

Rose King

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November 2, 2009

Ms Elaine M. Howle
California State Auditor
Investigations
California Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, CA 95814

RE: Whistleblower Complaint Report

Dear Ms Howle:

I assert in this complaint that state implementation of the voter-enacted statute known as the Mental Health Services Act (MHSA, Proposition 63, November 2004) is characterized by incompetence, waste, mismanagement, and costly inefficiencies as a result of a willful failure to comply with the language and intent of the law.

I believe that arbitrary state policies and regulations developed and promulgated by the Department of Mental Health (DMH) and Director Dr. Stephen W. Mayberg continue to waste state revenues at a time of critical need for mental health services. DMH policies are creating potential opportunities for conflicts of interest at state and local levels, promoting false and misleading interpretations of law, and causing delays and confusion in county mental health systems, which can result in harming the health and very lives of Californians.

The State of California has violated a trust with voters who enacted the MHSA, a majority of whom cast their votes in favor of the clear language and intent of the law as determined by the published Legislative Analyst's Analysis, provided in November 2004 Voter Pamphlets. The clear requirements for implementation explained in the analysis have legal standing as noted in related Attorney General Opinion No. 05-1007 of February 21, 2006.

As a consultant to the California Attorney General in 2005-07, I witnessed and reported on issues of noncompliance and widespread waste and inefficiency, affirmed in a state Department of Finance Performance Audit of May 2008.

- Five years after enactment, DMH has not produced an implementation plan.
- DMH has not complied with requirements for Integrated Systems of Care.
- The State is financing an arbitrary and noncompliant two-tier mental health system, the subject of public grievances and a source of waste and inefficiency.

Ms. Elaine M. Howle

Page 2

- MHSA planning supports an industry of contractors, consultants, committees, conferences, reports, reviews, focus groups, also the subject of grievances.

MHSA revenue is creating a separate, new tier of “Cadillac” mental health programs for newly recruited clients. The existing lower tier of programs continues to deteriorate, service and access declines, and current consumers are denied adequate treatment. In defiance of logic and the law, DMH requires counties to establish a separate, new bureaucracy of programs to obtain MHSA funds. DMH created funding categories and objectives not found in the MHSA, and instructed counties to spend a majority of funds on this new system.

State auditors analyzed the management of MHSA and surveyed county mental health directors, concluding in May 2008: *“DMH should develop a plan to address the observations and recommendations noted in this report. Implementing our recommendations will enable DMH to fulfill the intent of the MHSA and allow counties to readily implement programs and services to effectively treat and support the mentally ill.”* **The state DMH did not follow this recommendation.**

DMH declared that the complexity of the law prohibited compliance with requirements for integrated plans—an admission that should have called for intervention by the Secretary of Health and Human Services. By acts of both omission and commission on behalf of the State of California, I believe the Department of Mental Health fails to efficiently manage and direct implementation. I allege that improper actions, including those in conflict with the law, by the Director and an unknown number of his senior aides, have wasted time and money and harmed the health and lives of an unknown number of Californians. I believe the magnitude of continued waste and mismanagement of tax revenues warrant the attention of the California State Auditor. And the people of California who earnestly intended to improve community mental health services deserve the honest results they hoped for, and voted for.

Sincerely,

Rosemarie King, Complainant

The following complaint follows the guidelines of the Whistleblower Complaint Report provided by the office of the State Auditor.

Ms. Elaine M. Howle

Page 3

Primary Reference Attachments:

Ballot Proposition 63, Attachment #1

Official Title and Summary Prepared by the Attorney General, Analysis by the
Legislative Analyst, and Ballot Arguments, Attachment #2

Attorney General Opinion, Attachment #3

Department of Finance OSAE Performance Audit May 2008, Attachment #4

Summary of Allegations:

Allegation No. 1: DMH misuse of tax revenue, and failure to fund Systems of Care, creates unnecessary, wasteful state and local bureaucracies, and a new, noncompliant Two-Tier Mental Health System.

Allegation No. 2: As a result of incompetence, DMH does not implement requirement that counties produce a single, integrated plan, incorporating all provisions of the MHSA; instead DMH designs a fragmented, inefficient, and costly process that wastes resources.

