroup reviews regulations, county notices
October 2011	Community Stakeholder Summer Final Summary Report completed
January 2012	Governor Brown releases FY 2012-2013 Budget providing for the elimination of DMH and the transfer of existing programs to other state agencies
January 2012- March 2012	DMH/DHCS and Agency TBL Meetings
January 2012-July 2012	DMH Transition Meetings with DHCS, DPH, OSHPD, MHSOAC, Planning Council, and CMHDA
January 10, 2012	DMH Office of Community Services staff participates in a meet and greet with the Chief Deputy Directors and Deputy Directors of DHCS, DPH, OSHPD, and Social Services
January 20, 2012	DMH convenes Community Stakeholder Meeting with 228 phone lines. Presentation on Governor's Budget with representatives from DHCS, DPH, OSHPD, DSS, MHSOAC, and Mental Health Planning Council
May 14- 2012	DMH Transition Plan submitted to the Legislature
February – June 2012	DMH inventory of documents and contracts
February – June 2012	Meet with DHCS, OSHPD, MHSOAC, DPH and DSS staff to evaluate placement of programs and project management plans related to respective program transfer
February – June 2012	Logistically prepare for transition to respective state departments
July 2012	Target date for transfer of all DMH functions

### Changes to DMH Organizational Structure

With the passage of AB 100 and AB 102, DMH has undergone significant personnel changes. See Appendices G1 and G2 for DMH and Office of Community Services organizational charts.

## **PART B – PROGRAMMATIC TRANSITION**

### **OFFICE OF COMMUNITY SERVICES**

The Office of Community Services (OCS) represents the reorganized former Department of Mental Health Community Services Division (CSD) that, prior to AB 100 and AB 102 was organized into three Branches and one Section with a total of 147 positions. CSD had been responsible for administration of the Mental Health Services Act (MHSA) and Medi-Cal Specialty Mental Health, and Managed Care programs, which supported county mental health departments that provided, or contracted to provide, direct services to individuals with a mental illness.

OCS is currently managed by a Career Executive Assignment II position and organized into the following units that are managed by three Staff Service Manager I positions and a Health Education Consultant III.

#### **I. Mental Health Services Act (MHSA) Housing and Community Programs Support Unit**

- MHSA Housing Program
- MHSA Regulations
- DMH Letters and Information Notices
- MHSA Workforce Education and Training (WET)
- Fiscal Responsibilities
  - Annual MHSA Revenue and Expenditure Report (RER)
  - Reversion
- MHSA Issue Resolution Process
- Caregiver Resource Centers (CRC)
- Interagency Agreements

#### **II. Office of Suicide Prevention/State Level Prevention and Early Intervention Initiative Unit**

- Office of Suicide Prevention (OSP)
- Stigma and Discrimination Reduction
- Student Mental Health Initiative
- Veterans Mental Health
- Memorandum of Understanding

#### **III. Office of Multicultural Services Unit**

- Cultural Competence Plan Requirements (CCPR)
- California Reducing Disparities Project (CRDP)
- Cultural Competency Consultants
- Cultural Competence Regional Trainings

- Interpreter Training Program
- Interpreters for Stakeholder Meetings
- Committees

#### **IV. Grants and Data Management Unit**

- Grants Management
  - Substance Abuse and Mental Health Services Administration (SAMHSA) Grants
    - Community Mental Health Services Block (MHBG) Grant
    - Projects for Assistance in Transition from Homelessness
    - (PATH) Grant
  - Olmstead Grant
  - The Early Mental Health Initiative (EMHI) Program
- Data Management
  - Data Collection and Reporting (DCR)
  - Client Services Information (CSI) system
  - Management of SAMHSA's Data Infrastructure Grant (DIG)
  - Federal Reporting
  - Consumer Perception Survey (CPS) (Pursuant to federal SAMHSA Grant)
  - MHSAs Exhibit 6

#### **I. MHSAs HOUSING AND COMMUNITY PROGRAMS SUPPORT UNIT**

As part of last year's budget process, 7 MHSAs positions were retained to perform the work of the MHSAs Housing Program. Due to the workload associated with all of the remaining pieces of the MHSAs still at DMH, as well as the workload carried by the other units remaining at DMH, this Unit took on all the projects related to the MHSAs (invoicing of the CiMH contract, Revenue and Expenditure Report, Regulations, Issue Resolution Process, Caregiver Resource Centers, Workforce Education and Training, MHSAs Reversion, review of Information Notices, among others) to prepare for DMH's new role and responsibilities under AB 100 and AB 102.

This unit manages the \$400 million MHSAs Housing Program, the \$12 million (annual) Workforce Education and Training Statewide Project, the \$4.1 million CiMH contract, as well as serves as subject matter experts for all issues and policies related to the implementation of the MHSAs.

#### **MHSAs Housing Program**

In August 2008, DMH and the California Housing Finance Agency (CalHFA), in response to Executive Order S-07-06, implemented the MHSAs Housing Program, which provides funding for development, acquisition, construction and/or rehabilitation of

permanent supportive housing for individuals and their families who have a mental illness and are homeless, or at risk of homelessness.

In agreements reached with the California Mental Health Directors Association (CMHDA) and stakeholders, this program was funded with \$400 million from MHSAs Community Services and Supports funds.

Through an Interagency Agreement with CalHFA<sup>1</sup>, DMH is currently responsible for:

- Review and approval of the supportive service plan submitted for each proposed development;
- Monitoring outcome reporting data collection;
- Reviewing requests for changes to supportive service plans and budgets during/after program implementation; and,
- Preparing the semi-annual updates to the Legislature.

As of January 2012, the MHSAs Housing Program has received over 129 development applications requesting a total of \$271.3 million. There is approximately \$128.7 million currently available in the MHSAs Housing Program Fund.

The Governor's Budget proposes to transfer this program to DHCS.

### **MHSA Regulations**

Regulations related to implementing the MHSAs were started in early 2007. It was DMH's intent to develop regulations as each of the major components of the MHSAs was launched. Due to the extensive stakeholder process involved with the development and promulgation of regulations, only the Community Services and Supports (CSS) and Workforce Education and Training (WET) regulations were adopted in 2008.

After the passage of AB 100 and the recommendations of the AB 100 Workgroup, DMH determined that work on new regulations would be put on hold. The regulations, which had gone to public hearing, were allowed to expire and no new regulations have been developed. It is the intent of DMH to review regulations currently promulgated to determine their applicability, consistency and conformity with the AB 100 legislation. DMH will work jointly with DHCS in this process.

The authority and completion of the work to amend and/or repeal the MHSAs regulations will transfer to DHCS.

### **DMH Letters and Information Notices addressing MHSAs**

DMH developed several Letters and Information Notices to counties during the implementation of the MHSAs. After the passage of AB 100, CMHDA recommended that DMH rescind or modify various DMH Letters or Information Notices because local

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<sup>1</sup> This Interagency Agreement is also listed in the Interagency Agreements and MOUs section of this report.

auditors indicated there were many discrepancies between what counties were required to do by law and what they were directed to do in Letters or Information Notices. DMH is currently reviewing all Letters and Information Notices that are MHSA-related to determine their applicability, consistency, and with statutory conformity with AB 100. DMH will work jointly with DHCS in this process.

The task of completing the modifications and/or rescissions of the DMH MHSA-related Letters and Information Notices will transfer to DHCS.

### **MHSA Workforce Education and Training (WET)**

After DMH's Government Partners<sup>2</sup> unanimously approved the WET spending plan in FY 2008-2009, DMH and the Office of Statewide Health Planning and Development (OSHPD) put forward Spring Finance Letters (SFLs) to implement those activities. In FY 2008-2009, those SFLs were approved. As a result, DMH currently implements \$12.15 million in programs. These include:

- 10 stipend contracts for social workers, marriage and family therapists, clinical psychologists, and psychiatric mental health nurse practitioners;
- 3 contracts for psychiatric residency; and,
- 1 contract for a Statewide Technical Assistance Center (Working Well Together) which helps consumers and their families find and retain jobs and assists employers in hiring consumers and their families.

These programs are proposed to be transitioned to OSHPD. The Administration believes that this is a good fit because OSHPD currently administers:

- The MHSA-funded Mental Health Loan Assumption Program (MHLAP); and,
- A program, which adds a mental health track to, the Song-Brown Residency program for Physician Assistants.

The Governor's Budget proposes to transfer all DMH state-level WET programs and contracts to OSHPD. DMH is requesting a technical adjustment to the Governor's Budget: a one-time budget (BY) appropriation of \$15.0 million to support the Workforce Education and Training (WET) component. This will be appropriated to the Office of Statewide Health Planning and Development (OSHPD). This adjustment is consistent with the state-level WET workload identified for transfer from DMH to OSHPD as part of the FY 2012-13 Governor's Budget.

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<sup>2</sup>CMHDA, MHSOAC, California Mental Health Planning Council

## **Fiscal Responsibilities**

### **1. Annual MHSA Revenue and Expenditure Report (RER)**

The Annual MHSA RER was initially developed as a tool for counties to report to DMH on the expenditures related to MHSA funds for the purpose of calculating reversion of unspent funds. DMH was responsible for developing the RER, reviewing the county submissions, and calculating reversion. Post-AB 100, still unresolved is whether or not DMH will continue to have responsibility for the Annual MHSA RER (i.e., developing, reviewing, and calculating reversion) as this function has not been clarified. Currently, DMH continues to accept RERs submitted electronically. However, it must be determined if the authority and responsibility for review and confirmation of the RER has been rendered obsolete as DMH is no longer distributing MHSA funds.

Policy decisions and any responsibility related to the Annual MHSA Revenue and Expenditure Report will transfer to DHCS.

### **2. Reversion**

[WIC Section 5892(h)] establishes that reversion of funds (at three years and ten years, as specified in the MHSA) that have been distributed “but not spent for their authorized purpose shall revert to the State to be deposited into the fund and available for other counties in future years . . .” In order to meet the mandate of the statute, DMH established a fiscal reporting mechanism and process whereby counties could report how they utilized funds which had been distributed to them and what funds were left unspent. In its review of these reports, DMH could calculate the three year period and assess if a county had funds which were subject to reversion.

Guidance as to this reversion process, as well as how the three/ten year periods would be calculated was provided to counties in 2008; however, with the passage of AB 100, the issue of reversion becomes more complicated. Since these funds are now distributed by the State Controller’s Office, DMH (or any subsequent department) has no mechanism for implementing reversion.

The issue of reversion, however, still exists in the law.

### **MHSA Issue Resolution Process (IRP)**

In FY 2007-2008, a workgroup consisting of representatives of DMH, MHSOAC, California Mental Health Planning Council, and California Mental Health Directors Association met to advise DMH on the development of a procedure for filing and resolving issues related to the community program planning process, service access, and consistency between program implementation and approved MHSA plans. The objective of these meetings was to develop an Issue Resolution Plan (IRP) for consumers, family members and other stakeholders in order to allow them a process to file complaints related to the MHSA with DMH. In addition [WIC § 5845(d)(10)]

establishes that the MHSOAC may refer critical issues related to the performance of a county mental health program to DMH.

In an effort to address concerns brought to the DMH through the stakeholder processes, as well as the recommendations of the AB 100 Workgroup, in recent months, DMH has re-addressed the IRP with stakeholders. The old materials were reviewed as well and discussed with stakeholders during a series of meetings and it was agreed that for the next six months, an interim document would be acceptable, until the transition of DMH to the new state entity was completed. It was also agreed that when the transition was completed, DMH transferring staff would share and consider stakeholder concerns with DHCS in preparing a final issue resolution process.

Presently, the MHSOAC, CMHPC, as well as any county constituent, can file a complaint with DMH about issues related to the MHSA. More information about the scope of issues within DMH's purview is included in the interim document. DMH responds, using the interim IRP.

### **Caregiver Resource Centers (CRC)**

The Comprehensive Act for Families and Caregivers of Brain-impaired Adults [WIC § 4362-4367] Chapter 1658, Statutes of 1984, required DMH to contract with non-profit organizations to establish regionally based resource centers to ensure the existence of programs and services for brain impaired adults. The Act enabled the creation of a statewide system of Caregiver Resource Centers (CRCs) in California, with 11 designated CRCs providing services for caregivers in various service regions throughout the state.

DMH contracts with each of the CRCs and any of their host agencies in order to provide funding appropriated annually by the Legislature to DMH from the State General Fund (SGF).

The CRCs report to DMH twice annually. [WIC Section 2913] requires DMH to annually report specifically addressing four questions related to the effectiveness of CRCs.

The FY 2011-2012 appropriation for the CRCs is \$2.9 million. Currently, the Governor's Budget proposes to eliminate the CRC program.

### **Interagency Agreements/MOUs**

The MHSA Housing Program is administered through an Interagency Agreement with the California Housing Finance Agency (CalHFA). DMH is currently responsible for:

- Review and approval of the supportive service plan submitted for each proposed development;
- Monitoring outcome reporting data collection;

- Reviewing requests for changes to supportive service plans and budgets during/after program implementation; and,
- Preparing the semi-annual updates to the Legislature.

CalHFA is currently responsible for:

- The development of such lending operations as may be needed to implement the Program, including the review and underwriting of loan applications, approval of exceptions of proposals which may differ from the Term Sheet, the development of loan documentation, negotiations with borrowers and other lenders, the issuance of loan commitments, the closing of loans funded by the Act, determination of lien priorities, and servicing of all Program Loans.
- The implementation of regulatory agreements, the ongoing overview of asset management of the operations of Developments, during the terms of loans or regulatory agreements executed by CalHFA, which may or may not include physical inspection, and the workout, prepayment, amendment and/or foreclosure of loans in default.
- The development and administration of the Capitalized Operating Subsidy Reserves for any given Development, including but not limited to: (1) the determination of expected Capitalized Operating Subsidies Reserves needed to subsidize the Development, (2) the review and approval of budgets and audits (3) investment of the Program Funds and (4) disbursements of the Capitalized Operating Subsidy.
- All matters related to the handling, investment and disbursement of monies from the Program Account.

The Office of Community Services (OCS) formerly hosted meetings with 15 state partners that received MHSA state administration funds. The purpose of these quarterly meetings was to provide statewide collaboration and coordinated efforts of MHSA programs and services.

Currently, OCS provides subject matter expertise to the Department of Developmental Services (DDS) and the Administrative Office of the Courts (AOC) per MOUs. This includes attending quarterly coordination meetings, website updates, sharing of program information and updates for partner websites, linkages to advisory committees and remaining functions.

DDS received MHSA funds for FYs 2011-2012 through 2013-2014. Funding allows regional centers to develop and oversee innovative projects focusing on early intervention and treatment for children and adults. The DDS MOU is facilitating a \$750,000 competitive process in FY 2011-2012 to identify and fund new efforts and strategies to augment program outcomes and increase measurable outcomes

necessary to demonstrate a promising practice. There are six regional centers in California currently participating in the program augmentation efforts.

The AOC MOU targets both adults and juveniles in the judicial system and creates policy briefs related to juvenile mental health issues. AOC has designed courses for family court judges and staff related to parents with mental illness and impacts on children, and conducted site visits to three juvenile mental health courts as part of the mental health court evaluation project.

AOC released final report recommendations of the Task Force for Criminal Justice Collaboration on Mental Health Issues (TFCJCMHI).

The MOUs will transfer to the DHCS. There are 4 additional MOUs in the Office of Suicide Prevention and it is anticipated that those will also transfer to the DHCS.

### **Transition Activities**

The MHSA Housing and Community Programs Support Unit, in order to commence the transition process, is initiating a project management charter to capture and address the transition from DMH to DHCS and OSHPD. Staff is now participating in DHCS/OSHPD transition team meetings.

Below is the preliminary scope to complete the transition:

- Meet with DHCS/OSHPD facilities to determine space (logistical and infrastructure and respective system requirements);
- Meet with DHCS to clarify policy issues related to the MHSA Housing Program Interagency Agreement, disposition of funds currently held at CalHFA, and changes in requirements for small counties;
- Meet with DHCS to clarify fiscal policy issues related to the Annual MHSA Revenue and Expenditure Report, Reversion, Component Allocations, and Prudent Reserve;
- Meet with DHCS to clarify program issues related to annual updates, Information Notices, and Regulations;
- Meet with DHCS/OSHPD staff to determine integration of programs; and,
- Review and prepare contracts for transfer.

## **II. OFFICE OF SUICIDE PREVENTION/STATE LEVEL PREVENTION AND EARLY INTERVENTION INITIATIVE (OSP/SLPEI) UNIT**

In January and September 2007, the Mental Health Services Oversight and Accountability Commission (MHSOAC) approved five Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) Statewide Projects and corresponding funding set asides for \$184 million over the course of four years.

In May 2008, the MHSOAC determined that three Projects, Student Mental Health Initiative, Suicide Prevention and Stigma and Discrimination Reduction, would be most effectively implemented through a single administrative entity. At that point, the counties had the opportunity to assign those funds back to DMH for it to serve as the single administrative entity. Counties chose not to assign any of these funds to DMH.

In FY 2009-2010 it was determined that alternative options for funding statewide programs were needed and the MHSOAC took the lead on developing a new set of guidelines through which counties could assign statewide program dollars to either DMH, county regional partnerships, or the California Mental Health Services Authority (CalMHSA).

To date, 36 counties have assigned their funds to CalMHSA for the implementation of the following statewide projects: Suicide Prevention, Student Mental Health Initiative and the Stigma and Discrimination Reduction. In May 2010, DMH entered into an agreement with CalMHSA to develop and implement the three PEI programs, on a statewide or regional basis that conform to the "Guidelines for PEI Statewide Programs" issued by MHSOAC and the State Strategic Plans for these three projects.

