California on the Eve of Mental Health Reform

Baseline report on county mental health departments' structure, financing and expenditures, fiscal year 2003-04: One year prior to the Mental Health Services Act

11/6/07

Tracy L. Finlayson, PhD – Assistant Professor, San Diego State University*
Neal Adams, MD, MPH – Director of Special Projects, CiMH
Jennifer Rice, MPH – Pre-doctoral Scholar, UC Berkeley Petris Center
Mistique Felton, MPH – Senior Research Associate, UC Berkeley Petris Center**
Timothy T. Brown, PhD – Associate Director, UC Berkeley Petris Center**
Richard M. Scheffler, PhD – Director, UC Berkeley Petris Center

* Most of the work was done while Dr. Finlayson was a post-doctoral scholar with UC Berkeley's Petris Center

This report presents findings from a survey of county mental health directors as part of a larger study of Proposition 63/the Mental Health Services Act (MHSA) and the financing and delivery of mental health services in California. It is being conducted by the Nicholas C. Petris Center (*http://petris.org/*) at the UC Berkeley School of Public Health in partnership with the California Institute for Mental Health (*http://cimh.org*) and was funded by the California HealthCare Foundation.

**Corresponding Authors:
Mistique Felton, MPH
Senior Research Associate
Nicholas C. Petris Center on Health Care Markets and Consumer Welfare
University of California, Berkeley
50 University Hall, MC 7360
Berkeley, CA 94720-7380
Ph: 510-643-4104
Fx: 510-643-4281
mistique@petris.org
http://www.petris.org

Timothy T. Brown, PhD
Associate Director of Research and Training
Petris Center on Health Care Markets and Consumer Welfare
University of California at Berkeley
2150 Shattuck Avenue, Suite 525
Berkeley, CA 94720-7380
Ph: 510-643-4103
Fx: 510-643-4281
Em: tbpetris@berkeley.edu
http://www.petris.org

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FROM THE DIRECTOR

I am pleased to issue *California on the Eve of Mental Health Reform*, funded by the California HealthCare Foundation. As the Mental Health Services Act is implemented and counties move toward a more client-driven, recovery-oriented system, data on the counties' baseline orientation is paramount to measure progress. Each county is unique in terms of organization structure, income, population and ethnic mix. Therefore each county has begun the transformation process from a different point.

The bulk of the data used in this report is from a Petris Center survey of county mental health directors. Much of this information, on topics such as financing, organizational structure, staffing patterns, information technology and mental health boards, cannot be found elsewhere. We received responses from 44 directors, representing 98% of the California population. Key findings indicate that California's counties, while highly diverse, share some common features and strengths. These include: 1) high participation in innovative demonstration programs, 2) minimal spending on institutional care, 3) low administrative overhead, and 4) provision of care in languages beyond the state requirements. This report should not be used to compare counties or regions but to provide information on where counties are beginning their transformation process. While each county is different, the similarities between counties may be useful in providing lessons for improving the system as a whole. This report and survey is the first in a series of surveys to measure progress toward the MHSA goal of a transformed mental health system in California.

Sincerely,

Richard M. Scheffler, PhD, Director
Director, The Nicholas C. Petris Center on Health Care Markets & Consumer Welfare,
Distinguished Professor of Health Economics and Public Policy
University of California, Berkeley

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S. Leonard Syme, PhD, *Professor Emeritus of Epidemiology, University of California, Berkeley*

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Cheryl Cashin, PhD, *NIMH Post-Doctoral Fellow*

Saul Feldman, DPA *Chairman (and CEO) Emeritus, United Behavioral Health; and Commissioner, Mental Health Services Oversight and Accountability Commission*

Sukari Ivester, PhD, *Agency for Healthcare Research & Quality Post-Doctoral Fellow*

Stephen Mayberg, PhD, *Director, California Department of Mental Health*

Dave Mechanic, PhD, *Director, Institute for Health, Health Care Policy and Aging Research, Rutgers University*

Tanya Temkin, MPH, MCP *Research Associate, Kaiser Permanente—Regional Offices, Oakland, CA*

Leonard S. Miller, PhD*, Professor Emeritus of Social Welfare*

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PREFACE

This report summarizes baseline information derived from a survey of county mental health directors about key organizational and budgetary characteristics in California's county mental health departments. These findings are intended to provide stakeholders, policymakers, researchers and others with a snapshot of county and system characteristics prior to the implementation of the Mental Health Services Act (MHSA) of 2004, which was created by the passage of Proposition 63.

The Nicholas C. Petris Center on Health Care Markets & Consumer Welfare, part of the School of Public Health at the University of California, Berkeley, received funding from the California Healthcare Foundation to study the implementation of MHSA across the counties of California and examine the changes in the financing, organization and delivery of mental health services.

The Petris Center is using a multi-pronged approach to analyze this highly complex implementation and transformational process. The four prongs of the Petris Center study include:

1) Annual county mental health director surveys,
2) An analysis of the Community Services and Supports (CSS) plans submitted by the counties,
3) A qualitative analysis of the planning and implementation processes in 12 counties, and
4) An impact analysis of service delivery innovations.

The county mental health director survey provides a unique set of baseline information which can be used to better understand each county's experience and performance with MHSA implementation in later years. The analysis of the CSS plans assess the financial data and planned resource allocation of all participating counties and provides in-depth examination of planned programs and services in a subset of counties included in the Petris Center qualitative analysis. Through interviews of staff and stakeholders during two-day site visits, the qualitative analysis aims to compile detailed information about the management of the county mental health system and responses to the changing environment created by MHSA planning and implementation in the 12 participating counties. Lastly, the impact analysis of service delivery intends to document and uncover specific patterns of practice in the delivery of mental health services and learn what services funded by MHSA work best for different types of clients.

Information gathered from the mental health director survey describes elements of each county's organization, performance and financial status *prior* to MHSA implementation. The data collected pertains to fiscal year 2003/2004 and does *not* capture information on MHSA planning, implementation, or outcomes. Key findings indicate that California's counties, while highly diverse, share some common features and strengths. These include:

- A dedication to participation in innovative programs,
- The provision of language-specific and culturally competent care beyond that which is required by the state,
- Low administrative overhead,
- Minimal use of institutional care in favor of care that is community-based and consumer-oriented.

MHSA funds are earmarked for system transformation to be achieved through the creation of new and expanded community-based mental health services that are more consumer and family driven, culturally competent, and recovery-oriented. This report describes the counties' starting points as they embark on their individual transformational journeys as part of MHSA implementation. Changes over time in comparison to the baseline data reported here may indicate movement towards a recovery vision for each county as well as changes in the overall state mental health system. Those changes will be assessed in future surveys. Draft versions of this report were sent for review to staff at California Institute of Mental Health (CiMH), California Mental Health Directors Association (CMHDA), and all the participating counties.

EXECUTIVE SUMMARY

Background

Implementation of Proposition 63, now called the Mental Health Services Act (MHSA), is hoped to be a major lever of transformational change in California's public mental health system. In order to fully assess the impact of the changes brought about by MHSA implementation, it is necessary to have an understanding of each county's starting point. While the county mental health departments collectively have much in common, there are also significant differences among them that may impact the success of MHSA.

In California, each of the 58 counties as well as the City of Berkeley and the Tri-City Mental Health Center (Pomona, Claremont and La Verne) are designated as the local mental health authority responsible for providing mental health services.[1] The state's Department of Mental Health and the Department of Health Care Services (Medi-Cal) set broad program and fiscal policies and have specific legal and contractual requirements for the counties' mental health programs. At the same time, the counties have considerable flexibility and local control over the service delivery system, resulting in notable differences in county programs across the state. Identifying and understanding these differences may prove to be key to evaluating each county's efforts, strategies and accomplishments in MHSA implementation. In many respects, each county is its own "control" or point of comparison, but comparisons across counties in evaluating MHSA impacts may prove useful in identifying various factors that affect success in MHSA implementation and systems change.

Study Overview

In order to capture and describe both the similarities as well as differences among the counties, local county mental health directors and their staff were asked to complete a 43 item survey. This questionnaire was designed to address the paucity of baseline information on the state's county mental health programs. Survey administration was conducted in 2006 and collected data on Fiscal Year 2003-2004 (FY03-04), the year prior to MHSA implementation. Survey topics included questions that were organized into four major categories:

I. Budget/expenditures
II. Staffing patterns
III. Organizational structure, experience with innovative service models, and information technology
IV. Relationship with Mental Health Boards

Forty-four (44) counties, accounting for 98% of California's population, returned completed surveys. Data were analyzed and descriptive statistics were calculated for the entire state and by various subgroups.

[1] For additional background information on the mental health system in California and MHSA, please see report references

California's counties are extremely diverse in many respects: size, demographics including racial/ethnic mix, geography, and wealth. In order to organize the data and support an analysis of both similarities and differences, findings are reported by region as established by the California Mental Health Director's Association. The five regions include: Bay Area, Central, Southern, Los Angeles County and Superior. The study also compares the counties based on population size including small, medium, and large; corresponding to counties with populations under 200,000, between 200,000 and 800,000, and over 800,000 respectively. Data on Los Angeles County (LA), which includes nearly one third of the state's population and has many unique program characteristics, is reported separately. Much of this data is not available from the California Department of Mental Health (DMH) and cannot be verified by them. While DMH has reviewed this report, they have not verified any of its findings.

Main Findings

Counties demonstrated a baseline set of activities that may prove useful in preparing to implement the innovative, consumer-based, and recovery-oriented programs that are being funded under MHSA. As discussed below, most counties had experience participating in innovative programs, such as demonstration grants for recovery-based programs. Many of them provided services in languages beyond what was required by law, enhancing their outreach to underserved ethnic communities. Fiscally, counties spent very little on overhead and most of their budgets on services. Additionally, counties spent an average of 11% of their budgets on inpatient treatment for the seriously mentally ill not including state hospitals and Institutes for Mental Disease (IMDs). Counties therefore already engage in providing services that are more community-based than institution-based, further preparing them well for the recovery vision of MHSA.

California's counties are very diverse, an idea captured with the saying: "If you've seen one county, you've seen one county." The survey findings confirm that there was significant variation in several aspects of California's county mental health programs in FY 03-04. The significance of these differences - especially as pertains to MHSA implementation - is unclear at this time.

The major differences and similarities observed are organized into the main topic areas of the survey and summarized below.

I. Budget & Expenditures[2]

There were a number of findings related to county budgets and financing of mental health services prior to MHSA implementation that may be important to understanding the counties implementation strategies and practice. MHSA is expected to provide a 10% budget increase in the first few years to all counties. Data from the survey reveal that in FY03-04:

[2] Data analysis of Section I questions 8-17 of the Petris Center Director survey

- The median total mental health budget was $31,941,226 but this figure varied widely by county size. The values ranged from $766,565 to $1,066,000,000.
- Counties spent 90% of their budgets on staff and services, and an average of $5,011 per client.
- On average, Federal Financial Participation (FFP) and other state/federal funding accounted for almost half of counties' revenue.
- One-third of county revenues came from realignment on average.[3]
- On average, counties spent one third of their budgets on child and family services.
- Counties spend on average 32% of their budgets on contracted services, with Bay Area region counties and LA in particular spending a larger share of their budgets.
- On average, very small portions of county budgets were spent on state hospital (2%) or Institute for Mental Disease (IMD) beds (4%).[4]

II. Staffing Patterns[5]

A major challenge to success in MHSA implementation will likely involve issues of workforce capacity and competence. The Act includes specific categorical funding to address this facet of system transformation.[6] Counties will need to create new positions and hire more staff to support all their new and expanded programs and services under MHSA. There is also concern that both existing and new staff may not have the skills and abilities to support recovery-oriented practice. There has been speculation already that a shortage of trained staff will be a barrier to fully implementing planned services. Data from the survey pertaining to staffing and workforce revealed that for FY03-04:

- The average distribution of employees between clinical and administrative categories was 71% and 29%, respectively, not counting contract providers.
- Very few counties tracked staff tenure and turnover information.
- Fifty-nine percent (59%) of counties used temporary hires, primarily to meet non-medical staffing needs on average.
- Creating new staff positions took 5 months on average in all counties.
- Once positions were created, they were usually filled on average within 2-3 months, and counties were fairly satisfied with the quality and number of applicants.
- Southern counties were more satisfied and Superior counties were less satisfied with the applicant pool, suggesting regional

[3] AB 1288, 1991, known as Program Realignment
[4] One goal of MHSA is to reduce the need for institutionalization by consumers
[5] Data analysis of Section II, questions 1-4, 8-13 of the Petris Center Director survey
[6] The funding for education and training has not been released by the state

differences in the workforce.

Because California is such a culturally and linguistically diverse state, diversity in the workforce that reflects the population served and providing culturally competent services are critical issues related to MHSA implementation. Increasing access to care for underserved communities, removing language barriers and assuring the availability of culturally competent providers are key issues in the mental health system. Baseline data about staffing[7] from the survey and county cultural competence plans/reports revealed that in FY 03-04:

- 64% of counties provided mental health services in languages beyond the minimum threshold language[8] requirements.
- 24% of direct service providers and 13% of administrative staff were bilingual in one of the nine most common non-English languages on average.[9]

Lastly, the increased role of consumers and family members as staff and peer providers is an important objective of MHSA. An evaluation of baseline performance in FY 03-04 found that of the reporting counties:

- 16% had a consumer as a member of the management team.
- One third had a program for hiring consumers as county employees.
- Half had a program for employing consumers and 40% had a program for employing family members as part of community-based organizations.

III. Organizational Structure, Experience with Innovative Service Models, and Information Technology

Organizational Structure[10]

It is hypothesized that factors such as governance, leadership, reporting relationships/accountability and autonomy may influence counties and their mental health services management teams' MHSA implementation efforts and success in systems transformation. Key findings from the survey revealed that 39% of the mental health programs/departments are stand-alone agencies, while the rest are part of health or human service

[7] Data analysis of Section II question 6-7 Petris Center Director survey and the cultural competency reports

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

[9] Spanish, Chinese, Vietnamese, Hmong, Lao, Mien, Cambodian, Farsi, or Russian. Data is from the cultural competency reports

[10] Data analysis of Section I question 1-4 of the Petris Center Director survey

agencies. Stand-alone agencies may have a greater level of control over programming budgets and reporting to the Board of Supervisors.

Experience with Innovative Service Models[11]

One goal of MHSA is to meet the needs of the historically unserved and underserved, and deliver services within a model referred to as a "Full-Service Partnership" (FSP). FSPs integrate the delivery of all necessary mental health care services and supports. In this approach, consumers are provided with "whatever it takes" to achieve and sustain the highest quality of life and independent functioning possible in the least restrictive setting.

California passed a number of laws that provided funding for programs that would provide integrated services and a focus on outcome measures. California Assembly Bill AB34 passed in 1999 and AB2034 passed in 2000, focusing on the mental health needs of homeless adults. These program initiatives, along with Children's System of Care (CSOC), California Senate Bill (SB) 163 (Wraparound), and Mentally Ill Offender Crime Reduction Grants (MIOCRG) are considered by many to be the progenitors of the FSP service model.

Whether or not experience with these models and service strategies will impact MHSA implementation is unknown. While many counties had at least some experience with at least one of these initiatives, not all counties participated in these programs. The director survey found that:

- 68% of counties received AB34/2034 funding
- 82% of counties received CSOC funding
- 43% of counties received SB163 funding
- 57% of counties received MIOCRG funding

Information Technology[12]

The availability and sophistication of information technology (IT) may also prove to be an important consideration in MHSA implementation and system change. MHSA has earmarked funds to be dedicated to enhancing IT infrastructure and capacity within the counties.[13] Several questions on the director survey were intended to assess pre-MHSA IT status within the counties. Key findings about the availability/deployment of information technology in FY03-04 included the following:

[11] Petris analysis of data from DMH, FY02-03 Legislative report, FY03-04 Cost Report and Petris Center Director survey Section I questions 20-21
[12] Data analysis of Section 1 question 6 in the Petris Center Director survey
[13] Funds for this portion of MHSA have not been distributed yet

- More than two-thirds of counties relied on computers for conducting various administrative tasks.
- Less than half of counties computerized any clinical functions.
- A greater proportion of smaller counties had computerized clinical activities such as service/progress notes and treatment planning compared to medium and large counties.

