Keeping the Spirit of the MHSA Alive Despite Budget Cuts

CMHDA MHSA Committee
June 6, 2011

Significant Changes ahead for Community Behavioral Health Services

- Changes in MHSA Program Policies:
  - Elimination of plan review and approval by DMH and MHSOAC
  - Elimination of annual updates to a county's 3-year plan but there is still a requirement to have "updates"
  - The "state" administers the Mental Health Services Fund (MHSF) and issues regulations
  - The MHSA state administrative fund cap is 3.5%
  - The MHSOAC, not DMH, MAY provide TA to "county mental health plans" if needed

Significant Changes ahead for Community Behavioral Health Services

- Changes in MHSA Fiscal Policies:
  - FY 2011-12 one time supplantation due to State's fiscal crisis, allowing the MHS Fund rather than State General Fund, to pay for non-MHSA funded programs ($862 million)
    - Medi-Cal Specialty Mental Health Managed Care
    - EPSDT
    - Education-Related Mental Health Services (AB 3632)
  - Beginning in FY 2012-13 AB 100 changed the way in which revenues are made available
    - Funds are distributed as deposits are made into the MHS Fund on a monthly basis

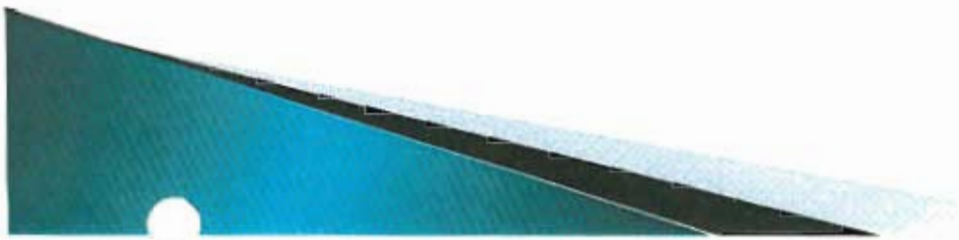
Significant Changes ahead for Community Behavioral Health Services

- Governor's May Revision Made Substantial Proposals to Reorganize State Government including:
  - Creation of a New Department of State Hospitals
  - Transfer of Medi-Cal Administration for Community Mental Health to the Department of Health Care Services (DHCS)
  - Elimination of DMH and Department of Alcohol and Drug Programs (DADP)
  - All remaining DMH community mental health and DADP functions will shift to an "unnamed" department to be outlined in the Governor's January 2012-13 budget proposal

Unknowns ...

- What will be the remaining role, if any, of DMH in the MHSA? If not DMH, then who?
- What if Realignment does not pass, will advocates sue the state claiming a violation of the Act?
- What is local MHSA plan approval and what does a plan look like?
- Will we ever get simplified MHSA administrative requirements?
- What if actual revenues exceed estimated component funding and what if they don't reach estimated component funding?
- Will accessing the prudent reserve but at the discretion of counties?
- How will reversion be calculated and by who?

In the midst of all this uncertainty for community behavioral health services and the MHSA –
How are counties "keeping the spirit of the MHSA alive?"



Key Questions for Discussion

So AB 100 allows for the "one-time" supplantation of state general fun obligations with the MHS Fund. What does this mean for counties?

- Supplantation is described in WIC Section 5891(a) and CA Code of Regulations Title 9 Division 1 Chapter 14 Article 4 Section 3410 and Article 5 Section 3500

Key Questions for Discussion

With AB 100 are counties still required to follow all guidelines and regulations?

When will there every be a streamlined set of regulations and reporting requirements?

If I change my program significantly previous guidance would say I have to submit an "update" do I still have to do that?

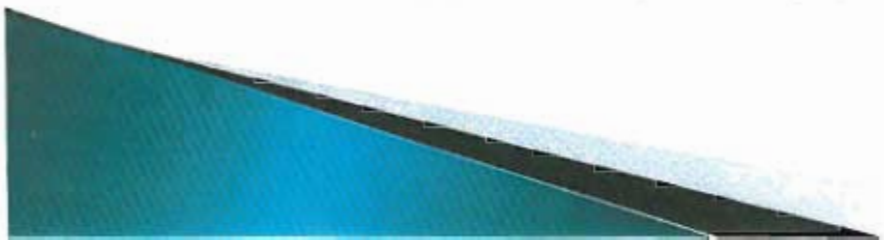
In fact - why are we submitting anything if nobody is going to review it?