### **Office of Suicide Prevention (OSP)**

AB 509, introduced in 2007, heightened awareness for the need of an Office of Suicide Prevention (OSP). The OSP was established administratively in 2008 within the DMH by gubernatorial order to the California Health and Human Services Agency. The work of the Office is guided by the *California Strategic Plan on Suicide Prevention: Every Californian is Part of the Solution*.

OSP serves as a statewide resource center on suicide prevention in California and provides technical assistance and subject matter expertise for state and local partners. It also functions as a liaison with national partners (including SAMHSA, Suicide Prevention Resource Center, American Association of Suicidology, National Suicide Prevention Lifeline, and other state suicide prevention program coordinators) and facilitates a forum for information sharing for accredited suicide prevention crisis centers.

The OSP is responsible for:

- Disseminating the California Strategic Plan on Suicide Prevention;
- Convening and facilitating monthly conference calls with county suicide prevention liaisons, and the California Crisis Centers Consortium;
- Developing and disseminating monthly electronic newsletter and annual county level suicide data profiles; and,
- Coordinating activities with the California Mental Health Services Authority (CalMHSA) to implement the Suicide Prevention Statewide Project.

The Governor's Budget proposes to transfer the Office of Suicide Prevention to DHCS.

## **Stigma and Discrimination Reduction**

The Stigma and Discrimination Reduction program provides subject matter expertise for state and local partners, and maintains a stigma and discrimination website. It provides technical assistance on the California Strategic Plan, disseminates it, and monitors its implementation.

Scope of work for Stigma and Discrimination Reduction includes:

- Conduct presentations at local and state conferences, and coordinate activities with the CalMHSA Stigma and Discrimination Reduction Statewide Project;
- Coordinate with United Advocates for Children and the National Alliance on Mental Illness California to coordinate the program activities with their Mental Health Services Act Memorandum of Understanding (MOU) contract deliverables; and,
- Maintain a stigma and discrimination website within the DMH site.

The Governor's Budget proposes to transfer the Stigma Reduction and Discrimination work to the DHCS.

## **DMH's Student Mental Health Initiative**

DMH's Student Mental Health Initiative, funded by MHSA state administrative funds, supports the California Department of Education and California Community Colleges Office of the Chancellor in addressing student mental health needs in the K-12 system and the community college system through MOUs with the two agencies, respectively. This effort is not the same as the MHSA Student Mental Health Initiative Statewide Project, although this funding supports coordination with that Statewide Project.

This Student Mental Health Initiative:

- Maintains a student mental health website, and coordinates activities with CalMHSA on the MHSA Student Mental Health Initiative Statewide Project;
- Responds to requests for information from a broad range of stakeholders;
- Serves as DMH liaison on MHSA MOU with the California Department of Education and Chancellor's Office of the California Community Colleges (COCCC); and,
- Participates on the COCCC Mental Health Advisory Committee meetings and coordinates occasional in-state events such as trainings and conferences.

The Governor's Budget proposes to transfer the Student Mental Health Initiative to DHCS.

## **Veterans' Mental Health**

The OSP provides subject matter expertise and technical assistance on veterans' mental health and works collaboratively with California Department of Veterans Affairs and California Military Department/California National Guard.

Veterans' Mental Health functions include:

- Providing subject matter expertise and technical assistance on veterans' mental health;
- Serving as DMH liaison for MOUs for the Mental Health Services Act with the California Department of Veterans Affairs and California Military Department/California National Guard;
- Maintaining a veteran's mental health website;
- Hosting and facilitating a weekly Veterans Mental Health Partners conference call;
- Serving as the California liaison with national partners such as SAMHSA on veterans strategic initiatives; and,
- Hosting public speaking events on topics related to veterans' issues that educate and build working relationships.

The Governor's Budget proposes to transfer the Veterans Mental Health work to the DHCS.

## **Transition Activities**

The Office of Suicide Prevention and State Level Prevention and Early Intervention Initiative Unit, in order to commence the transition process, is initiating a project management charter to capture and address the transition from DMH to DHCS. Staff have also participated in a meet and greet with DHCS' Chief Deputy Director and DHCS' Acting Deputy Director of Mental Health and Substance Use Disorder Services.

Below is the preliminary scope to complete the transition:

- Meet with DHCS staff to determine future of State Level Prevention Programs;
- Define the role of the State Level Prevention Unit in the implementation of the three Statewide Projects: Suicide Prevention, Stigma and Discrimination Reduction and Student Mental Health, being implemented by CalMHSA;
- Define the role of the Office of Suicide Prevention. When the Office was established, it was envisioned as having a role on program implementation, but with no funding and the current loss of positions, the Office has not been able to do the work as originally envisioned;
- Define the role DHCS has regarding the MHSA State Interagency MOUs and BCPs that DMH had developed with these agencies; and,
- Meet with DHCS facilities to determine space needs (logistical and infrastructure and respective system requirements).

### **III. OFFICE OF MULTICULTURAL SERVICES (OMS)**

The mission of DMH OMS is to strengthen the Department's focus and ability to provide culturally and linguistically competent mental health services to the diverse populations of California.

OMS has four positions funded by the MHPA and provides leadership direction to DMH for promoting and establishing culturally and linguistically competent mental health services within the public mental health system through actions internally and externally to DMH. This is accomplished through collaboration with community stakeholders, projects aimed at reducing disparities, contracts with a focus on cultural competence, and participation and/or leadership of the committees on page 30.

The Governor's Budget proposes to transfer the Office of Multicultural Services to the proposed Office of Health Equity at the Department of Public Health (DPH).

#### **Cultural Competence Plan Requirements (CCPR)**

OMS implements, develops and oversees the CCPR and annual updates that are required for all county Mental Health Plans (MHPs) (58 counties including Tri Cities and City of Berkeley) throughout the state. OMS coordinates the review and approval of the county CCPRs and the CCPR annual updates. OMS conducts CCPR reviewer trainings, reviews team meetings, and provides technical assistance to county staff on the development and implementation of the plan. Additionally, OMS works with DMH's Medi-Cal Compliance Oversight (MCO) in January of each year to develop new language for the Fiscal Year protocol and attends all Compliance Advisory Committee meetings. OMS provides technical assistance to MCO throughout the year as they review county efforts and present at all statewide Quality Improvement Coordinator meetings.

The Cultural Competence Advisory Committee (CCAC) members serve as the subject matter experts in the development of the CCPRs and the Multi-provider Cultural Competence Consultant Contract (see below), which consists of 17 contractors who are utilized to assist with plan reviews and other key CCPR functions.

The Governor's Budget proposes to transfer the CCPR functions to DHCS and the CCAC and Multi-provider contract are proposed to transfer with the OMS staff and remaining functions to the proposed Office of Health Equity at DPH.

#### **California Reducing Disparities Project (CRDP)**

This is a key statewide policy initiative to improve access, quality of care and increase positive outcomes for racial, ethnic and cultural communities. In partnership with the Mental Health Services Oversight and Accountability Commission (MHSOAC) and in coordination with the California Mental Health Directors Association (CMHDA) and the California Mental Health Planning Council (CMHPC), and in response to the call for

national action, DMH has begun implementation of this project to reduce mental health disparities and seek solutions for historically underserved communities.

MHSA state administrative funds of \$1.5 million have been provided annually to fund seven contracts (see Part A. Administrative Transition – CRDP Projects), which are designed to ensure identification of community defined evidence that works to improve access and quality of care for historically underserved populations. A California Reducing Disparities Strategic Plan will then be developed to guide implementation of community-defined strategies.

To implement and evaluate those strategies identified in the statewide strategic plan and in addition to the \$1.5 million allocated annually in administrative funds, DMH Information Notice 07-19, delineates \$15 million per year for four years (\$60 million total) to be set aside from the MHSA Prevention and Early Intervention (PEI) component. The allocation will support the implementation and evaluation of community defined practices for reducing ethnic and cultural disparities which will be inclusive of a community participatory evaluation component.

The Governor's Budget proposes to transfer OMS' California Reducing Disparities Project to the proposed Office of Health Equity at DPH. DPH will consult with counties and stakeholders to implement this project to reduce disparities in mental health.

The May Revision proposes a technical adjustment, whereby these funds are preserved by appropriating them from MHSA state administrative funds to DPH. They are proposed to be appropriated as \$15 million per year for a period of four years (total \$60 million) for the CRDP.

### **Translation Services**

OMS currently monitors a deliverable-based contract with Avantpage to provide translation and cross translation services in 12 threshold languages for DMH and other DMH MHSA partners to comply with the Dymally-Alatorre Bilingual Services Act (1973), which requires California State agencies to provide translated materials and serve monolingual customers in languages other than English.

The OMS utilizes this contract to provide translation and cross translation services for MHSA related documents for state and local partners. The scope of work includes translation of various hard copy documents and DMH website materials related to the MHSA into identified threshold languages. Threshold languages, determined on an annual basis, are languages identified as the primary language of 3,000 Medi-Cal beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area, as defined in Title 9, California Code of Regulations, Section 1810.410(f)(3). Priority will be given to those threshold languages representing the highest percentage of the population. Threshold languages include, but are not limited to: Arabic; Armenian; Cambodian; Chinese; Farsi; Hmong; Korean; Lao; Russian; Spanish; Tagalog; and Vietnamese.

This contract provides Limited English Proficiency (LEP) individuals access to:

- a) MHSA hardcopy documents; and
- b) DMH Website, as it relates to the MHSA.

The Governor's Budget proposes to transfer OMS' Translation Services to the proposed Office of Health Equity at DPH.

### **Cultural Competency Consultants**

OMS currently monitors a Master Multi-Provider County Mental Health Cultural Competency Consultant contract which includes 17 cultural competence consultants to advise DMH on how to ensure cultural competence in policy, practices, and procedures to reduce disparities. The primary responsibility of the CCCs is to assist with the review of MHSA related county plans and DMH CCPRs. Consultants will continue to provide cultural competency perspectives, expert knowledge and feedback while reviewing MHSA and CCPRs.

The Governor's Budget proposes to transfer OMS' cultural competency contracts to the proposed Office of Health Equity at DPH.

### **Cultural Competence Regional Trainings**

OMS has ongoing budget authority to provide California Brief Multicultural Scale regional trainings to county mental health providers. OMS is currently working on a contract amendment for its contract with the California Institute of Mental Health to augment and extend the current contract to add additional deliverables that would allow counties to receive cultural competence training utilizing the CBMCS training curriculum. This amendment would provide for fiscal resources to bring together a workgroup to make recommendations on updating training modules and establish guidelines to become a CBMCS Master Trainer. This would allow county staff to receive cultural competence training at low or no cost and assist county staff in becoming resident trainers in their respective geographic area.

The Governor's Budget proposes to transfer OMS' Cultural Competence regional trainings to the proposed Office of Health Equity at DPH.

### **Interpreter Training Program**

OMS has ongoing authority to provide an interpreter training program and skill development to mental health providers working with unserved, underserved, and inappropriately served multicultural communities. OMS is currently working with DMH leadership to either issue a Request for Proposal or allocate this funding to a current contract to implement the activities.

The Governor's Budget proposes to transfer OMS' Interpreter Training Program to the proposed Office of Health Equity at DPH.

### **Interpreters for Stakeholder Meetings**

OMS has ongoing authority to improve access for Limited English Proficient (LEP) consumers and family members by providing interpreters at stakeholder meetings. OMS is currently working with DMH leadership to issue a Request for Proposal (RFP) or allocate this funding to a current contract to implement the activities.

The Governor's Budget proposes to transfer OMS' RFP work to the proposed Office of Health Equity at DPH.

### **Committees**

OMS participates in the following committees:

- Cultural Competence Advisory Committee (CCAC);
- Mental Health Services and Oversight and Accountability Commission (MHSOAC) Cultural and Linguistic Competence Committee (CLCC);
- California Mental Health Directors Association (CMHDA) Social Justice Advisory Committee;
- State Interagency Team Workgroup;
- Ethnic Services Committee and Regional Ethnic Service Managers;
- MHSA Partners Forum; and,
- California Mental Health Planning Council.

### **Transition Activities**

OMS, in order to commence the transition process, is initiating project management planning to capture and address the transition from DMH to DPH. OMS staff is now participating in DPH transition team meetings.

Below is the preliminary scope to complete the transition plan:

- Meet with DMH leadership regarding the future of the CRDP and the \$60 million for the implementation phase;
- Meet with DPH leadership to provide an overview of current OMS functions and activities, to learn more about the proposed Office of Health Equity's guiding principles, and the role of the Cultural Competence Advisory Committee;
- Meet with DPH and DHCS leadership to discuss the role OMS staff will have as subject matter experts in providing consultation and technical assistance to DHCS staff relative to the county Cultural Competence Plan Requirements;
- Meet with DPH facilities to determine space (logistical, infrastructure and respective system requirements);

- Maintain communication with contractors to ensure a successful transition of contracts by providing updated contact information and written notification of any deviation of contract oversight, terms, etc.; and,
- Keep stakeholders informed of transition activities via committee participation, emails and conference calls.

#### **IV. GRANTS AND DATA MANAGEMENT UNIT**

The Grants and Data Management Unit is responsible for the administration of federal and state Grants as well as county public mental health data collection for DMH. The unit oversees the Substance Abuse and Mental Health Services Administration (SAMHSA) Grants: the Community Mental Health Services Block Grant (MHBG), Projects for Assistance in Transition from Homelessness (PATH), Data Management Infrastructure Grant (DIG), and the Olmstead Grant. In addition to the federal grants, this unit oversees the implementation of the Early Mental Health Initiative (EMHI). The Grants and Data Management Unit is responsible for the administration of \$77 million in state and federal grant funds. It is also responsible for the management of the funding for the mental health portion of the California Health Interview Survey (CHIS) in the amount of \$800,000 through FY 2012-2013.

This unit is also responsible for the Data Collection and Reporting (DCR) system, which provides information about outcomes across key quality of life domains (financial support, health status, emergency intervention, substance abuse, housing, employment, education, and legal issues) for individuals enrolled in the MHSA Full Service Partnerships (FSP) programs. Finally, the Grants and Data Management Unit is responsible for the Client and Service Information (CSI) system, which collects client demographics, service information and periodic client-related information updates.

The Governor’s Budget proposes that the state and federally funded grant programs, as well as Data Management functions transfer to DHCS. The Governor’s Budget proposes that funding for the EMHI program transfer to the California Department of Education (CDE).

#### **A. Grants Management**

##### **Substance Abuse and Mental Health Services Administration (SAMHSA) Grants**

##### **1. Community Mental Health Services Block Grant (MHBG)**

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) provides grant funds to establish or expand an organized community-based system of care for providing non-Title XIX (Medicaid) mental health services to children with Serious Emotional Disturbances (SED) and adults with Serious Mental Illness (SMI). States are required to submit an application for each fiscal year the State is seeking

funds. These funds are used to: (1) carry out the State plan contained in the application; (2) evaluate programs and services; and (3) conduct planning, administration, and educational activities related to the provision of services.

California allocates these federal funds to counties through a formula. DMH receives approximately \$53 million for the implementation of the MHBG Program. The MHBG provides flexible funding to states and territories to provide comprehensive community mental health services to adults and children.

The responsibilities of the unit include the administration of the MHBG. This includes designating a State Block Grant Contact (SBGC) to serve as liaison between SAMHSA and Counties. The SBGC is responsible for formulating, disseminating, collecting, approving and submitting the MHBG Application and Implementation Report to SAMHSA for approval in conjunction with the California Mental Health Planning Council.

The Bureau of State Audits (BSA) conducted a follow-up review of the MHBG for Community Mental Health Services for the FY ending 2010-2011. The BSA report included three findings to improve DMH's administration of its federal program. The following are the three outstanding audit findings, which will transfer to DHCS:

- DMH does not ensure that counties' expenditures were only for allowable activities and costs;
- DMH continues to lack policies and procedures to adhere to the earmarking requirements; and,
- DMH's calculation of its expenditures for certain activities related to its maintenance of effort requirements remain problematic.

The Governor's Budget proposes to transfer the \$53 million SAMHSA Mental Health Block Grant to DHCS.

## **2. Projects for Assistance in Transition from Homelessness (PATH) Grant**

The PATH program is administered by CMHS, a component of SAMHSA. The PATH Program was authorized by the Stewart B. McKinney Homeless Assistance Amendments Act of 1990. In accordance with the Public Health Services (PHS) Act Section 521-525, the PATH program provides funds for specific, allowable community based services for persons with serious mental illness and co-occurring substance abuse disorders who are homeless or at imminent risk of becoming homeless. As of State Fiscal Year (SFY) 2011-2012, all PATH funded programs are required to provide outreach and case management services at a minimum. This program is state administered and locally operated by the county or through county sub-contractors. California receives approximately \$9 million in federal grants for the implementation of this program.

The responsibilities of the unit include oversight of the PATH program for both program and fiscal components. This includes designating a State PATH Contact (SPC) to act as a liaison between SAMHSA and the Counties. The SPC is responsible for submitting both the PATH Application and Annual Report to SAMHSA, formulating, disseminating, collecting, approving, and submitting the annual PATH Request for Application (RFA) to counties.

The Governor's Budget proposes to transfer the \$9 million PATH Grant to DHCS.