Allegation No. 3: DMH implementation procedures lack context and standards, and foster potential conflicts-of-interest and questionable spending priorities. The inefficient, noncompliant DMH policies are associated with unstated and unaccountable motives.

COMPLAINANT:

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I am presently retired from state and federal service: I directly witnessed the improper activity that I allege, both as a private citizen advocate and as a Principal Consultant on Mental Health (8/05 – 1/07) to then-Attorney General Bill Lockyer, also a member of the MHSA Oversight and Accountability Commission created by Prop 63. I consulted on formation of the oversight body, developed policy proposals, operating procedures, and communications in concert with the AG's OAC designee Tricia Wynne, and worked with OAC and DMH staff and commissioners on numerous implementation issues. From 2007 – 2009, I produced memorandum, commentary, and correspondence in communication with DMH and other principals, and made presentations at the invitation of various public and private agencies, in which I point out fundamental problems and violations of the intent of the Act.

My extensive knowledge of Prop 63 and W&I codes is also based upon employment history, including consultant to Assembly Speaker on Joint Committee on Mental Health

Ms. Elaine M. Howle

Page 4

Reform, and consultant to the Assembly Health Committee for then-Committee Chair Helen Thomson, when I developed statutory language and concepts that became a working draft for the initiative (2000-02). At the same time, I began working with Prop 63 proponents to test the waters for an omnibus ballot initiative. I served on the Prop 63 initiative drafting committee in 2002-03 and represented the National Alliance for Mental Illness CA as a member of the State Board of Directors. As Chief of Staff to the California Lieutenant Governor, I was instrumental in forming a state task force on serious mental illness in 1986, which led to legislation cited by the California Mental Health Directors Association as the foundation of the Systems of Care model. In addition to service in civic leadership roles, I have been a lead professional in research and development of related legislative and state reports, as well as legislation. My history of government service includes employment in the U.S. Congress, and with California State Constitutional Officers and Assembly and Senate leaders in numerous roles beginning in January 1975.

MHSA Oversight and Accountability Commission

Sixteen members have been appointed to the Mental Health Services Oversight and Accountability Commission (MHSOAC). Twelve members have been appointed by Governor [Arnold Schwarzenegger](#), joining four State government appointed officials.

The Commission advises the governor and legislature regarding actions the State may take to improve care and services for people with mental illness, and is required to annually review and approve each county mental health program for expenditures. The first meeting of the MHSOAC was held July 7, 2005. In accordance with MHSA requirements, the Commission shall consist of 16 voting members as follows:

1. The Attorney General or his or her designee
2. The Superintendent of Public Instruction or his or her designee
3. The Chairperson of the Senate Health and Human Services Committee or another member of the Senate selected by the President pro Tempore of the Senate
4. The Chairperson of the Assembly Health Committee or another member of the Assembly selected by the Speaker of the Assembly
5. Twelve appointees of the Governor, who shall seek individuals who have had personal or family experience with mental illness, to include:
 - two persons with a severe mental illness
 - a family member of an adult or senior with a severe mental illness
 - a family member of a child who has or has had a severe mental illness
 - a physician specializing in alcohol and drug treatment
 - a mental health professional
 - a county Sheriff,
 - a Superintendent of a school district
 - a representative of a labor organization
 - a representative of an employer with less than 500 employees
 - a representative of an employer with more than 500 employees
 - a representative of a health care services plan or insurer
 - State government appointees

ALLEGATIONS AND EVIDENCE DOCUMENTS

Whistleblower Complaint to California State Auditor—November 2, 2009

MHSA BACKGROUND. Voters enacted the statute known as the Mental Health Services Act (MHSA) with the passage of Proposition 63 on November 2, 2004, designating new tax revenues for community mental health.