IV. Relationship with Local Mental Health Boards[14]

Although local Mental Health Boards have had a long-standing status defined by state law, the actual functioning of these boards and their local impact and leadership has varied across the state. However, under MHSA, the role of the local Mental Health Boards was further specified - the Boards were empowered to hear public testimony as well as review and comment on the county's Community Services and Support (CSS) Plans for MHSA before the plans were submitted to the state. This suggests that past Board performance may be a factor in MHSA planning and implementation. Some of the findings for FY-03-04 related to local Board function included the following:

- Most Boards met 11-12 times per year and the county mental health Director or representative attended nearly every Board meeting.
- 93% of county directors reported positive relationships with their Boards.
- 83% of county directors reported using the Board frequently as a leadership/management resource.
- Southern counties gave a much higher rating of the effectiveness of their Mental Health Boards than other counties on average (8 versus 5 on a 1-10 scale).

In conclusion, this report presents baseline survey information from California county mental health departments that is not available elsewhere, and includes data regarding organizational structure, services provided, budget, staffing patterns, and relationship with their Mental Health Boards in FY 03-04, before the implementation of MHSA. The data were gathered and presented in order to describe the range of "starting points" for counties as they embark on their individual transformational journeys as part of MHSA implementation. It is difficult to interpret their significance at this time beyond noting the range, as well as the similarities, which exists across and among the counties. There is nothing in this report that should necessarily be construed as best or optimal. Some of the differences between counties may prove to be incidental over time with little if any impact on efforts at systems change. On the other hand, some factors may prove to be critical variables for success in MHSA implementation, while others may prove to simply be markers or measures of change. Several of the

[14] Data analysis of Section III questions 1-4 of the Petris Center Director survey

measures reported here may change over time, as MHSA programs and services become implemented. Changes in some of these measures may indicate movement towards a recovery vision and transformation in the state mental health system and can be assessed in the next annual director survey.

BACKGROUND

The California Department of Mental Health (DMH) and local county mental health departments[15] have been challenged to enhance and transform the mental health service delivery system by the passage of Proposition 63, the Mental Health Services Act (MHSA), in November 2004.

The MHSA is landmark legislation that places a 1% tax on adjusted gross incomes over $1 million. The new funds are earmarked for system transformation through the provision of new and expanded community-based mental health services that are more consumer and family-driven, culturally competent, and recovery-oriented. The first priority is to meet the needs of severely mentally ill adults and severely emotionally disturbed children who have been previously unserved or underserved, with services to be expanded to all clients in the mental health system in the future.

The MHSA includes five components/funding strategies, preceded by a community planning process: Community Services and Supports (CSS), capital facilities and technological needs, education and training (workforce development), prevention and early intervention, and innovation in mental health services.[16] The community planning and CSS components were implemented first. Services in the CSS are to be provided predominantly through Full Service Partnerships, which is a model for providing services and supports with flexible funding, assertive outreach, and small caseloads.

[15] We use the term "Mental Health" throughout this report but in some counties it is called "Behavioral Health"
[16] These different components of MHSA are discussed in more detail later in the budget section

In order to fully assess the impact of the changes brought about by MHSA implementation, it is necessary to have an understanding of each county's starting point. In California, the state's Department of Mental Health and the Department of Health Care Services (Medi-Cal) set broad program and fiscal policy and have specific legal and contractual requirements for the new county mental health programs under MHSA. At the same time, the counties have considerable flexibility and local control over their service delivery systems, resulting in notable differences in county programs across the state. In many respects, each county is its own "control" or point of comparison. So while the county mental health plans collectively have much in common, there are also significant differences among them that could potentially impact MHSA success. Identifying and understanding these differences may prove to be key to evaluating each county's efforts, strategies and accomplishments in MHSA implementation. Likewise, comparisons across counties in evaluating MHSA impact may prove useful in identifying factors that universally affect success in MHSA implementation and systems change.

The research team at the UC Berkeley School of Public Health Nicholas C. Petris Center, in partnership with the California Institute for Mental Health (CiMH), developed a survey for all California county mental health directors as part of a larger evaluation study of the financial and organizational changes brought about by MHSA implementation. There is a paucity of baseline information on California's 58 county mental health programs, and the research

team plans to conduct surveys regularly to track changes in organizational function and performance.

This report presents a summary of findings from the first county mental health director survey and provides unique baseline data for the majority of counties from Fiscal Year 2003-2004 (FY03-04), the year prior to MHSA implementation.

Survey overview, development, and administration

In order to capture and describe both the similarities as well as differences among the counties, local county mental health directors and their staff were asked to complete a 43 item survey. The survey was designed to elicit specific, detailed baseline information about the county mental health departments in four broad areas. These topics were selected to represent key areas expected to change under MHSA and provide descriptive information about the counties that does not readily exist elsewhere. The item organization and distribution is summarized in Table 1:

TABLE 1: Survey* Topics, Fiscal Year 2003-2004	**# of items**
Budget and expenditures	20
Staffing patterns	12
Organizational structure, experience with innovative service models, and information technology	6
Relationship with Mental Health Board/Commission	5

* Note: See Appendix 4 for entire survey. If you have any questions or need further information, contact the Petris Center research team by e-mail at mhsastudy@berkeley.edu or call 510-643-4100

The survey instrument also provided respondents an opportunity for open-ended notes of clarification about responses or other comments.

Survey development and pre-testing occurred during the Fall of 2005. The research team sought specific feedback from key informant mental health leaders and experts around the state, including staff from the DMH, past directors, and researchers at UC Berkeley. Input was also solicited from county directors themselves at their Monthly All-Directors Meeting (MADM) in October, 2005. Additionally, Ventura and Kern counties pilot tested the near-final version of the survey, and provided helpful comments and feedback leading to question clarification and survey refinement.

The final eight-page survey was a password protected and locked Word form document, chosen to facilitate fast and easy electronic completion along with the capacity to save and share the file readily. Surveys were emailed to county mental health directors at the end of January, 2006 along with a personalized cover letter requesting responses within one month. A minimum goal of 40 responding counties was set based on past county-based research in the state. Follow-up efforts began in March, 2006, with the research team and CiMH staff sending reminder e-mails, making phone calls offering any needed clarification or technical assistance, and asking for completion commitments in person at MADMs. Counties received at least one of these follow-ups per month until the survey was returned. This data was collected while counties were engaged in the MHSA planning process.

After nine months, in a final effort to collect data from the remaining (primarily smaller) non-respondent counties, a $500 donation to a local non-governmental organization of the county mental health director's choice was offered as an incentive to complete the survey. By the end of November 2005, 44 counties had returned completed surveys, and together these counties account for 98% of California's population. All non-respondents were small counties as well as the Berkeley City programs and had populations less than 200,000; most had populations under 75,000. Returned surveys were very complete, with little missing data. Data from the 44 counties were reviewed, apparent response and coding errors were corrected, and the final data analyzed, including the calculation of descriptive statistics. While the Petris Center received feedback from the DMH on the survey questions, the final data has not been verified by the state.

Each responding county will also receive a more detailed custom report with their responses compared to state aggregate, regional, and population size subgroup statistics.

Survey Results

In the state of California, the 58 counties are designated mental health plans that are responsible for the provision of local mental health services (the two exceptions are the City of Berkeley, which has a Mental Health Department separate from Alameda County and the Tri-City Mental Health Center serving the communities of Pomona, Claremont and La Verne in Southern California). In

1991, realignment legislation shifted some of the administrative and fiscal responsibility for health, social and mental health services from the state to counties to increase flexibility, stability of funding and local control. This realignment legislation also established the local Mental Health Boards and a state-wide monitoring system.[17] Empirical research by Scheffler and colleagues showed that costs decreased while the percentage of consumers with severe psychiatric diagnosis and the number of clients with a higher level of functional impairment increased after realignment.[18]

California is extremely diverse in multiple respects—ranging from racial and ethnic representation to differences in the size, populations, geography and wealth of counties. For example, Los Angeles (LA) county alone includes nearly one third of the state's population and has 11 threshold language[19] groups. In addition, each county's mental health programs are unique owing to a long-standing divesture of central authority to local programs.[20] This inevitably

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

[18] Snowden L, Scheffler R, Zhang A. "The impact of realignment on the client population in California'spublic mental health system." Adm Policy Ment Health. 2002 Jan;29(3):229-41; Scheffler R, Zhang A, Snowden L. "The impact of realignment on utilization and cost of community based mental health services in California." Adm Policy Ment Health. 2001 Nov;29(2):129-43; Scheffler RM, Wallace NT, Hu TW, Garret AB, Bloom JR. "The effects of decentralization on mental health service costs in California." Mental Health Research Review. 1998; 5:31-32

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

[20] For more information, see the Legislative Analyst's Office 2001 Report "Realignment Revisited: An Evaluation of the 1991 Experiment In State-County Relations" at http://lao.ca.gov/ [Accessed 3/26/07]

creates challenges in attempting to interpret data with the county as the unit of comparison.

State aggregate statistics from analysis of the survey responses are presented in this report. Various subgroups were explored as well to uncover potential differences by region or size. Regional geographic breakdowns followed the county groupings regularly used by DMH and CMHDA, and include the Bay Area, Central, Southern, Superior, and LA County, which are displayed in Figure 1. This report includes survey responses from 11 of the 12 Bay Area counties, 15 of the 19 Central counties, 9 of the 10 Southern counties, 9 of the 16 Superior counties, and LA County. Sutter and Yuba jointly run their mental health program and are treated as one county in our analysis.

Population size was another important consideration. Responding counties were grouped into the following categories often used by DMH, CMHDA, and state legislature, which are Small counties (under 200,000 population), Medium counties (200,000-800,000 population), Large counties (over 800,000 population, excluding LA county), and LA county. This report includes survey responses from 17 of 30 the Small counties, all 17 Medium sized counties, all 9 Large counties, and LA county. Figure 2 is a state map highlighting the 44 responding counties by population size groups.

Data on county population size was obtained from 2003 Rand California Population and Demographic Statistics, which used the state Department of Finance as a source.[21] There is some correlation between region and size. For

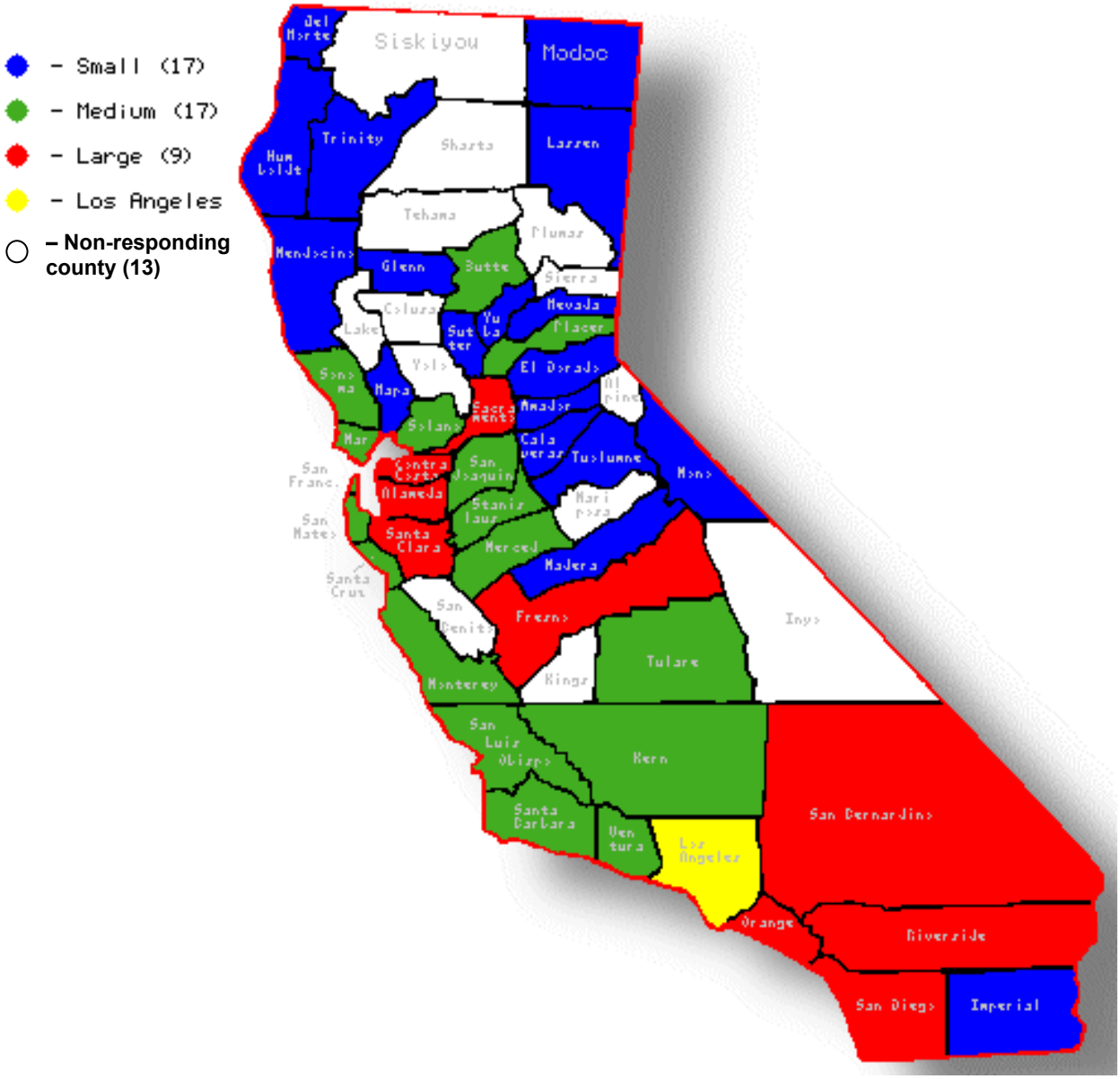
[21] Rand (2007). "Total Population Estimates in California" Available online: http://ca.rand.org/stats/popdemo/popest.html. [Accessed 4/7/07]

example, the Superior region, which consists of 10 counties, has 9 counties with populations under 200,000 residents. Throughout this report, numbers are adjusted per client and many dollar amounts are presented as budget percentages to maximize comparability across counties.

FIGURE 1: California Counties by Mental Health Region

Source: California Mental Health Directors Association (2007). California County Maps by Mental Health Region. [On-line]. Available: http://www.cmhda.org/regionalorg.html (Accessed 3/13/07).

FIGURE 2: Responding Counties by Size



Source: http://monarch.tamu.edu/~smrs/13463637.gif

Counties were involved in a range of baseline activities that may prove useful to them in preparing to implement the innovative, consumer-based, and recovery-oriented programs that are being funded under MHSA. As discussed below, many counties had experience participating in innovative programs, such as demonstration grants for recovery-based programs. Many of them provided services in languages beyond what was required by law, enhancing their outreach to underserved ethnic communities. Fiscally, counties spent very little on overhead and most of their budgets on services. Additionally, counties spent small percentages of their budgets on the use of hospital beds for the seriously mentally ill. This all suggests that counties already engage in providing services that are more community-based than institution-based, further preparing them for success in fulfilling the recovery vision of MHSA.

The survey findings confirm that California's counties are also very diverse and show significant variation in several aspects of California's county mental health programs in FY03-04. The significance of these differences - especially as they pertain to MHSA implementation--is unclear at this time.

The major differences and similarities observed are organized into the main topic areas of the survey and presented in the forthcoming sections.

RESULTS:

I. FISCAL YEAR 2003-04 BUDGET AND EXPENDITURES

New MHSA funds will increase each county's overall mental health budget by approximately 10% for the first few years, and include six components/funding strategies for targeting different aspects of mental health services:[22]

1) *Community Planning Process*: provides funding for counties and DMH to engage consumers, family members and other stakeholders, including providers, law enforcement, county mental health officials, organized labor and others, in the planning process
2) *Community Services and Supports*: provides funding for direct services to people with serious mental illness [23]
3) *Capital Facilities and Technological Needs*: provides funding for increasing the number and variety of community-based facilities which support integrated service experience for clients and family members as well as funding to improve information technology capabilities[24]

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[22] The full text of MHSA can be found at: http://www.dmh.cahwnet.gov/MHSA/docs/Mental_Health_Services_Act_Full_Text.pdf [Accessed 7/12/07]

[23] Department of Mental Health (DMH) requirements for Community Services and Supports (CSS) Plans. For more information, see DMH's "A Draft Readers Guide to Mental Health Services Act, Community Services and Supports Three-Year Program and Expenditure Plan Requirements." http://www.dmh.ca.gov/mhsa/docs/A_Draft_Readers_Guide_to_Mental_Health_Services_Act.pdf. [Accessed 3/20/07]

[24] The division of funds between capital facilities and technological needs has not yet been determined.

4) *Education and Training (Workforce Development):* calls for a statewide needs assessment for mental health professionals and the development of a five-year plan to address the shortage of qualified personnel
5) *Prevention and Early Intervention:* funds the development of outreach programs for families, providers, and others to recognize early signs of mental illness, improve early access to services, and programs to reduce stigma and discrimination
6) *Innovation:* funds new programs that increase access to the underserved, promote interagency collaboration and increase quality of services

In order to fully understand the overall financial impact of MHSA, it will be useful to first understand the size of the county mental health budgets, their sources of revenue, spending per client, and other expenditure patterns in FY 03-04, before any new MHSA funds were received.