### **3. Olmstead Grant**

The Supreme Court ruled in 1999 that, under the Americans with Disabilities Act (ADA), public services for people with disabilities must be provided in the most integrated setting possible, giving them the opportunity to live independently in the community and not segregated in institutional settings (*Olmstead v. L.C.* (1999) 527 U.S. 581). SAMHSA helps states expand resources and opportunities for people with serious mental illnesses to live in their home communities through The New Freedom Initiative (NFI) grant funds. SAMHSA initially offered grants of \$20,000 per year for three years to state Mental Health Authorities to support efforts to build coalitions and promote community based care.

DMH staff helped the California Health and Human Services Agency (CHHS) Long Term Care Council (LTC) develop the California Olmstead Plan using statewide stakeholder input to establish its priorities. The plan was submitted to the Legislature in May of 2003 and updated in 2005. The responsibilities of the program include submission of the annual request of funds and progress report to SAMHSA, to act as a liaison between the contractor and SAMHSA, as well as contract management.

The Governor's Budget proposes to transfer the \$20,000 Olmstead Grant to DHCS.

### **4. The Early Mental Health Initiative (EMHI) Program**

The EMHI Program provides matching grants to Local Educational Agencies (LEA) to implement early mental health intervention and prevention programs for students in K-3. Grant funding is provided for one three-year cycle to publicly-funded elementary schools. EMHI serves students in K-3 grades experiencing mild to moderate school adjustment difficulties. The SFY 2010-2011 Statewide Evaluation Report data shows 79 percent improvement in social behaviors and school adjustment of targeted students, as a direct result of the EMHI intervention. The EMHI programs served over 15,000 students in FY 2010-2011.

The responsibilities of this program include the oversight of EMHI program agreements with 152 LEAs and 431 school sites, seven contracts with school districts for services of technical assistance coordinators (TACs), and for the Data Evaluator on both the program and fiscal aspect.

The Governor's Budget proposes to transfer the EMHI program (\$15 million) to CDE. These funds are proposed to be included in the new K-12 flexible funding formula. The funds are sent directly to the school district staff. No staff is transferring to CDE. The Administration proposes to repeal this grant program in statute.

## **B. Data Management**

### **1. Data Collection and Reporting (DCR) System**

Mental health providers report information and outcomes of the MHSA Full Service Partnership (FSP) program directly to the DCR system. Current regulations require MHPs to collect partner outcome FSP data [CCR Title 9 § 3620.10] and submit it to DMH within 90 days of occurrence [CCR Title 9 § 3530.30]. The Partnership Assessment Form (PAF) gathers baseline information about the partner, while Key Event Tracking (KET) and Quarterly Assessment (3M) gather follow up information.

The Governor's Budget proposes to transfer the DCR system to DHCS.

### **2. Client and Services Information (CSI) System**

The CSI System is DMH's largest and most representative database of clients and services delivered by California's County/City/Mental Health Plan programs. A basic principle of CSI is that it reflects Medi-Cal and non-Medi-Cal clients and services.

The CSI System:

- Collects, after 60 days of the close of each month, client demographics (age, race/ethnicity, gender), service information, periodic client-related information updates;
- Provides Institutions for Mental Diseases (IMD) reporting to DHCS; and,
- Contributes data for annual DMH SAMHSA Mental Health Block Grant reporting.

Due to lack of maintenance to the CSI system, CSI failed on October 7, 2011, resulting in the inability of counties to submit data to DMH. Working with IT contractors, DMH was able to get the CSI system back in operation on January 23, 2012. Staff will continue to monitor the system and work with our contractors to receive and process CSI data.

The Governor's Budget proposes to transfer the CSI system to DHCS.

### **3. Management of SAMHSA's Data Infrastructure Grant (DIG)**

This is a three-year federal grant awarded to DMH, which is used to support data infrastructure, and activities that go towards reporting California's mental health client data to SAMHSA. The annual grant award must be matched equally by the State. Annual progress reports are due to SAMHSA detailing accomplishments towards the

goals stipulated by the Department. This grant is currently in the second year of the three year cycle.

The Governor's Budget proposes to transfer the SAMHSA DIG to DHCS.

#### **4. Federal Reporting**

The Department is required to report annually to SAMHSA using the Uniform Reporting System (URS) tables and the National Outcome Measures (NOMs) found in the MHBG Application and Implementation Report.

The Governor's Budget proposes to transfer the Federal reporting work to DHCS.

#### **5. Consumer Perception Survey (CPS) (SAMHSA)**

The information collected from the annual survey conducted during a two-week period reflects the client's (or family member's) perception of satisfaction with, and effectiveness of the services they have received and quality of life. These data are used for reporting on SAMHSA's NOMs, whose reporting is required under the MHBG. However, funding the administration of the survey is problematic now that MHSAs funding is no longer available.

The Governor's Budget proposes to transfer the responsibility of the Consumer Perception Survey to DHCS.

#### **6. Quarterly Reports**

This unit is responsible for the processing of counties' quarterly reports for the Community Services and Supports component of the MHSAs. These data are used by the MHSOAC to report on the MHSAs FSP clients receiving services. DCR data is also used to report to SAMHSA in the annual Implementation Report.

The Governor's Budget proposes to transfer the Quarterly Reports and work to DHCS.

#### **7. Involuntary Detention Quarterly Report**

State law (WIC § 5402) requires DMH to annually collect and publish quantitative data on involuntary detention.

This includes the number of persons: admitted for 72-hour evaluation and treatment, 14-day treatment, additional 14-day intensive (suicidal) treatment, 30-day intensive treatment, 180-day post certification intensive treatment, and transferred to mental health facilities pursuant to Penal Code Sections 4011.6 and 4011.8 (mentally disordered persons detained in county jail or juvenile detention facilities) for whom temporary conservatorships are established, and for whom permanent conservatorships

are established in each county. The Data Management team works with county mental health directors to collect data pertaining to involuntary detention.

### **Transition Activities**

The Federal and State Grants and Data Management Unit, in order to commence the transition process, is initiating a project management charter to capture and address the transition from DMH to DHCS. OCS staff is also participating in DHCS transition team meetings.

Below is the preliminary scope to complete the transition:

- Meet with DHCS to clarify policy issues and fiscal issues related to the administration and implementation of the Olmstead Grant, Community Mental Health Services Block Grant (MHBG) and Projects for Assistance in Transition from Homelessness (PATH) Grants, and changes in requirements for small counties;
- DMH shall review the retention requirements for Olmstead contract, County MHBG applications, County PATH applications, and any other fiscal-related reports;
- Meet with DHCS facilities to determine space for grant staff (logistical, infrastructure and respective system requirements);
- Meet with DHCS to clarify data issues related to current data systems and compatibility;
- Meet with DHCS to clarify program issues related to annual updates, Information Notices, and Regulations;
- Meet with DHCS facilities to determine space for research data staff (logistical, infrastructure and respective system requirements);
- Meet with DHCS to clarify policy issues related to the administration and implementation of the DIG and MHBG grants;
- Meet with DHCS to clarify fiscal policy issues related to the DIG and MHBG grants; and,
- Meet with DHCS regarding issues related to responsibility for the Consumer Perception Survey.

### **CALIFORNIA MENTAL HEALTH PLANNING COUNCIL**

Federal law (Public Law 102-321(1992) and PL106-310 (2000)) requires every state to have a mental health planning council in order to receive the Community Mental Health Services Block Grant from Substance Abuse and Mental Health Services Administration (SAMHSA). The California Mental Health Planning Council (CMHPC) is a 40-member advisory body appointed by the Director of DMH. Federal statute details the composition of the Council. The CMHPC was established in state law (WIC 5771) in 1993. For federal and state statutes, see Appendices H and I.

The CMHPC reviews and comments on the SAMHSA MHBG Application as well as the Implementation Report; and the Chair attends the national meeting each year in

Washington, D.C. In addition to the review of the application and annual implementation report, the federal law also specifies certain activities the CMHPC is required to perform, including advocating for adults with serious mental illness and children with severe emotional disturbances; and also annually monitoring, reviewing and evaluating the allocation and adequacy of mental health services within California.

The CMHPC accomplishes its statutory responsibilities by forming committees that meet to deliberate on advocacy strategies and policy/planning issues, to direct projects and to develop issue papers. The goal of this work is to meet statutory responsibilities to advocate for effective, quality mental health, to review, assess, and make recommendations regarding all components of California's mental health systems and report to the Legislature and the Governor; and to advise the Legislature, DMH and county boards on mental health issues and the policies and priorities that the State should be pursuing in developing its mental health system. Additionally, the CMHPC utilizes its quarterly meetings as a vehicle to seek stakeholder and public input on mental health issues and concerns.

In addition, there are specific duties for the CMHPC under the Mental Health Services Act (MHSA). Pursuant to WIC 5820(e), the CMHPC reviews and approves the 5-year plan for Workforce Education and Training (WET). WIC § 5821(a) also provides that the CMHPC advise DMH on education and training policy development and provide oversight for the Department's Education and Training Plan development. To fulfill this responsibility, the CMHPC has a Human Resources Committee (HRC). It uses its meetings to conduct oversight of county WET programs and statewide projects administered by DMH.

The HRC also oversees a Human Resources Development Project (HRDP), funded in the SAMHSA MHBG since 2003, in partnership with DMH. The HRDP advises, consults, and informs the HRC in meeting its core priorities and functions in the MHSA, as well as, providing technical assistance to county mental health programs and agencies in developing and implementing their three-year workforce and education plans. HRDP advises DMH in its development of a needs assessment for public mental health workforce capacity and the 5 Year-WET Plan. HRDP represents the HRC and the CMHPC on boards, commissions, tasks force, and forums to ensure the promotion of behavioral health workforce development and deployment strategies in California and nationally.

The MHSA also provides that CMHPC be involved in the performance evaluation of Community Services and Supports services provided in the Adult System of Care and the Children's System of Care. This work is provided by CMHPC's Quality Improvement Committee (QIC). The QIC develops paradigms to evaluate mental health services. It reviews performance outcome data to evaluate the performance of county mental health programs' Full Service Partnership programs. Furthermore, local mental health boards and commissions (MHB/Cs) interpret their local data and report their interpretation to the CMHPC. The QIC develops a workbook to provide MHB/Cs with their data and a format for reporting their interpretation. The CMHPC then compiles a statewide report.

The CMHPC is an independent entity, but depends on DMH for administrative support functions including personnel, accounting, legal and budgets as well as the appointment of the Council members. The CMHPC activities are funded through administrative dollars from the SAMHSA Block Grant and the MHSAs. The CMHPC currently administers two contracts for the recording of the meetings and printing of materials.

The functions of the CMHPC related to DMH will transfer to DHCS.

### **Transition Activities**

The CMHPC, in order to commence the transition process, is initiating a project management charter to capture and address the transition from DMH to DHCS.

Following is the preliminary scope to complete the transition:

- Determine which documents to bring to DHCS, which documents to scan and store electronically, which documents to archive and which to discard;
- Meet with DHCS leadership to clarify roles, functions, procedures, lines of communication, etc.;
- Review existing advisory structures within DHCS to discern connections, intersections and applicable policies/procedures for operation;
- Meet with DHCS facilities staff to determine space and infrastructure needs;
- Meet with DHCS technology staff to discuss public access via technology, in order to notify and advise public in advance; and,
- Develop a plan to brief Planning Council members including a joint meeting with CMHPC membership and DHCS leadership.

## **PROGRAM COMPLIANCE**

### **Licensing and Certification**

The Department of Mental Health (DMH) Licensing and Certification (L&C) Branch is responsible for implementing and maintaining a system of assuring compliance related to facility licensing and program certification of a range of 24-hour psychiatric and rehabilitation care facilities. The programs subject to licensure and certification by DMH are: Mental Health Rehabilitation Centers (MHRCs), Psychiatric Health Facilities (PHFs), Skilled Nursing Facilities with Special Treatment Programs (SNFs/STPs), Community Residential Treatment Systems (CRTS) -- also known as Social Rehabilitation Programs (SRPs) -- and Community Treatment Facilities (CTFs).

The following (and Appendix K) describes those administrative functions in the DMH L&C that are being proposed for transfer to the Department of Social Services (DSS) and Department of Health Care Services (DHCS).

The DSS will assume responsibilities for licensing of MHRCs and PHFs.

The DHCS will assume responsibilities for certification of SNFs/STPs, CRTS/SRPs and CTFs.

## **CRTS/SRPs**

The CRTS/SRPs are licensed by DSS and the mental health program components are certified by the DMH. The CRTS/SRP requirements are set forth in the California Welfare and Institutions Code (WIC), Sections 5670, 5670.5 and 5671. The regulations for interpreting these provisions of statutes are contained in Article 3.5 (Commencing with Section 531) of Chapter 3, in Division 1, of Title 9 in the California Code of Regulations (CCR).

There are three categories of CRTS/SRPs that are defined in Sections 5670 and 5671 of the WIC, and Sections 531 through Section 535 of Title 9 of the CCR:

- 1) **Short-Term Crisis Residential:** Offers alternatives to acute hospitalization; provides stabilization and diagnostic services for no longer than three months.
- 2) **Transitional Residential:** Provides an activity program that encourages utilization of community resources for no longer than 18 months.
- 3) **Long-Term Residential:** Provides rehabilitation services for the chronically mentally ill who need long-term support and care for up to two to three years, in order to develop independent living skills.

These treatment service programs are designed to serve adults who are in need of mental health treatment and are unable to care for themselves in an independent living situation, but can be cared for in a CRTS/SRP that provides psychiatric care in a normal home environment.

CRTS/SRPs provide a wide range of alternatives to acute psychiatric hospitalization and institutional care based on the principles of residential community-based treatment. This includes a high level of care provided in a homelike setting, stringent staff requirements, 24-hour-a-day, seven-day-a-week supervision and treatment assistance and community participation at all levels.

CRTS/SRP program services include, but are not limited to: intensive diagnostic work, including learning disability assessment; full-day treatment program with an active prevocational and vocational component; special education services; outreach to develop linkages with the general social service system; and counseling to aid clients in developing the skills to move toward a less structured setting.

The CRTS/SRP, as mandated by statute and regulations, requires the DMH to certify social rehabilitation programs in community care facilities licensed by the DSS. The program certification by the DMH is a condition of licensure by the DSS. The

certification process includes a rigorous on-site review of operations, clinical practice standards, policies and procedures and treatment modalities.

### **SNFs/STPs**

SNFs/STPs operate under Title 22, California Code of Regulations (CCR), Sections 72443-72475, and DMH's Policies and Directives.

In order for an SNF to be certified as an STP, it must meet the licensing and certification requirements of the Department of Public Health (DPH). It is necessary that the facility be licensed as a Medicaid-certified SNF.

STPs are designed to serve clients who have a chronic psychiatric impairment and whose adaptive functioning is moderately impaired. The monitoring of SNFs/STPs occurs annually by the DMH as stipulated by Title 22. The DMH conducts the annual review at the facility after reviewing and approving the updated written program plan together with any written requests for modification to the previously approved program. Confirmation of program compliance is done by random review of client charts. DMH reviewers attend groups and activities to evaluate clients' attendance and participation. Facility records are also reviewed to ensure compliance with Title 22 in the areas of staffing coverage requirements, staff qualifications, in-service training requirements and provision of required rehabilitation services individualized to client needs. Documents such as seclusion and restraint logs, denial of patients' rights and personnel records are also reviewed.

DPH licensing staff may be present simultaneously to conduct a facility licensing review as provided in Health and Safety Code (HSC), Section 1422.1. Specifically, HSC provides that

*“the DPH, shall conduct, when feasible, annual licensing inspections of licensed, long-term health care facilities providing special treatment programs for the mentally disordered, concurrently with inspections conducted by the DMH for the purposes of approving the special treatment program.”*

STP services are those therapeutic services provided to mentally disordered persons having special needs in one or more of the following areas: self-help skills, behavioral adjustment, and interpersonal relationships. They include pre-vocational preparation and pre-release planning. Other program services include group and individual counseling; instruction on personal care and medication management; and use of community and personal resources.

### **CTFs**

CTFs are secured (locked) community residential treatment facilities providing mental health services to adolescents who are diagnosed as Severely Emotionally Disturbed

(SED). The DMH is responsible for the development and distribution of 400 CTF beds within the five Mental Health Regions of California.

The CTF licensing category was designed to provide an alternative to state hospital or out-of-state placement and to enable children with mental health needs to receive treatment in less restrictive, more appropriate settings, closer to their families' homes. To be licensed as a CTF, the treatment facility must have the capacity to provide "secure containment."

In order for a child to be placed in a CTF, all the following criteria must be met: (1) the child may require a period of containment to participate in and benefit from mental health treatment, and the CTF program must be reasonably expected to improve the child's mental disorder; (2) the child must be seriously emotionally disturbed; (3) other, less restrictive interventions must have been attempted and proven insufficient, or the child is an inpatient in a psychiatric hospital, a state hospital, or an out-of-state placement; (4) the county interagency placement committee must provide certification for the child to be placed in the CTF; and (5) consent from parents, the court, or the conservator must be properly obtained.

## **PHFs**

Title 22, Division 5 of the CCR constitutes DMH PHF licensing review protocols. These regulations represent the criteria used by DMH to conduct the initial and annual licensure of PHFs.

PHFs are licensed to provide acute inpatient psychiatric treatment to individuals with major mental disorders in a nonhospital setting. PHFs provide 24-hour inpatient care for mentally disordered, incompetent or other persons described in Division 5 (commencing with Section 500) or Division 6 (commencing with Section 6000) of the Welfare and Institution Code (WIC). PHFs are specifically prohibited from admitting or treating prospective patients with primary diagnoses of chemical dependency-related disorders and eating disorders. Further, PHFs may admit and treat only patients who have no physical illness or injury that would require treatment beyond what ordinarily could be treated on an outpatient basis. PHFs mainly provide acute psychiatric treatment services to individuals subject to involuntary commitment under the LPS Act.