Here's what the law said:

1. MHSA revenue shall be used to expand existing county Systems of Care for children, adults, and older adults, and to develop new preventive and innovative mental health programs.
2. In the first three years of implementation, a portion of the county funds will be used to strengthen infrastructure of workforce, capital facilities, and technology.
3. In the fourth fiscal year, MHSA allocates 75% for existing county Systems of Care, 20% for county prevention/early intervention, 5% for all state administration; five percent of the counties' revenue is for innovation.
4. Counties shall develop a single integrated plan to implement all provisions.
5. The state DMH shall issue requirements for the integrated county plans.
6. The DMH, Mental Health Planning Council, a new Oversight and Accountability Commission, and counties have both separate and shared management duties.
7. Community stakeholders, including county mental health boards/commissions, shall review, comment, and make recommendations on integrated county plans, and have the tools to participate in implementation.

Here's what the state DMH did:

1. Not inform partners or public of the statutes defining county Systems of Care.
2. Not fund expansion of the proven, existing county Systems of Care.
3. Not develop integrated implementation plans, but operate an unstructured design, open to arbitrary decisions, ad-hoc planning, corruption of purpose.
4. Declare that it was too complicated to implement an integrated plan, so DMH would issue Requirements and Regulations for one component of the law at a time—and counties would repeat the planning process to submit, budget, and manage six separate and independent plans.
5. Divide the Systems of Care money into three newly-contrived categories of money and programs, give the plan a different name, and issue 65-page requirements for county plans, which were 300—1,000 pages when submitted.
6. Misinform and mislead implementation partners and the public by requiring counties to spend a majority of service funds on new programs for new clients, and alleging that the “Two-Tier” design is consistent with intent of the MHSA.
7. Create a complicated, unnecessary bureaucracy, and a vast network of planning consultants and contractors, while spending five years and hundreds of millions of dollars on an inept and wasteful system serving less than five percent of need.

DMH incompetence, and unknown and undeclared motives, waste money and cost lives. On the fifth anniversary of passage by voters, MHSA has not been implemented, and has not served its declared “Purpose and Intent,” nor relieved the grievous conditions found in the MHSA “Findings and Declarations.”

Department of Mental Health implementation policies do not comply with:

- The language and intent of the law;
- The Legislative Analyst's ballot statement;
- Proponents' ballot arguments;
- Proponents' publication illustrating timeline and planning process;
- Expectations of proposition advocates, stakeholders, and voters;
- Performance standards of Office of State Audits and Evaluations (OSAE).

Major issues of Noncompliance with serious impact are:

- Refusal/lack of professional capacity to produce a coherent implementation plan;
- Failure/Refusal to guide counties in development of a single, integrated plan, incorporating all funded components;
- Arbitrary, incompetent, and fragmented implementation design, requiring every county to produce at least six separate plans, delaying services, wasting money on inefficient administration, and enriching private contractors;
- Diversion of "Systems of Care" funds to a separate, parallel "Two-Tier" system;
- Regulations and Requirements that alter the statutory "target population," mislead consumers, counties, providers, and stakeholders, and promote the deception that MHSA monies must be spent on new programs for new clients.

Consequences of Noncompliance:

- Development of an unnecessary, costly, new bureaucracy in the Department of Mental Health (DMH), related state agencies, and in every county, due to arbitrary, unfounded, and discriminatory state policies;
- Waste of tax revenue fostering a vast and unnecessary planning, meeting, consulting, conferencing industry at state and county levels;
- An ad-hoc structure and process, with no defined boundaries or standards of care, inviting conflicts-of-interest, special interest dominance, and a proliferation of private contracting that impedes accountability;
- The county mental health "Systems of Care" to be expanded with MHSA tax revenue have significantly deteriorated in quality of service and capacity, county executives predict increases in suicides and incarcerations as a result of denying treatment, and the state of emergency accelerates.
- Five years of planning, \$48.5 million annual state administrative costs, a critical state audit, and 16 oversight commissioners have not implemented the law or produced an accountability report. There is no end in sight and none predicted.

Violations of the law are arbitrary, undocumented, opposed by stakeholders, and sharply criticized in a 2008 OSAE audit. Noncompliance is not supported by policy research, government studies, best practices, or public demand. Policies are not compatible with recommendations of state government reports of this decade, published by the California Little Hoover Commission, California Mental Health Planning Council, and Joint Legislative Committee on Mental Health Reform.

