BACKGROUND INFORMATION

INFORMATIONAL HEARING

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1
ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER DR. JOAQUIN ARAMBULA, CHAIR

MONDAY, DECEMBER 9, 2019

1:00 P.M., STATE CAPITOL, ROOM 437

"THE PROMISE OF PROPOSITION 63 AND THE FUTURE OF MENTAL HEALTH FUNDING IN CALIFORNIA"

Purpose of Hearing

Consistent with national trends, California is in the midst of an unprecedented mental health crisis. This crisis manifests itself in the form of rising suicide rates, increased substance abuse, addiction and overdose deaths, and an alarming increase in homelessness. This crisis has evolved despite significant and increasing public resources being invested in both prevention as well as mental health treatment. Approximately 13.5 million California residents are enrolled in the Medi-Cal program, the state's health care safety net, which guarantees mental health care to those who need it. Moreover, only a small percentage (6-7 percent) of California's population lacks health insurance of any kind, and mental health parity laws have been adopted federally and locally to ensure access to mental health care. Finally, counties annually invest hundreds of millions of Mental Health Services Act (MHSA) dollars in prevention and early intervention. In light of these significant investments, once must wonder…what are we doing wrong?

The Subcommittee is interested in gaining a better understanding of how California's county-based mental health system has succeeded in serving Californians well, and how it has failed. This hearing hopes to explore and potentially answer the following questions:

Panel 1 - Proposition 63: Successes and Challenges

- *What are the most significant achievements and successes of the MHSA?*
- *What are the most significant shortcomings of the MHSA?*

- *What is the history and potential future for MHSA funding of infrastructure and workforce?*
- *How well are MHSA-funded mental health services integrated with substance abuse disorder services?*

Panel 2 - Prevention and Early Intervention

- *Should California increase its investment in prevention and early intervention (PEI)?*
- *Should the state limit the PEI options for counties based on best practices?*
- *What are examples of model, evidenced-based PEI programs already operating?*
- *What challenges have counties faced, if any, in spending their MHSA PEI funds?*
- *What is the status of implementation of SB 1004 (2018)?*

Panel 3 - Proposition 63: Transformation to Outcomes-Based

- *How should Prop 63 be reformed, and how can it become outcomes-based?*
- *Do we have the data we need to implement an outcomes-based mental health system?*
- *Should certain populations be prioritized?*

Panel 4 - CalAIM (Behavioral Health) Presentation

- *What are the CalAIM behavioral health proposals and reactions from counties to them?*
- *How would CalAIM and the MHSA affect one another?*
- *How would CalAIM affect the bifurcated mental health delivery system (managed care and counties)*
- *What overlaps are there between Whole Person Care and Full Service Partnerships?*

Mental Health Services Act ("Proposition 63")

The Mental Health Services Act (MHSA), passed as Proposition 63 in 2004, became effective January 1, 2005, and established the Mental Health Services Fund (MHSF). Revenue generated from a one percent tax on personal income in excess of one million dollars is deposited into the MHSF.

According to DHCS's 2019 MHSA Expenditure Report (released in February 2019) the 2019 Governor's Budget indicated approximately $2,094.8 billion was deposited into MHSF in Fiscal Year (FY) 2017-18. The 2019 Governor's Budget projected that $2,398.1 billion would be deposited into MHSF in FY 2018-19 and $2,377.6 billion would be deposited into MHSF in FY 2019-20. Approximately $2,085.5 billion was expended from

MHSF in FY 2017-18. Additionally, $2,294.1 billion was estimated to be expended in FY 2018-19 and $2,250.1 billion in FY 2019-20.[i]