The scope of practice for PHFs is defined in Health and Safety Code, Section 1250.2 (a). It was specifically noted in the law that many counties did not have adequate 24-hour acute psychiatric inpatient facilities, that many counties did not have any beds or services for persons needing acute 24-hour inpatient care, and that such services could be provided in a non-hospital setting. If a patient cannot be treated as an outpatient for problems, the patient cannot be treated at a PHF no matter what the patient's level of psychiatric acuity may be. PHFs were created in 1978 by an act of the California Legislature to provide a low cost alternative to hospital-based care. Acute Psychiatric Hospitals employ a medical model; whereas, PHFs employ a multidisciplinary model consistent with its enabling legislation which called for an innovative approach to acute

inpatient psychiatric care. PHFs were conceptualized and designed to be an alternative to acute psychiatric hospitals which are traditionally based on a medical model.

## **MHRCs**

MHRCs were established through legislation -- Senate Bill (SB) 2017 (Leslie), Statutes of 1994 and Assembly Bill (AB) 2862 (Thomson), Statutes of 1998 -- to provide for the development of an innovative psychiatric rehabilitation program in close collaboration with county mental health departments and DMH. In creating MHRCs, the Legislature's intent was to create innovative programs that were alternatives to hospital care. They also wanted a licensing category for more appropriate staffing and programming for adults with a serious mental illness (SMI) who would move away from skilled nursing facilities that had historically handled the more elderly, physically and medically compromised populations.

MHRCs provide community-based, intensive support and rehabilitation services designed to assist persons, 18 years or older, with mental disorders who would have been placed in a state hospital or other mental health facility to develop the skills to become self-sufficient and capable of increasing levels of independent functioning. MHRCs mainly provide mental health treatment services to individuals on conservatorship under the Lanterman-Petris-Short (LPS) Act. MHRC regulations prohibit admission of individuals who are non-ambulatory, who require a level or levels of medical care not provided, who would be appropriately served by an acute psychiatric hospital, or who are diagnosed only with a substance abuse or eating disorder.

MHRCs provide services designed to assist persons who are seriously disabled by a mental illness to develop skills for achieving self-sufficiency and independent living in the community. The program services are to include, but are not limited to, clinical treatment such as psychiatric and psychological services, learning disability assessment and educational services, pre-vocational and vocational counseling, development of independent living, self-help and social skills, and community outreach to develop linkages with other local support and service systems.

To ensure the physical well being of the mentally ill persons residing in a MHRC, providers are responsible for the provision, at minimum, of any needed physician, pharmacy, rehabilitation program, dietary and social services.

## **Transition Activities**

The L&C Branch, in order to commence the transition process, is initiating a project management charter to capture and address the transition from DMH to DSS and DHCS.

Below is the preliminary scope to complete the transition:

- Determine which documents to bring to either DHCS and DSS, which documents to scan and store electronically, which documents to archive and which to discard;
- Meet with DHCS and DSS leaderships to clarify roles, functions, procedures, lines of communication, etc.;
- Review existing advisory structures within DHCS and DSS to discern connections, intersections and applicable policies/procedures for operation; and,
- Meet with DHCS and DSS facilities staff to determine space and infrastructure needs.

The Governor's Budget proposes to transfer the function for licensing of MHRCs and PHFs to DSS. DSS will create a new branch for the substance use disorder and mental health facility licensing program and the staff it will receive. This branch will be headed by a Branch Chief who will report directly to the Deputy Director of Community Care Licensing (CCL) at DSS.

The Governor's Budget proposes to transfer the function for certification of SNFs/STPs, CRTS/SRPs and CTFs to DHCS.

## **CONCLUSION**

In partnership with the Health and Human Services Agency and the receiving departments and entities, DMH will support the effective transfer of program responsibilities out of the Department. The success of this transition will necessarily include collaboration with the Legislature, counties, and stakeholders to ensure the seamless transition of state administration of community mental health services.

The DMH Stakeholder website created for the non-Medi-Cal transition will continue to be a resource for developments on this transition as they occur through the state budget process:

[http://www.dmh.ca.gov/Services\\_and\\_Programs/Medi\\_Cal/Medi\\_Cal\\_Transfer.asp](http://www.dmh.ca.gov/Services_and_Programs/Medi_Cal/Medi_Cal_Transfer.asp).

# APPENDICES

## Ch. 33

## Senate Bill No. 87

Item	Amount
Portability and Accountability Act (HIPAA) of 1996.	
4300-301-0001—For capital outlay, Department of Developmental Services.....	2,043,000
Schedule:	
(2) 55.65.300-Developmental Centers: Automatic Fire Sprinkler Systems—Preliminary plans and working drawings.....	2,043,000
4300-491—Reappropriation, Department of Developmental Services. The balances of the appropriations provided in the following citations are reappropriated for the purposes and subject to the limitations, unless otherwise specified, in those appropriations:	
0001—General Fund	
(1) Item 4300-301-0001, Budget Act of 2009 (Ch. 1, 2009–10 3rd Ex. Sess., as revised by Ch. 1, 2009–10 4th Ex. Sess.)	
(1) 55.25.270-Fairview: Upgrade Fire Alarm System—Construction	
4440-001-0001—For support of Department of Mental Health.....	48,443,000
Schedule:	
(1) 10-Community Services.....	57,577,000
(2) 20-Long-Term Care Services.....	28,882,000
(3) 35.01-Departmental Administration.....	16,560,000
(4) 35.02-Distributed Departmental Administration.....	-16,560,000
(5) Reimbursements.....	-21,770,000
(6) Amount payable from the Federal Trust Fund (Item 4440-001-0890)....	-3,517,000
(7) Amount payable from the Mental Health Services Fund (Item 4440-001-3085).....	-12,339,000
(8) Amount payable from the Licensing and Certification Fund, Mental Health (Item 4440-001-3099).....	-390,000
Provisions:	
1. Upon order of the Department of Finance, and following 30-day notification to the Joint Legislative Budget Committee, the Controller shall transfer between this item and Item 4440-016-0001 those funds that are necessary for direct community services, as well as administrative and ancillary services related to the provision of direct services.	

Item

2. Notwithstanding Section 26.00, the Department of Finance may authorize the transfer of expenditure authority between Schedules (1) and (2) in order to accurately reflect expenditures in these programs.
3. A transition plan for the transfer of state administrative functions for the operation of the Early and Periodic Screening, Diagnosis, and Treatment Program, the Mental Health Managed Care Program, and applicable functions related to Medicaid requirements to the State Department of Health Care Services shall be provided to all fiscal and applicable policy committees of the Legislature as soon as feasible, but no later than October 1, 2011.

A transition plan for other programmatic functions and components within the State Department of Mental Health shall be provided to all fiscal and applicable policy committees upon completion, but no later than February 1, 2012.

These transition plans may be updated by the Administration and provided to all fiscal and applicable policy committees of the Legislature upon completion, but no later than May 15, 2012.

Reorganization of Department of Mental Health Functions

Future placement of DMH Community Mental Health functions, programs, funding, and positions

Function or Program	Recipient Department	State Operations	Local Assistance	Positions	Total
<ul style="list-style-type: none"> <li>▪ Certification Compliance for:                             <ul style="list-style-type: none"> <li>➢ Crisis Stabilization Units (CSUs)</li> <li>➢ Skilled Nursing Facilities with Special Treatment Programs (SNFs/STPs)</li> <li>➢ Social Rehabilitation Program/Community Residential Treatment systems (CRTs)</li> <li>➢ Community Treatment Facilities (CTFs)</li> </ul> </li> <li>▪ Data Management: Client Services Information system (CSI) &amp; Data Collection and Reporting system (DCR)</li> <li>▪ MHSa Legal, Fiscal, and Policy                             <ul style="list-style-type: none"> <li>➢ Regulations &amp; County Notification Clean-up</li> <li>➢ Legislative Reports</li> </ul> </li> <li>▪ MHSa Housing Program, Administrative Staff – Accounting</li> <li>▪ Mental Health Services Act (MHSa or Prop 63) Issue Resolution</li> <li>▪ Office of Suicide Prevention</li> <li>▪ State Level Prevention Programs                             <ul style="list-style-type: none"> <li>➢ MHSa Student Mental Health Initiative</li> <li>➢ MHSa Stigma and Discrimination Reduction Project</li> <li>➢ Veterans Mental Health</li> </ul> </li> <li>▪ Substance Abuse and Mental Health Services Administration (SAMHSA) Grants:                             <ul style="list-style-type: none"> <li>➢ Community Mental Health Services Block Grant (MHBG)</li> <li>➢ Projects for Assistance in Transition from Homelessness (PATH)</li> <li>➢ Data Infrastructure Grant (DIG)</li> <li>➢ Olmstead Grant</li> </ul> </li> <li>▪ Training Contracts – California Institute for Mental Health (CiMH)</li> <li>▪ California Mental Health Services Act (CalMHSA) for statewide prevention programs<sup>1</sup></li> <li>▪ California Health Interview Survey (CHIS)</li> <li>▪ Policy Management</li> <li>▪ Administrative Staff – IT</li> <li>▪ The California Mental Health Planning Council (CMHPC)</li> <li>▪ County Cultural Competence Plan Requirement (CCPR)</li> </ul>	Department of Health Care Services (DHCS)	\$11,086,000	\$61,235,000	41.0	\$72,321,000
<ul style="list-style-type: none"> <li>▪ Licensing Mental Health Rehabilitation Centers</li> <li>▪ Licensing Psychiatric Health Facilities</li> <li>▪ Approval of Lanterman-Petris-Short (LPS) Act County Designated Facilities (WIC 5150/5585.55)</li> </ul>	Department of Social Services (DSS)	\$1,124,000	\$0	12.0	\$1,124,000

<sup>1</sup> Dollars are not included because they were distributed to CalMHSA by 2009

Reorganization of Department of Mental Health Functions

Future placement of DMH Community Mental Health functions, programs, funding, and positions

Function or Program	Recipient Department	State Operations	Local Assistance	Positions	Total
Training Contracts (Consumer Groups, MHSA Technical Assistance, and MHSA Program Evaluation )	Mental Health Services Oversight and Accountability Commission (MHSOAC)	\$1,651,000	\$0	0.0	\$1,651,000
<ul style="list-style-type: none"> <li>▪ Office of Multicultural Services</li> <li>▪ Cultural Competence Advisory Committee</li> <li>▪ California Reducing Disparities Project (CRDP) – (7 contracts currently funded with \$1.5 million on-going MHSA state administrative funds for Ethnically and Culturally Specific Programs and Interventions)</li> <li>▪ CRDP Prevention Early Intervention Statewide Project - DMH Information Notice 07-19, delineates \$15 million per year for four years (\$60 million total) to be set aside from the MHSA PEI component.</li> <li>▪ Translation Contract</li> <li>▪ Multi-Provider (Cultural Competence Consultant Contract)</li> <li>▪ Cultural Competence and Interpreter Training Contracts</li> </ul>	Department of Public Health (CDPH)	\$2,349,000	\$0	4.0	\$2,349,000
Early Mental Health Initiative (EMHI)	Department of Education (CDE)	\$0	\$15,000,000	0.0	\$15,000,000
Mental Health Services Act Workforce Education and Training (WET) Contracts: <ul style="list-style-type: none"> <li>➤ Stipends (11, one of which is monitoring students)</li> <li>➤ Psychiatric Residency (3)</li> <li>➤ Statewide Technical Assistance Center (1)</li> </ul>	Office of Statewide Health Planning and Development (OSHPD)	\$105,000	\$12,150,000	1.0	\$12,255,000
<b>TOTALS</b>		<b>\$16,315,000</b>	<b>\$88,385,000</b>	<b>58.0</b>	<b>\$104,700,000</b>

**Assembly Bill No. 100**

CHAPTER 5

An act to amend Sections 5813.5, 5846, 5847, 5890, 5891, 5892, and 5898 of the Welfare and Institutions Code, relating to mental health services, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor March 24, 2011. Filed with  
Secretary of State March 24, 2011.]

LEGISLATIVE COUNSEL'S DIGEST

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*The people of the State of California do enact as follows:*

SECTION 1. (a) The Legislature hereby finds and declares that the statutory changes in this act are consistent with, and further the intent of, the Mental Health Services Act. These specified changes are necessary to adequately fund essential mental health services that would otherwise be significantly and substantially reduced or eliminated absent this temporary funding support.

(b) Further, it is the intent of the Legislature to ensure continued state oversight and accountability of the Mental Health Services Act. In eliminating state approval of county mental health programs, the Legislature expects the state, in consultation with the Mental Health Services Oversight and Accountability Commission, to establish a more effective means of ensuring that county performance complies with the Mental Health Services Act.

SEC. 2. Section 5813.5 of the Welfare and Institutions Code is amended to read:

5813.5. Subject to the availability of funds from the Mental Health Services Fund, the state shall distribute funds for the provision of services under Sections 5801, 5802, and 5806 to county mental health programs. Services shall be available to adults and seniors with severe illnesses who meet the eligibility criteria in subdivisions (b) and (c) of Section 5600.3. For purposes of this act, seniors means older adult persons identified in Part 3 (commencing with Section 5800) of this division.

(a) Funding shall be provided at sufficient levels to ensure that counties can provide each adult and senior served pursuant to this part with the medically necessary mental health services, medications, and supportive services set forth in the applicable treatment plan.

(b) The funding shall only cover the portions of those costs of services that cannot be paid for with other funds including other mental health funds, public and private insurance, and other local, state, and federal funds.

(c) Each county mental health programs plan shall provide for services in accordance with the system of care for adults and seniors who meet the eligibility criteria in subdivisions (b) and (c) of Section 5600.3.

(d) Planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers:

(1) To promote concepts key to the recovery for individuals who have mental illness: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.

(2) To promote consumer-operated services as a way to support recovery.

(3) To reflect the cultural, ethnic, and racial diversity of mental health consumers.

(4) To plan for each consumer's individual needs.

(e) The plan for each county mental health program shall indicate, subject to the availability of funds as determined by Part 4.5 (commencing with Section 5890) of this division, and other funds available for mental health services, adults and seniors with a severe mental illness being served by

this program are either receiving services from this program or have a mental illness that is not sufficiently severe to require the level of services required of this program.

(f) Each county plan and annual update pursuant to Section 5847 shall consider ways to provide services similar to those established pursuant to the Mentally Ill Offender Crime Reduction Grant Program. Funds shall not be used to pay for persons incarcerated in state prison or parolees from state prisons.

(g) The department shall contract for services with county mental health programs pursuant to Section 5897. After the effective date of this section the term grants referred to in Sections 5814 and 5814.5 shall refer to such contracts.

SEC. 3. Section 5846 of the Welfare and Institutions Code is amended to read:

5846. (a) The commission shall issue guidelines for expenditures pursuant to Part 3.2 (commencing with Section 5830), for innovative programs, and Part 3.6 (commencing with Section 5840), for prevention and early intervention, no later than 180 days before the fiscal year for which the funds will apply.

(b) The commission may provide technical assistance to any county mental health plan as needed to address concerns or recommendations of the commission or when local programs could benefit from technical assistance for improvement of their plans.

(c) The commission shall ensure that the perspective and participation of members and others suffering from severe mental illness and their family members is a significant factor in all of its decisions and recommendations.

SEC. 4. Section 5847 of the Welfare and Institutions Code is amended to read:

5847. Integrated Plans for Prevention, Innovation, and System of Care Services.

(a) It is the intent of the Legislature to streamline the approval processes of the State Department of Mental Health and the Mental Health Services Oversight and Accountability Commission of programs developed pursuant to Sections 5891 and 5892.

(b) Each county mental health program shall prepare and submit a three-year plan. The plan and update shall include all of the following:

(1) A program for prevention and early intervention in accordance with Part 3.6 (commencing with Section 5840).

(2) A program for services to children in accordance with Part 4 (commencing with Section 5850), to include a program pursuant to Chapter 4 (commencing with Section 18250) of Part 6 of Division 9 or provide substantial evidence that it is not feasible to establish a wraparound program in that county.

(3) A program for services to adults and seniors in accordance with Part 3 (commencing with Section 5800).

(4) A program for innovations in accordance with Part 3.2 (commencing with Section 5830).

(5) A program for technological needs and capital facilities needed to provide services pursuant to Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850). All plans for proposed facilities with restrictive settings shall demonstrate that the needs of the people to be served cannot be met in a less restrictive or more integrated setting.

(6) Identification of shortages in personnel to provide services pursuant to the above programs and the additional assistance needed from the education and training programs established pursuant to Part 3.1 (commencing with Section 5820).

(7) Establishment and maintenance of a prudent reserve to ensure the county program will continue to be able to serve children, adults, and seniors that it is currently serving pursuant to Part 3 (commencing with Section 5800), the Adult and Older Adult Mental Health System of Care Act, Part 3.6 (commencing with Section 5840), Prevention and Early Intervention Programs, and Part 4 (commencing with Section 5850), the Children's Mental Health Services Act, during years in which revenues for the Mental Health Services Fund are below recent averages adjusted by changes in the state population and the California Consumer Price Index.

(c) The State Department of Mental Health shall not issue guidelines for the Integrated Plans for Prevention, Innovation, and System of Care Services before January 1, 2012.

(d) The programs established pursuant to paragraphs (2) and (3) of subdivision (b) shall include services to address the needs of transition age youth ages 16 to 25.