Components of the integrated plan are stipulated in MHSA “*Integrated Plans for Prevention, Innovation and System of Care Services*” (Sections 5847 and 5848 added to W&I codes). The funding schedule and program provisions of the law call for a single implementation plan in each county; infrastructure components support Systems of Care expansion and delivery of services.

“Systems of Care” for children, adults, and older adults are a specific model of delivering mental health services, developed and codified in California statutes over a period of more than 20 years, with broad participation of mental health community interests. Systems of Care are “*client-centered, culturally competent, and fully accountable*” (W&I code 5600.2). Systems of Care provide for a specified range of treatment options, are based upon specific principles and recovery/treatment philosophy, and emphasize the importance of coordinated, comprehensive, and integrated services (W&I code 5802).

Expansion of A Proven Model is the essential purpose of MHSA. The stated purpose of expanding integrated Systems of Care is to provide client and cost-effective services to consumers of every age, in every county, now denied essential treatment because of inadequate funding. W&I codes state that a System of Care “*...is vital for successful management of mental health care in California....*” Integration and collaboration are primary elements of success.

ALLEGATION #1.

DMH Misuses MHSA Tax Revenue to Create Costly, New Bureaucracy for a Noncompliant, “Two-Tier” Mental Health System. DMH Fails to Implement Law Expanding Mental Health “Systems of Care.” Consumers, counties, and stakeholders are misled and misinformed.

DMH and Director Mayberg arbitrarily violated MHSA statutes requiring expansion of existing county mental health “Systems of Care,” which are defined in existing W&I codes and in the MHSA. (Attachment #5 codes) Instead, DMH required counties to create new mental health programs and recruit new mental health clients, thus establishing a separate, dual mental health system. DMH-contrived policies and practices, which are not in compliance with the language or intent of the law, create continuing inefficiencies, waste of state revenue, and unnecessary bureaucratic procedures, compounded many times over by DMH requirements imposed upon counties.

This complaint does not focus on the questionable legality of DMH actions, but the highly questionable costs resulting from policies that defy logic and the law. What is the rationale for the unnecessary extravagance of starting new programs? What is the rationale for recruiting new clients when so many counties report that every client now in the system is poorly served?

In my experience, counties are prepared for a coherent, integrated, and orderly implementation of the law—expansion of Systems of Care and development of new prevention services. The May 2008 state *Performance Audit, Final Report, Office of State Audits and Evaluations* likewise concludes: “DMH should develop a plan to address the observations and recommendations noted in this report. Implementing our recommendations will enable DMH to fulfill the intent of the MHSA and **allow counties to readily implement programs and services to effectively treat and support the mentally ill.**” (Attachment #4 OSAE)

DMH has not developed any configuration of a plan to meet the purposes recommended by OSAE. The state DMH continues to follow a complicated, inefficient, and independent course of no known design—and the outcome is a costly, dual-level of service, contrary to the cost-efficient policy and promise of the law. **Two-Tier Plan.** DMH implementation policies create a “Two-Tier” or dual-level system, in which MHSA programs are separate from the base system and largely unknown, even to providers. DMH requires counties to invest a majority of MHSA funds in a separate “Cadillac” tier of comprehensive services for newly recruited clients, while current clients continue to receive inadequate services in a lower tier system, where quality and access are further deteriorating.

Clients in the Lower Tier are “underserved,” receive inadequate or inappropriate treatment, and are denied services essential to recovery. Counties report 90-100 Percent of their client population is in this category. **Clients recruited for the Upper Tier** funded by MHSA are “unserved,” receiving no mental health services prior to treatment in the new program.

The base mental health system that has never been properly funded or capable of providing appropriate treatment does not significantly benefit from MHSA revenue, and quality of services are declining further because of county budget cuts. This is the DMH plan that effectively abandons the people and programs deprived of success for decades, in order to start anew with different clientele and different programs. This DMH “Two-Tier” plan, justified by Director Mayberg, is in conflict with the intent of the MHSA law. (There is also no guarantee that people in the costly, Upper Tier programs are receiving superior services, because they are not necessarily tied to an evidence-based practice, and not within Systems of Care.)