Total budget overview

In the survey, counties were asked to report their total mental health budget for FY 03-04, accounting for all sources of revenues and areas of expenditures, including grants. Table 2 shows the median (midpoint) and range of unadjusted total county budgets, excluding the county contribution (which was 6% on average).

TABLE 2: Median (midpoint) Values and Range of Total Budgets (Excluding County Contributions), FY 03-04 (Before MHSA)				
			Range	
Group	Name (# of counties)	Median	Min	Max
REGIONS	Bay Area (10)	$58,425,085	$10,303,598	$157,296,066
	Central (13)	$19,175,824	$758,899	$180,170,366
	Southern (9)	$74,232,335	$14,076,337	$182,303,082
	Superior (9)	$3,981,740	$1,200,000	$32,969,163
POP SIZE	Small (16)	$6,787,280	$758,899	$21,250,000
	Medium (16)	$41,741,605	$19,175,799	$123,772,275
	Large (9)	$137,011,590	$86,997,974	$182,303,082
	LA	$991,380,000		
	Survey Average (42)	$31,898,584	$758,899	$991,380,000

Source: Data analysis of Petris Center Director Survey
Notes: The 42 counties represent 97% of the California population
See Appendix 3 for calculations

Table 3 below shows the average percent of budget spent on services, and total budget including county contributions. The mean, median (midpoint), and range values are summarized. The median budget was $31,941,226, but budgets ranged widely statewide from $766,565 to $1,066,000,000.

TABLE 3: Average, Median and Range of Total Budgets (Including County Contributions), FY 03-04 (Before MHSA)						
		% budget spent on services			Range	
Group	Name		Average	Median	Min	Max
REGIONS	Bay Area	88%	$83,095,411	$45,680,210	$12,413,973	$201,599,183
	Central	89%	$37,194,535	$18,146,417	$766,565	$181,440,449
	Southern	91%	$91,379,793	$74,982,157	$14,076,337	$198,155,524
	Superior	92%	$10,272,352	$4,021,960	$1,200,000	$33,302,185
POP SIZE	Small	89%	$7,735,831	$4,308,167	$766,565	$21,250,000
	Medium	90%	$50,482,979	$41,000,000	$20,858,434	$165,029,700
	Large	93%	$151,102,505	$165,074,205	$91,771,622	$201,599,183
	LA	93%	$1,066,000,000			
Survey Average (44)		90%*	$77,628,234	$31,941,226	$766,565	$1,066,000,000

Source: Data analysis of Petris Center Director Survey
Notes: *Represents data from 42 counties which is 97% of the state's population. Average, median and range data is from 44 counties representing 98% of the California population
See Appendix 3 for calculations

Table 4 shows the average budget per client based upon the number of clients served in each county from DMH Client Services Information (CSI) data from FY 03-04).[25] The basic distribution statistics of median, standard deviation (SD), and minimum and maximum values of the adjusted total budget per client is also displayed to present a sense of the range and variation. When the Petris average is compared to data from DMH, the numbers are similar showing only a 10% difference between the two ($5,016 for state numbers vs. $5,577 from the Petris survey).[26] Additionally, survey data for cost per capita are comparable to data collected by the US Department of Health Services ($105 vs. $109 respectively).[27]

As expected, budgets were related to the size of the client population in the county, and larger counties had bigger budgets than smaller counties. Medi-Cal requires that counties do not spend more than 15% of their budgets on overhead/administrative costs. Generally, counties did spend 15% or less (the average is 10%), but seven counties reported spending a slightly higher percentage (16-23%) of their budgets on overhead costs in FY 03-04.

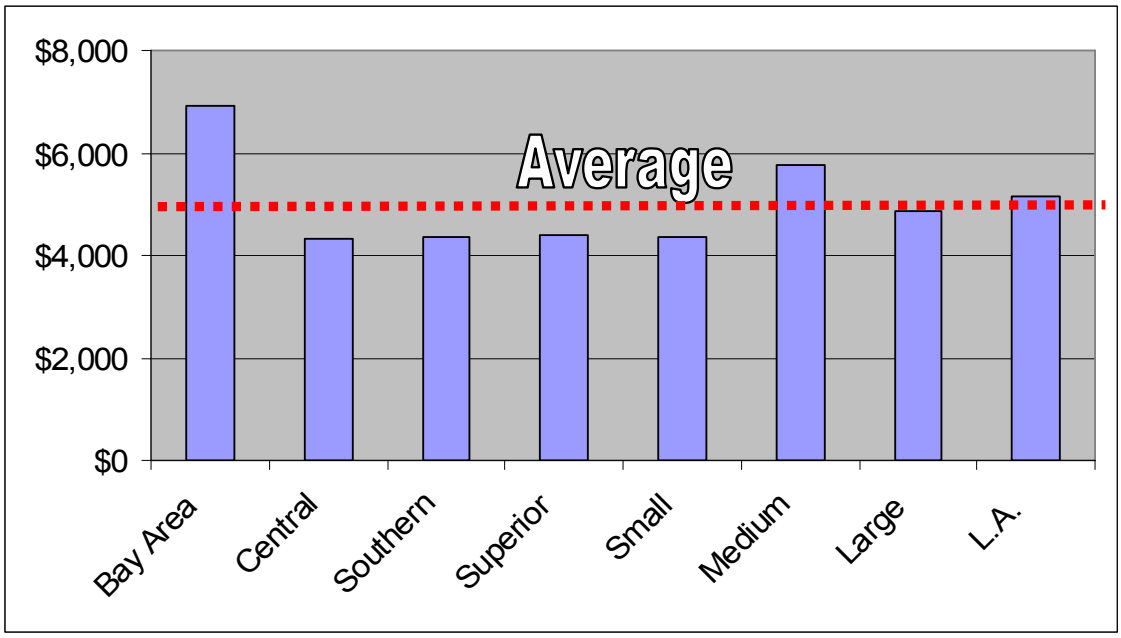
[25] Except for 7 counties, where FY 03-04 CSI data was not available, and FY 02-03 data was used instead
[26] When data from DMH takes into account all 58 counties, the average drops to $4,762. DMH numbers from personal communications with DMH staff
[27] Data from US Department of Human Services reported in Health, United States, 2006

TABLE 4: Distribution of Mental Health Budgets per Client, FY 03-04 (Before MHSA)						
		(Mean = total budget / total clients)				
Group	Name (# of Counties)	Mean	Median	SD	min	max
REGIONS	Bay Area (11)	$7,813	$7,684	$1,077	$6,592	$10,328
	Central (14)	$4,777	$4,075	$1,297	$3,484	$7,520
	Southern (9)	$4,822	$4,223	$1,500	$3,486	$7,451
	Superior (9)	$4,846	$5,261	$1,743	$1,745	$6,971
POP SIZE	Small (17)	$4,951	$3,990	$2,077	$1,745	$10,328
	Medium (17)	$6,364	$6,607	$1,558	$3,622	$8,361
	Large (9)	$5,276	$4,223	$1,726	$3,486	$8,308
	LA county	$5,550				
Survey Average (44)		**$5,577**	**$5,467**	**$1,866**	**$1,745**	**$10,328**

Source: Data analysis of Total Budget from Petris Center Director Survey and Total Clients Served per County from CSI (Client Service Information) data FY 03-04
Notes: SD=Standard deviation. The 44 counties represent 98% of the California population. See Appendix 3 for calculations

The following graph (Figure 3) displays the average county mental health expenditures per client in FY 03-04 compared to the state average (as calculated in the survey) of $5,011. Expenditure estimates came from the survey data; the portion of the reported budget spent on services only (the reported overhead and administrative costs were excluded) were adjusted per capita client. Bay Area counties had a higher than average expenditure per client in FY 03-04.

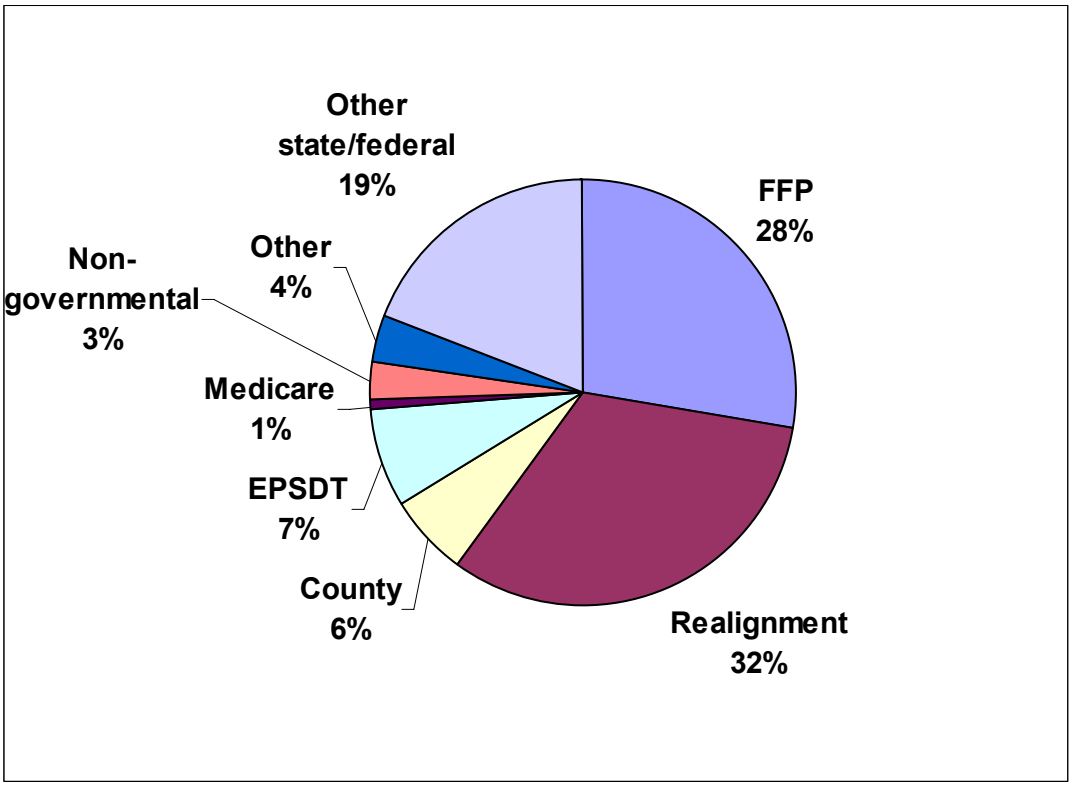
FIGURE 3: Average Mental Health Expenditure per Client FY 03-04 (Before MHSA)



Source: Petris Center analysis of data from CSI (Client Service Information) data FY 03-04 and Petris Center Director Survey
Notes: Data from 44 counties, which represent 98% of the California population
Survey Average = $5,011 per client
See Appendix 3 for calculations

California's county mental health systems reported the distribution of revenue sources shown in Figure 4. On average, the majority of a county's revenue came from three major sources in FY 03-04. Federal Financial Participation (FFP) associated with Medi-Cal and other state/federal funding accounted for about half of the counties' revenue. One-third of county revenues came from realignment. The source data, including the range of responses, is summarized below in Table 5.

FIGURE 4: Average Distribution of Revenue Sources, FY 03-04 (Before MHSA)



Source: Data analysis of Petris Center Director Survey
Notes: "Other" revenue sources include patient fees, insurance, and grants, among other sources reported by counties. "Other state and federal" sources cannot be further subdivided into its component categories
FFP = federal financial participation EPSDT = Early and Periodic Screening, Diagnosis, and Treatment (may include state funds or state, and federal revenue sources)
Data from 42 counties, which represent 97% of the California population
See Appendix 3 for calculations

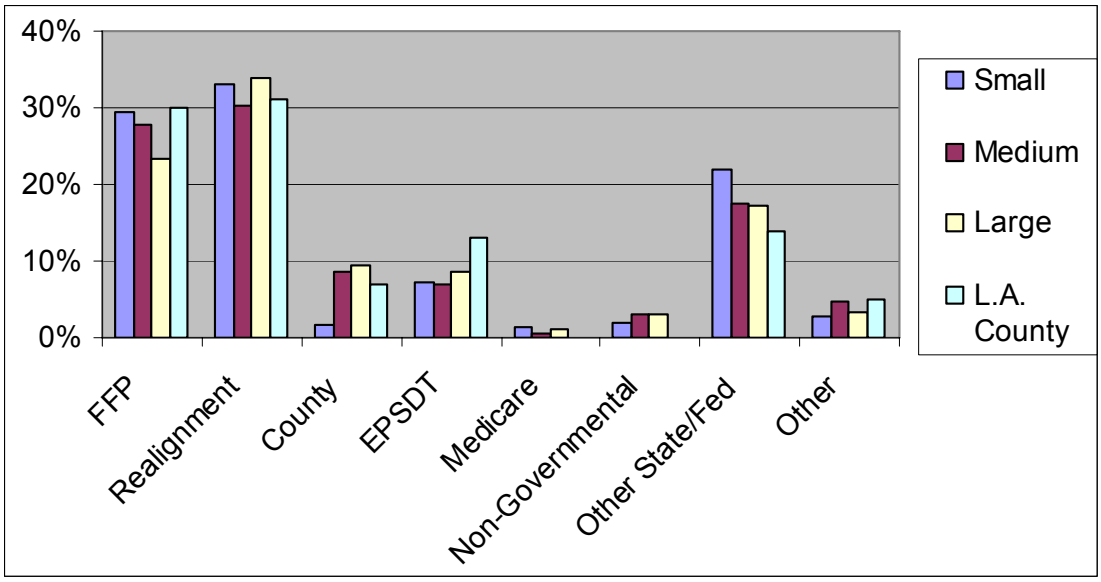
TABLE 5: Average Distribution of Revenue Sources, FY 03-04 (Before MHSA)

Category	Average	Range
FFP	28%	14-51%
Realignment	32%	15-54%
County	6%	0-31%
EPSDT	7%	0-21%
Medicare	1%	0-16%
Non-governmental	3%	0-22%
Other	4%	0-36%
Other state/federal	19%	1-38%

Source: Data analysis of Petris Center Survey
Notes: Data from 42 counties, which represent 97% of the California population
See Appendix 3 for calculations

A few important differences in the distribution of revenue sources existed by population size and are detailed in the graph below (Figure 5). Historically and in FY 03-04, small counties received less county support as a percentage of total budget compared to other counties. LA County received a slightly higher proportion of revenues from EPSDT than other groups of counties, and any revenues from Medicare or non-governmental sources were negligible.

FIGURE 5: Distribution of Revenue Sources, by Population Size, FY 03-04 (Before MHSA)



Source: Data analysis of Petris Center Director Survey
Notes: Data from 42 counties, which represent 97% of the California population
See Appendix 3 for calculations

While counties are required by law to contribute a fixed percentage of the county budget to mental health services, many counties used discretionary money to fund mental health beyond the requirement, which is commonly

referred to as the county "overmatch". Bay Area counties had a higher percent of county overmatch to mental health funding in FY 03-04 relative to other counties, while the Central region, Superior region, LA and small counties had a smaller contribution. The Central region, medium sized and large counties spent the greatest percentage of their budgets on inpatient treatment (Table 6).