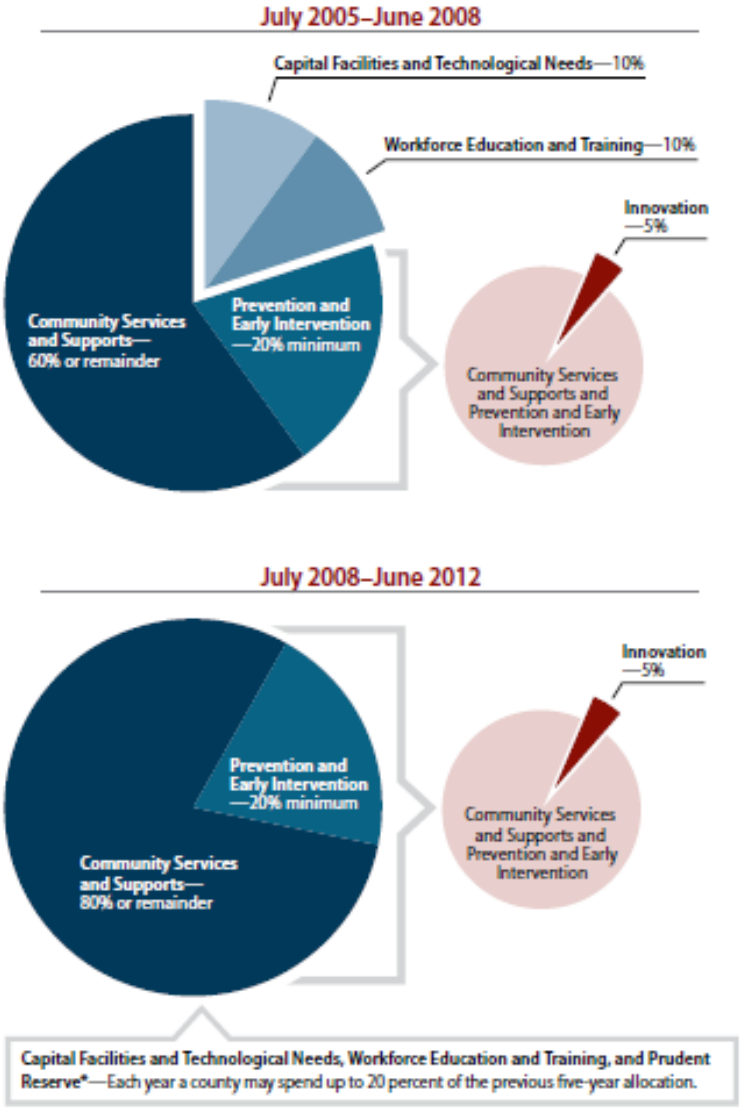
The MHSA addresses a broad continuum of prevention, early intervention, and service needs as well as providing funding for infrastructure, technology, and training for the community mental health system. The MHSA specifies five required components:

1. Community Services and Supports (CSS) - 76% of Revenue
2. Prevention and Early Intervention (PEI) - 19% of Revenue
3. Innovation (INN) - 5% of Revenue
4. Capital Facilities and Technological Needs (CF/TN)
5. Workforce Education and Training (WET)

On a monthly basis, the State Controller's Office (SCO) distributes funds deposited into the MHSF to counties. Counties expend the funds for the required components consistent with a local plan, which is subject to a community planning process that includes stakeholders and requires approval by the County Board of Supervisors. Per Welfare and Institutions Code (W&I) Section 5892(h), counties with population above 200,000 have three years to expend funds distributed for CSS, PEI, and INN components. Counties with less than 200,000 have five years to expend funds distributed for CSS, PEI and INN components. All counties had ten years to expend funds distributed for CF/TN and WET components. In addition to local programs, MHSA authorizes up to 5 percent of revenues for state administration, supporting a wide array of functions performed by a variety of state entities.