A stakeholder in a September 2009 survey by National Alliance on Mental Illness (NAMI) California confirmed the local results: *“There has been a definite and pronounced trend toward two tiers of care in which those receiving services through the [MHSA] are getting much more intensive supports—but those clients not in MHSA have become victims of budget cuts.”* The NAMI Survey asked members if a state-sponsored “Five Year Anniversary Event” to celebrate MHSA success had merit. This same stakeholder did not support a celebration as the pace of implementation has been glacial due to DMH interpretation of the law, and many respondents opposed an event because of the history of extravagant waste of MHSA funds on planning meetings, events, hotel rentals, etc. (namicalifornia.org)

EVIDENCE:

ONE. The ballot language of Proposition 63 and the Legislative Analyst’s Analysis are the foundation of evidence of noncompliance and resulting waste and incompetence. **THE LAW.** DMH Regulations, Requirements, and numerous Department “Letters” are not in compliance with provisions of ballot measure Prop 63 and are in conflict with the Legislative Analyst’s Analysis provided to November 2004 voters, particularly as it relates to expansion of existing county Systems of Care for mental health. Program content for these systems, such as service models, principles, range of treatment options, etc., were already spelled out in pre-existing W&I codes, and these provisions were known to many counties and to active stakeholders. Instead of ensuring consistent application and understanding of these systems and “proven” programs specified by the MHSA, state DMH Director Mayberg created an unnecessary and unauthorized, new level of bureaucracy in state agencies and in every county, requiring every county to “reinvent the wheel” and establish a new, parallel mental health system. DMH actions deviating from requirements are the source of wasted time and money

DMH did not comply with the law governing the use of MHSA funds, and requiring that revenue be spent as follows:

- **Official Title and Summary—Prepared by the Attorney General**
Mental Health Services Expansion, Funding. Provides funds to counties to expand services and develop innovative programs and integrated service plans for mentally ill children, adults and seniors...

- Legislative Analyst’s Analysis section “How This Funding Would Be Spent.” “Children’s System of Care. Expansion of existing county system of care services...”
Adult System of Care. Expansion of existing county system of care services...”
- Statutory language of MHPA, Section 5. Article 11. Services for Children with Severe Mental Illness. 5878.1 (a) “...establish programs that assure services will be provided to severely mentally ill children as defined in Section 5878.2 and they be part of the children’s system of care...” **Section 7. Section 5813.5 (c).** *Each county mental health program shall provide for services in accordance with the system of care for adults and seniors...” “These funds shall only be used to pay for the programs authorized in Section 5892. These funds may not be used to pay for any other program.” MHPA funds “shall be distributed to county mental health programs for services to persons with severe mental illnesses pursuant to **Part 4 for the Children’s System of Care and Part 3 for the Adult and Older Adult System of Care.**” (See Attachment #2 for complete documents.)*

DMH violates the specific intent of the law and clear language of the law in these public documents, and does not produce the predicted efficiencies of expanding model programs.

TWO. DMH Requirements Issued in August 2005 Illustrate Noncompliance with MHPA Law and Cause Inefficiencies, Delays, and Unnecessary Bureaucracy.

DMH DOCUMENTS. Noncompliant DMH Requirements and Regulations diverted funds intended to enhance and upgrade county systems. DMH arbitrarily chose to create a discriminatory “Two-Tier” and increasingly fragmented community mental health system, separating MHPA programs from the counties’ base systems. DMH documents mislead counties and stakeholders.

In August 2005, DMH issued a 65-Page “Three-Year Program and Expenditure Plan Requirements,” falsely claiming requirements were consistent with provisions and priorities of the MHPA, but failing to fund expansion of Systems of Care as required by law, and as Prop 63 promised to voters. DMH falsely claims in the August 2005 “Requirements” document that diversion of Systems of Care funding is consistent with “MHPA priorities.” (Attachment #6 DMH Requirements) DMH also falsely claims that priorities reflect desires of various stakeholders and implementation partners. There is no evidence to support these claims. Current evidence from stakeholders disputes these claims.