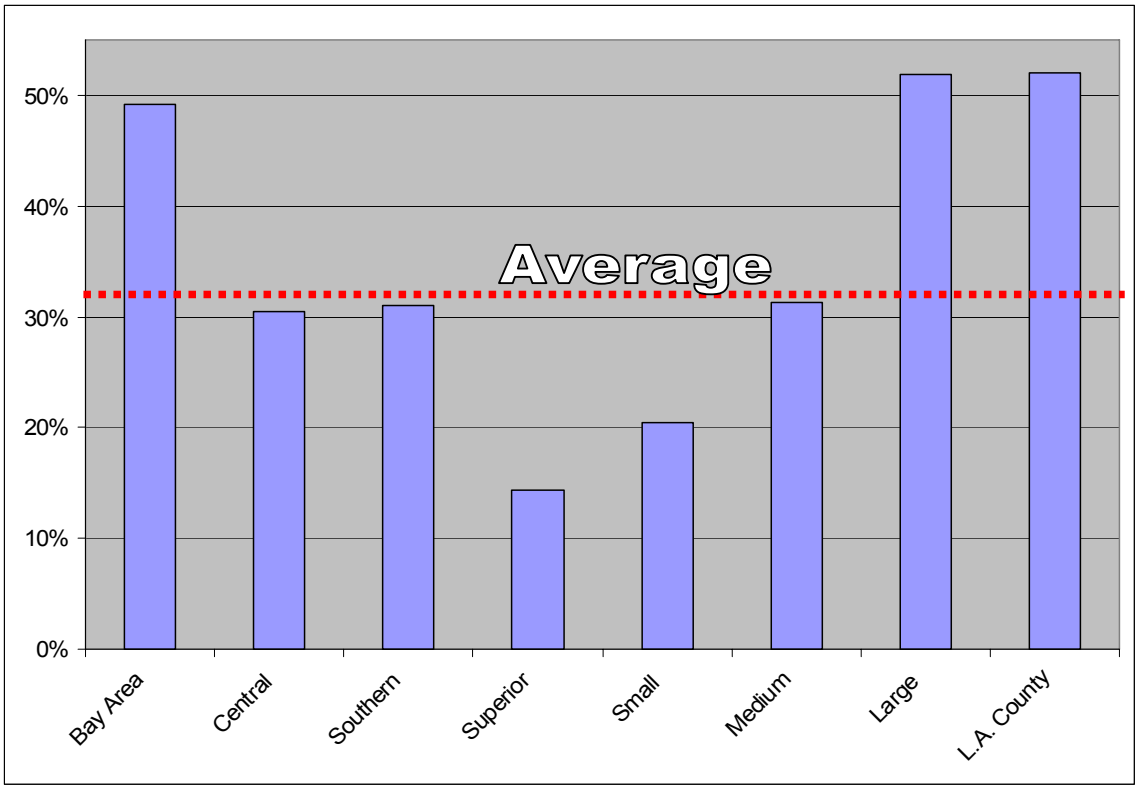
TABLE 6: Average Mental Health Budget Statistics for FY 03-04

Group	County	% Budget from County Overmatch	% Budget Spent on Inpatient treatment
REGIONS	Bay Area	**12%**	**9%**
	Central	**3%**	**13%**
	Southern	**5%**	**12%**
	Superior	**0%**	**7%**
POP SIZE	Small	**2%**	**7%**
	Medium	**7%**	**13%**
	Large	**8%**	**13%**
	LA	**0%**	**10%**
Survey Average (43)		**5%**	**11%**

Source: Data analysis of Petris Center Director Survey
Notes: This does not include Institutes for Mental Disease (IMD) beds, Nursing Facilities (NF), or state hospitals
Data from 43 counties, which represent 97% of the California population
See Appendix 3 for calculations

There was variation in the extent to which counties utilize community-based and other contract providers to provide services. On average, counties reported spending about one-third (32%) of their budgets on contract services in FY03-04. Los Angeles, the Bay Area region, and larger counties spent more on contract services (Figure 6).

FIGURE 6: Percent of Budget Spent on Contracted Services, FY 03-04 (Before MHSA)



Source: Data analysis of Petris Center Director Survey
Notes: Survey Average = 32%
Data from 42 counties, which represent 97% of the California population
See Appendix 3 for calculations

Detailed Expenditures: Beds

The survey asked counties to report specific dollar amounts spent on state hospital beds, IMD beds, and the number of beds or bed-days used of each. For counties that reported the number of beds used, a bed-day estimate was calculated. These statistics are of interest because a targeted outcome of MHSA community supports and services is a reduction in inpatient utilization. The counties were also asked to report what percentage of their budgets were spent on inpatient care that did not include IMD, state hospital, or Skilled Nursing Facility (NF) use.

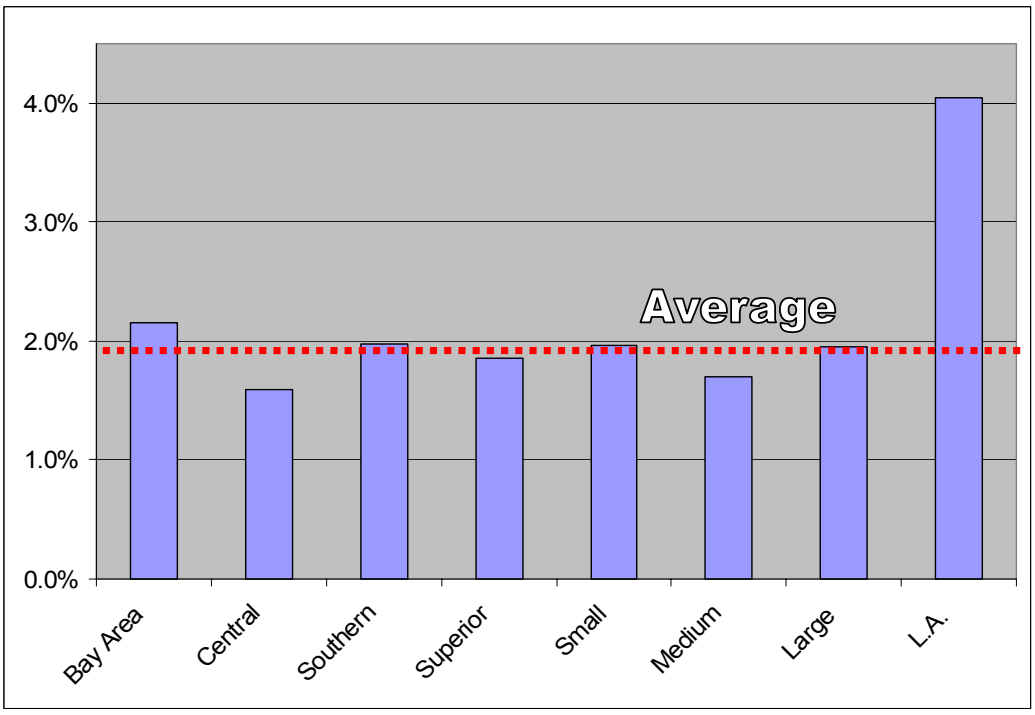
Baseline information on inpatient hospital use as a percentage of total budget, presented here, will help future assessments of MHSA success in this area. As seen in Table 7, counties spent an average of 11% of their mental health budgets on inpatient services, with the highest percentage (13%) being spent in the Central region and the lowest (7%) in the Superior region. Small counties spent the least (7%) on inpatient services, while medium and large counties spent the most (13%). In terms of per capita expenditures, the Bay Area region spent the most per client ($681) on inpatient services, while the Superior region spent the least ($320). Small counties spent the least per client ($317) while medium sized counties spent the most ($792). The average for all counties was $576 per client.

TABLE 7: Average Inpatient Services Expenditures, NOT Including IMD, State or Nursing Facilities, FY 03/04 (Before MHSA)				
Group	**Name (# of Counties)**	**% Budget Spent on Inpatient Services**	**Average County Spending on Inpatient Services**	**Amount Spent per Client**
REGIONS	Bay Area (10)	9%	$9,590,675	$681
	Central (14)	13%	$5,400,191	$631
	Southern (9)	12%	$10,956,921	$639
	Superior (9)	7%	$577,199	$317
POP SIZE	Small (17)	7%	$606,085	$311
	Medium (16)	13%	$6,149,576	$792
	Large (9)	13%	$18,513,316	$699
	LA	10%	$102,336,000	$533
	Survey Average (43)	**11%**	**$8,782,616**	**$576**

Source: Petris Center analysis of data from CSI (Client Service Information) data FY 03-04 and Petris Center Director Survey.
Notes: IMD = Institutes for Mental Disease
Data from 43 counties which represent 97% of the California population
See Appendix 3 for calculations

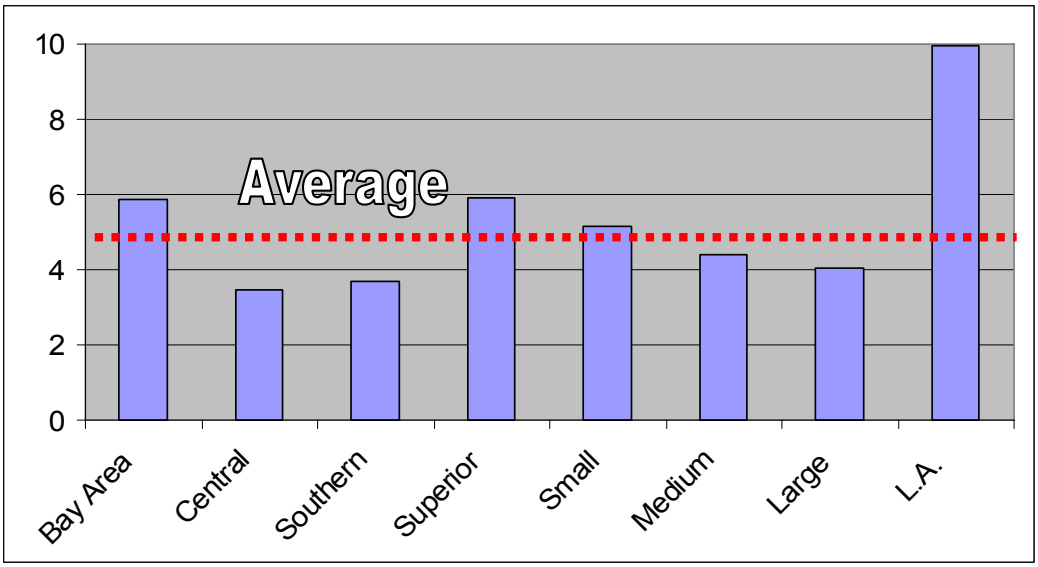
Counties are responsible for meeting the cost of care for patients under civil commitment at the state hospitals. In FY 03-04, between 1-4% of mental health budgets were spent on state hospital beds (Figure 7). The county average was 1.9% of the mental health budget. On average, most county groups used 2.5 to 6 state bed-days per 1,000 population in FY 03-04 (Figure 8). Los Angeles had the highest, with approximately 10 state bed-days per 1,000 population. The survey average was 4.7 bed-days per 1,000 population.

FIGURE 7: Percent Total Mental Health Budget Spent on State Hospital Beds



Source: Data analysis of Petris Center Director Survey
Notes: Survey Average = 1.9%
Data from 43 counties which represent 97% of the California population
See Appendix 3 for calculations

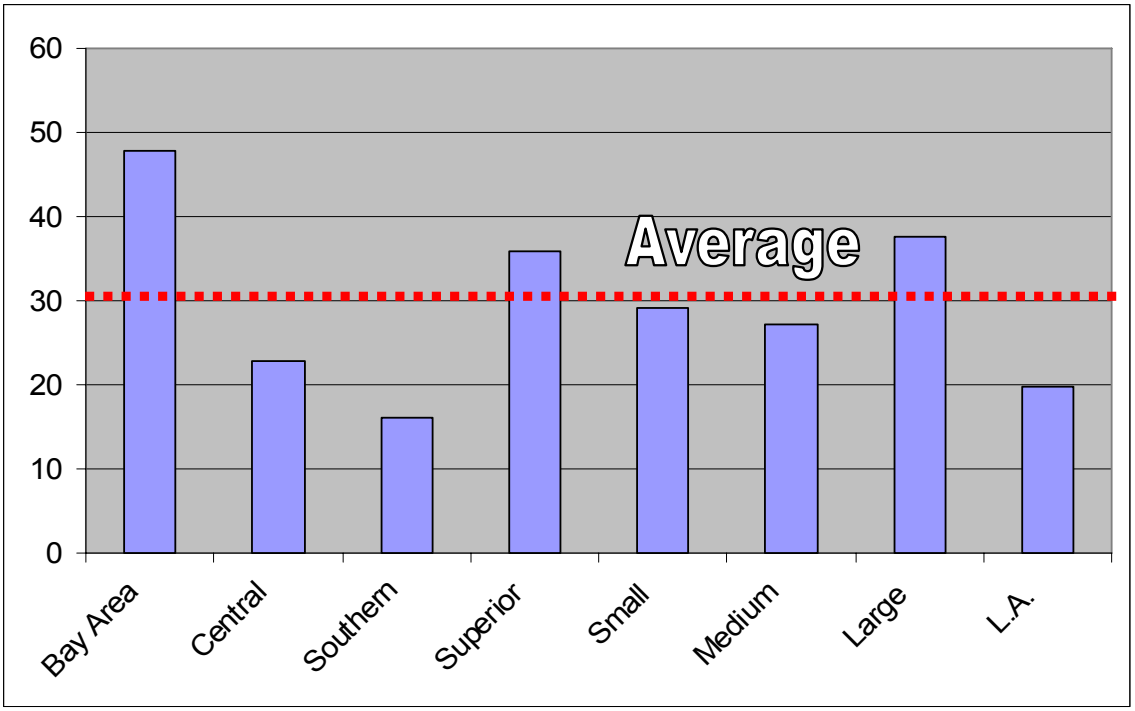
FIGURE 8: Average Number of State Hospital Bed-days per 1,000 Population, FY 03-04 (Before MHSA)



Source: Petris Center analysis of RAND 2003 population data and Petris Center Director Survey
Notes: Survey Average = 4.74
Data from 43 counties which represent 97% of the California population
See Appendix 3 for calculations

Counties are also solely responsible for providing/paying for extended inpatient care in Institutes for Mental Disease (IMD) beds, which provide less costly and more local alternatives to the state hospital. The rates of utilization and per day client costs vary significantly by county. In FY 03-04, between 0-12% of mental health budgets were spent on IMD beds, with a survey average of 4%. IMD bed-days per 1,000 population were generally higher than state bed-days (Figure 9). It was the highest in the Bay Area region (47.8), and the county average was 30.0. The Southern region and Los Angeles have the lowest number of IMD bed-days per 1,000 population.

FIGURE 9: Average Number of IMD Bed-days per 1,000 Population, FY 03-04 (Before MHSA)

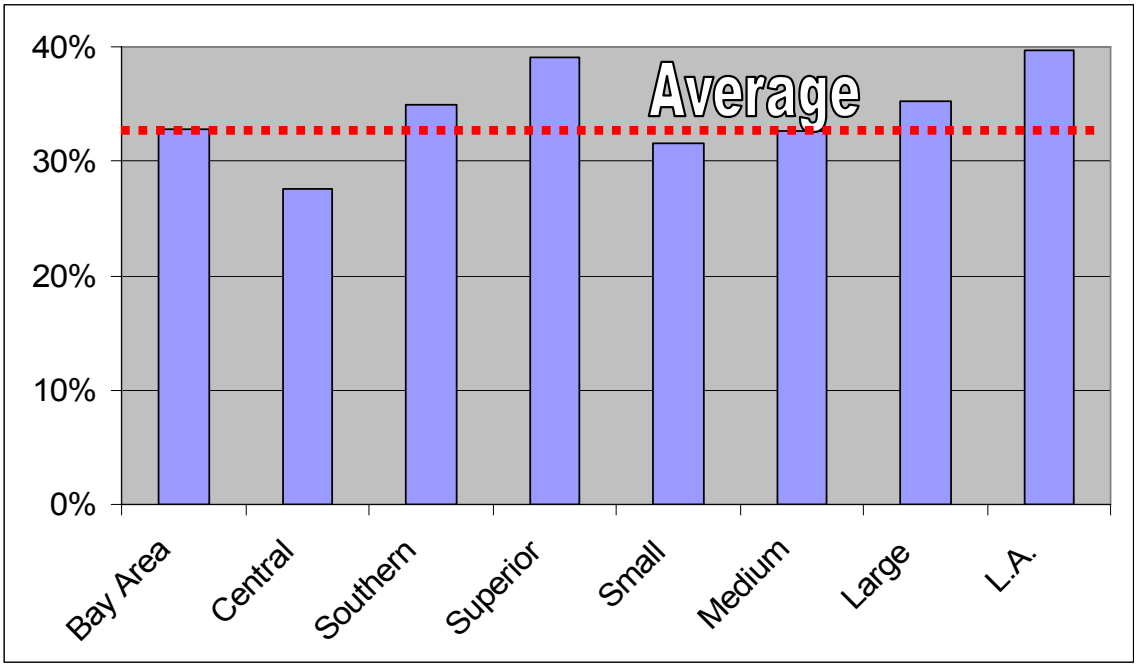


Source: Petris Center analysis of RAND 2003 population data and Petris Center Director Survey
Notes: Survey Average = 30.04
IMD = Institutes for Mental Disease
Data from 42 counties which represent 97% of the California population
See Appendix 3 for calculations

Detailed Expenditures: Child/Family Services (CFS)

The average expenditure on Child and Family Services (CFS) was about 31 million dollars, or about 33% of mental health budgets.[28] An analysis of regional variations revealed that LA and the Superior region spent larger portions of their budgets on Child and Family Services in FY 03-04, while the Central region spent the least (Figure 10). Differences in the percentage of children in these regions may be responsible for these differences.