Figure 1 (on the following page, from the 2013 State Audit) displays the proportions of a county's total MHSA allocation that must be spent for each of the five components. The allocation requirements for the Facilities and Training components changed beginning in fiscal year 2008–09, so the figure reflects two time periods. For fiscal years 2005–06 through 2007–08, the MHSA required the allocation of 10 percent of the funds to Facilities and 10 percent to Training. From fiscal year 2008–09 onward, funding for these two MHSA components was at the counties' discretion; however, if a county chose to plan programs for the Facilities and Training components, each year Mental Health could apportion up to a total of 20 percent of the county's average Community Supports allocation received over the previous five-year period to these components.[ii]

Figure 1
Apportionment of Mental Health Services Act Funds to Counties



Sources: Mental Health Services Act and Proposition 63 of 2004.

* State law requires counties to maintain a prudent reserve to ensure that service levels will continue in the event that revenues for the Mental Health Services Fund fall below recent averages.

iii

Table 2: MHSA Estimated Revenue By Component[4] (Dollars in Millions)

	FY 2017-18	FY 2018-19	FY 2019-20
Community Services and Supports (Excluding Innovation)	1,512.4	1,731.5	1,716.6
Prevention and Early Intervention (Excluding Innovation)	378.1	432.9	429.1
Innovation	99.5	113.9	112.9
State Administration[5]	104.7	119.9	118.9
Total Estimated Revenue	**2,094.8**	**2,398.1**	**2,377.6**

iv

Table 3a: MHSA Expenditures
Local Assistance
Governor's Budget 2019
(Dollars in Thousands)

	Actual	Estimated	Projected
	FY 2017-18	FY 2018-19	FY 2019-20
Local Assistance			
Department of Health Care Services • MHSA Monthly Distributions to Counties[6]	2,009,301	2,009,301	2,009,301
CSS (Excluding Innovation)	1,527,069	1,527,069	1,527,069
PEI (Excluding Innovation)	381,767	381,767	381,767
INN	100,465	100,465	100,465
Office of Statewide Health Planning and Development • WET State Level Projects (Not Including Mental Health Loan Assumption Program (MHLAP) funds)	14,174	11,000	0
California Health Facilities Financing Authority	3,999	144,000	144,000
Housing and Community Development	4,550	1,650	0
Mental Health Services Oversight and Accountability Commission	0	20,000	20,000
Department of Developmental Services • Contracts with Regional Centers	740	740	740
Department of Veterans Affairs	269	1,270	1,270
Total Local Assistance	**2,033,033**	**2,187,961**	**2,175,311**

v

The following is a description of the major components of the MHSA included in the DHCS 2019 MHSA Expenditure Report:

Community Services and Supports

CSS, the largest component, is 76% of county MHSA funding. CSS funds direct services to individuals with severe mental illness. These services are focused on recovery and resilience while providing clients and families an integrated service experience. CSS has four service categories:

- Full Service Partnerships
- General System Development

- Outreach and Engagement
- MHSA Housing Program

Full Service Partnerships

Full Service Partnerships (FSPs) consist of a service and support delivery system for the public mental health system's (PMHS) hardest to serve clients, as described in W&I Sections 5800 et. seq. (Adult and Older Adult Systems of Care) and 5850 et. seq. (Children's System of Care). The FSP is designed to serve Californians in all phases of life that experience the most severe mental health challenges because of illness or circumstance. FSPs provide substantial opportunity and flexibility in services for a population that has been historically underserved and greatly benefits from improved access and participation in quality mental health treatment and support services. FSPs provide wrap-around or "whatever it takes" services to clients. The majority of CSS funds are dedicated to FSPs.

General System Development

General System Development (GSD) funds are used to improve programs, services, and supports for the identified initial full service populations, and for other clients consistent with MHSA target populations. GSD funds help counties improve programs, services, and supports for all clients and families and are used to change their service delivery systems and build transformational programs and services. For example, GSD services may include client and family services such as peer support, education and advocacy services, and mobile crisis teams. GSD programs also promote interagency and community collaboration and services, and develop the capacity to provide values-driven, evidence-based and promising clinical practices. This funding may only be used for mental health services and supports to address mental illness or emotional disturbance.