Key Questions for Discussion

What is the status of the CMHDA distribution workgroup's recommendations for the FY 2011-12 allocations for Medi-Cal Specialty Mental Health Managed Care, EPSDT and Educational-Related Mental Health Services (AB 3632)?

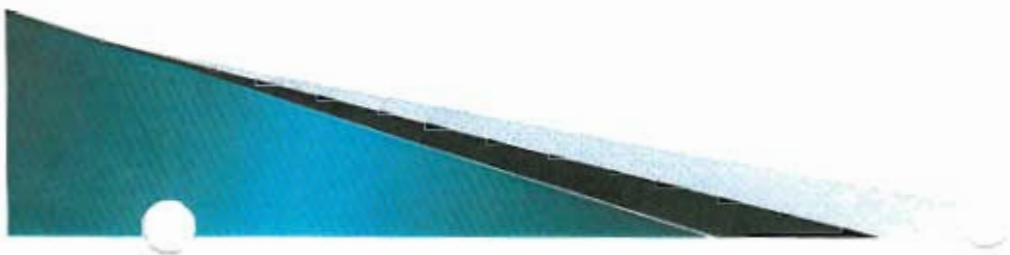
Is there enough money for EPSDT?

Are counties using more MHSA as EPSDT match and what are the local pressures?



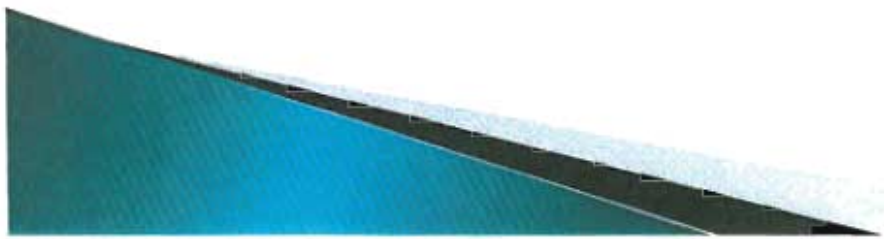
Key Questions for Discussion

How have counties transferred CSS to PEI in an effort to move expenditures for outreach and engagement, etc., into PEI?



Key Questions for Discussion

What are some strategies for continued implementation of WET programs that provide necessary training for skill development, team building, cultural competency, etc., when there are no staff who can be taken away from service duties to participate in the training opportunities?



Key Questions for Discussion

During these times of significant changes how are counties communicating with their boards/ commissions and local stakeholders?

Are there some "change management" strategies to share?

Key Questions for Discussion

If the State's primary remaining role is performance monitoring, compliance and evaluation, are counties developing the capacity to have systems and a workforce that practices continuous quality improvement?

How can the MHSA help support this shift?

Key Questions for Discussion

In the coming year there will be continued pressure to expand services to individuals returning to the community after being incarcerated in a state institution.

How are counties preparing for this?

Is MHSA being discussed as a solution to this growing population?

Other Key Questions for Discussion?

Presented to MHSOAC May 26, 2011

NOTE Change the Title!

Assembly Bill 100 (AB 100) Workgroup Report

Draft

Purpose

The purpose of the AB 100 Workgroup was to develop consensus recommendations regarding some of the issues that resulted from the enactment of AB 100 which amended the Mental Health Services Act (MHSA) by, among other things, eliminating state review and approval of county MHSA plans.

Background

On March 24, 2011 Governor Brown signed into law AB 100, an urgency bill which went into effect immediately. AB 100 made several changes to the MHSA including how it is administered. Some of the major changes include:

- Deleted requirement that the Department of Mental Health (DMH) and the Mental Health Services Oversight and Accountability Commission (MHSOAC) annually review and approve county plans and updates.
- Deleted requirement that a county annually update the 3-year plan but still required that there be updates.
- The Commission, instead of DMH, may provide technical assistance to any county mental health plan as needed.
- The "state" instead of DMH will administer the Mental Health Services Fund (MHSF).
- The "state" instead of DMH will issue regulations.
- Starting July 1, 2012 the Controller shall distribute on a monthly basis to counties all unexpended and unreserved[1] funds on deposit in the MHSF as of the last day of the prior month.
- Reduced the administrative funds reserved for DMH, MHSOAC, and California Mental Health Planning Council (CMHPC) from five percent (5%) to three and half percent (3.5%) and that these funds are subject to legislative appropriation.[2]
- Provided for a one time transfer of $862M from the MHSF which is not subject to repayment to be distributed in the following order:
  - $183,600,000 for Medi-Cal Specialty Health Managed Care;
  - $98,586,000 for mental health services for special education pupils (generally referred to as AB 3632)[3];

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[1] "Unreserved funds" are those funds that are not held in trust or are not set forth in component allocations.