FIGURE 10: Percent Total Budget Spent on Child and Family Services, FY 03-04 (Before MHSA)



Source: Data analysis of Petris Center Director Survey, Section I, Question 18
Notes: Data for spending on child and adolescent mental health services
Survey Average = 33%
Data from 40 counties which represent 95% of the California population

[28] Child and Family Services refers to Child and adolescent mental health services

Of particular interest is what funding streams counties can use for CFS expenditures (Table 8). EPSDT (Early Prevention Screening, Diagnosis and Treatment) revenue represented an average of 24% of the CFS county budget, with a low of 17% in the Bay Area and a high of 32% in the Superior Region. Realignment funding as spent specifically on CFS represented 18% of CFS budgets with a range of 16-19% in the different regional and population groupings. Differences in percentages were not great by population size, with more variation across regions, which used different funding strategies for CFS.

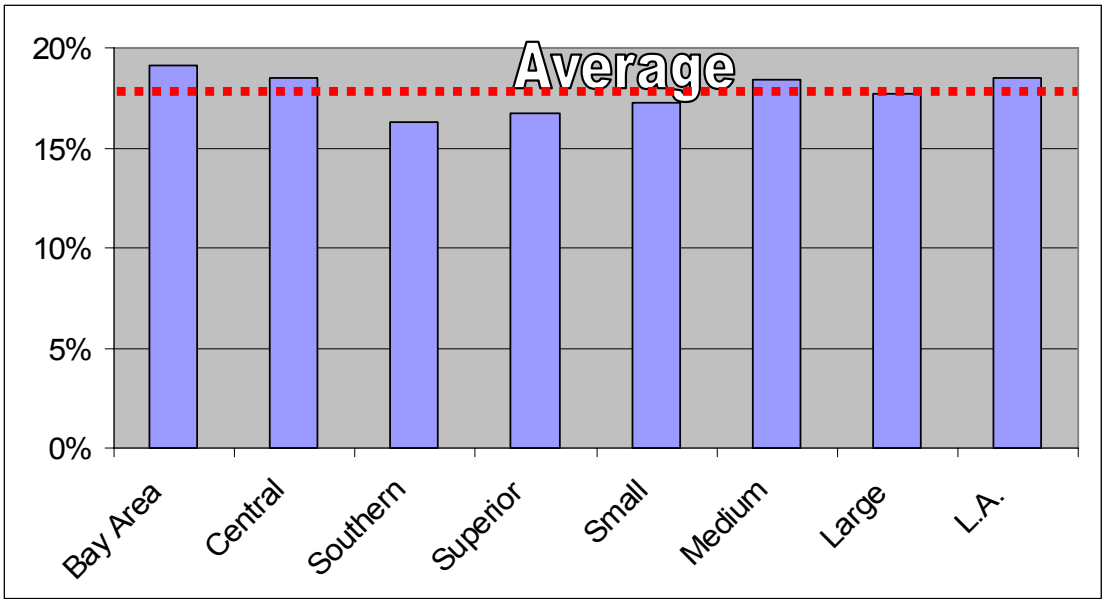
Table 8: Child and Family Services (CFS) Expenditures and Sources of Revenue, FY 03-04 (Before MHSA)

Group	Name (# of counties)	Total CFS Spending	EPSDT* as % of CFS Budget	Realignment as % of CFS Budget
REGIONS	Bay Area	$29,062,435	17%	19%
	Central	$13,699,421	26%	18%
	Southern	$33,602,239	21%	16%
	Superior	$4,445,981	32%	17%
POP SIZE	Small	$2,570,302	27%	17%
	Medium	$16,191,146	21%	18%
	Large	$55,135,630	24%	18%
	LA	$422,839,384	33%	18%
Survey Average (40)		**$30,012,044**	**24%**	**18%**

Source: Data analysis of Petris Center Director Survey and DMH FY 03-04 Cost Reports
Notes: ESPDT = Early Periodic Screening, Diagnosis and Treatment
*EPSDT may include state funds or state and FFP funds
Data from 40 counties which represent 95-96% of the California population
See Appendix 3 for calculations

The average percent of realignment budget spent on child and family services in FY 03-04 was 17.8% (Figure 11). This percentage varied slightly by county size, and more by region, with Bay Area counties spending the highest percentage (19%) and Southern counties spending the lowest percentage (16%).

FIGURE 11: Percent Realignment Budget Spent on Child and Family Services, FY 03-04 (Before MHSA)



Source: Data analysis of Petris Center Director Survey and DMH FY 03-04 Cost Reports
Notes: Survey Average = 17.8%
Data from 40 counties which represent 96% of the California population
See Appendix 3 for calculations

Counties reported either the dollar amount or percent of direct expenditures (excluding in-kind) spent on peer and family support services. Percentages were converted to dollar amounts and divided by total client population for comparability (Table 9). The Central region counties, on average, spent a greater amount per client on adult and child peer and family support services compared to the other regions. Small counties spent the most on these services compared to medium and large counties.

TABLE 9: Average Spending per Client on Adult and Child Peer and Family Support Services, FY 03-04 (Before MHSA)

Group	Name	Adult	Child
REGIONS	Bay Area	$39.35	$27.41
	Central	$63.50	$95.71
	Southern	$24.40	$14.84
	Superior	$11.11	$59.81
POP SIZE	Small	$50.18	$109.43
	Medium	$28.51	$21.37
	Large	$29.55	$8.75
	Survey Average	**$37.88**	**$54.07**

Source: Petris Center analysis of CSI (Client Service Information) data FY 03-04 and Petris Center Director Survey
Notes: Counties could include any services they felt constituted adult and child peer and family support services here. Dollar amounts for children and adults were divided by the total client population
Adult and child data from 38 and 40 counties which represent 66% and 64% of the California population, respectively. Data not available for LA county
See Appendix 3 for calculations

II. FISCAL YEAR 2003-04 STAFFING PATTERNS

Counties will need to hire more staff to support the new and expanded programs and services under MHSA. There has been speculation already that a shortage of trained staff will be an issue and barrier to fully implementing planned services. Understanding historic issues related to workforce retention and recruitment may also be significant in understanding success in MHSA implementation.

Table 10 presents FY 03-04 data on the reported distribution of clinical and administrative staff, excluding contracted workers. The survey included a question about union penetration as well, and the majority (73%) of counties reported high union penetration (76-100%). It is unclear what impact unions and existing contracts will have on MHSA hiring and implementation, but they may have a significant effect on the future.

TABLE 10: Distribution of Employees who are Clinical or Administrative, Excluding Contracted Workers, FY 03-04 (Before MHSA)

Group	Name (# of counties)	Clinical	Administrative
REGIONS	Bay Area (11)	77.9%	22.1%
	Central (14)	69.0%	31.0%
	Southern (9)	71.8%	28.2%
	Superior (9)	67.3%	32.7%
POP SIZE	Small (17)	65.4%	34.6%
	Medium (17)	78.6%	21.4%
	Large (9)	69.6%	30.4%
	L.A.	67.7%	32.3%
	Survey Average (44)	**71.4%**	**28.6%**

Source: Data analysis of Petris Center Director Survey
Notes: Total number of employees reported in the survey (not FTEs) includes all who reported as clinical or administrative. Data on other possible categories was not collected. The clinical category refers to those who provided billable clinical services
Data from 44 counties which represent 98% of the California population
See Appendix 3 for calculations

Several survey questions explored clinical staff tenure, competency, vacancies, and the time required to create and fill new positions, as well as satisfaction with the number and quality of applicants to open positions. Twenty-five (25) counties (57%) had formal mechanisms for evaluating clinical staff competency. Not all counties track detailed information about tenure, so there is not complete data from all 44 responding counties in the tables below.

Very few counties (16%) report tracking staff tenure or turnover data. Los Angeles County does not generally track this information, but provided an estimate of the average tenure of medical staff, and one of the six counties that does track turnover did not have estimates of tenure. Some potentially interesting trends emerged among the few counties that provided this information, although these trends should be interpreted cautiously given the small sample size. Other counties of similar size or in the same region may have different staff tenure patterns. Average tenure of medical staff was 13 years in medium sized counties and 12 years in small counties, higher than in large sized counties (Table 11). This suggests a relatively more stable clinical workforce in smaller sized counties and enhanced continuity of care. In contrast, larger counties appeared to have more staff turnover, and relied more on temporary hires, particularly for non-medical staffing needs.

TABLE 11: Tracking of Staff Tenure, FY 03-04 (Before MHSA)

Group	Name	# Counties that tracked Tenure and Turnover (N)	Average Tenure Medical Staff (years)	Average Tenure Non-Medical Staff (years)
REGIONS	Bay Area	1 (9%)	N/A	N/A
	Central	2 (14%)	12	8
	Southern	2 (22%)	6	7
	Superior	2 (22%)	13	15
POP SIZE	Small	2 (12%)	12	7
	Medium	2 (12%)	13	12
	Large	3 (33%)	6	7
	L.A.	N/A	6.4	N/A
	Survey Average	**7 (16%)**	**10**	**9**

Source: Data analysis of Petris Center Director Survey, Section II, Question 8
Note: Based on data from 7 counties that reported tracking tenure

Twenty-six (26) counties (59%) reported using temporary hires to meet their staffing needs in FY 03-04 (Table 12). Most of the Bay Area and Southern region counties used temporary hires. Very few Superior region counties used temporary hires, while in LA County, only 1% of clinical staff were temporary hires and they did not use any temporary hires for administrative needs. Temporary hires constituted a fairly small proportion of medical staff in counties (range 1-21%, survey average of 10%). The extent of utilization of temporary hires for administrative staffing needs varied more widely (range 0-28%, survey average of 22%).

TABLE 12: Use of Temporary Hires, FY 03-04 (Before MHSA)

Group	Name	# Counties Using Temporary Hires (%)	Temporary Hires as % of Clinical Staff	Temporary Hires as % of Non-clinical Staff
REGIONS	Bay Area	9 (82%)	5%	23%
	Central	5 (36%)	21%	20%
	Southern	9 (100%)	9%	24%
	Superior	2 (22%)	9%	25%
POP SIZE	Small	5 (29%)	9%	10%
	Medium	12 (71%)	8%	28%
	Large	8 (89%)	14%	26%
	L.A.	1	1%	0%
	Survey Average	**26 (59%)**	**10%**	**22%**

Source: Data analysis of Petris Center Director Survey
Notes: Data for the percentage of temporary hires is only available for 21 of the 26 counties who used them. Forty-four counties representing 98% of the population answered the Petris survey question about whether they used temporary hires
See Appendix 3 for calculations

Under MHSA, many new positions are being created within county mental health departments, as detailed in the CSS Plans. Creating new positions in FY 03-04 took an average of 5 months in all counties (Table 13). Once positions were created, they were usually filled within 2-3 months, and counties were fairly satisfied with the quality and number of applicants. Southern counties were more satisfied while Superior counties were less satisfied with the applicant pool in FY 03-04.

TABLE 13: Hiring Patterns in FY 03-04 (Before MHSA)

Group	Name	Average # Months to Create New Position	Average # Months to Fill New Position┼	% Vacant Clinical Positions	Satisfaction with Number, Quality of Applicants *
REGIONS	Bay Area	5	2	10%	6
	Central	4	3	9%	5
	Southern	6	3	9%	7
	Superior	5	3	10%	4
POP SIZE	Small	5	3	11%	5
	Medium	6	3	10%	6
	Large	4	2	6%	6
	L.A.	12	3	7%	N/A
Survey Average		**5**	**3**	**9%**	**5**

Source: Data analysis of Petris Center Director Survey
Notes: * On a scale of 1-10 with 1=not at all satisfied and 10=very satisfied
┼This refers to average months to fill a new position once it is created
Data from 41 to 44 counties representing 61% to 98% of the California population
See Appendix 3 for calculations

Language Services

Increasing access to care and culturally competent providers are key issues in the mental health system, particularly in a state as culturally and linguistically diverse as California. Many individuals may experience cultural and/or language barriers when seeking care[29] and there is significant disparity in access across ethnic and racial groups in the state. MHSA emphasizes reaching out to and successfully engaging previously unserved and underserved individuals.

A *threshold language* is defined by a population of greater than 3,000 beneficiaries or 5% of the Medi-Cal population (whichever is lower) that speak a language other than English. Counties are required to evaluate threshold language needs annually and to provide language access services accordingly. DMH monitors the threshold language requirements every year and their findings are available on the DMH webpage. Only one responding county was identified by DMH as being in noncompliance of language threshold requirements in FY03-04.

Overall, the California counties seem to do a good job of accommodating different language and translation needs. Sixty-four percent (64%) of responding counties provided mental health services in languages beyond the minimum threshold language requirements. Two counties noted contracting with a translation/interpreter service to ensure appropriate access to care for all clients and availability of all languages. In counties that did not contract with a translation service, services were

[29] For additional information on this topic, see Overcoming language barriers to public mental health services in California, by Joan R. Bloom, Mary Masland, Crystal Keeler, Neal Wallace, and Lonnie R. Snowden (April 2005). Available online: http://www.ucop.edu/cprc/mhservicebarriers.pdf [Accessed 3/20/07]

provided in an average of 3 additional languages (range 1-16). In addition, many counties reported providing American Sign Language services.

The majority of counties filed cultural competence reports with DMH between 1997 and 2004. These reports include data on bilingual staff in county mental health departments along with other details about the counties' efforts to address the needs of diverse populations. Direct service providers and administrative staff who spoke the most common threshold languages (Spanish, Chinese, Vietnamese, Hmong, Lao, Mien, Cambodian, Farsi, and Russian) were tabulated in terms of full-time equivalents (FTE), and the percent of FTE bilingual staff by type are reported below (Table 14). There may be more bilingual staff in the counties that are not accounted for here who speak other less common languages.

TABLE 14: Bilingual* Staff, FY 03-04 (Before MHSA)

Group	Name	Bilingual * as % FTE Direct Service Providers	Bilingual* as % FTE Administrative Staff
REGIONS	Bay Area	28%	14%
	Central	23%	13%
	Southern	33%	17%
	Superior	10%	4%
POP SIZE	Small	19%	12%
	Medium	21%	12%
	Large	39%	11%
	LA	33%	38%
	Survey Average	**24%**	**13%**

Source: Petris Center analysis of data coded from County Cultural Competency Reports from 2002-2004
Notes: In a few cases, 1997-1999 numbers were used as they were the only numbers available (in some years, these reports were unavailable and/or not required by DMH to be completed by some counties).
FTE = full-time equivalent
*Bilingual in Spanish, Chinese, Vietnamese, Hmong, Lao, Mien, Cambodian, Farsi, or Russian, the most common non-English languages spoken throughout the state
Administrative bilingual staff and direct bilingual service provider data from 40 and 42 counties which represent 91% and 92% of the California population respectively
See Appendix 3 for calculations

Consumers and Family Members as Employees

The role and involvement of consumers and family members in the county mental health systems are critical to assess prior to MHSA as the creation of new roles and involvement for these stakeholders is central to MHSA values and implementation. The wellness and recovery philosophy/principles guiding MHSA call for a larger and more significant role for consumers and family members in a range of activities including treatment planning and system governance.[30] For FY 03-04, seven counties (16%) had a consumer as a member of the management team. Ten counties (19%) of the 53 that filed cultural competency reports (data from one year between 1999 and 2004) indicated that self-identified consumers are employees in the mental health system. Many counties do not collect data on the number of consumers working in the mental health department, so these numbers are likely underestimates of the actual number of consumer employees around the state. Six of those ten counties reporting consumer employees had 4 FTE consumer employees or fewer, accounting for less than 4% of total reported FTE. In three counties, higher rates of consumers employmees as a percentage of total employees was reported. One county reported 3 FTE (15% of FTE), one county reported 9 FTE (12% of FTE) and another county reported 45 FTE (8% of total FTE). Los Angeles County reported 1,490 FTE consumer employees (about 28% of total FTE).

[30] MHSA full text Section 7, 5813.5d, Section 8, 5822 g & h. Available online: http://www.dmh.cahwnet.gov/MHSA/docs/Mental_Health_Services_Act_Full_Text.pdf [Accessed 7/12/07]

As part of the Petris Center director's survey, counties were asked to report if there were programs for employing consumers and family members as direct county employees or as part of community-based organizations (CBOs) in FY 03-04. This data is presented in Table 15.