Outreach and Engagement Activities

Outreach and engagement activities are specifically aimed at reaching populations who are unserved or underserved. The activities help to engage those reluctant to enter the system and provide funds for screening of children and youth. Examples of organizations that may receive funding include Racial-ethnic community-based organizations, mental health and primary care partnerships, faith-based agencies, tribal organizations, and health clinics.

Capital Facilities and Technological Needs

The Capital Facilities and Technological Needs (CF/TN) component provided funding from FY 2007-08 to enhance the infrastructure needed to support implementation of MHSA, which includes improving or replacing existing technology systems and/or developing capital facilities to meet increased needs of the local mental health system. Counties received $453.4 million for CF/TN projects and had through FY 2016-17 to expend these funds.

Funding for Capital Facilities must be used to acquire, construct, and/or renovate facilities that provide services and/or treatment for those with severe mental illness or that provide administrative support to MHSA funded programs. Funding for Technological Needs must be used for county technology projects with the goal of improving access to and delivery of mental health services.

Workforce Education and Training

In 2004, MHSA allocated $444.5 million for the Workforce Education and Training (WET) component. These funds support counties and the Office of Statewide Health Planning and Development (OSHPD) to enhance the public mental health workforce.

Local WET Programs

In FY 2006-07 and FY 2007-08, counties received $210 million of the total allocation for local WET programs. They had through FY 2016-17 to expend these funds.

Statewide WET Programs

Pursuant to W&I Section 5820, OSHPD develops and administers statewide mental health workforce development programs to increase the number of qualified personnel serving individuals who have a serious mental illness. In 2008, $234.5 million was set aside from the total $444.5 million WET allocation for state-administered WET programs. From 2008 to 2013, the former Department of Mental Health (DMH) administered the first Five-Year Plan of $119.8 million. The responsibility for administering the plan was transferred to OSHPD in 2013.

AB 74 (2019 Budget Act) includes expenditure authority of $60 million ($35 million General Fund and $25 million Mental Health Services Fund) to implement the 2020-25 Five-Year WET Plan, which addresses workforce shortages in the state's public mental health system. The budget also includes budget bill language requiring regional partnerships to provide a 33 percent match of local funds to be eligible for funding through the plan.

In addition, a one-time appropriation of $1 million was included in the 2018 budget and a $2.7 million (General Fund) one-time appropriation in the 2019 budget to support the Primary Care Clinical Psychiatry Fellowship Scholarship Program, administered in partnership with the University of California at Irvine Medical School.

Innovation

The MHSA allocates 5% of MHSA funds distributed to counties for the Innovation (INN) component, which provides counties the opportunity to design and test time-limited new or changing mental health practices that have not yet been demonstrated as effective. The purpose of INN is to infuse new, effective mental health approaches into the mental health system, both for the originating county and throughout California. The purpose of an INN project is to increase access to underserved groups, increase the quality of services including measurable outcomes, promote interagency and community collaboration, or increase access to mental health services, including but not limited to, services provided through permanent supportive housing.

For the last two years, the MHSOAC has been working to strengthen the overall strategy for mental health Innovation by encouraging counties to be more strategic in their investment, providing technical assistance and training, assisting with research and evaluation and dissemination. The INN component requires counties to invest in innovations that have the potential to fundamentally transform mental health services and the outcomes achieved. INN funding allows counties to test new, unproven approaches to service delivery, or adapt existing strategies with a potential to become tomorrow's best practices to improve mental health services.

The MHSOAC reviews and approves funding for INN programs for county mental health departments. Additionally, the MHSOAC provides technical assistance to help counties in their planning process. Since 2016, the MHSOAC has authorized more than $338 million in funding to support INN programs statewide.

During fiscal year 2016-17 the MHSOAC approved over $68 million, in fiscal year 2017-18 the MHSOAC approved over $149 million, and during the first four months of fiscal year 2018-19 the MHSOAC has approved over $121 million.