[2] As a result of this reduction the Proposed Conference Compromise provides for the reduction or elimination of MHSA funding for approximately seventeen other state entities.

[3] The Governor's May Revision did not affect this one time transfer for fiscal year 2011/12 but did propose that starting in fiscal year 2012/13 the AB 3632 program no longer be realigned to counties but instead be realigned to school districts.

- 50% of each county's 2011/12 MHSA component allocations not to exceed $488,000,000;
- $579,000,000 for Early and Periodic Screening, Diagnostics and Treatment (EPSDT); and
- the remainder of each county's 2011/12 component allocation.

AB 100 also contained Legislative intent language specifying that it was the Legislature's intent to ensure continued state oversight and accountability of the MHSA and that in eliminating state approval of county mental health programs, the Legislature expects the state in consultation with MHSOAC to establish a more effective means of ensuring that county performance complies with the MHSA.

Because several changes made by AB 100 needed clarification before they could be implemented, Sherri Gauger, Executive Director of the MHSOAC convened a workgroup in an effort to try to develop consensus recommendations. Including its first meeting on March 30, 2011 the Workgroup met seven times for a total of 18 hours.

The participants of the AB 100 Workgroup were: Cliff Allenby, Acting Director, Department of Mental Health; Ann Arneill-Py, Executive Director, California Mental Health Planning Council; Jessica Cruz, Executive Director, National Alliance on Mental Illness, California; Sherri Gauger, Executive Director, MHSOAC; Sharon Kuehn, Executive Director, California Network of Mental Health Clients; Patricia Ryan, Executive Director, California Mental Health Directors Association; Rusty Selix, Executive Director, Mental Health Association, California; and Oscar Wright, Chief Executive Officer, United Advocates for Children and Families.

Mission and Core Principles of the AB 100 Workgroup

The AB 100 Workgroup agreed on the following mission:

- Do no harm to the intent of the MHSA.
- Reach consensus around "governance."
- Clarify AB 100.
- Do a gap analysis of AB 100 and identify potential amendments to the MHSA.
- Identify common issues in the MHSA that need to be addressed.

The AB 100 Workgroup also reached consensus that any recommendations made by the Workgroup would be guided by the following core principles:

- Further the purpose and intent of the MHSA as specified in Section 3 (the Purpose and Intent Section of the MHSA).
- Alter the MHSA only to accomplish the agreed upon goals consistent with the intent of the Act.

- Only have processes that are necessary to accomplish the purpose of the MHSA.
- Focus primarily on outcomes.
- As the Workgroup clarifies AB 100, it should look for opportunities to actively involve clients and family members.
- Acknowledge the likelihood of realignment and seek appropriate clarification to accomplish the MHSA's purpose.

The Workgroup agreed that a final report with AB 100 Workgroup recommendations would be written and presented to the MHSOAC, the Administration, the CMHPC, and other Boards as appropriate for approval. Workgroup participants agreed that information discussed in the meetings could be shared with staff and stakeholders throughout the process.

Priority Issues Discussed by the AB 100 Workgroup

One of the first items of business for the AB 100 Workgroup was to decide what clarifications to AB 100 were the most critical and time sensitive. The Workgroup agreed to work on the following twelve priorities:

1. Identify who is the "state" in the different provisions of the Welfare and Institutions (W&I) Code in which AB 100 replaced DMH with the "state."
2. Clarify the new MHSA fund distribution method under AB 100 and how it will work.
3. Identify a mechanism to assure county compliance with MHSA values to replace state level review and approval of county plans eliminated by AB 100.
4. Identify who is in charge of performance outcomes.
5. Identify a process to ensure the collecting and reporting of comparative outcomes data and evaluation of the results.
6. Determine how to ensure that Workforce Education and Training (WET) funds are protected under the new funding distribution.
7. Identify a process by which higher performing counties can assist lower performing counties to improve their effectiveness.
8. Clarify the role and purpose of the mental health services performance contract.
9. Clarify the relationship between regulations, guidelines, plans and moving to an integrated 3-Year plan with outcomes.
10. Identify an effective local process which assures that counties will meaningfully consider stakeholder input.
11. Identify an effective process to make sure county plans comply with the law.
12. Define the MHSOAC's role in providing Technical Assistance to counties.