(e) Each year the State Department of Mental Health, in consultation with the California Mental Health Directors Association, the Mental Health Services Oversight and Accountability Commission, and the Mental Health Planning Council, shall inform counties of the amounts of funds available for services to children pursuant to Part 4 (commencing with Section 5850), and to adults and seniors pursuant to Part 3 (commencing with Section 5800). Each county mental health program shall prepare expenditure plans pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850), and updates to the plans developed pursuant to this section. Each expenditure update shall indicate the number of children, adults, and seniors to be served pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850), and the cost per person. The expenditure update shall include utilization of unspent funds allocated in the previous year and the proposed expenditure for the same purpose.

(f) A county mental health program shall include an allocation of funds from a reserve established pursuant to paragraph (6) of subdivision (b) for services pursuant to paragraphs (2) and (3) of subdivision (b) in years in which the allocation of funds for services pursuant to subdivision (d) are not adequate to continue to serve the same number of individuals as the county had been serving in the previous fiscal year.

SEC. 5. Section 5890 of the Welfare and Institutions Code is amended to read:

5890. (a) The Mental Health Services Fund is hereby created in the State Treasury. The fund shall be administered by the state. Notwithstanding Section 13340 of the Government Code, all moneys in the fund are, except as provided in subdivision (d) of Section 5892, continuously appropriated, without regard to fiscal years, for the purpose of funding the following programs and other related activities as designated by other provisions of this division:

(1) Part 3 (commencing with Section 5800), the Adult and Older Adult System of Care Act.

(2) Part 3.6 (commencing with Section 5840), Prevention and Early Intervention Programs.

(3) Part 4 (commencing with Section 5850), the Children's Mental Health Services Act.

(b) Nothing in the establishment of this fund, nor any other provisions of the act establishing it or the programs funded shall be construed to modify the obligation of health care service plans and disability insurance policies to provide coverage for mental health services, including those services required under Section 1374.72 of the Health and Safety Code and Section 10144.5 of the Insurance Code, related to mental health parity. Nothing in this act shall be construed to modify the oversight duties of the Department of Managed Health Care or the duties of the Department of Insurance with respect to enforcing these obligations of plans and insurance policies.

(c) Nothing in this act shall be construed to modify or reduce the existing authority or responsibility of the State Department of Mental Health.

(d) The State Department of Health Care Services, in consultation with the State Department of Mental Health, shall seek approval of all applicable federal Medicaid approvals to maximize the availability of federal funds and eligibility of participating children, adults, and seniors for medically necessary care.

(e) Share of costs for services pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) of this division, shall be determined in accordance with the Uniform Method for Determining Ability to Pay applicable to other publicly funded mental health services, unless this Uniform Method is replaced by another method of determining co-payments, in which case the new method applicable to other mental health services shall be applicable to services pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) of this division.

SEC. 6. Section 5891 of the Welfare and Institutions Code is amended to read:

5891. (a) The funding established pursuant to this act shall be utilized to expand mental health services. Except as provided in subdivision (j) of Section 5892 due to the state's fiscal crisis, these funds shall not be used to supplant existing state or county funds utilized to provide mental health services. The state shall continue to provide financial support for mental health programs with not less than the same entitlements, amounts of allocations from the General Fund or from the Local Revenue Fund 2011

in the State Treasury, and formula distributions of dedicated funds as provided in the last fiscal year which ended prior to the effective date of this act. The state shall not make any change to the structure of financing mental health services, which increases a county's share of costs or financial risk for mental health services unless the state includes adequate funding to fully compensate for such increased costs or financial risk. These funds shall only be used to pay for the programs authorized in Section 5892. These funds may not be used to pay for any other program. These funds may not be loaned to the state General Fund or any other fund of the state, or a county general fund or any other county fund for any purpose other than those authorized by Section 5892.

(b) Notwithstanding subdivision (a), the Controller may use the funds created pursuant to this part for loans to the General Fund as provided in Sections 16310 and 16381 of the Government Code. Any such loan shall be repaid from the General Fund with interest computed at 110 percent of the Pooled Money Investment Account rate, with interest commencing to accrue on the date the loan is made from the fund. This subdivision does not authorize any transfer that would interfere with the carrying out of the object for which these funds were created.

(c) Commencing July 1, 2012, on or before the 15th day of each month, the Controller shall distribute to each Local Mental Health Service Fund established by counties pursuant to subdivision (f) of Section 5892, all unexpended and unreserved funds on deposit as of the last day of the prior month in the Mental Health Services Fund, established pursuant to Section 5890, for the provision of programs and other related activities set forth in Part 3 (commencing with Section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850). Funding distributions shall be based on the amount specified in the county mental health program's three-year plan or update, as required by Section 5847. Nothing in this subdivision shall affect subdivision (a) or (b).

SEC. 7. Section 5892 of the Welfare and Institutions Code is amended to read:

5892. (a) In order to promote efficient implementation of this act allocate the following portions of funds available in the Mental Health Services Fund in 2005–06 and each year thereafter:

(1) In 2005–06, 2006–07, and in 2007–08 10 percent shall be placed in a trust fund to be expended for education and training programs pursuant to Part 3.1.

(2) In 2005–06, 2006–07 and in 2007–08 10 percent for capital facilities and technological needs distributed to counties in accordance with a formula developed in consultation with the California Mental Health Directors Association to implement plans developed pursuant to Section 5847.

(3) Twenty percent for prevention and early intervention programs distributed to counties in accordance with a formula developed in consultation with the California Mental Health Directors Association pursuant to Part 3.6 (commencing with Section 5840) of this division.

(4) The allocation for prevention and early intervention may be increased in any county which the department determines that the increase will decrease the need and cost for additional services to severely mentally ill persons in that county by an amount at least commensurate with the proposed increase. The statewide allocation for prevention and early intervention may be increased whenever the Mental Health Services Oversight and Accountability Commission determines that all counties are receiving all necessary funds for services to severely mentally ill persons and have established prudent reserves and there are additional revenues available in the fund.

(5) The balance of funds shall be distributed to county mental health programs for services to persons with severe mental illnesses pursuant to Part 4 (commencing with Section 5850), for the children's system of care and Part 3 (commencing with Section 5800), for the adult and older adult system of care.

(6) Five percent of the total funding for each county mental health program for Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division, shall be utilized for innovative programs in accordance with Sections 5830, 5847, and 5848.

(b) In any year after 2007–08, programs for services pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) of this division may include funds for technological needs and capital facilities, human resource needs, and a prudent reserve to ensure services do not have to be significantly reduced in years in which revenues are below the average of previous years. The total allocation for purposes authorized by this subdivision shall not exceed 20 percent of the average amount of funds allocated to that county for the previous five years pursuant to this section.

(c) The allocations pursuant to subdivisions (a) and (b) shall include funding for annual planning costs pursuant to Section 5848. The total of these costs shall not exceed 5 percent of the total of annual revenues received for the fund. The planning costs shall include funds for county mental health programs to pay for the costs of consumers, family members, and other stakeholders to participate in the planning process and for the planning and implementation required for private provider contracts to be significantly expanded to provide additional services pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) of this division.

(d) Prior to making the allocations pursuant to subdivisions (a), (b) and (c), funds shall be reserved for the costs for the State Department of Mental Health, the California Mental Health Planning Council, and the Mental Health Services Oversight and Accountability Commission to implement all duties pursuant to the programs set forth in this section. These costs shall not exceed 3.5 percent of the total of annual revenues received for the fund. The administrative costs shall include funds to 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. The amounts allocated for administration shall include amounts sufficient to ensure adequate research and evaluation regarding the effectiveness of services being provided and achievement of the outcome measures set forth in Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division. The amount of funds available for the purposes of this subdivision in any fiscal year shall be subject to appropriation in the annual Budget Act.

(e) In 2004–05 funds shall be allocated as follows:

(1) Forty-five percent for education and training pursuant to Part 3.1 (commencing with Section 5820) of this division.

(2) Forty-five percent for capital facilities and technology needs in the manner specified by paragraph (2) of subdivision (a).

(3) Five percent for local planning in the manner specified in subdivision (c).

(4) Five percent for state implementation in the manner specified in subdivision (d).

(f) Each county shall place all funds received from the State Mental Health Services Fund in a local Mental Health Services Fund. The Local Mental Health Services Fund balance shall be invested consistent with other county funds and the interest earned on the investments shall be transferred into the fund. The earnings on investment of these funds shall be available for distribution from the fund in future years.

(g) All expenditures for county mental health programs shall be consistent with a currently approved plan or update pursuant to Section 5847.

(h) Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which have not been spent for their authorized purpose within three years shall revert to the state to be deposited into the fund and available for other counties in future years, provided however, that funds for capital facilities, technological needs, or education and training may be retained for up to 10 years before reverting to the fund.

(i) If there are still additional revenues available in the fund after the Mental Health Services Oversight and Accountability Commission has determined there are prudent reserves and no unmet needs for any of the programs funded pursuant to this section, including all purposes of the Prevention and Early Intervention Program, the commission shall develop a plan for expenditures of these revenues to further the purposes of this act and the Legislature may appropriate these funds for any purpose consistent with the commission's adopted plan which furthers the purposes of this act.

(j) For the 2011–12 fiscal year, General Fund revenues will be insufficient to fully fund many existing mental health programs, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), Medi-Cal Specialty Mental Health Managed Care, and mental health services provided for special education pupils. In order to adequately fund those programs for the 2011–12 fiscal year and avoid deeper reductions in programs that serve individuals with severe mental illness and the most vulnerable, medically

needy citizens of the state, prior to distribution of funds under paragraphs (1) to (6), inclusive, of subdivision (a), effective July 1, 2011, moneys shall be allocated from the Mental Health Services Fund to the counties as follows:

(1) Commencing July 1, 2011, one hundred eighty-three million six hundred thousand dollars (\$183,600,000) of the funds available as of July 1, 2011, in the Mental Health Services Fund, shall be allocated in a manner consistent with subdivision (c) of Section 5778 and based on a formula determined by the state in consultation with the California Mental Health Directors Association to meet the fiscal year 2011–12 General Fund obligation for Medi-Cal Specialty Mental Health Managed Care.

(2) Upon completion of the allocation in paragraph (1), the Controller shall distribute to counties ninety-eight million five hundred eighty-six thousand dollars (\$98,586,000) from the Mental Health Services Fund for mental health services for special education pupils based on a formula determined by the state in consultation with the California Mental Health Directors Association.

(3) Upon completion of the allocation in paragraph (2), the Controller shall distribute to counties 50 percent of their 2011–12 Mental Health Services Act component allocations consistent with Sections 5847 and 5891, not to exceed four hundred eighty-eight million dollars (\$488,000,000). This allocation shall commence beginning August 1, 2011.

(4) Upon completion of the allocation in paragraph (3), and as revenues are deposited into the Mental Health Services Fund, the Controller shall distribute five hundred seventy-nine million dollars (\$579,000,000) from the Mental Health Services Fund to counties to meet the General Fund obligation for EPSDT for fiscal year 2011–12. These revenues shall be distributed to counties on a quarterly basis and based on a formula determined by the state in consultation with the California Mental Health Directors Association. These funds shall not be subject to reconciliation or cost settlement.

(5) The Controller shall distribute to counties the remaining 2011–12 Mental Health Services Act component allocations consistent with Sections 5847 and 5891, beginning no later than April 30, 2012. These remaining allocations shall be made on a monthly basis.

(6) The total one-time allocation from the Mental Health Services Fund for EPSDT, Medi-Cal Specialty Mental Health Managed Care, and mental health services provided to special education pupils as referenced shall not exceed eight hundred sixty-two million dollars (\$862,000,000). Any revenues deposited in the Mental Health Services Fund in fiscal year 2011–12 that exceed this obligation shall be distributed to counties for remaining fiscal year 2011–12 Mental Health Services Act component allocations, consistent with Sections 5847 and 5891.

(k) Subdivision (j) shall not be subject to repayment.

(l) Subdivision (j) shall become inoperative on July 1, 2012.

SEC. 8. Section 5898 of the Welfare and Institutions Code is amended to read:

5898. The state shall develop regulations, as necessary, for the State Department of Mental Health, the Mental Health Services Oversight and Accountability Commission, or designated state and local agencies to implement this act. Regulations adopted pursuant to this section shall be developed with the maximum feasible opportunity for public participation and comments.

SEC. 9. This act addresses the fiscal emergency declared and reaffirmed by the Governor by proclamation on January 20, 2011, pursuant to subdivision (f) of Section 10 of Article IV of the California Constitution.

SEC. 10. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make changes necessary for implementation of the Budget Act of 2011, it is necessary that this act take effect immediately.

**Assembly Bill No. 102**

CHAPTER 29

An act to amend Sections 12693.55, 12696.05, 12697.10, 12698, and 12698.26 of, and to repeal Sections 12695.04 and 12696.5 of, the Insurance Code, to amend Sections 14017.7, 14105.18, 14105.28, 14105.191, 14105.192, 14105.45, 14105.451, 14105.455, 14154, and 14165 of, to add Sections 14011.78, 14301.4, and 15916 to, and to add Chapter 8.9 (commencing with Section 14700) to Part 3 of Division 9 of, the Welfare and Institutions Code, relating to health, and making an appropriation therefor, to take effect immediately, bill related to the budget.

[Approved by Governor June 28, 2011. Filed with  
Secretary of State June 29, 2011.]

LEGISLATIVE COUNSEL'S DIGEST

SEC. 20. Chapter 8.9 (commencing with Section 14700) is added to Part 3 of Division 9 of the Welfare and Institutions Code, to read:

CHAPTER 8.9. TRANSITION OF COMMUNITY-BASED MEDI-CAL MENTAL HEALTH

14700. (a) (1) It is the intent of the Legislature to transfer to the State Department of Health Care Services, no later than July 1, 2012, the state administration of Medi-Cal specialty mental health managed care, the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, and applicable functions related to federal Medicaid requirements, from the State Department of Mental Health.

(2) It is further the intent of the Legislature for this transfer to occur in an efficient and effective manner, with no unintended interruptions in service delivery to clients and families. This transfer is intended to do all of the following:

(A) Improve access to culturally appropriate community-based mental health services, including a focus on client recovery, social rehabilitation services, and peer support.

(B) Effectively integrate the financing of services, including the receipt of federal funds, to more effectively provide services.

(C) Improve state accountabilities and outcomes.

(D) Provide focused, high-level leadership for behavioral health services within the state administrative structure.

(b) Effective July 1, 2012, the state administrative functions for the operation of Medi-Cal specialty mental health managed care, the EPSDT Program, and applicable functions related to federal Medicaid requirements, that were performed by the State Department of Mental Health shall be transferred to the State Department of Health Care Services. This state administrative transfer shall conform to a state administrative transition plan provided to the fiscal and applicable policy committees of the Legislature as soon as feasible, but no later than October 1, 2011. This state administrative transition plan may also be updated by the Governor and provided to all fiscal and applicable policy committees of the Legislature upon its completion, but no later than May 15, 2012.

(c) All regulations and orders concerning Medi-Cal specialty mental health managed care and the EPSDT Program shall remain in effect and shall be fully enforceable unless and until readopted, amended, or repealed by the State Department of Health Care Services, or until they expire by their own terms.

14701. (a) The State Department of Health Care Services, in collaboration with the State Department of Mental Health and the California Health and Human Services Agency, shall create a state administrative and programmatic transition plan, either as one comprehensive transition plan or separately, to guide the transfer of the Medi-Cal specialty mental health

managed care and the EPSDT Program to the State Department of Health Care Services effective July 1, 2012.

(1) Commencing no later than July 15, 2011, the State Department of Health Care Services, together with the State Department of Mental Health, shall convene a series of stakeholder meetings and forums to receive input from clients, family members, providers, counties, and representatives of the Legislature concerning the transition and transfer of Medi-Cal specialty mental health managed care and the EPSDT Program. This consultation shall inform the creation of a state administrative transition plan and a programmatic transition plan that shall include, but is not limited to, the following components:

(A) Plan shall ensure it is developed in a way that continues access and quality of service during and immediately after the transition, preventing any disruption of services to clients and family members, providers and counties and others affected by this transition.

(B) A detailed description of the state administrative functions currently performed by the State Department of Mental Health regarding Medi-Cal specialty mental health managed care and the EPSDT Program.

(C) Explanations of the operational steps, timelines, and key milestones for determining when and how each function or program will be transferred. These explanations shall also be developed for the transition of positions and staff serving Medi-Cal specialty mental health managed care and the EPSDT Program, and how these will relate to, and align with, positions at the State Department of Health Care Services. The State Department of Health Care Services and the California Health and Human Services Agency shall consult with the Department of Personnel Administration in developing this aspect of the transition plan.

(D) A list of any planned or proposed changes or efficiencies in how the functions will be performed, including the anticipated fiscal and programmatic impacts of the changes.

(E) A detailed organization chart that reflects the planned staffing at the State Department of Health Care Services in light of the requirements of subparagraphs (A) through (C) and includes focused, high-level leadership for behavioral health issues.

(F) A description of how stakeholders were included in the various phases of the planning process to formulate the transition plans and a description of how their feedback will be taken into consideration after transition activities are underway.

(2) The State Department of Health Care Services, together with the State Department of Mental Health and the California Health and Human Services Agency, shall convene and consult with stakeholders at least twice following production of a draft of the transition plans and before submission of transition plans to the Legislature. Continued consultation with stakeholders shall occur in accordance with the requirement in subparagraph (F) of paragraph (1).

(3) The State Department of Health Care Services shall provide the transition plans described in paragraph (1) to all fiscal committees and

appropriate policy committees of the Legislature no later than October 1, 2011. The transition plans may also be updated by the Governor and provided to all fiscal and applicable policy committees of the Legislature upon its completion, but no later than May 15, 2012.