In February 2018, the MHSOAC hosted its first innovation summit and brought together more than 300 stakeholders, mental health care professionals, policy makers and innovation leaders and others together to share and accelerate innovative approaches for transformation.

As a follow up to that effort, the MHSOAC proposed the establishment of an Innovation Incubator. The 2018-19 Budget included an allocation of $2.5 million to enhance innovation strategies to reduce the numbers of those deemed incompetent to stand trial (IST) in the criminal justice system. The MHSOAC is currently developing a business plan to launch the Incubator.

Prevention and Early Intervention

The MHSA allocates 19% of MHSA funds distributed to counties for Prevention and Early Intervention (PEI) programs and services. The overall purpose of the PEI component is to prevent mental illnesses from becoming severe and disabling, with an emphasis on improving timely access to services for underserved populations. The PEI component enumerates outcomes that seek to move the public mental health system from an exclusive focus on late-onset crises to inclusion of a proactive "help first" approach.

PEI focuses on reducing negative outcomes that may result from untreated mental illness, such as:

- suicide,
- incarceration,
- school failure or drop out,
- unemployment,
- homelessness,
- prolonged suffering; and,
- removal of children from the family home.

The Mental Health Services Oversight and Accountability Commission (MHSOAC) provides oversight of county mental health systems, including county prevention and early intervention strategies. The MHSOAC issues and provides technical assistance for PEI regulations. As part of this work, the MHSOAC has developed a database to track the PEI programs, who they serve and available outcomes.

As part of an ongoing effort, the MHSOAC established a Learning Collaborative, designed to provide counties with guidance and support needed for successful program implementation. To highlight successes, tackle challenges, and encourage inter-county collaboration, this learning community meets quarterly in order to address concerns and drive improvement initiatives.[vi]

SB 1004 (Wiener, Moorlach, Chapter 843, Statutes of 2018)
SB 1004 requires, on or before January 1, 2020, the MHSOAC to establish priorities for the use of PEI funds that include, but are not limited to:

1. Childhood trauma prevention and early intervention, as defined, to deal with the early origins of mental health needs;

2. Early psychosis and mood disorder detection and intervention, as defined;

3. Outreach and engagement strategies that target secondary school and transition-age youth, with priority on partnerships with college mental health programs;

4. Culturally competent and linguistically appropriate prevention and intervention;

5. Strategies targeting the mental health needs of older adults, as specified; and,

6. Other programs the MHSOAC identifies, with stakeholder participation, that are proven effective in achieving, and are reflective of, the PEI component goals stated in the MHSA.

The bill also requires, on or before January 1, 2020, the MHSOAC to develop a statewide strategy for monitoring the implementation of MHSA PEI programs, including enhancing public understanding of PEI and creating metrics for assessing the effectiveness of how PEI funds are used and the outcomes that are achieved. Finally, the bill requires the MHSOAC to establish a strategy for technical assistance, support, and evaluation to support the successful implementation of the objectives, metrics, data collection, and reporting strategy required in this bill.

CAL-AIM
The administration has launched a major Medi-Cal reform initiative called “Cal-AIM.” The following is a description of the initiative from the “Cal-AIM High-Level Summary:”

The Department of Health Care Services (DHCS) has developed a framework for the upcoming waiver renewals that encompasses broader delivery system, program and payment reform across the Medi-Cal program, called CalAIM: California Advancing and Innovating Medi-Cal. CalAIM advances several key priorities of the Administration by leveraging Medicaid as a tool to help address many of the complex challenges facing California’s most vulnerable residents, such as homelessness, insufficient behavioral health care access, children with complex medical conditions, the growing number of

justice-involved populations who have significant clinical needs, and the growing aging population.

CalAIM has three primary goals:

- Improve quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems and payment reform.