The Workgroup reached consensus on all of the above-listed priorities and provides the following recommendations to implement the consensus.

Priority No. 1: Identify who is the "state" in the different W&I Code provisions in which AB 100 replaced DMH with the "state."

Recommendation:
The "state" will be determined by the Administration.

Priority No. 2: Clarify the new MHSA fund distribution method under AB 100 and how it will work.

Recommendations:

- **MHSA funds that are set forth in Component Allocations should be considered "reserved" for purpose of fund distribution for Fiscal Year 2012/13 under W&I Code Section 5891(c).**
- **Component Allocations should be published for the Prevention and Early Intervention (PEI) Statewide Reducing Disparities Project.**
- **The MHSA specifically "reserves" the funds to pay for WET programs and the 3.5% administrative fund to pay the cost of DMH, MHSOAC, and CMHPC and thus these funds are not part of the unreserved funds to be distributed commencing Fiscal Year 2012/13.**
- **DMH[4] in consultation with, the MHSOAC, CMHPC, and California Mental Health Directors Association (CMHDA) should continue providing to the counties yearly estimates of the funding for each MHSA component pursuant to W&I Code Section 5847(e).**
- **County submission of the Revenue and Expenditure Report should not be a prerequisite for distribution of funds to a county.**
- **The current Revenue and Expenditure Report should be either eliminated or simplified to a one page revenue and expenditure report requiring summary information by MHSA component. If eliminated then the Medi-Cal Specialty Mental Health Cost Report should be modified to report such amounts by each MHSA component. Whatever report is used must include sufficient information on the condition of the local MHSF and information necessary to support continued evaluation of MHSA programs. This report should be easy to understand and made available to stakeholders.**

[4] Through out this report DMH is identified as having a continuing role in the administration of the MHSA; however, the Governor's May Revision proposes to eliminate the DMH and transfer the state-level responsibilities associated with Medi-Cal programs to Department of Health Care Services during fiscal year 2011/12. The 2012/13 Governor's Budget will contain a proposal on where the remaining functions should be transferred. Because the new state entity is not known whenever "DMH" is used in this report it is intended to also include the new state entity that will take on DMH's responsibilities.

Mental Health Services Fund (MHSF) Distribution Process

AB 100 provides for a different method of MHSA fund distribution for fiscal year 2011/12 than for distribution starting in Fiscal Year 2012/13 and is silent regarding distribution of Pre-Fiscal Year 2011/12 funds. Below is a summary of the recommended MHSA fund distribution process:

Distribution of Pre-Fiscal Year 11/12 Component Funds (AB 100 silent)

- By the end of May 2011 DMH will issue Information Notice to provide a mechanism for counties to request release of all remaining pre-2011/12 Fiscal Year funds.
- Commencing July 2011 counties will follow the procedure set forth in the Information Notice and submit a form requesting release of the Pre-Fiscal Year 2011/12 funds.
- The State Controller upon notification from DMH that counties have submitted their fund requests will release all Pre-Fiscal Year 2011-12 funds.

Distribution of Fiscal Year 2011/12 Component Funds (W&I Code §5892(j))

- Counties submit Fiscal Year 2011/12 update.
- Commencing August 1, 2011, the State Controller releases 50% of Fiscal Year 2011/12 Component Allocations to counties.
- Commencing no later than April 30, 2012, the State Controller releases remaining Fiscal Year 2011/12 Component Allocations to counties.

Distribution Commencing Fiscal Year 2012-13 (W&I Code §5891(c))

- January 2012 DMH in consultation with MHSOAC, CMHPC, and CMHDA estimate fiscal year 2012/13 funding from Governor's Proposed Budget and calculate county specific component funding estimates (Component Allocations).
- February 2012 DMH publishes county-specific Fiscal Year 2012/13 Component Allocations.
- March and April 2012 Counties prepare Fiscal Year 2012/13 update
- May 2012 DMH publishes Revised Component Allocations estimates based on Governor's May Revision.
- June 2012 Counties finalize Fiscal Year 2012/12 update and submit.
- Commencing July 1, 2012 the State Controller releases Fiscal Year 2012/13 Component Allocations on a monthly basis.