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# California Department of Mental Health Community Stakeholder Summer

## Final Summary Report

October 2011

This report is located on the DMH website at:

[http://www.dmh.ca.gov/Services\\_and\\_Programs/Medi\\_Cal/Medi\\_Cal\\_Transfer.asp](http://www.dmh.ca.gov/Services_and_Programs/Medi_Cal/Medi_Cal_Transfer.asp)

Prepared by Eileen Jacobowitz, EJC Consulting  
for the  
California Department of Mental Health

In collaboration with the California Institute for Mental Health



## **Listing of Stakeholder Correspondence Regarding Transition**

1. Association of CA Caregiver Resource Centers (CRC)
2. CA Mental Health Planning Council
3. California Coalition for Mental Health (CCMH)
4. California Emergency Management Agency (CalEMA)
5. California Mental Health Directors Association
6. Mental Health Association in California
7. Mental Health Services Oversight Accountability Commission's (MHSOAC) Role in a Changing Mental Health Services Environment
8. National Alliance on Mental Illness (NAMI)
9. Office of Multi-Cultural Services (OMS) Support Letter
10. Racial and Ethnic Mental Health Disparities Coalition (REMHDCO)
11. Rose King Comments on Community Services and Supports
12. Stakeholder Comments Submitted Online
13. University of California, Los Angeles (UCLA)
14. United Advocates for Children and Families

All correspondence listed may be found on the Department of Mental Health's website at:

[http://www.dmh.ca.gov/Services\\_and\\_Programs/Medi\\_Cal/Medi\\_Cal\\_Transfer.asp](http://www.dmh.ca.gov/Services_and_Programs/Medi_Cal/Medi_Cal_Transfer.asp)

# CONTRACTS TRANSFERRING TO OTHER DEPARTMENTS\*

Appendix G

Whole Dollars

Fund Source

Department	Type of Transfer	Contractor	Description of Services	FY 2012-13		Fund Source			
				Total Contract Amt	Amount	SGF	FFP	FTF	MHSF
OSHPD	MHSA Local Assistance	CalSWEC	Stipend Program - Social Workers	\$ 46,518,556	\$ 5,818,340	\$ -	\$ -	\$ -	\$ 5,818,340
OSHPD	MHSA Local Assistance	University of California, San Francisco	Stipend Program - Psych Nurse	\$ 1,145,219	\$ 219,460	\$ -	\$ -	\$ -	\$ 219,460
OSHPD	MHSA Local Assistance	California Institute of Integral Studies	Stipend Program - Psych Nurse	\$ 373,898	\$ 120,478	\$ -	\$ -	\$ -	\$ 120,478
OSHPD	MHSA Local Assistance	Azusa Pacific University	Stipend Program - Psych Nurse	\$ 1,178,134	\$ 99,999	\$ -	\$ -	\$ -	\$ 99,999
OSHPD	MHSA Local Assistance	California State University, Fresno Foundation	Stipend Program - Psych Nurse	\$ 582,561	\$ 99,160	\$ -	\$ -	\$ -	\$ 99,160
OSHPD	MHSA Local Assistance	Phillips Graduate Institute	Stipend Program - Marriage & Family Therapist	\$ 10,688,000	\$ 1,859,000	\$ -	\$ -	\$ -	\$ 1,859,000
OSHPD	MHSA Local Assistance	Alliant University	Stipend Program - Marriage & Family Therapist	\$ 1,034,651	\$ 330,898	\$ -	\$ -	\$ -	\$ 330,898
OSHPD	MHSA Local Assistance	CSU, Chico Research Foundation	Stipend Program - Marriage & Family Therapist	\$ 940,748	\$ 191,832	\$ -	\$ -	\$ -	\$ 191,832
OSHPD	MHSA Local Assistance	Loma Linda University	Stipend Program - Marriage & Family Therapist	\$ 342,255	\$ 2,000	\$ -	\$ -	\$ -	\$ 2,000
OSHPD	MHSA Local Assistance	California Psychology Internship Council	Stipend Program - Clinical Psychologists	\$ 5,134,096	\$ 809,144	\$ -	\$ -	\$ -	\$ 809,144
OSHPD	MHSA Local Assistance	Palo Alto University	Stipend Program - Clinical Psychologists	\$ 1,224,810	\$ 256,545	\$ -	\$ -	\$ -	\$ 256,545
OSHPD	MHSA Local Assistance	California Institute for Mental Health	Statewide Technical Assistance Center	\$ 2,400,000	\$ 800,000	\$ -	\$ -	\$ -	\$ 800,000
OSHPD	MHSA Local Assistance	UCLA Kern	Psych Residency Program RFP <sup>1</sup>	\$ 1,350,000	\$ 450,000	\$ -	\$ -	\$ -	\$ 450,000
OSHPD	MHSA Local Assistance	UC Davis	Psych Residency Program	\$ 2,523,523	\$ 474,099	\$ -	\$ -	\$ -	\$ 474,099
OSHPD	MHSA Local Assistance	Regents of the UC, San Francisco	Psych Residency Program	\$ 1,322,504	\$ 299,814	\$ -	\$ -	\$ -	\$ 299,814
OAC	MHSA Support	CA Assn. of Local MH Boards and Commissions	Support, education, training and TA to CFM	\$ 166,500	\$ 55,500	\$ -	\$ -	\$ -	\$ 55,500
OAC	MHSA Support	California Network of Mental Health Clients <sup>3</sup>	Support by and for mental health clients	\$ 1,643,850	\$ 547,950	\$ -	\$ -	\$ -	\$ 547,950
OAC	MHSA Support	National Alliance on Mental Illness (NAMI) <sup>3</sup>	Peer-to-peer self-help training for consumers	\$ 1,909,197	\$ 636,399	\$ -	\$ -	\$ -	\$ 636,399
OAC	MHSA Support	United Advocates for Children and Families	Promote and support leadership by CFM	\$ 581,485	\$ 193,729	\$ -	\$ -	\$ -	\$ 193,729
OAC	MHSA Support	United Advocates for Children and Families <sup>3</sup>	Gateway to Hope project	\$ 630,000	\$ 210,000	\$ -	\$ -	\$ -	\$ 210,000
DPH	MHSA Support	Avantpage <sup>3</sup>	Translation services	\$ 270,000	\$ 90,000	\$ -	\$ -	\$ -	\$ 90,000
DPH	MHSA Support	Master Multi-Provider Cultural Competency <sup>3</sup>	Training on cultural competence related topics	\$ 252,000	\$ 84,000	\$ -	\$ -	\$ -	\$ 84,000
DPH	MHSA Support	African American Health Institute of San Bernardino County <sup>3</sup>	Reducing Disparities Population Report	\$ 611,052	\$ 200,000	\$ -	\$ -	\$ -	\$ 200,000
DPH	MHSA Support	Equality California Institute, Inc. <sup>3</sup>	Reducing Disparities Population Report	\$ 644,000	\$ 200,000	\$ -	\$ -	\$ -	\$ 200,000
DPH	MHSA Support	Native Health Center, Inc. <sup>3</sup>	Reducing Disparities Population Report	\$ 670,000	\$ 200,000	\$ -	\$ -	\$ -	\$ 200,000
DPH	MHSA Support	Regents of the UC of CA. <sup>3</sup>	Reducing Disparities Population Report	\$ 669,736	\$ 200,000	\$ -	\$ -	\$ -	\$ 200,000
DPH	MHSA Support	Pacific Clinics <sup>3</sup>	Reducing Disparities Population Report	\$ 670,000	\$ 200,000	\$ -	\$ -	\$ -	\$ 200,000
DPH	MHSA Support	California Pan Ethnic Health Network <sup>3</sup>	Facilitator/Writer of the CRDP Strategic Plan	\$ 462,713	\$ 200,000	\$ -	\$ -	\$ -	\$ 200,000
DPH	MHSA Support	Mental Health Association in California <sup>3</sup>	Coalition for reducing disparities strategic plan	\$ 1,100,000	\$ 300,000	\$ -	\$ -	\$ -	\$ 300,000

# CONTRACTS TRANSFERRING TO OTHER DEPARTMENTS\*

## Whole Dollars

Fund Source

Department	Type of Transfer	Contractor	Description of Services	Total Contract Amt	FY 2012-13				
					Amount	SGF	FFP	FTF	MHSF
DPH	MHSA Support	TBD <sup>4</sup>	Interpreter Training Curriculum	\$ -	\$ 48,000	\$ -	\$ -	\$ -	\$ 48,000
DPH	MHSA Support	TBD <sup>4</sup>	Cultural Competency Training Curriculum	\$ -	\$ 137,000	\$ -	\$ -	\$ -	\$ 137,000
DPH	MHSA Support	TBD <sup>4</sup>	Administrative Completion of Interpreter Curriculum	\$ -	\$ 100,000	\$ -	\$ -	\$ -	\$ 100,000
DHCS	Federal Funds	California State University Sacramento	Olmstead IMD Training Manual <sup>5</sup>	\$ 60,000	\$ 60,000	\$ -	\$ -	\$ 60,000	\$ -
DHCS	MHSA Support	California Institute for Mental Health (CIMH) <sup>3</sup>	Training & technical asst, consultation and outcomes monitoring for MHSA-funded county programs	\$ 12,584,977	\$ 4,144,000	\$ -	\$ -	\$ -	\$ 4,144,000
DHCS	MHSA Support	California Mental Health Services Authority (CalMHSA) <sup>5</sup>	Implement PEI State Wide Projects SP, SDR and SMHI	\$ 160,000,000	\$ -	\$ -	\$ -	\$ -	\$ -
DHCS	MHSA Support	Regents of the University of California, LA <sup>3</sup>	California Health Information Survey (CHIS)	\$ 2,400,000	\$ 800,000	\$ -	\$ -	\$ -	\$ 800,000
<b>36 Total Contracts</b>									
				<b>\$ 262,084,465</b>	<b>\$ 20,437,347</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 60,000</b>	<b>\$ 20,377,347</b>

DEPARTMENT	TYPE OF TRANSFER		FUND SOURCE			
	NON MEDI-CAL	SGF	FFP	FTF	MHSF	
OSHPD	\$ 11,830,769	\$ -	\$ -	\$ -	\$ 11,830,769	
OAC	\$ 1,643,578	\$ -	\$ -	\$ -	\$ 1,643,578	
DPH	\$ 1,959,000	\$ -	\$ -	\$ -	\$ 1,959,000	
DHCS	\$ 5,004,000	\$ -	\$ -	\$ 60,000	\$ 4,944,000	
<b>Grand Total</b>	<b>\$ 20,437,347</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 60,000</b>	<b>\$ 20,377,347</b>	

**Footnotes:**

\*Excludes amounts for MOUs and grants with direct allocations to counties and other state agencies.

<sup>1</sup>These contracts end in FY 11-12, however the Departments receiving the funds will initiate new contracts.

<sup>2</sup> Multi-funded Contract. FY 12-13 amount reflects Medi-Cal portion only.

<sup>3</sup>Conference Compromise MHSA Contracts (AB 100)

<sup>4</sup>These contract activities have been authorized through the Conference Compromise (AB 100) however, the Departments receiving the funds will initiate new contracts.

<sup>5</sup>Funds distributed in full as of 11-12 and contract extended for time only through 12-13.

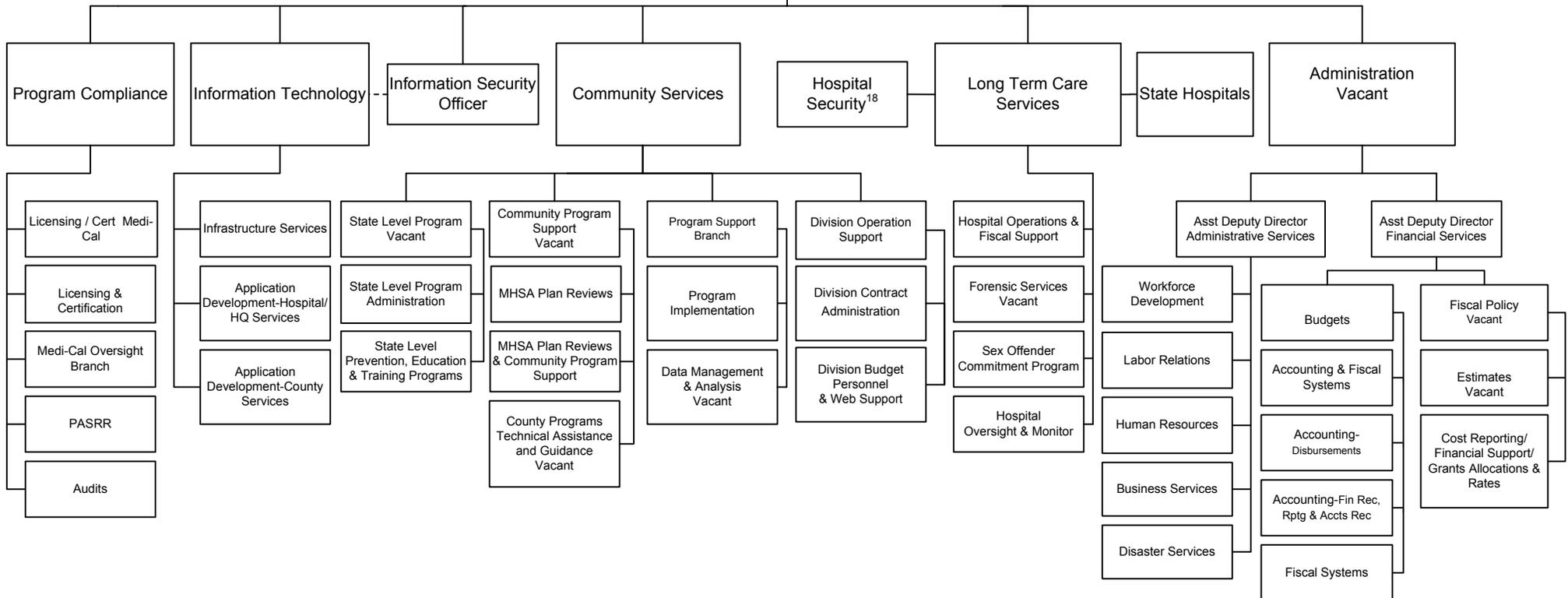
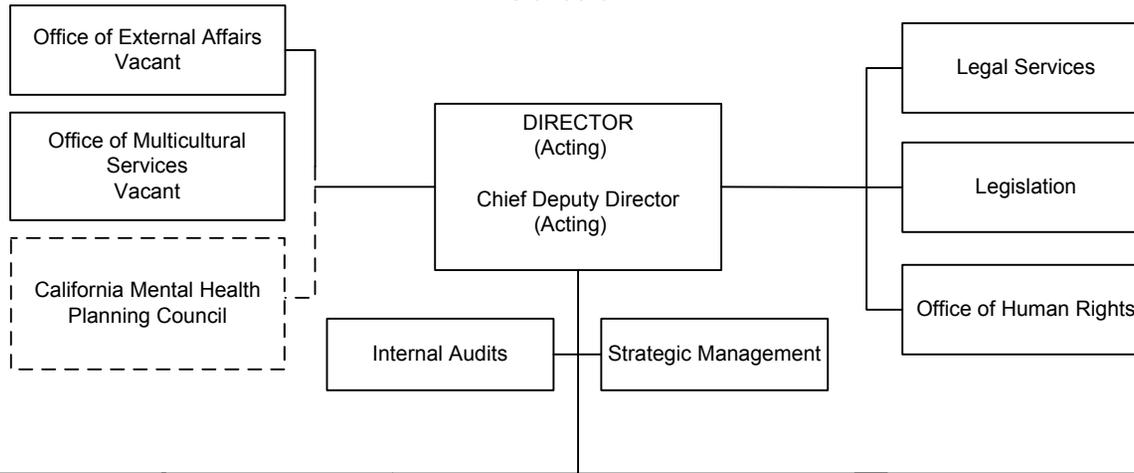
DMH HQ TOTAL

Total Positions: 550  
 MHSA Funded Positions: 113  
 Vacant Positions: 60  
 Propose Transfer to DHCS: 119.5