- Identify and manage member risk and need through Whole Person Care Approaches and addressing Social Determinants of Health;
  - Require plans to submit local population health management plans.
  - Implement new statewide enhanced care management benefit.
  - Implement in lieu of services (e.g. housing navigation/supporting services, recuperative care, respite, sobering center, etc.).
  - Implement incentive payments to drive plans and providers to invest in the necessary infrastructure, build appropriate enhanced care management and in lieu of services capacity statewide.
  - Evaluate participation in Institutions for Mental Disease Serious Mental Illness/Serious Emotional Disturbance Section 1115 Expenditure Waiver.
  - Require screening and enrollment for Medi-Cal prior to release from county jail.
  - Pilot full integration of physical health, behavioral health, and oral health under one contracted entity in a county or region.
  - Develop a long-term plan for improving health outcomes and delivery of health care for foster care children and youth.

- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility;

  Behavioral Health
  - Behavioral health payment reform
  - Revisions to behavioral health inpatient and outpatient medical necessity criteria for children and adults
  - Administrative behavioral health integration statewide
  - Regional contracting
  - Substance use disorder managed care program renewal and policy improvements.[vii]

Appendix 1: Historical Information

In November 2004, California voters passed Proposition 63 (the Mental Health Services Act or MHSA). MHSA established a one percent income tax on personal income over $1 million for the purpose of funding mental health systems and services in California. In an effort to effectively support the mental health system, the Act creates a broad continuum of prevention, early intervention, innovative programs, services, and infrastructure, technology and training elements.

AB 5 (Chapter 20, Statutes of 2009-10 3rd Ex. Sess.) amended W&I §§ 5845, 5846, and 5847. This law, enacted as urgency legislation, clarified that MHSOAC shall administer its operations separate and apart from the former DMH, streamlined the approval process for county plans and updates, and provided timeframes for the former DMH and MHSOAC to review and/or approve plans.

AB 100 (Chapter 5, Statutes of 2011) amended W&I §§ 5813.5, 5846, 5847, 5890, 5891, 5892, and 5898. This law dedicated FY 2011-12 MHSA funds on a one-time basis to non-MHSA programs such as Early and Periodic Screening, Diagnostic and Treatment, Medi-Cal Mental Health Managed Care, and mental health services provided for special education pupils. This bill also reduced the administrative role of the former DMH. This bill deleted the county's responsibility to submit plans to the former DMH and the former DMHs responsibility to review and approve these plans. To assist counties in accessing funds without delay, Section 5891 was amended to direct the State Controller to continuously distribute, on a monthly basis, MHSA funds to each county's Local MHSF. This bill also decreased MHSA state administration from 5 percent to 3.5 percent.

AB 1467 (Chapter 23, Statutes of 2012) amended W&I §§ 5840, 5845, 5846, 5847, 5848, 5890, 5891, 5892, 5897, and 5898. Provisions in AB 1467 transferred the remaining state MHSA functions from the former DMH to DHCS and further clarified roles of MHSOAC and DHCS. Section 5847 was amended to provide county board of supervisors with the authority to adopt plans and/or updates provided the county comply with various laws such as Sections 5847, 5848, and 5892. In addition, the bill amended the stakeholder process counties are to use when developing their three-year program and expenditure plan and annual updates.

SB 82 (Chapter 34, Statutes of 2013), known as the Investment in Mental Health Wellness Act of 2013, utilizes MHSA funds to expand crisis services statewide. This bill also restored MHSA state administration from 3.5 percent to 5 percent.

AB 1618 (Chapter 43, Statutes of 2016) established the No Place Like Home Program that is administered by the Department of Housing and Community Development. This bill also requires DHCS to: conduct program reviews of county performance contracts to determine compliance; post the county MHSA three-year program and expenditure plans, summary of performance outcomes reports and MHSA revenue and expenditure reports; and allows DHCS to withhold MHSA funding from counties that are not submitting expenditure reports timely.