TABLE 15: Employment Patterns, FY 03-04 (Before MHSA)

	# of Counties	(%)
Program to directly employ consumers	14	33%
Program to employ consumers as part of CBOs	22	50%
Program to directly employ family members	19	45%
Program to employ family members as part of CBOs	17	40%

Source: Petris Center Director Survey, Section II, Questions 23-26
Notes: CBO = community based organization.
Data from 41 to 43 counties representing 94-97% of the California population

III. ORGANIZATIONAL STRUCTURE, EXPERIENCE WITH INNOVATIVE SERVICE MODELS, AND INFORMATION TECHNOLOGY

Organizational Structure

The diversity in California counties as seen in population, geography, and ethnic mix is also reflected in how county departments and services are organized. This is especially true for the state's 58 county Mental Health Departments whose organizational structure as well as the scope of programs and services varies significantly by county. While the State's Department of Mental Health sets broad policy, counties have significant flexibility in implementation and the opportunity to adapt services and programs to meet their local needs. Table 16 below summarizes some aspects of county mental health departments that help illustrate the extent of the variation.

Where the mental health department is placed within the broader organizational structure of health and human services could affect the scope of services provided and the community's ability to interact with this department when needed. In over half the counties, the mental health department is part of a county Health or Human Services Agency and the director reports to the larger umbrella agency chief. Thirty-nine percent (39%) of mental health departments are stand-alone agencies, and may have greater control over budgets, programming, and Board of Supervisor access relative to their counterparts. Mental health departments are all accountable to Boards of Supervisors and the county executive or county administrative officer (CEO or CAO). However, most (80%) county mental health directors communicate to their CAOs through their department heads.

Other interesting details about the organization of county mental health programs include the following:

- The majority (89%) of counties had a Medical Director in FY 03-04, although it is unknown if this person worked part-time or full-time
- 59% indicated that the mental health department was responsible for substance abuse services, but it is not known if they provide those services directly or not
- 32% reported contracting with consumer or family operated agencies for service provision in FY 03-04

TABLE 16: Overview of Organizational Structure and Scope of Services, FY 03-04 (Before MHSA)

Group	Name (# of counties)	Independent Agency	Communicate with CAO via Dept. Head	Medical Directors (full or part time)	Substance abuse services responsibility	Contract with consumer/ family operated agencies
REGIONS	Bay Area (11)	0	8	11	4	8
	Central (14)	7	12	12	8	1
	Southern (9)	5	7	9	7	3
	Superior (9)	4	8	6	7	1
POP SIZE	Small (17)	8	15	13	12	1
	Medium (17)	6	13	16	10	6
	Large (9)	2	7	9	4	6
	LA	1	0	1	0	1
Survey Average (44)		**17 (39%)**	**35 (80%)**	**39 (89%)**	**26 (59%)**	**14 (32%)**

Source: Data analysis of Petris Center Director Survey, Section I, Questions 1-4 and 16
Notes: It is unknown if the Department Head is the CAO (County Administrative Officer) in a county, if Medical Directors worked full-time or part-time, or if substance abuse services are only administratively combined with mental health services (they may not necessarily be clinically integrated)
Data from 44 counties representing 98% of the California population

Experience with Innovative Service Models

MHSA calls for counties to develop, enhance and/or expand a range of outreach activities as well as services and supports to individuals (and families) of all ages who have historically been unserved or underserved by the system.[31] The primary service model is referred to as a "Full-Service Partnership" (FSP), in which the delivery of all necessary mental health and other services is highly integrated and consumers are provided with "whatever it takes" to sustain a high quality of life and independent functioning in the least restrictive setting. FSPs are a new way of delivering care where there is a partnership between the client and provider with a commitment to do all that is required to improve the lives of clients. The FSP model builds on the success of the Assembly Bill (AB) 34 and 2034 programs and other similar programs for adults and children. However, not all counties participated in those earlier initiatives. MHSA expands the resources for all counties to provide and expand these services.

A county's experience in offering different programs and services prior to MHSA may provide insight into challenges and success in implementing MHSA. In addition to AB 34/2034, Children's System of Care (CSOC), Senate Bill (SB) 163 Wraparound Program, and the Mentally Ill Offender Crime Reduction (MIOCR) Grants are all examples of significant demonstration, grant-funded, and/or innovative service delivery model programs similar to FSPs that were implemented in some counties in recent years prior to MHSA. However, not all counties were part of these demonstration programs or able to obtain funds from grants to support the programs over time. There

[31] For more information, see DMH's "A Draft Readers Guide to Mental Health Services Act, Community Services and Supports Three-Year Program and Expenditure Plan Requirements." Available online: http://www.dmh.ca.gov/mhsa/docs/A_Draft_Readers_Guide_to_Mental_Health_Services_Act.pdf [Accessed 3/20/07]

may well be other unique and innovative pre-MHSA programs in many counties that are not captured here, but these four programs in particular are noteworthy since many counties received additional funding for them and comparisons can be made across counties.

CSOC [32] and SB 163 Wraparound[33] are grant-funded programs for children, and very prescriptive in terms of how and what types of services are to be provided. MIOCR grants[34] support the implementation and evaluation of locally developed projects aimed at reducing jail recidivism for those individuals with mental illness and criminal justice involvement. Many of those projects followed an Assertive Community Treatment (ACT) model. AB 2034 programs [35] were built on many of the principles reflected in the FSPs and focused on outreach, housing and integrating needed services for adults with mental illness who were homeless or involved with the criminal justice system.

These programs were not uniformly funded across the state. Small counties had the smallest percentage of programs while all counties in the medium and large size counties participated in at least one of these programs (Table 17). Experience with these other programs may influence counties' starting points under MHSA. Counties that have had experience implementing these various programs may have an easier time planning for and implementing MHSA Full Service Partnership programs and be

[32] For more CSOC information, see: http://www.dmh.cahwnet.gov/SpecialPrograms/child.asp [Accessed 3/20/07]
[33] For more SB 163 Wraparound information, see: http://www.childsworld.ca.gov/Family-Cen_318.htm [Accessed 3/20/07]
[34] For more MIOCR information, see: http://www.cdcr.ca.gov/DivisionsBoards/CSA/cppd/microg/mioanalysis/analysis.htm [Accessed 3/20/07]
[35] For more information on AB 2034 see: 1) http://ab34.org/, 2) AB 2034 Program Experiences in Housing Homeless People with Serious Mental Illness, Martha R. Burt, Jacquelyn Anderson. December 2005. www.csh.org/index.cfm?fuseaction=Page.viewPage&PageID=3621, 3) Effectiveness of Integrated Services for Homeless Adults with Serious Mental Illness, Report to the Legislature 2003. California Department of Mental Health, Stephen W. Mayberg, Ph.D. Director. May 2003. Available online: www.dmh.cahwnet.gov/AOAPP/Int_Services/docs/Leg_Report_2003.pdf

better prepared to meet their service goals. The programs are grouped by children and adult services in the following table. Notably, 4 counties (9%) did not have prior experience with any of the four demonstration or grant-funded FSP-type programs listed above.

TABLE 17: Past Experience with Demonstration, Grant-Funded FSP-Type Programs, FY 03-04 (Before MHSA)

		Children's services *		Adult's services **		
Group	Name (# of Counties)	**CSOC**	**SB 163 Wraparound**	**MIOCRG I or II**	**AB2034**	**No past experience**
REGIONS	Bay Area (11)	9	5	9	10	0
	Central (14)	11	5	5	8	2
	Southern (9)	9	5	7	8	0
	Superior (9)	6	3	3	3	2
POP SIZE	Small (17)	13	5	3	6	3
	Medium (17)	14	6	14	15	1
	Large (9)	8	7	7	8	0
	LA (1)	1	1	1	1	0
	Survey Average (44)	**36 (82%)**	**19 (43%)**	**25 (57%)**	**30 (68%)**	**4 9%)**

Source: *Petris Center Director Survey data. **Petris Center analysis of adult services data from DMH.
Notes: CSOC = Children's System of Care
Data from 44 counties which represents 98% of the California population
See Appendix 3 for more source information and calculation

Table 18 summarizes the impact of funding received from these four programs as a percent of the total mental health budget for FY 03-04. CSOC had funding from both state and federal sources, and these amounts are shown separately. State and other funding sources have not maintained steady support for these programs, and in some cases, they were isolated projects that served a relatively small proportion of clients. Since FY03-04, state funding for CSOC has been cut. The first MIOCR initiative was discontinued after several years, but some counties have recently been

funded under a third cycle of MIOCR grants. AB2034 has been discontinued in the FY 07-08 state budget.

CSOC funds appear to have constituted a larger portion of the total mental health budget in Central region, Superior region than in other regions in FY 03-04. Wraparound programs were a larger portion of Bay Area, Central and small county budgets. Superior region and smaller counties had higher percentages of their total budget from MIOCR Grants. AB2034 programs were a larger portion of Central and small county budgets.

TABLE 18: Percent Budget Spent on Demonstration, Grant-Funded, FSP Type Programs, FY 03-04 (Before MHSA)

		Children's services*			Adult's services**	
Group	Name	**CSOC (state funding)**	**CSOC (federal funding)**	**SB 163 Wraparound**	**MIOCRG I or II**	**AB2034**
REGIONS	Bay Area	0.9%	1.8%	2.9%	5.0%	1.7%
	Central	5.9%	2.8%	2.9%	6.3%	4.1%
	Southern	0.8%	0.3%	0.7%	4.1%	1.9%
	Superior	3.8%	1.9%	0.8%	8.5%	2.8%
POP SIZE	Small	6.0%	2.5%	2.9%	10.7%	4.3%
	Medium	1.8%	2.2%	1.3%	5.8%	2.5%
	Large	0.5%	0.6%	1.8%	2.4%	1.3%
	LA	0.6%	0.2%	***	0.8%	1.6%
	Survey Average	**3.0%**	**1.8%**	**1.9%**	**5.3%**	**2.5%**

Source: *Data analysis of Petris Center Director Survey. **Petris Center analysis of adult services data from DMH.
Notes: *** For LA county, the Department of Children and Family Services was the lead Wraparound agency. DMH supported the program with Medi-Cal funds for mental health services
Data for state CSOC funding was available for 33 of the 36 participating counties. Data for federal CSOC funding was available for 30 of the 36 participating counties
See Appendix 3 for calculations

States also receive grant funds through the Substance Abuse and Mental Health Services Administration (SAMHSA). Funds are available in block grants for substance abuse prevention and treatment or community mental health services.[36] Some funds are discretionary for various mental health, substance prevention and substance abuse treatments. A wide range of programs and services focusing on all different age groups are supported annually.[37]

In FY 03-04, only three counties did not receive any funding from SAMHSA Grants. Table 19 displays the funding received as a percent of total mental health budget in FY03-04. Similar to the programs discussed earlier, the Superior region, the Central region and small counties had slightly higher percentages of total budget from SAMHSA Grants.

TABLE 19: Percent Budget from SAMHSA Grants, FY 03-04 (Before MHSA)

Group	Name (# of Counties)	
REGIONS	Bay Area(11)	1.76%
	Central (13)	2.39%
	Southern (9)	1.62%
	Superior (8)	2.33%
POP SIZE	Small (15)	2.53%
	Medium (17)	1.81%
	Large (9)	1.63%
	LA	1.40%
	Survey Average (42)	**2.03%**

Source: Petris Center analysis of DMH FY 03-04 Cost Reports and Petris Center Director Survey data
Notes: SAMHSA = Substance Abuse and Mental Health Services Administration
Data from 42 counties which represent 98% of the California population
See Appendix 3 for calculations

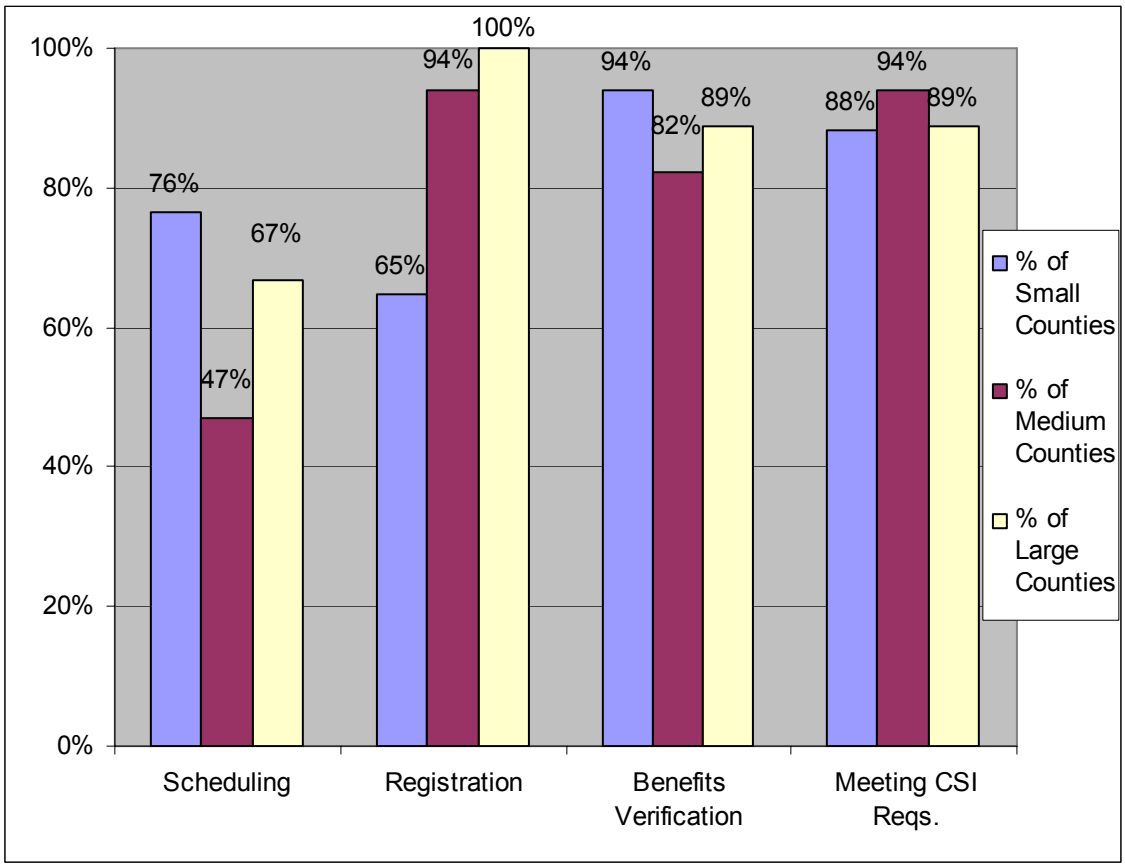
[36] http://www.samhsa.gov/StateSummaries/ca.aspx
[37] See http://www.samhsa.gov/StateSummaries/detail/ca.aspx for a detailed list of funded programs from FY 04-05

Information Technology

One of the six MHSA components is capital facilities and technological needs. While the details about funding for this component are not yet available, it remains an important topic. The implementation of Information Technology (IT) — both hardware and software — is rapidly expanding in the county mental health systems, although sizable differences across the counties continue to exist. MHSA funding will support some amount of further IT development.

For example, all 44 counties had computerized billing systems in place in FY 03-04. Three counties also specified using computers for managed care authorizations and other general office operations. Overall, many administrative and several clinical functions have been computerized. Figure 12 below displays administrative uses for computers by county size.