DEPARTMENT OF MENTAL HEALTH

As of 05/01/11

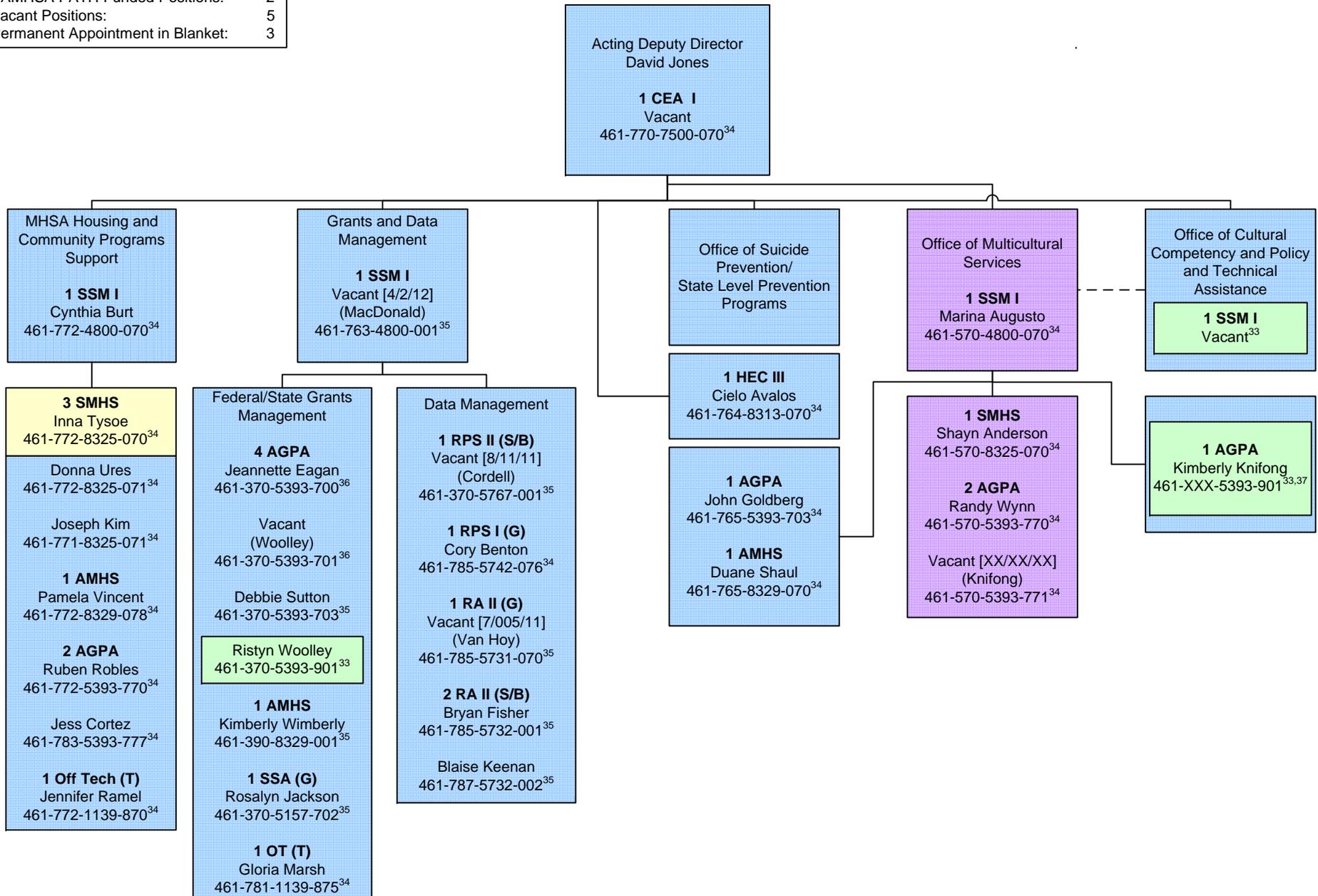
Appendix H-1



Department of Mental Health  
**OFFICE OF COMMUNITY SERVICES**

Current as of 5/14/12

DIVISION TOTAL	
Total Positions:	28
MHSA Funded Positions:	18
SAMHSA BLOCK Funded Positions:	8
SAMHSA PATH Funded Positions:	2
Vacant Positions:	5
Permanent Appointment in Blanket:	3



<sup>33</sup>Permanent appointment in blanket  
<sup>34</sup>MHSA Funded Position Authorized in AB 100 (24 total)  
<sup>35</sup>SAMHSA BLOCK Funded Position  
<sup>36</sup>SAMHSA PATH Funded Position  
<sup>37</sup>MHSA Position (blanket funded)

**CALIFORNIA MENTAL HEALTH PLANNING COUNCIL**  
**Welfare and Institutions Code Section 5771 et seq.**

5571.

(a) Pursuant to Public Law 102-321, there is the California Mental Health Planning Council. The purpose of the planning council shall be to fulfill those mental health planning requirements mandated by federal law.

(b)(1) The planning council shall have 40 members, to be comprised of members appointed from both the local and state levels in order to ensure a balance of state and local concerns relative to planning.

(2) As required by federal law, eight members of the planning council shall represent various state departments.

(3) Members of the planning council shall be appointed in a manner that will ensure that at least one-half are persons with mental disabilities, family members of persons with mental disabilities, and representatives of organizations advocating on behalf of persons with mental disabilities. Persons with mental disabilities and family members shall be represented in equal numbers.

(4) The Director of Mental health shall make appointments from among nominees from various mental health constituency organizations, which shall include representatives of consumer-related advocacy organizations, representatives of mental health professional and provider organizations, and representatives who are direct service providers from both the public and private sectors. The director shall also appoint one representative of the California Coalition on Mental Health.

(c) Members should be balanced according to demography, geography, gender and ethnicity. Members should include representatives with interest in all target populations, including, but not limited to, children and youth, adults, and older adults.

(d) The planning council shall annually elect a chairperson and a chair-elect.

(e) The term of each member shall be three years, to be staggered so that approximately one-third of the appointments expire in each year.

(f) In the event of changes in the federal requirements regarding the structure and function of the planning council, or the discontinuation of federal funding, the State Department of Mental Health shall propose to the Legislature modifications in the structure of the planning council that the department deems appropriate.

5771.1

The members of the Mental Health Services Oversight and Accountability Commission established pursuant to Section 5845 are members of the California Mental Health Planning Council. They serve in an ex officio capacity when the council is performing its statutory duties pursuant to Section 5772. Such membership shall not affect the composition requirements for the council specified in Section 5771.

5771.3

The California Mental Health Planning Council may utilize staff of the State Department of Mental Health, to the extent they are available, and the staff of any other public or private agencies that have an interest in the mental health of public and that are able and willing to provide those services.

5771.5

(a)(1) The Chairperson of the California Mental Health Planning Council, with the concurrence of a majority of the members of the California Mental Health Planning Council, shall appoint an executive officer who shall have those powers delegated to him or her by the council in accordance with this chapter.

(2) The executive officer shall be exempt from civil service.

(b) Within the limit of funds allotted for these purposes, the California Mental Health Planning Council may appoint other staff it may require according to rules and procedures of the civil service system.

5772

The California Mental Health Planning Council shall have the powers and authority necessary to carry out the duties imposed upon it by this chapter, including, but not limited to, the following:

- (a) To advocate for effective, quality mental health programs.
- (b) To review, assess, and make recommendations regarding all components of California's mental health system, and to report as necessary to the Legislature, the State Department of Mental Health, local boards, and local programs.
- (c) To review program performance in delivering mental health services by annually reviewing performance outcome data as follows:
  - (1) To review and approve the performance outcome measures.
  - (2) To review the performance of mental health programs based on performance outcome data and other reports from the State Department of Mental Health and other sources.
  - (3) To report findings and recommendations on programs' performance annually to the Legislature, the State Department of Mental Health, and the local boards.
  - (4) To identify successful programs for recommendation and for consideration of replication in other areas. As data and technology are available, identify programs experiencing difficulties.
- (d) When appropriate, make a finding pursuant to Section 5655 that a county's performance is failing in a substantive manner. The State Department of Mental Health shall investigate and review the finding, and report the action taken to the Legislature.
- (e) To advise the Legislature, the State Department of Mental Health, and county boards on mental health issues and the policies and priorities that this state should be pursuing in developing its mental health system.
- (f) To periodically review the state's data systems and paperwork requirements to ensure that they are reasonable and in compliance with state and federal law.
- (g) To make recommendations to the State Department of Mental Health on the award of grants to county programs to reward and stimulate innovation in providing mental health services.
- (h) To conduct public hearings on the state mental health plan, the Substance Abuse and Mental Health Services Administration block grant, and other topics, as needed.
- (i) To participate in the recruitment of candidates for the position of Director of Mental Health and provide advice on the final selection.
- (j) In conjunction with other statewide and local mental health organizations, assist in the coordination of training and information to local mental health boards as needed to ensure that they can effectively carry out their duties.

- (k) To advise the Director of Mental Health on the development of the state mental health plan and the system of priorities contained in that plan.
- (l) To assess periodically the effect of realignment of mental health services and any other important changes in the state's mental health system, and to report its findings to the Legislature, the State Department of Mental Health, local programs, and local boards, as appropriate.
- (m) To suggest rules, regulations, and standards for the administration of this division.
- (n) When requested, to mediate disputes between counties and the state arising under this part.
- (o) To employ administrative, technical, and other personnel necessary for the performance of its powers and duties, subject to the approval of the Department of Finance.
- (p) To accept any federal fund granted, by act of Congress or by executive order, for purposes within the purview of the California Mental Health Planning Council, subject to the approval of the Department of Finance.
- (q) To accept any gift, donation, bequest, or grants of funds from private and public agencies for all or any of the purposes within the purview of the California Mental Health Planning Council, subject to the approval of the Department of Finance.

## 5772.5.

- (a) It is the intent of the Legislature that the planning council do all of the following:
  - (1) Review and monitor the implementation of counties' efforts to improve the provision and quality of mental health services to foster children.
  - (2) Advocate to reduce the stigma and discrimination against persons with mental health needs.
  - (3) Work with advocacy organizations to remove barriers facing children and youth who need mental health care.
- (b) This section shall remain in effect only until January 1, 2007, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2007, deletes or extends that date.

**STATE MENTAL HEALTH PLANNING COUNCIL**  
**42 U.S.C., 300x., Sections 1914 and 1915**

Section 1914. State Mental Health Planning Council

- (a) **IN GENERAL**—A funding agreement for a grant under section 1911 is that the State involved will establish and maintain a State mental health planning council in accordance with the conditions described in this section.
- (b) **DUTIES**—A condition under subsection (a) for a Council is that the duties of the Council are--
- (1) To review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
  - (2) To serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems; and
  - (3) To monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State
- (c) **MEMBERSHIP**—
- (1) **IN GENERAL**—A condition under subsection (a) for a Council is that the Council be composed of residents of the State, including representatives of—
    - (A) The principal State agencies with respect to—
      - (i) Mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
      - (ii) The development of the plan submitted pursuant to title XIX of the Social Security Act;
    - (B) Public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
    - (C) Adults with serious mental illnesses who are receiving (or have received) mental health services; and
    - (D) The families of such adults or families of children with emotional disturbances.
  - (2) **CERTAIN REQUIREMENTS**—A condition under subsection (a) for a Council is that—
    - (A) With respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and
    - (B) Not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.
- (d) **DEFINITION**—For purposes of this section, the term “Council” means a State mental health planning council.

## DEPARTMENT OF MENTAL HEALTH LICENSING AND CERTIFICATION

The Department of Mental Health (DMH) Licensing and Certification (L&C) Branch is responsible for implementing and maintaining a system of assuring compliance related to facility licensing and program certification of a range of 24-hour psychiatric and rehabilitation care facilities. The programs subject to licensure and certification by DMH are: Mental Health Rehabilitation Centers (MHRCs), Psychiatric Health Facilities (PHFs), Skilled Nursing Facilities with Special Treatment Programs (SNFs/STPs), Community Residential Treatment Systems (CRTS) -- also known as Social Rehabilitation Programs (SRPs) -- and Community Treatment Facilities (CTFs).

The following describes those administrative functions in the DMH L&C that are being proposed for transfer to the Department of Social Services (DSS) and Department of Health Care Services (DHCS).

The DSS will assume responsibilities for licensing of MHRCs and PHFs.

The DHCS will assume responsibilities for certification of SNFs/STPs, CRTS/SRPs and CTFs.

### CRTS/SRPs

The CRTS/SRPs are licensed by DSS and the mental health program components are certified by the DMH. The CRTS/SRP requirements are set forth in the California Welfare and Institutions Code (WIC), Sections 5670, 5670.5 and 5671. The regulations for interpreting these provisions of statutes are contained in Article 3.5 (Commencing with Section 531) of Chapter 3, in Division 1, of Title 9 in the California Code of Regulations (CCR).

There are three categories of CRTS/SRPs that are defined in Sections 5670 and 5671 of the WIC, and Sections 531 through Section 535 of Title 9 of the CCR:

- 1) **Short-Term Crisis Residential:** Offers alternatives to acute hospitalization; provides stabilization and diagnostic services for no longer than three months.
- 2) **Transitional Residential:** Provides an activity program that encourages utilization of community resources for no longer than 18 months.
- 3) **Long-Term Residential:** Provides rehabilitation services for the chronically mentally ill who need long-term support and care for up to two to three years, in order to develop independent living skills.

These treatment service programs are designed to serve adults who are in need of mental health treatment and are unable to care for themselves in an independent living situation, but can be cared for in a CRTS/SRP that provides psychiatric care in a normal home environment.

CRTS/SRPs provide a wide range of alternatives to acute psychiatric hospitalization and institutional care based on the principles of residential community-based treatment. This includes a high level of care provided in a homelike setting, stringent staff requirements, 24-hour-a-day, seven-day-a-week supervision and treatment assistance and community participation at all levels.

CRTS/SRP program services include, but are not limited to: intensive diagnostic work, including learning disability assessment; full-day treatment program with an active prevocational and vocational component; special education services; outreach to develop linkages with the general social service system; and counseling to aid clients in developing the skills to move toward a less structured setting.

The CRTS/SRP, as mandated by statute and regulations, requires the DMH to certify social rehabilitation programs in community care facilities licensed by the DSS. The program certification by the DMH is a condition of licensure by the DSS. The certification process includes a rigorous on-site review of operations, clinical practice standards, policies and procedures and treatment modalities.

Annual onsite reviews to evaluate CRTS/SRP compliance with Title 9 regulations are conducted by the DMH L&C. An onsite review includes, but is not limited to, interviews with staff and clients and review of clients' charts, staff in-service training records, program staff resumes, groups/activities, outside resource contracts and agreements, all logs, documents, financial records and policies concerning regulatory practices within the facility.

DMH L&C also reviews the facility requirements for qualifications of mental health treatment staffing, including training qualifications of treatment staff and treatment procedures. In addition, DMH conducts interviews with clients as well as the staff.

At the time of the onsite surveys, clients' charts are randomly selected and reviewed to verify that:

- the problems for which the client was initially admitted to the CRTS/SRP are identified in the treatment/care plan;
- the care plan consists of a synthesis of the following assessments: (1) Health and psychiatric histories; (2) Psychosocial skills; (3) Social support skills; (4) Current psychological, educational, vocational and other functional limitations; (5) Medical needs, as reported; and, (6) Meal Planning, shopping and budgeting skills;
- the identified client population is clinically appropriate for the CRTS/SRP;
- the profile and grouping criteria as described in the CRTS/SRP Plan have been implemented; and
- CRTS/SRP services are being delivered as specified in DMH approved plan.

Upon completion of the onsite review, the reviewer holds an exit conference with the program director and facility staff to discuss review findings. Within 30 calendar days

following completion of the review, the DMH sends both a letter of either approval or deficiencies and a copy of the completed review protocol to the facility and the DSS.

An annual CRTS certification is enclosed with a letter of approval. A letter of deficiencies will include a due date for the facility to submit a written plan of correction. Following the DMH's review and acceptance of the plan of correction, a certificate with a letter of approval is sent to the facility. The DMH may conduct additional reviews to ensure that deficiencies have been corrected.

The DMH L&C may refuse to approve a CRTS/SRP or may withdraw approval of, or decertify, a program at any time for good cause, including but not limited to the following:

- failure to implement or maintain the approved program plan/plan of operation;
- substantial noncompliance with applicable regulations; or
- revocation of the Social Rehabilitation Facility's license by the DSS.

### **SNFs/STPs**

SNFs/STPs operate under Title 22, California Code of Regulations (CCR), Sections 72443-72475, and DMH's Policies and Directives.

In order for an SNF to be certified as an STP, it must meet the licensing and certification requirements of the Department of Public Health (DPH). It is necessary that the facility be licensed as a Medicaid-certified SNF.

Title 22, CCR, describes and defines programs that serve clients who have a chronic psychiatric impairment and whose adaptive functioning is moderately impaired. STP services are those therapeutic services provided to mentally disordered persons having special needs in one or more of the following areas: self-help skills, behavioral adjustment, and interpersonal relationships. They also include pre-vocational preparation and pre-release planning.

The primary focus of the DMH survey has been and remains the structure and operation of the STP.

STPs are designed to serve clients who have a chronic psychiatric impairment and whose adaptive functioning is moderately impaired. The monitoring of SNFs/STPs occurs annually by the DMH as stipulated by Title 22. The DMH conducts the annual review at the facility after reviewing and approving the updated written program plan together with any written requests for modification to the previously approved program. Confirmation of program compliance is done by random review of client charts. DMH reviewers attend groups and activities to evaluate clients' attendance and participation. Facility records are also reviewed to ensure compliance with Title 22 in the areas of staffing coverage requirements, staff qualifications, in-service training requirements and provision of required rehabilitation services individualized to client needs. Documents

such as seclusion and restraint logs, denial of patients' rights and personnel records are also reviewed.

DPH licensing staff may be present simultaneously to conduct a facility licensing review as provided in Health and Safety Code (HSC), Section 1422.1. Specifically, HSC provides that

“the DPH, shall conduct, when feasible, annual licensing inspections of licensed, long-term health care facilities providing special treatment programs for the mentally disordered, concurrently with inspections conducted by the DMH for the purposes of approving the special treatment program.”

STP services are those therapeutic services provided to mentally disordered persons having special needs in one or more of the following areas: self-help skills, behavioral adjustment, and interpersonal relationships. They include pre-vocational preparation and pre-release planning. Other program services include group and individual counseling; instruction on personal care and medication management; use of community and personal resources.

Program monitoring of the STP shall include, but not be limited to, a review of:

- the approved STP Plan;
- a sample of client charts;
- program staff in-service training records;
- program staff schedules and time cards;
- Denial of Rights Log; and,
- Restraint and Seclusion records;

and will ensure the following:

- each client's treatment/care plans are appropriately addressing identified treatment needs;
- the identified client population is clinically appropriate for the STP;
- treatment groups are designed to address clients' treatment needs;
- clients are attending their scheduled programming;
- equipment utilized for various program services is adequate for client needs and conforms to the approved STP Plan;
- the STP's overall integrity
- provision for client care and welfare; and
- investigation of complaints against the STP.