AB 114 (Chapter 38, Statutes of 2017) provided that funds subject to reversion as of July 1, 2017, were deemed reverted and returned to the county of origin for the originally intended purpose. This bill also increased the time that small counties (less than 200,000) have to expend MHSA funds from 3 years to 5 years, and provided that the reversion period for INN funding begins when MHSOAC approves the INN project.

SB 192 (Chapter 328, Statues of 2018) amended Sections 5892 and 5892.1. This bill clarified that a county's prudent reserve for their Local MHSF shall not exceed 33% of the average CSS revenue received in the local MHSF, in the previous five (5) years. This bill required counties to reassess the maximum amount of the prudent reserve every five (5) years and to certify the reassessment as part of its Three-Year Program and Expenditure Plan or annual update. This bill also established the Reversion Account within the fund, and required MHSA funds reverting from the counties, and the interest accrued on those funds, be placed in the Reversion Account.[viii]

AB 74 (2019 Budget Act) includes expenditure authority from the Mental Health Services Fund (Proposition 63 State Admin) of $50 million in 2019-20 and $10 million annually thereafter for the Mental Health School Services Act (SB 75, 2019 education budget trailer bill), a competitive grant program to establish mental health partnerships between county mental health or behavioral health departments and school districts, charter schools, and county offices of education. These partnerships will support: (1) services provided on school campuses; (2) suicide prevention; (3) drop-out prevention; (4) outreach to high-risk youth and young adults, including, but not limited to, foster youth, youth who identify as lesbian, gay, bisexual, transgender, or queer (LGBTQ), and youth who have been expelled or suspended from school; (5) placement assistance and development of a service plan that can be sustained over time for students in need of ongoing services; and, (6) other prevention, early intervention, and direct services, including, but not limited to, hiring qualified mental health personnel, professional development for school staff on trauma-informed and evidence-based mental health practices, and other strategies that respond to the mental health needs of children and youth.

AB 74 (2019 Budget Act) includes expenditure authority from the Mental Health Services Fund of $20 million in 2019-20 to support the Early Psychosis Intervention (EPI) Plus program, established by AB 1315 (Mullin), Chapter 414, Statutes of 2017, but never previously funded. With this funding, the EPI Plus program will develop a competitive grant program for counties to expand access to evidence-based early psychosis and mood disorder detection and intervention services for transition-aged youth and young adults at high risk for, or experiencing, psychotic symptoms.

AB 74 (2019 Budget Act) includes expenditure authority from the Mental Health Services Fund of $15 million in 2019-20 for a grant program to establish youth drop-in centers that provide integrated mental health services for individuals between 12 and 25 years of age and their families, with a focus on vulnerable and marginalized youth and disparity populations including, but not limited to, LGBTQ, homeless, and indigenous youth.

Appendix 2: RAND Corporation Reports on the MHSA/Proposition 63

Ashwood JS, Briscombe B, Collins RL, et al. *Investment in social marketing campaign to reduce stigma and discrimination associated with mental illness yields positive economic benefits to California.* Santa Monica, CA: RAND; 2016. https://www.rand.org/pubs/research_reports/RR1491.html

Ashwood JS, Briscombe B, Ramchand R, May E, Burnam MA. *Analysis of the benefits and costs of CalMHSA's investment in Applied Suicide Intervention Skills Training (ASIST).* Santa Monica, CA: RAND; 2015. https://www.rand.org/pubs/research_reports/RR1115.html

Ashwood JS, Kataoka SH, Eberhart NK, et al, *The Mental Health Services Act in Los Angeles County: Evaluating Program Reach and Outcomes*, Santa Monica, Calif.: RAND Corporation, RB-10008-CMHSA, 2018. https://www.rand.org/pubs/research_briefs/RB10008.html