Background for Fiscal Year 2011/12

AB 100 amended W&I Code §5892 to add subdivision (j) which sets forth the MHSA fund distribution for Fiscal Year 2011/12 providing for a one time diversion of $862M for Medi-Cal Specialty Health Managed Care, AB 3632 program, and EPSDT. The order of distribution is delineated in subdivision (j). The Governor's May Revision did not affect this one time transfer for fiscal year 2011/12 but did propose that starting in Fiscal Year 2012/13 the AB 3632 program no longer be realigned to counties but instead be realigned to school districts.

Background for Fiscal Year 2012/13
AB 100 also amended W&I Code Section 5891 to provide for a monthly distribution for MHSA programs commencing July 1, 2012 to each county all unexpended and unreserved funds on deposit as of the last day of the prior month in the MHSF. The funding distribution shall be based on the amount specified in the county's three-year plan or update.

The definition of "unexpended" is fairly self-explanatory and the AB 100 Workgroup focused its discussion on what is "unreserved". The MHSA specifies two categories of funds that are reserved and thus not subject to the monthly distribution of unreserved funds: the three and half percent (3.5%) of the MHSF to pay the administrative costs of DMH, MHSOAC, and CMHPC pursuant to W&I Code Section 5892(d) and the funds for WET which are statutorily mandated by W&I Code Section 5892(a)(1) to be held in a trust fund.

In addition, the Workgroup agreed, after consulting with MHSOAC fiscal consultant, Mike Geiss, that funds set forth in Component Allocations to counties are "reserved". As part of this discussion concern was raised as to whether the Prevention and Early Intervention (PEI) Statewide Reducing Disparities project funding which the MHSOAC had set aside was reserved since Component Allocations had not yet been published. Even though the MHSOAC has set aside $60M for the PEI Statewide Reducing Disparities project the AB 100 Workgroup recommends that county Component Allocations should be published to be consistent with the definition of "reserved" discussed above.

AB 100 did not change W&I Code Section 5847(e), the provision of the MHSA which provided for yearly notification to the counties of how much MHSA funds are available to each county. Accordingly, DMH in consultation with, the MHSOAC, CMHPC, and CMHDA should continue providing to the counties yearly estimates of the funding for each MHSA component.

Priority No. 3: Identify a mechanism to assure county compliance with MHSA values to replace state level review and approval of county plans eliminated by AB 100.

Recommendations:

- **In addition to the annual mental health performance contract and targeted training and technical assistance, an MHSA state level issue resolution process can provide a mechanism to assure county compliance with the MHSA values.**
- **DMH should with input from MHSOAC, CMHPC, CMHDA, client, family members, and other stakeholders revisit, complete, and implement the MHSA state level issue resolution process. This process is not intended to replace current state and federal grievance and complaint processes.**

Priority No. 4: Identify who is in charge of performance outcomes.

Recommendation:

- **MHSOAC is in charge of the performance outcomes.**

Background

W&I Code Section 5845(a) established the MHSOAC to "oversee" the Adult and Older Adult Mental Health System of Care Act, the Children's Mental Health Services Act, and the MHSA. In addition, W&I Code Section 5845(d)(6) authorizes the MHSOAC to obtain data and information to utilize in its "oversight, review, and evaluation capacity" regarding projects and programs supported with the MHSA funds. The Adult and Older Adult Mental Health System of Care Act and the Children's Mental Health Services Act are incorporated into the MHSA by reference and set forth performance outcomes that counties should be achieving with MHSA and related public expenditures. This recommendation is consistent with the statutory authority granted the MHSOAC.

Priority No. 5: Identify a process to ensure the collecting and reporting of comparative outcomes data and evaluation of the results.

Recommendations:

- **DMH should continue to be responsible for collecting the data. Funds should be allocated to DMH to ensure its data collection and reporting capacity.**
- **MHSOAC should be responsible for ensuring the reporting of the comparative performance outcomes data.**
- **CMHPC should continue to be responsible for approving the key priority indicators and to work with mental health boards to interpret their local performance indicators.**
- **Ensuring achievement and improvement in performance outcomes should not be punitive, except when a county is resistant to making improvements and requires a corrective action plan as set forth under Priority #7. There is a difference between achievement of positive performance outcomes and compliance with the statutory requirements. Training and technical assistance should be used to help counties better their performance outcomes.**

Background on the Prioritizing of the Performance Outcomes to be Reported

The process of prioritizing the performance outcomes that are specified in statute for the adult system of care, the children's system of care, and the MHSA was lengthy and involved client, family, and other stakeholders. The CMHPC vetted the prioritized performance outcomes and indicators through multiple public hearings throughout the state. The list of priority performance outcomes was then approved by both CMHPC and the MHSOAC which included stakeholder input.