The DMH reviewers will verify that:

- The identified client population is clinically appropriate for the STP.
- The profile and grouping criteria as described in the program plan have been implemented.
- STP services are being delivered as specified in the DMH-approved plan.
- Clients are attending their scheduled programming.

- There is at least one hour of direct program staff time for each six program hours.
- There are sufficient program staff members, other than the Program Director, to provide the scheduled client services.
- The space available for the various program services is adequate for client needs and conforms to the approved STP Plan.
- The equipment utilized for the various program services is adequate for client needs and conforms to the approved STP Plan.
- The problems for which the client was initially admitted to the STP are identified in the treatment/care plan.
- The client's treatment/care plan appropriately addresses the identified problems.
- The care plan consists of a synthesis of the following assessments:
  - Medical
  - Nursing
  - Dietetic
  - Social Services
  - Psychological.

## **CTFs**

CTFs are secured (locked) community residential treatment facilities providing mental health services to adolescents who are diagnosed as Severely Emotionally Disturbed (SED). The DMH is responsible for the development and distribution of 400 CTF beds within the five Mental Health Regions of California.

The CTF licensing category was designed to provide an alternative to state hospital or out-of-state placement and to enable children with mental health needs to receive treatment in less restrictive, more appropriate settings, closer to their families' homes. To be licensed as a CTF, the treatment facility must have the capacity to provide "secure containment."

In order for a child to be placed in a CTF, all the following criteria must be met: (1) the child may require a period of containment to participate in and benefit from mental health treatment, and the CTF program must be reasonably expected to improve the child's mental disorder; (2) the child must be seriously emotionally disturbed; (3) other, less restrictive interventions must have been attempted and proven insufficient, or the child is an inpatient in a psychiatric hospital, a state hospital, or an out-of-state placement; (4) the county interagency placement committee must provide certification for the child to be placed in the CTF; and (5) consent from parents, the court, or the conservator must be properly obtained.

Program monitoring of the CTF shall include, but not be limited to, a review of:

- a sample of client charts;
- program staff in-service training records;
- program staff schedules and time cards;

- Denial of Rights Log;
- Restraint and Seclusion records;
- Discharge and Release Procedures;
- Licensed Mental Health Treatment Staffing;
- Child and Family Involvement and Participation; and
- Special investigations;

and will ensure the following:

- each client's treatment/care plans are appropriately addressing identified treatment needs;
- the identified client population is clinically appropriate for the CTF;
- treatment groups are designed to address clients' treatment needs;
- clients are attending their scheduled programming; and
- provision for client care and welfare.

## **PHFs**

Title 22, Division 5 of the CCR constitutes DMH PHF licensing review protocols. These regulations represent the criteria used by DMH to conduct the initial and annual licensure of PHFs.

PHFs are licensed to provide acute inpatient psychiatric treatment to individuals with major mental disorders in a nonhospital setting. PHFs provide 24-hour inpatient care for mentally disordered, incompetent or other persons described in Division 5 (commencing with Section 500) or Division 6 (commencing with Section 6000) of the Welfare and Institution Code (WIC). PHFs are specifically prohibited from admitting or treating prospective patients with primary diagnoses of chemical dependency-related disorders and eating disorders. Further, PHFs may admit and treat only patients who have no physical illness or injury that would require treatment beyond what ordinarily could be treated on an outpatient basis. PHFs mainly provide acute psychiatric treatment services to individuals subject to involuntary commitment under the LPS Act.

The scope of practice for PHFs is defined in Health and Safety Code, Section 1250.2 (a). It was specifically noted in the law that many counties did not have adequate 24-hour acute psychiatric inpatient facilities, that many counties did not have any beds or services for persons needing acute 24-hour inpatient care, and that such services could be provided in a non-hospital setting. If a patient cannot be treated as an outpatient for problems, the patient cannot be treated at a PHF no matter what the patient's level of psychiatric acuity may be. PHFs were created in 1978 by an act of the California Legislature to provide a low cost alternative to hospital-based care. Acute Psychiatric Hospitals employ a medical model; whereas, PHFs employ a multidisciplinary model consistent with its enabling legislation which called for an innovative approach to acute inpatient psychiatric care. PHFs were conceptualized and designed to be an alternative to acute psychiatric hospitals which are traditionally based on a medical model.

PHFs may admit and provide treatment services to:

- Individuals involuntarily detained (commitment under the Lanterman-Petris-Short [LPS] Act) for 72-hour evaluation and treatment pursuant to Welfare and Institutions Code (WIC) Section 5150 et seq.;
- Individuals certified for additional intensive treatment as suicidal under WIC Section 5260;
- Individuals certified for intensive treatment under WIC Section 5250; and,
- Any individual post-certified as a demonstrated danger of substantial physical harm to others under WIC Section 5300.

**Please note:** PHFs are considered non-medical facility and for that reason, PHFs are not under the jurisdiction of Office of Statewide Health Planning and Development (OSHPD). OSHPD has regulation development and code enforcement responsibilities for (1) hospital buildings which are licensed acute care facilities (2) skilled nursing facilities and (3) intermediate care facilities which provide skilled nursing level services. PHFs are reviewed only under local building codes as residential facilities.

The DMH L&C unit is directly responsible for the initial licensure and ongoing oversight of PHFs, including annual onsite facility review to ensure PHFs' compliance with the California Code Regulations, Title 22, Division 5, Chapter 9, and applicable state and federal laws. To ensure the physical well being of the mentally ill persons residing in a PHF, facilities are responsible for the provision, at minimum, of any needed physician, pharmacy, rehabilitation program, dietary and social services.

Measures used to assess program performance and evaluate compliance include but are not be limited to annual onsite review of PHFs using protocols/regulations to ensure compliance with programmatic regulatory requirements. During an onsite survey of a PHF, DMH reviewer's interview staff and clients, observe clinical groups and activities and review the facilities:

- Administrative Records
- Personnel Records
- Client Charts
- Physical Plant Records
- Unusual Occurrence and Complaint Records
- Denial of Rights and R&S Records.

The above records are reviewed to verify that:

- Patients are receiving care and supervision as required by statute and regulations;
- PHF services are being delivered as specified in the DMH-approved Plan of Operation;
- The problems for which the patient is initially admitted to the PHF are identified in the treatment/service plan;

- The patient's treatment/care plan appropriately addresses the identified problems (the care plan consists of a synthesis of assessments relating medical, nursing, dietetic and psychiatric rehabilitation programs);
- Facility meets staffing and Criminal Background Check requirements;
- Patients are provided with adequate medical and psychiatric care; and,
- Facility and grounds are maintained in clean and sanitary conditions at all times.

## Staffing

PHF staffing levels were developed based on the premise that individuals with mental disorders and were physically, would be appropriately admitted for treatment. PHF staffing regulations were designed to provide full-time equivalent (FTE) coverage on a seven-day (weekly) basis.

Below are the PHF staff requirements as specified in the regulations.

Each facility shall meet the following full-time equivalent staff-to-census ratio, in a 24-hour period:

In-Patient Census	1-10	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-90	91-100
Licensed Mental Health Professionals	1	2	3	4	5	6	7	8	9	10
Nursing Staff	4	5	6	8	10	12	14	16	18	20
Mental Health Workers	3	5	8	10	13	15	18	20	23	25
<b>Totals</b>	<b>8</b>	<b>12</b>	<b>17</b>	<b>22</b>	<b>28</b>	<b>33</b>	<b>39</b>	<b>44</b>	<b>50</b>	<b>55</b>

In addition, PHFs must meet the following staffing requirements:

- Registered nurse, employed at 40 hours per week;
- Clinical Director who is a licensed Mental Health Professional
- Psychiatrist/Physician;
- Administrator (can also be the Clinical Director);
- Rehabilitation Service providers (occupational therapists, physical therapists or recreation therapists, under the direction of the clinical director);
- Dietitian,;
- Pharmaceutical Service providers (licensed pharmacists, either onsite or available for consultation).

## MHRCs

MHRCs were established through legislation -- Senate Bill (SB) 2017 (Leslie), Statutes of 1994 and Assembly Bill (AB) 2862 (Thomson), Statutes of 1998 -- to provide for the development of an innovative psychiatric rehabilitation program in close collaboration

with county mental health departments and DMH. In creating MHRCs, the Legislature's intent was to create innovative programs that were alternatives to hospital care. They also wanted a licensing category for more appropriate staffing and programming for adults with a serious mental illness (SMI) who would move away from skilled nursing facilities that had historically handled the more elderly, physically and medically compromised populations.

MHRCs provide community-based, intensive support and rehabilitation services designed to assist persons, 18 years or older, with mental disorders who would have been placed in a state hospital or other mental health facility to develop the skills to become self-sufficient and capable of increasing levels of independent functioning. MHRCs mainly provide mental health treatment services to individuals on conservatorship under the Lanterman-Petris-Short (LPS) Act. MHRC regulations prohibit admission of individuals who are non-ambulatory, who require a level or levels of medical care not provided, who would be appropriately served by an acute psychiatric hospital, or who are diagnosed only with a substance abuse or eating disorder.

MHRCs provide services designed to assist persons who are seriously disabled by a mental illness to develop skills for achieving self-sufficiency and independent living in the community. The program services are to include, but are not limited to, clinical treatment such as psychiatric and psychological services, learning disability assessment and educational services, pre-vocational and vocational counseling, development of independent living, self-help and social skills, and community outreach to develop linkages with other local support and service systems.

To ensure the physical well being of the mentally ill persons residing in a MHRC, providers are responsible for the provision, at minimum, of any needed physician, pharmacy, rehabilitation program, dietary and social services.

DMH conducts onsite facility review to ensure compliance with regulations. The onsite facility reviews determine substantial facility compliance with application regulations and program objectives.

Measures used to assess program performance and evaluate compliance include but are not limited to annual onsite review of MHRCs using protocols/regulations to ensure compliance with programmatic regulatory requirements. During an onsite survey of a MHRC, DMH reviewer's interview staff and clients, observe clinical groups and activities and review the facilities:

- Administrative Records
- Personnel Records
- Client Charts
- Physical Plant Records
- Unusual Occurrence and Complaint Records
- Denial of Rights
- Criminal Background Check Records
- Restraint and Seclusion records

- Program staff in-service training records
- Program staff schedules and time cards.

The above records are reviewed to verify that:

- Patients are receiving care and supervision as required by statute and regulations;
- MHRC services are being delivered as specified in the DMH-approved Plan of Operation;
- The problems for which the client is initially admitted to the MHRC are identified in the treatment/service plan;
- The client's treatment/care plan appropriately addresses the identified problems;
- The care plan consists of a synthesis of assessments relating to medical, nursing, dietetic and psychiatric rehabilitation programs;
- Facility meets staffing and Criminal Background Check requirements;
- Patients are provided with adequate medical and psychiatric care;
- Facility and grounds are maintained in clean and sanitary conditions at all times;
- The identified client population is clinically appropriate for the MHRC;
- The profile and grouping criteria as described in the program plan have been implemented;
- Clients are attending their scheduled programming;
- There are sufficient program staff, other than the Program Director, to provide the scheduled client services;
- The space available for the various program services is adequate for client needs and conforms to the approved MHRC; and,
- The equipment utilized for the various program services is adequate for client needs and conforms to the approved MHRC Plan;

## **Staffing**

MHRC – requires less nursing staff coverage (0.6 licensed nursing staff hours and 0.6 unlicensed nursing staff hours per resident per day) based on DMH regulations governing MHRCs, as a non-nursing type of facility. As a community based psychosocial rehabilitation program, MHRC requires more program hours based on the requirement for one program staff hour for each five resident hours in the facility.

Regulations require that MHRC staffing include, at a minimum: Medical Director, Director of Nursing Services, Licensed Nurses, Licensed Mental Health Professionals, Consulting Pharmacist and Program and Activity Director.

## **Nursing Service Staff**

Each MHRC shall provide for the full-time equivalent of nursing staff for the provision of nursing services, as follows:

- For MHRCs with 42 beds or more, 0.6 licensed nursing staff hours and 0.6 unlicensed staff hours for each client during each 24-hour period, on a seven-day (weekly) basis.

In addition, MHRCs must meet the following staffing requirements:

- Registered nurses, employed at 40 hours per week;
- Program Director,
- Facility Director,
- Rehabilitation Service providers (occupational therapists, Art therapists, Music Therapist, Music therapist or recreation therapists);
- Dietitian, available for consultation;
- Pharmaceutical Service providers (licensed pharmacists available for consultation);
- One program staff hour for each five resident hours in the facility; and,
- One (1) hour of activity program staff time for each seven (7) hours of activity programs provided to each client.

Department of Mental Health  
Licensing & Certification  
MHRC / PHF Surveys  
Document Request List

**Please Note:** This list may not be exhaustive of the documents required during an onsite survey and the Department of Mental Health reserves the right to request additional documents as deemed necessary to complete the onsite review.

Documents Requested At Entrance Conference	MHRC	PHF
<b>GENERAL SURVEY</b>		
1. Set of keys for each surveyor	X	X
2. Organizational Chart with Staff Names included	X	X
3. Resume of the Clinical/Rehabilitation Program Director	X	X
4. Resumes of all new staff hired after the last DMH review. If a staff does not have the minimum qualifications required, a specific written plan of supervision should be present, which includes frequency and number of hours of training, subjects to be covered, and a description of supervision provided.	X	X
5. List of program staff with their date of hire and time base (full or part time)	X	
6. Staffing Records reflecting daily staff coverage, to include fulltime, part time, and on call staff (Schedules and actual time card records)	X	X
7. Annual In-service Training Calendar	X	X
8. New Employee Orientation Records	X	X
9. Employee In-service Training Records/In-Service Training Documentation	X	X
10. Access to Employee Health Records (Physical, PPD)	X	X
11. Plan of Operation which should include a definition of purpose, goals, and services of the organization.	X	X
12. Financial Plan	X	X
13. Current written contracts with the county(ies)	X	X
14. Copy of written transfer agreement with health or other facilities	X	X
15. Written contracts or agreements with outside agencies, if any, providing treatment, and/or rehabilitation services	X	X
16. Census and List of current clients and their room numbers	X	X
17. Activity Schedule	X	X
18. Group Schedule	X	X
19. Group Client Hours ( Past 3 months)	X	
20. Policy and Procedure Manuals	X	X
21. Restraint / Seclusion Log	X	X
22. Denial of Rights Logs	X	X
<b>23. Monthly/Quarterly H&amp;S Code 1180 S&amp;R Data Collection documents and proof of submittal to the County on a quarterly basis</b>	X	X
24. Incident Log	Past year	Past 3 years
25. Incident Reports (Past 3 months)	X	X
26. Access to Client Records including 5-10 closed records	X	X

## MHRC / PHF Surveys - List of Requested Documents

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Documents Requested At Entrance Conference	MHRC	PHF
<b>GENERAL SURVEY <i>continued</i></b>		
27. Access to Medication Records	X	X
28. Performance Improvement / Quality Improvement Minutes (Past year)	X	X
29. Safety / Risk Management Minutes/Reports (Past year)	X	X
30. Pharmacy Committee Minutes/Reports (Past year)	X	X
31. Clinical Staff Monthly Minutes		X
32. Formal peer review and utilization review program (Policy & Procedure / Meeting Minutes)		X
33. Quality Assurance Records	X	X
34. Governing Body / Medical Professional Bylaws		X
35. Bonds P & P and copy of bond		X
<b>PHYSICAL PLANT</b>	<b>MHRC</b>	<b>PHF</b>
1. Facility Disaster Plan	X	X
2. Current Fire Life Safety / Fire Clearance	X	X
3. Maintenance Policy and Procedure Manuals	X	X
4. Fire Safety and Disaster Manuals	X	X
5. Fire and Disaster Drill Logs	X	X
6. Maintenance Log Books (Generator, Water Temps, Work Logs)	X	X
7. Housekeeping Policies and procedures/Manuals	X	X
<b>CRIMINAL BACKGROUND CLEARANCE (CBC)</b>	<b>MHRC</b>	<b>PHF</b>
1. Copy of current CBC Policy and Procedure	X	X
2. List of <b>All</b> Employees, Contract Staff, Volunteers, students and Interns <b>hired after last DMH Review.</b> <ul style="list-style-type: none"> <li>List to be in alphabetical order by last name, with titles, date of hire, live scan date, and date of clearance.</li> </ul>	X	X
3. List of All Current Employees, Contract Staff, Volunteers and Students. <ul style="list-style-type: none"> <li>List to be in alphabetical order by last name, with titles, date of hire, live scan date, and date of clearance.</li> </ul>	X	X
4. Copy of all DMH Clearance Letters & LiveScan Applications for all Employees, Contract Staff, Volunteers, Students & Interns <b>hired after last DMH Review.</b> <ul style="list-style-type: none"> <li>If LiveScan applications and clearance letter are already in a binder, we will utilize that binder. If not, making a binder is highly recommended for future use.</li> </ul>	X	X
5. List of employees no longer working at the facility. <ul style="list-style-type: none"> <li>List to be in alphabetical order by last name, with titles, date of hire, live scan date, date of clearance, and date of termination.</li> </ul>	X	X
6. Copy of all "No Longer Interested" forms of employees no longer working at the facility, in alphabetical order by last name. <ul style="list-style-type: none"> <li>If in a binder, we will utilize that binder, if not, we highly recommend for future use.</li> </ul>	X	X