Ashwood JS, Kataoka SH, Eberhart NK, et al, *Evaluation of the Mental Health Services Act in Los Angeles County: Implementation and Outcomes for Key Programs*, Santa Monica, Calif.: RAND Corporation, RR-2327-CMHSA, 2018. https://www.rand.org/pubs/research_reports/RR2327.html

Ashwood JS, Stein BD, Briscombe B, et al. *Payoffs for California college students and taxpayers from investing in student mental health.* Santa Monica, CA: RAND; 2015. https://www.rand.org/pubs/research_reports/RR1370.html

Collins, RL, Eberhart NK, Marcellino W, Davis L, and Roth E, *Evaluating Los Angeles County's Mental Health Community Engagement Campaign*, Santa Monica, Calif.: RAND Corporation, RB-10037-CMHSA, 2018. https://www.rand.org/pubs/research_briefs/RB10037.html

Collins, RL, Eberhart NK, Marcellino W, Davis L, and Roth E, *Evaluation of Los Angeles County's Mental Health Community Engagement Campaign*, Santa Monica, Calif.: RAND Corporation, RR-2754-CMHSA, 2018. https://www.rand.org/pubs/research_reports/RR2754.html

Collins RL, Wong EC, Roth EA, Cerully JL, Marks J. *Changes in mental illness stigma in California during the statewide stigma and discrimination reduction initiative.* Santa Monica, CA: RAND; 2015. https://www.rand.org/pubs/research_reports/RR1139.html

Collins RL, Wong EC, Breslau J, Burnam MA, Cefalu M, Roth EA. *Social Marketing of Mental Health Treatment : California's Mental Illness Stigma Reduction Campaign.* American Journal of Public Health; 2019. https://www.rand.org/pubs/external_publications/EP67975.html

Eberhart NK. On the Road to Mental Health: Highlights from Evaluations of California's Statewide Mental Health Prevention and Early Intervention Initiatives, Santa Monica, Calif.: RAND Corporation, RB-9917-CMHSA, 2016. https://www.rand.org/pubs/research_briefs/RB9917.html

McBain RK, Ashwood JS, Eberhart NK, Montemayor CK, and Azhar GS, *Los Angeles County's Mental Health Full Service Partnerships Yield Cost Savings*, Santa Monica, Calif.: RAND Corporation, RB-10041-CMHSA, 2018. https://www.rand.org/pubs/research_briefs/RB10041.html

McBain RK, Ashwood JS, Eberhart NK, Montemayor CK, and Azhar GS, *Evaluating Cost Savings Associated with Los Angeles County's Mental Health Full Service Partnerships*, Santa Monica, Calif.: RAND Corporation, RR-2783-CMHSA, 2018. https://www.rand.org/pubs/research_reports/RR2783.html

Ramchand R, Roth EA, Acosta JD, Eberhart NK. *Adults newly exposed to "Know the Signs" campaign report greater gains in confidence to intervene with those who might be at risk for suicide than those unexposed to the campaign.* Santa Monica, CA: RAND; 2015. https://www.rand.org/pubs/research_reports/RR1134.html

Appendix 3: State Audits of the MHSA/Proposition 63

Mental Health Services Act:
The State's Oversight Has Provided Little Assurance of the Act's Effectiveness, and Some Counties Can improve Measurement of Their Program Performance
Report 2012-122, Released August 15, 2013
https://www.auditor.ca.gov/pdfs/reports/2012-122.pdf

Mental Health Services Act:
The State Could Better Ensure the Effective Use of Mental Health Services Act Funding
Report 2017-117, Released February 27, 2018
https://www.auditor.ca.gov/pdfs/reports/2017-117.pdf

[i] MHSA Expenditure Report 2019
[ii] State Audit 2013
[iii] State Audit 2013
[iv] MHSA Expenditure Report 2019
[v] MHSA Expenditure Report 2019
[vi] MHSA Expenditure Report 2019
[vii] DHCS CalAIM High-Level Summary
[viii] MHSA Expenditure Report 2019