Further stakeholder input was obtained by the MHSOAC Evaluation Committee when developing the scope of work for the Request for Proposals (RFP) which resulted in the contract with UCLA. The MHSOAC obtained further stakeholder input before it approved the scope of work for the RFP.

To ensure that the comparative performance outcomes reports developed by UCLA provide meaningful and useful information to assist in continuous quality improvement of programs, UCLA will seek stakeholder input on a draft standardized template for reporting the information before it finalizes the reports. The draft template for the statewide comparative outcomes report is scheduled to be completed on June 30, 2011, the draft statewide comparative performance outcomes report is scheduled to be released on December 31, 2011 and the first final report is scheduled for completion on March 31, 2012.

The contract with UCLA is one part of a continuing effort to obtain comparative performance outcomes reporting. The MHSOAC Evaluation Committee is continuing to prioritize the use of the funds annually appropriated for the purpose of ongoing evaluation.

Priority No. 6: Determine how to ensure that WET funds are protected under the new funding distribution.

Recommendation:

- **The State must comply with W&I Code §5892(a)(1) which provides for WET funds to be in a trust fund.**

Background

As discussed in Priority No. 2, the WET funds are in a trust fund pursuant to W&I Code §5892(a)(1) and thus are "reserved" and not included in the "unexpended and unreserved funds" which will be distributed under W&I §5891(c). No action is necessary to protect these funds under the new funding distribution.

Priority No. 7: Identify a process by which higher performing counties can assist lower performing counties to improve their effectiveness.

Recommendations:

The process for higher performing counties to assist lower performing counties to improve their effectiveness involves a multi-tier approach.

- **First, the comparative performance outcomes reports will identify the higher performing counties.**
- **Second, some counties will see the higher performing counties and, without assistance, will replicate what is working well and improve their performance outcomes.**
- **Third, some counties will need training and technical assistance to improve their effectiveness.**

- **Fourth, a few counties that, despite training and technical assistance, are still resisting improvement efforts will need to submit a corrective action plan.**
- **DMH should use its statutory authority under W&I Code §5897(d) to request such a corrective action plan and the MHSOAC should use its statutory authority under W&I Code §5845(d)(10) to refer to DMH critical issues relating to performance of a county mental health program.**

Background
The first two types of performance did not require further discussion by the Workgroup. The Workgroup agreed that counties needing technical assistance to help make improvements could be helped through the California Institute for Mental Health (CiMH) training and technical assistance contract with DMH and the MHSOAC's technical assistance. For further discussion and recommendations relating to technical assistance see Priority No. 12. The Workgroup acknowledged that there may be a few counties that continuingly resist improvement efforts and would require a corrective action plan to improve their performance outcomes.

Priority No. 8: Clarify the role and purpose of the mental health services performance contract (Performance Contract).

Recommendations:
- **DMH should, as required by W&I Code Section 5897(c), implement MHSA programs through the Performance Contract instead of through the current MHSA Agreement.**
- **The Performance Contract should be streamlined and some of the provisions strengthened including emphasizing qualitative local stakeholder involvement in the planning process and the cultural competency requirements.**
- **DMH in consultation with the MHSOAC, CMHPC, CMHDA, client, family members, and other stakeholders should determine what other viable approach is available to address the issues for which the Performance Outcome Committee, established in W&I Code Section 5611, and the Quality Improvement Committee, mentioned in W&I Code Section 5614.5, were established. Additional resources may be required.**

Background
The Performance Contract was developed and added to the Welfare and Institutions (W&I) Code Sections 5650 et seq during the initial realignment as a way to ensure county accountability. The W&I Code commencing with Section 5650 provides for specific county assurance and reports that must be part of the Performance Contract. W&I Code Section 5655 provides for an enforcement mechanism to deal with non-compliance which includes: (1) withholding part or all of the mental health funds from the county; (2) requiring a county corrective action plan; and/or (3) filing a court action to compel compliance.

Priority 9: Clarify the relationship between regulations/guidelines/plans and moving to an integrated 3-year plan with outcomes?