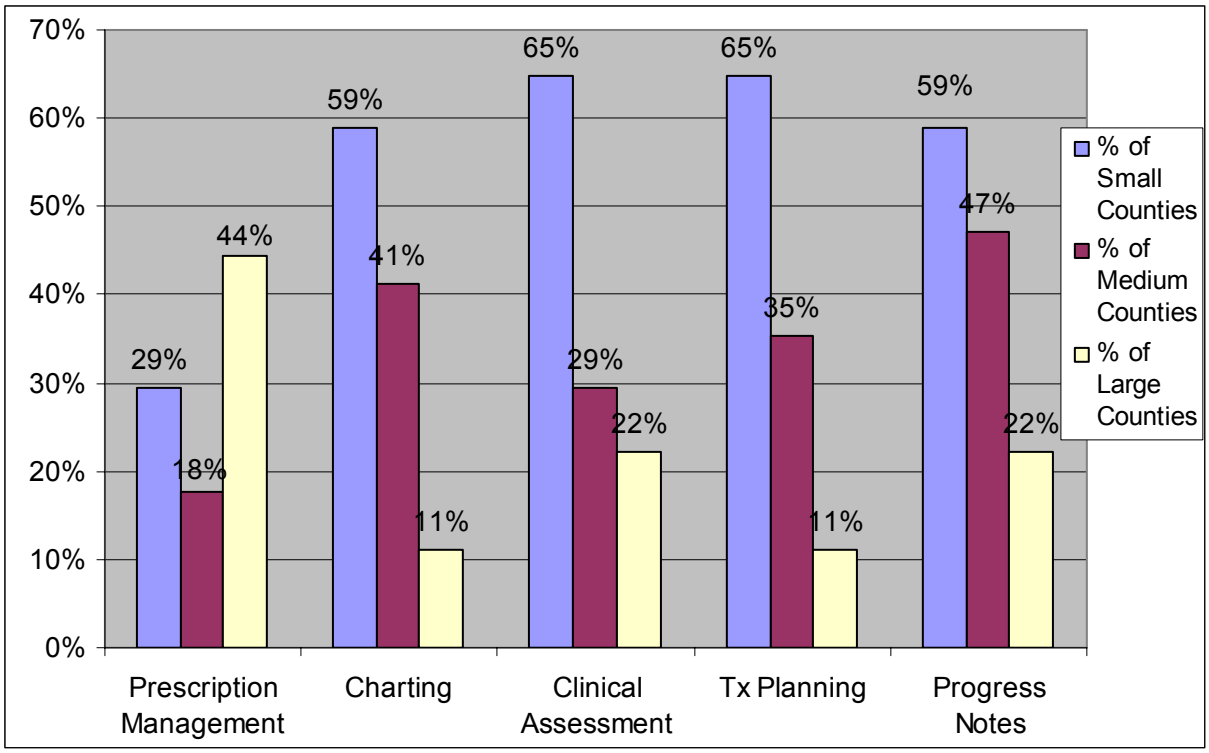
FIGURE 12: Distribution of Computerized Administrative Functions by County Size, FY 03-04 (Before MHSA)



Source: Data analysis of Petris Center Director Survey, Section I, Question 6.
Notes: CSI= Client Services Information
Data from 44 counties which represent 98% of the California population

Overall, fewer than two-thirds of the counties used computers for clinical functions related to direct client service delivery (making progress notes, charting, clinical assessment, treatment planning, or prescription management). Notably, a greater proportion of smaller counties used computers for clinical functions (Figure 13). Computerized treatment planning and clinical management tasks are at the cutting edge of innovation. It is possible that clinical functions were computerized more frequently in smaller counties because the costs and complexity of automation are more manageable in smaller organizations.

FIGURE 13: Distribution of Computerized Clinical Functions, by County Size, FY 03-04 (Before MHSA)



Source: Data analysis of Petris Center Director Survey, Section I, Question 6
Notes: Tx= treatment
Data from 44 counties which represent 98% of the California population

IV. RELATIONSHIP WITH MENTAL HEALTH BOARD/COMMISSION

Mental Health Boards have a special role to play in county mental health governance in general and in MHSA planning and implementation in particular. The Mental Health Boards are required to review and comment on county plans and updates.[38] Additionally, Mental Health Boards were empowered to hear public testimony as well as review and comment on the Community Services and Support (CSS) Plans before counties could submit the plans to the state. In the Petris Center study, survey questions asked counties to rate their relationship and interaction with their Boards. On average, Boards met 11-12 times in FY 03-04, but a few counties held meetings as few as four times, and others as often as 24 times that year. Mental health directors or their representatives attended all Board meetings, save one county in which the director did not attend any Mental Health Board meetings.

Statewide, the majority of counties reported positive relationships with their Boards and used them as resources in FY 03-04 (Table 20). Ninety-three percent (93%) rated the relationship as good or better. Most counties also used their Boards as resources sometimes (40%) or often (43%).

When asked to rate Boards' effectiveness in advocating with the Board of Supervisors on a 1-10 scale (1=not at all effective, 10=very effective), Southern counties had a much higher rating of the effectiveness of their Mental Health Boards (average score of 8 out of 10) compared to the average and other subgroups (average score was 5 out of 10).

[38] See Section 10 Part 3.7, 5848b in the full text of the Mental Health Services Act

TABLE 20: Relationship with Mental Health Board/Used as Resource						
		Relationship with Board		Used Board as Resource		
Group	Name (# of counties)	Fair or Poor	Good, Very Good, or Excellent	Never or Rarely	Sometimes	Often
REGION	Bay Area(11)	2	9	1	6	4
	Central (12)	1	11	3	7	2
	Southern (9)	0	9	0	2	7
	Superior (9)	0	9	3	1	5
POP SIZE	Small (16)	2	15	5	6	6
	Medium (16)	1	15	2	9	5
	Large (9)	0	8	0	1	7
	LA		1		1	
	Survey Average (42)	**3 (7%)**	**39 (93%)**	**7 (17%)**	**17 (40%)**	**18 (43%)**

Source: Data analysis of Petris Center Director Survey, Section III, Question 4-5
Data from 42 counties which represent 95% of the California population

CONCLUSION

This report presented baseline information about California county mental health departments that is otherwise not generally available, and included data regarding budget, organizational structure, services provided, staffing patterns, and relationship with their Mental Health Boards in FY 03-04, before the implementation of MHSA. The data was gathered and presented in order to describe the range of "starting points" for counties as they embark on their individual transformational journeys as part of MHSA implementation. It is difficult to interpret the significance of the data at this time beyond noting the range and variance that exists across the counties—there is nothing in this report that should necessarily be construed as best or optimal. Some of the findings and trends of difference may prove to be incidental over time with little if any impact on efforts at systems change. On the other hand, some factors may prove to be critical

variables for success in MHSA implementation, and others may prove to simply be markers or measures of change. Several of the measures reported here may change over time as MHSA programs and services become implemented. Changes in some of these measures may indicate movement towards a recovery vision and transformation in the state mental health system in the future, and will be monitored.

The next Director Survey, currently in development,[39] will assess variables specific to implementation of MHSA. The funds from MHSA are earmarked for system transformation through the provision of new and expanded community-based mental health services that are more consumer and family driven, culturally competent, and recovery-oriented. This report outlines the counties' starting points as they begin implementation of MHSA. The changes they experience will be assessed in future surveys.

[39] If you have any suggestions for data that should be considered for collection in future surveys, please contact the Petris Center Research team at mhsastudy@berkeley.edu or 510-643-4100

APPENDIX 1: References

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APPENDIX 2: Glossary of Select Commonly Used Mental Health Acronyms in Report.

AB	Assembly Bill
ACT	Assertive Community Treatment
CAO	County Administrative Officer
CEO	County Executive Officer
CFS	Child and Family Services
CBO	Community-based organizations
CIMH	California Institute for Mental Health
CMHDA	California Mental Health Director Association
CSI	DMH Client & Services Information System
CSS	Community Services and Supports Plan (part of MHSA)
CSOC	Children's System of Care
DMH	Department of Mental Health (State)
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
FFP	Federal Financial Participation
FSP	Full Service Partnership
FTE	Full-time equivalent (staff)
FY	Fiscal Year
IMD	Institutes for Mental Disease
IT	Information Technology
MADM	Monthly All-Director Meeting (of county mental health directors)
MHSA	Mental Health Services Act (formerly Proposition 63)
MIOCRG	Mentally Ill Offender Crime Reduction Grant
NF	Nursing Facilities
SAMHSA	Substance Abuse and Mental Health Services Administration
SB	Senate Bill

APPENDIX 3: Data Sources and Explanation of Calculations in Tables and Figures

TABLE 2: Median (midpoint) values and range of total budgets, excluding county contributions

Formula: Total Budget - (Percent of County Contribution x Total Budget)

Region and population grouping statistics use the county as the unit of analysis i.e. each county is given equal weighting

Total Budget is based on Survey Section I, Question 8.

Percent of County Contribution is based on Survey Section I, Question 10.

TABLE 3: Average, Median and Range of Total Budgets (Including County Contributions)

Formula: (1-PctAdmin)

Region and population grouping statistics use the county as the unit of analysis i.e. each county is given equal weighting

PctAdmin (Percent of Budget Spent on administrative costs or overhead) is based on Survey Section I, Question 9.

TABLE 4: Distribution of Mental Health Budgets per client

Formula: Total Budget/ Total Client Population

Region and population grouping statistics use the county as the unit of analysis i.e. each county is given equal weighting

Total Budget is based on Survey, Section I, Question 8.

Total Client Population is based on Client Services Information-combined unduplicated client total for FY 03/04. Used unduplicated client total for FY 02/03 for 8 counties with incomplete numbers in 03/04.

FIGURE 3: Average Mental Health Expenditure per Client

Formula: [Total Budget x (1-PctAdmin)] / Total Client Population

Region and population grouping statistics use the county as the unit of analysis i.e. each county is given equal weighting

Total Budget is based on Survey Section I, Question 8.

PctAdmin (Percent of Budget Spent on administrative costs or overhead) is based on Survey Section I, Question 9.

Total Client Population is based on Client Services Information-unduplicated client total for FY 03/04. Used unduplicated client total for FY 02/03 for 8 counties with incomplete numbers in 03/04.

FIGURE 4, TABLE 5 and FIGURE 5: Distribution of Revenue Sources, County Average

Distribution of Revenue Sources is based on Survey Section I, Question 10. Region and population grouping statistics use the county as the unit of analysis i.e. each county is given equal weighting

TABLE 6: Average Mental Health Budget Statistics

Percent of Budget from County Overmatch is based on Survey Section I, Question 11.

Percent of Budget Spent on Inpatient Treatment is based on Survey Section I, Question 13.

Region and population grouping statistics use the county as the unit of analysis i.e. each county is given equal weighting

FIGURE 6. Percent of Budget Spent on Contracted Services

Percent of Budget Spent on Contracted Services is based on Survey Section I, Question 12.

Region and population grouping statistics use the county as the unit of analysis i.e. each county is given equal weighting

TABLE 7: Average Inpatient Services Expenditures, NOT Including IMD, State or Nursing Facilities

Total Amount Spent on Inpatient Treatment is based on:

Formula: (Percent of Budget Spent on Inpatient Treatment x Total Budget)

Region and population grouping statistics use the county as the unit of analysis i.e. each county is given equal weighting

Amount Spent per Client is based on:

Formula: (Percent of Budget Spent on Inpatient Treatment x Total Budget)/Total Client Population

Region and population grouping statistics use the county as the unit of analysis i.e. each county is given equal weighting

Percent of Budget Spent on Inpatient Treatment is based on Survey Section I, Question 13.

Total Budget is based on Survey Section I, Question 8.

Total Client Population is based on Client Services Information-unduplicated client total for FY 03/04. Used unduplicated client total for FY 02/03 for 8 counties with incomplete numbers in 03/04.

FIGURE 7: Percent Total Mental Health Budget Spent on State Hospital Beds

Formula: Amount Spent on State Hospital Beds/Total budget

Region and population grouping statistics use the county as the unit of analysis i.e. each county is given equal weighting

Amount Spent on State Hospital Beds is based on Survey Section I, Question 14.

Total Budget is based on Survey Section I, Question 8.

FIGURE 8: Average Number of State Hospital Bed-days per 1,000 Population

Formula: (Amount Spent on State Hospital Beds/rate of 436) / (2003 Population/1000)

Region and population grouping statistics use the county as the unit of analysis i.e. each county is given equal weighting

Amount Spent on State Hospital Beds is based on Survey Section I, Question 14.

Rate of 436 is based costs of $436 per day for state hospital beds according to sources from DMH.

2003 Population is based on 2003 data from RAND.

FIGURE 9: Average Number of IMD Bed-days per 1,000 Population

Formula: (Amount Spent on IMD Beds/Rate of 155.57) / (2003 Population/1000)

Region and population grouping statistics use the county as the unit of analysis i.e. each county is given equal weighting

Amount Spent on IMD Beds is based on Survey Section I, Question 16.

Rate of 155.57 the average cost of $155.57 per day in IMD which is based on the average of:

Formula: IMD Spend/# IMD beddays

IMD Spend is based on Survey Section I, Question 16.

 # IMD beddays is based on Survey Section I, Question 17.

2003 Population is based on 2003 data from RAND.

FIGURE 10: Percent Total Budget Spent on Child and Family Services

Percent Total Budget Spent on CFS is based on Survey Section I, Question 18.

Region and population grouping statistics use the county as the unit of analysis i.e. each county is given equal weighting

TABLE 8: Child and Family Services (CFS) Expenditures and Sources of Revenue

Total CFS Spending is based on:

Formula: Percent Total Budget Spent on CFS x Total budget

Region and population grouping statistics use the county as the unit of analysis i.e. each county is given equal weighting

EPSDT as % of CFS Budget is based on:

Formula: (Percent EPSDT x Total budget) / (Percent Total Budget Spent on CFS x Total budget)

Region and population grouping statistics use the county as the unit of analysis i.e. each county is given equal weighting

Total Budget is based on Survey Section I, Question 8.

Percent Total Budget Spent on CFS is based on Survey Section I, Question 18.

Percent EPSDT is based on Survey Section I, Question 10.

Realignment as % of CFS Budget is based on Survey Section I, Question 19.*

** If Realignment as % of CFS Budget is reported as dollar amount, use calculation:*

Formula: Realignment as % of CFS Budget ($)/ Realignment Budget

Realignment Budget is based on DMH FY 03-04 Cost Reports.

FIGURE 11: Percent Realignment Budget Spent on Child and Family Services

Realignment as % of CFS Budget is based on Survey Section I, Question 19.*

* If *Realignment as % of CFS Budget* is reported as dollar amount, use calculation:

Formula: Realignment as % of CFS Budget ($)/ Realignment Budget

Region and population grouping statistics use the county as the unit of analysis i.e. each county is given equal weighting

Realignment Budget is based on DMH FY 03-04 Cost Reports.

TABLE 9: Average Spending per Client on Adult and Child Peer and Family Support Services

Average Spending per Client on Adult Peer and Family Support Services is based on:

Formula: Adult Peer Svc spd ($)/Total Client Population

Region and population grouping statistics use the county as the unit of analysis i.e. each county is given equal weighting

Adult Peer Svc spd is based on Survey Section I, Question 22.*

* If *Adult Peer Svc spd* is reported as percent, use calculation:

Formula: Pct Adult Peer Svc x Total budget

Average Spending per Client on Child Peer and Family Support Services is based on:

Formula: Child Peer Svc spd ($)/Total Client Population

Region and population grouping statistics use the county as the unit of analysis i.e. each county is given equal weighting

Child Peer Svc spd is based on Survey Section I, Question 22.*

* If *Child Peer Svc spd* is reported as percent, use calculation:

Formula: Pct Child Peer Svc x Total budget

Region and population grouping statistics use the county as the unit of analysis i.e. each county is given equal weighting

Total Client Population is based on Client Services Information-unduplicated client total for FY 03/04. Used unduplicated client total for FY 02/03 for 8 counties with incomplete numbers in 03/04.

TABLE 10: Percent Employees who are Clinical or Administrative, Excluding Contracted Workers

Percent of Clinical Employees is based on:

Formula: # Clinical Employees/ Total # of Employees

Region and population grouping statistics use the county as the unit of analysis i.e. each county is given equal weighting

Percent of Administrative Employees is based on:

Formula: # Administrative Employees/ Total # of Employees

Region and population grouping statistics use the county as the unit of analysis i.e. each county is given equal weighting

 # Clinical Employees is based on Survey Section II, Question 3.

 # Administrative Employees is based on Survey Section II, Question 4.

Total # of Employees is based on:

Formula: # Clinical Employees + # Administrative Employees

TABLE 11: Tracking of Staff Tenure

Tracking of Staff Tenure is based on Survey Section II, Question 8.

Region and population grouping statistics use the county as the unit of analysis i.e. each county is given equal weighting

TABLE 12: Use of Temporary Hires

Temporary Hires as % of Total Clinical is based on:

Formula: Temporary Medical Employees/ # Clinical Employees

Region and population grouping statistics use the county as the unit of analysis i.e. each county is given equal weighting

Temporary Hires as % of Total Administrative is based on:

Formula: Temporary Non-Medical Employees/ # Administrative Employees

Region and population grouping statistics use the county as the unit of analysis i.e. each county is given equal weighting

Temporary Medical Employees is based on Survey Section II, Question 9.

Temporary Non-Medical Employees is based on Survey Section II, Question 9.

 # Clinical Employees is based on Survey Section II, Question 3.

 # Administrative Employees is based on Survey Section II, Question 4.

TABLE 13: Hiring Patterns

Average # Months to Create New Position is based on Survey Section II, Question 10.

Average # Months to Fill New Position is based on Survey Section II, Question 11.

Region and population grouping statistics use the county as the unit of analysis i.e. each county is given equal weighting

% Vacant Clinical Positions is based on:

Formula: Vacancies / # Clinical Employees

Region and population grouping statistics use the county as the unit of analysis i.e. each county is given equal weighting

Vacancies is based on Survey Section II. Question 12.

 # Clinical Employees is based on Survey Section II, Question 3.

Satisfaction with Number, Quality of Applicants is based on Survey Section II, Question 13.

TABLE 14: Bilingual Staff

% FTE Bilingual Direct Service Providers is based on:

Formula: 2002 DSP Bilingual/Total DSP FTE

Region and population grouping statistics use the county as the unit of analysis i.e. each county is given equal weighting

2002 DSP Bilingual is based on data from Cultural Competency Reports.

Total DSP FTE is based on data from Cultural Competency Reports.

% FTE Bilingual Administrative Staff is based on:

Formula: 2002 Admin Bilingual/ Total Admin FTE

2002 Admin Bilingual is based on Cultural Competency Reports.

Total Admin FTE is based on Cultural Competency reports.

Region and population grouping statistics use the county as the unit of analysis i.e. each county is given equal weighting

TABLE 15: State Employment Patterns

Region and population grouping statistics use the county as the unit of analysis i.e. each county is given equal weighting

Program to Directly Employ Consumers is based on Survey Section II, Question 23.

Program to Employ Consumers as part of CBOs is based on Survey Section II, Question 24.

Program to Directly Employ Family Members is based on Survey Section II, Question 25.

Program to Employ Family Members as part of CBOs is based on Survey Section II, Question 26.

TABLE 16: Overview of organizational structure and scope of services

Region and population grouping statistics use the county as the unit of analysis i.e. each county is given equal weighting

Independent Agency is based on Survey Section I, Question 1.

Communicate with CAO via Dept. Head is based on Survey Section I, Question 2.

Medical Directors (full or part time) is based on Survey Section I, Question 3.

Substance Abuse Services Provided is based on Survey Section I, Question 4.

Contract with Consumer/Family Operated Agencies is based on Survey Section II, Question 16.

TABLE 17: Past Experience with Demonstration, Grant-Funded FSP-Type Programs

Region and population grouping statistics use the county as the unit of analysis i.e. each county is given equal weighting

CSOC is based on Survey Section I, Question 20.

SB 163 Wraparound is based on Survey Section I, Question 21.

MIOCRG I or II is based on data from the Mentally Ill Offender Crime Reduction Grant Program Legislative Report 2004

AB2034 is based on "EFFECTIVENESS OF INTEGRATED SERVICES FOR HOMELESS ADULTS WITH SERIOUS MENTAL ILLNESS" 2003 Legislative report.

No Past Experience is based on answers to the preceding four grant-funded programs questions. Counted Yes if county responded No to Survey Section I, Questions 20-21 and DMH data reported no funding for MIOCRG and AB2034.

TABLE 18: Percent Budget Spent on Demonstration, Grant-Funded, FSP Type Programs

CSOC (State Funding) is based on:

Formula: CSOC State Funds/Total budget

Region and population grouping statistics use the county as the unit of analysis i.e. each county is given equal weighting

CSOC State Funds is based on Survey Section I, Question 20.

Total Budget is based on Survey Section I, Question 8.

CSOC (Federal Funding) is based on:

Formula: CSOC Federal Funds/Total budget

Region and population grouping statistics use the county as the unit of analysis i.e. each county is given equal weighting

CSOC Federal Funds is based on Survey Section I, Question 20.

Total Budget is based on Survey Section I, Question 8.

SB 163 Wraparound is based on:

Formula: Wraparound State Amt/Total budget

Region and population grouping statistics use the county as the unit of analysis i.e. each county is given equal weighting

Wraparound State Amount is based on Survey Section I, Question 21.

Total Budget is based on Survey Section I, Question 8.

MIOCRG I or II is based on:

Formula: MIOCRG Amt/Total budget

Region and population grouping statistics use the county as the unit of analysis i.e. each county is given equal weighting

MIOCRG I or II is based on data from the Mentally Ill Offender Crime Reduction Grant Program Legislative Report 2004

Total Budget is based on Survey Section I, Question 8.

AB2034 is based on:

Formula: AB2034 Amt/ Total budget

Region and population grouping statistics use the county as the unit of analysis i.e. each county is given equal weighting

AB2034 Amt is based on "EFFECTIVENESS OF INTEGRATED SERVICES FOR HOMELESS ADULTS WITH SERIOUS MENTAL ILLNESS" 2003 Legislative report.

Total Budget is based on Survey Section I, Question 8.

TABLE 19: Percent Budget from SAMHSA Grants

Percent Budget from SAMHSA Grants is based on:

Formula: SAMHSA Amt/Total budget

Region and population grouping statistics use the county as the unit of analysis i.e. each county is given equal weighting

SAMHSA Amt is based on DMH FY 03-04 Cost Reports.

Total Budget is based on Survey Section I, Question 8.

FIGURE 12: Distribution of computerized administrative functions, by county size

Distribution of computerized administrative functions is based on Survey Section I, Question 6.

Region and population grouping statistics use the county as the unit of analysis i.e. each county is given equal weighting

FIGURE 13: Distribution of computerized clinical functions, by county size

Distribution of computerized clinical functions is based on Survey Section I, Question 6.

Region and population grouping statistics use the county as the unit of analysis i.e. each county is given equal weighting

TABLE 20: Relationship with Mental Health Board/Used as Resource

Relationship with MHB is based on Survey Section III, Question 4.

Used Board as Resource is based on Survey Section III, Question 5.

Region and population grouping statistics use the county as the unit of analysis i.e. each county is given equal weighting

APPENIDIX 4: Petris Center Survey Questions of Financial and Organization Characteristics of County Mental Health Systems

Survey #1
1/23/06

California Mental Health Services Act:
A study of financial and organizational change

This survey is part of a study of Proposition 63 and the financing and delivery of mental health services in California. It is being conducted by the Nicholas C. Petris Center (*http://petris.org/*) at the UC Berkeley School of Public Health in partnership with the California Institute for Mental Health (*http://cimh.org*) and was funded by the California Health Care Foundation.

The purpose of this survey is to gather baseline information about each county mental health department in California in the year prior to Proposition 63. The questions are about your department's organizational structure, spending, staffing, and relationships with other organizations (such as advocacy groups and providers) and your Mental Health Board/Commission.

INSTRUCTIONS:
This survey is a Word form document. You need to answer the questions electronically on the form by clicking the appropriate response boxes or selecting responses from drop-down menus to closed-ended questions, and typing in answers to open-ended questions in the spaces provided. At the end of each section there is a place for open-ended comments where any clarification of responses can be entered.
Save all responses by renaming the file with your county name. You can also print the survey.

Please complete the survey form electronically by Monday, February 13, 2006 and return it via email to MHSAstudy@berkeley.edu.

We will provide you with individual data in real time about how your county compares to aggregate numbers for groups of counties of similar size and aggregate state numbers.

If you have any questions or concerns, please contact Neal Adams at 408-591-2110 or nadams@cimh.org.

Survey Release:
This study has been approved by the UC Berkeley Committee for Protection of Human Subjects.

Your participation in this research is voluntary. There are no foreseeable risks to you from participating in this questionnaire, no direct monetary benefits to you, and no costs to you, other than your time. We may have follow-up calls regarding this survey. The results of this survey will be tabulated and stored in a limited access computer file. All responses will be confidential.

In accordance with standard research protocol, please indicate that you understand and agree to these conditions: ☐ YES ☐ NO

I. SYSTEM PROFILE

We're interested in understanding the organizational structure and general scope of your Department. **Please answer the following questions for fiscal year 2003-2004 (FY 03-04), the year before Proposition 63 passed.**

1. **In FY 03-04**, who did your Department report to? Select one:
   - ☐ Health Department
   - ☐ Other, please specify: _____

2. **In FY 03-04**, did all communications with your County's Administrative or Executive Officer (CAO or CEO) have to go through your Department Head? Select one: ☐ YES ☐ NO

3. **In FY 03-04**, was there a Medical Director in the county for mental health? Select one: ☐ YES ☐ NO

4. **In FY 03-04**, was your department responsible for substance abuse services? Select one: ☐ YES ☐ NO

5. **In FY 03-04**, did anyone who self-identified as a consumer participate on the management team? Select one: ☐ YES ☐ NO

6. **In FY 03-04,** did you use computers for any of the following (select all that apply):
   - ☐ Registration
   - ☐ Meeting CSI requirements
   - ☐ Billing
   - ☐ Scheduling
   - ☐ Charting
   - ☐ Clinical assessment
   - ☐ Prescription management
   - ☐ Treatment planning
   - ☐ Progress notes
   - ☐ Benefits verification
   - ☐ Other, please specify: _____

The next set of questions asks about your budget from fiscal year 2003-04 (FY 03-04).

7. Please provide the contact information for the budget staff person in your Department we can contact with any follow-up questions we may have:
   Name: _____
   Title: _____
   Email: _____
   Phone: (___) ___-_____ Extension: _____

8. **In FY 03-04**, what was the size of your total budget for mental health? (Total revenues and total expenditures from all sources, including grants) Fill in: $ _____

9. **In FY 03-04**, what percentage of your total budget was spent on county administrative costs/overhead? Fill in: ___ %

10. **In FY 03-04**, what percentage of your revenues came from each of the following sources (Fill in):
    ___ % FFP (federal financial participation)
    ___ % state realignment funds
    ___ % county dollars
    ___ % EPSDT
    ___ % Medicare
    ___ % non-governmental funds
    ___ % other state and federal funds
    ___ % other payers (please specify: _____)

11. **In FY 03-04**, what percentage of your total budget was made up of county overmatch dollars (county dollars above state-mandated effort)? Fill in: ___%

12. **In FY 03-04**, what percentage of your total budget was spent on services provided by persons or organizations not employed by the county mental health department? Fill in: ___ %

13. **In FY 03-04**, what percentage of your budget was spent on inpatient treatment (NOT including IMDs, NFs, and state hospitals)? Fill in: ___%

14. **In FY 03-04**, how much did your county spend on state hospital beds? Fill in: $__

15. **In FY 03-04**, how many state hospital beds were used?
    Fill in: ____ number of beds, or ____ number of bed-days

16. **In FY 03-04**, how much did your county spend on IMD beds? Fill in: $ _____

17. **In FY 03-04**, how many IMD beds were used?
    Fill in: ____ number of beds, or ____ number of bed-days

18. **In FY 03-04**, what percentage of your total budget or approximate dollar amount was spent on child and family services? Fill in: ___ % or $ _____

19. **In FY 03-04**, what percentage of your realignment budget or approximate dollar amount was spent on child and family services? Fill in: ___ % or $ _____

20. **In FY 03-04**, did you have a Children's System of Care (CSOC) program?
    Select one: ☐ YES ☐ NO
    ➘ IF YES, please indicate funding sources for the program (Fill in):
    What approximate dollar amount was funded by the state? $ _____
    What approximate dollar amount was federally funded? $ _____

21. **In FY 03-04**, did you have a SB 163 Wraparound Program?
    Select one: ☐ YES ☐ NO
    ➘ IF YES, what approximate dollar amount was funded by the state? Fill in: $ _____

22. **In FY 03-04**, what percentage of your total budget or approximate dollar amount was spent on the following (Fill in):
    In your answer, please include direct expenditures, not in-kind
    Adult peer and family support services? ___ % or $ _____
    Child peer and family support services? ___ % or $ _____

23. **In FY 03-04**, did you have a program for employment of peers/consumers as direct county employees?
    Select one: ☐ YES ☐ NO
    ➘ IF YES, how many consumers (in FTE, full-time equivalents) were (Fill in):
    Paid for non-clinical work? _____ number of FTE
    Paid for clinical work? _____ number of FTE

24. **In FY 03-04**, did you have a program for employment of peers/consumers as part of community based organizations (CBOs)?
Select one: ☐ YES ☐ NO
➘ IF YES, how many consumers (in FTE, full-time equivalents) were (Fill in):
Paid for non-clinical work? _____ number of FTE
Paid for clinical work? _____ number of FTE

25. **In FY 03-04**, did you employ family members of consumers as direct county employees?
Select one: ☐ YES ☐ NO
➘ IF YES, how many family members (in FTE, full-time equivalents) were (Fill in):
Paid for non-clinical work? _____ number of FTE
Paid for clinical work? _____ number of FTE

26. **In FY 03-04**, did you employ family members of consumers as part of community based organizations (CBOs)?
Select one: ☐ YES ☐ NO
➘ IF YES, how many family members (in FTE, full-time equivalents) were (Fill in):
Paid for non-clinical work? _____ number of FTE
Paid for clinical work? _____ number of FTE

27. **In FY 03-04**, did you contract with consumer/ family operated agencies to provide services?
Select one: ☐ YES ☐ NO
➘ IF YES, what was the total (county spending + contracted) amount spent on provision of services? Fill in: $ _____

If you have any comments or points of clarification about your response to any questions in this section, please note it here:

_____

_____

II. STAFFING

Please answer the following questions for fiscal year 2003-2004 (FY 03-04), the year before Proposition 63 passed.

1. Please provide contact information for a knowledgeable Human Resource person in your Department who we can contact in the next month to obtain detailed information about staffing patterns. We will be asking this person about the number and type of different staff at the Department and average tenure and salaries of medical and non-medical staff.

   Name: _____
   Title: _____
   Email: _____
   Phone: (___) ___- ____ Extension: _____

2. **In FY 03-04**, what percentage of the mental health workforce in your county was unionized? Fill in: ___ %, or if you must estimate, select one:
   0-25%
   26-50%
   51-75%
   76-100%

3. **In FY 03-04,** what was the total number of employees who provide billable clinical services working in your department? Fill in: _____ number of employees

4. **In FY 03-04,** what was the total number of administrative employees working in your department? Fill in: _____ number of employees

5. **In FY 03-04**, did you have any formal mechanism for evaluating clinical staff competency? Select one: ☐ YES ☐ NO

6. **In FY 03-04**, were any areas of noncompliance related to state requirements for language thresholds identified during an audit by DMH? Select one: ☐ YES ☐ NO

7. **In FY 03-04,** did your county offer mental health services in languages beyond those required by minimum threshold language requirements?
   Select one: ☐ YES ☐ NO
   ➘ IF YES, please specify which languages (Select all that apply):

☐ Spanish	☐ Russian
☐ Vietnamese	☐ Tagalog
☐ Cantonese	☐ Farsi
☐ Mandarin	☐ Arabic
☐ Other Chinese language	☐ Armenian
☐ Hmong	☐ Other, please specify:
☐ Cambodian	_____

8. **In FY 03-04,** did your department track the tenure and turnover of staff?
   Select one: ☐ YES ☐ NO
   ➘ IF YES, what was the average tenure of medical staff?_____year
   What was the average tenure of non-medical staff?
   _____years

9. **In FY 03-04,** did your county ever use temporary hires/locum tenens from local placement agencies to fill any vacancies?
   Select one: ☐ YES ☐ NO
   ➘ IF YES, How many temporary hires were for medical staff vacancies? _____ staff
   How many temporary hires were for non-medical staff vacancies?
   _____ staff

10. **In FY 03-04,** how long did it usually take to create a new position, given your county's personnel hiring procedures?
    Fill in: _____ months (use fractions if necessary, e.g., 1.5 months)

11. **In FY 03-04,** how long did it usually take to fill a position once it had been posted? Fill in: _____ months (use fractions if necessary, e.g., 1.5 months)

12. **In FY 03-04,** excluding positions held for vacancy savings, at any given point in time, on average, how many vacant clinical positions did you have? Fill in: _____ number of vacant clinical positions

13. **In FY 03-04,** if you tried to fill a vacant position, were you satisfied with the number and quality of applicants when you are trying to fill a position?
    Select one: ☐ N/A, or 1=not at all satisfied, 10=very satisfied:___

III. COUNTY MENTAL HEALTH BOARD/COMMISSION

Please answer the following questions for fiscal year 2003-2004 (FY 03-04), the year before Proposition 63 passed.

1. **In FY 03-04**, how often did the Mental Health Board/ Commission in your county meet? Fill in: _____ number meetings/year

2. **In FY 03-04**, how many Mental Health Board/ Commission meetings did you (or your representative) attend? Fill in: _____ number of meetings attended

3. **In FY 03-04**, how effective was the Board in advocating with the Board of Supervisors? 1=not at all effective, 10=very effective. Select one: ___

4. **In FY 03-04,** how was your relationship with your county Mental Health Board/ Commission? Select one:
   Poor
   Fair
   Good
   Very Good
   Excellent

5. **In FY 03-04**, how often did you use your county Mental Health Board/ Commission as a resource? Select one:
   Never
   Rarely
   Sometimes
   Often

Please share any comments or points of clarification about survey responses here: _____
_____

Please save your responses by renaming the file with your county name and then return the completed document via email to MHSAstudy@berkeley.edu.

You may also want to print a copy of this completed survey for your records.

After we have received responses from all 58 counties, you will receive a short report with survey results about how your county compares to aggregate numbers for groups of counties of similar size and aggregate state numbers.

THANK YOU VERY MUCH FOR YOUR TIME!