Recommendations:

- DMH and MHSOAC staff with input from client and family members and CMHDA take the lead to review the regulations, Information Notices, and guidelines to determine if they should be repealed, modified, or kept.
- Section 3320 of Title 9 of the California Code of Regulations which requires counties to adopt specified standards in planning, implementing, and evaluating the programs and/or services provided with MHSA funding should be kept as is currently written. The section requires community collaboration, cultural competence, client driven, family driven, wellness recovery and resilience focused, and integrated service experiences for clients and their families as defined in Sections 3200 et seq.
- In the future only regulations and information notices should be issued.
- A work plan should be developed to ensure that new regulations are issued within the next year. The work plan should include stakeholder process to provide input into the proposed regulations.
- MHSOAC shall be provided an opportunity to concur with the regulations issued by the state relating to the MHSA.

Priority 10: Identify an effective local process which assures that counties will meaningfully consider stakeholder input.

Recommendations:

- A healthy stakeholder process should include stakeholder participation in plan development, implementation, evaluation and major budget decisions.
- Amend regulations and reporting forms to emphasize that the local stakeholder process should be a qualitative instead of a quantitative process.
- The language currently in the Performance Contract regarding local stakeholder participation should be strengthened to emphasize a qualitative local stakeholder process instead of a quantitative process.
- Compliance with the local stakeholder process should be incorporated into the Performance Contract Requirements which shall include statewide standards for the stakeholder process which will be reflected in regulations and information notices to be developed.
- MHSA Administrative funds should be used to assist in building local capacity for clients and family members to ensure the appropriate state and county agencies give full considerations to concerns about quality, structure of service delivery, or access to services pursuant to W&I Code Section 5892(d).

Priority 11: Identify an effective process to make sure county plans comply with the law.

Recommendations:

- **DMH should use the Performance Contract to implement MHSA programs as mandated by W&I 5897(c).**
- **The MHSA County Plan including the stakeholder process should be incorporated into the Performance Contract as part of the contract deliverables.**
- **The Performance Contract must be effectively monitored by the state entity charged with contract monitoring to ensure county plans comply with the law.**
- **The state should use the enforcement mechanism set forth in W&I Code Section 5655 in case of non-compliance with the law.**

Background

As mentioned above under Priority No. 8, the W&I Code provides for specific county assurance and reports that must be part of the Performance Contract. One of the statutory provisions contained in the Performance Contract is the assurance that the county will comply with the law. The Performance Contract would have provisions that address the county plans and the planning process as discussed under Priority No. 10. The State entity charged with monitoring the deliverables of the Performance Contract would then have the responsibility for ensuring that county plans comply with the law. In case of non-compliance, W&I Code Section 5655 provides for an enforcement mechanism.

In addition, as part of its oversight and accountability responsibility the MHSOAC is authorized under W&I Code §5845 to refer critical issues relating to performance of a county mental health program to DMH under W&I Code §5655 which gives DMH enforcement authority to deal with counties that are not in compliance with the law including the MHSA by: (1) withholding part or all of the mental health funds from the county; (2) requiring a county corrective action plan; and/or (3) filing a court action to compel compliance.

Priority 12: Define the MHSOAC's role in technical assistance to counties.

Recommendations:

- **The MHSOAC should continue to provide technical assistance for plan development when counties request assistance.**
- **The MHSOAC should focus on technical assistance related to identified outcomes and indicators consistent with the MHSA evaluations.**

- **The MHSOAC's role of providing oversight and accountability includes facilitating the delivery of training and technical assistance to county/program and providing oversight to the state entity that has the contracts with CiMH or other selected contractors to ensure that training and technical assistance includes:**
  - **what the counties want;**
  - **what clients, family members, unserved and underserved communities, and providers believe counties/programs need; and**
  - **what supports positive program outcomes based on research.**
- **The training and technical assistance contracts should stay with DMH or with whatever state entity that takes over DMH's responsibilities.**
- **The training and technical assistance contracts should include input from clients, family members, unserved and underserved communities, counties, and providers. To ensure this input an advisory group should be formed to assist the state to develop the deliverables for the contracts. This group should include representatives of members of the AB 100 Workgroup and representatives from unserved and underserved communities.**

Next Steps:

The AB 100 Workgroup participants are presenting the group's recommendations to the Administration, the MHSOAC, the CMHPC, and relevant Boards. If full approval is obtained, the Workgroup participants will take appropriate responsibility for operationalizing these recommendations.