- **Needless New Funding Categories.** DMH caused delays, costly inefficiencies, and wasted state and county time and money because DMH “Requirements” separated some provisions of the Act from others, arbitrarily and unnecessarily created three new categories of funding, along with three separate program objectives, not found in the Act, and created a new “target population.”
- **Increased Fragmentation in a Separate System.** DMH further complicated the process by deciding to rename the “Systems of Care” programs and refer to them as “Community Services and Supports,” again unnecessarily increasing

administrative burdens and causing confusion and inconsistent application of provisions in county systems. DMH states that the new name is intended to create a separate identity for MHSAs programs—indicative of plans to establish a separate, Two-Tier System.

- **Unnecessary Administrative Burdens.** By failing to fund Systems of Care, DMH Requirements multiplied county burdens, and required counties to propose multiple work plans in three separate funding categories for each of four separate age groups, all of which required separate planning, budgeting, monitoring, reporting, and evaluating. To obtain funding for a fragmented portion of the MHSAs, counties submitted plans which ranged from 300 to 1,000 pages (affirmed by OSAE Final Report, pg. 12), each of which had to be reviewed by DMH and the OAC, were often returned to counties for revisions, and then in a lengthy approval process, every county sent a delegation to a Sacramento meeting, which I frequently attended as a representative of OAC. Meetings included as many as 25 participants, with MHSAs-funded contractors as “consultants” and an “expert pool” of stakeholders in the elaborate review.
- **Unnecessary Delays.** County mental health directors questioned whether the benefits of the revenue outweighed the county administrative burden, while many reported that no clients in their county were “fully served.” OSAE investigations illustrate the burden on such small, rural counties as Amador, where the process for final approval of a single component took 211 days for county revisions, and 336 days at DMH for review. Similarly, Lassen took 256 days for the county process and 232 days for DMH review. (See Attachment #4, OSAE)

THREE. DMH Is Unresponsive to Department of Finance, Office of State Audits and Evaluations, May 2008, Final Report—California Department of Mental Health, MHSAs Performance Audit

OSAE PERFORMANCE AUDIT. Noncompliant DMH Regulations, County Plan Requirements, and instructions in Department “Letters” are characterized as “*inefficient...repetitive and redundant...cumbersome and lengthy process...*,” among many other critical findings of the Office of State Audits and Evaluations, May 2008 Performance Audit. (Attachment #4 OSAE) State auditors also affirm that the implementation process deviates from MHSAs requirements, and that DMH does not document claims that such deviations are agreed to by unknown “stakeholders.” The Final Report analyzes performance in three functional areas: “Development and Implementation Process...Plan Review and Approval Process...Fund Distribution Process.” OSAE observations also note: “*ineffective communication and coordination,*” “*inconsistent guidance,*” “*inefficient review processes,*” and make 19 Recommendations for “*corrective actions.*”

- **State and counties operate without an implementation plan. There is no coherent state plan and no expectation of state leadership.** The excellent analysis by OSAE auditors has not produced overall management improvements. Counties must now independently determine how to resolve the problem of a “Two-Tier” System caused by state ineptitude and/or design. The implementation process remains dysfunctional. A key finding in Executive Summary, Pg 1,

evaluation of the development and implementation process is that ***“a documented plan of the MHSA development and implementation does not exist...”***

- **Absent a plan, state promotes dual-system of services.** The continued failure to produce an implementation plan more than a year after the critical OSAE audit and years after 2006 requests by OAC Commissioners is further evidence of intent to divert funds from Systems of Care in order to fund the parallel, dual-system conceived of by DMH. Dr. Mayberg explains his intent to do so in correspondence to me in August 2007. (Attachment #7 DMH Letter) He does not explain the advantages to DMH of operating without a plan, but it facilitates the development of the Two-Tier System. (Attachment #8, February and March 2006 Memorandum, which I prepared for public meetings of MHSOAC, DMH, and principal stakeholders.)
- **Funding is delayed as a result of arbitrary DMH policy.** Also in OSAE “Executive Summary”, Page 1, state auditors find ***“fund distribution not in compliance with the MHSA...”*** Absent an implementation plan, DMH principals fund county programs which deviate from voter intent to expand county “Systems of Care,” the service model identified in MHSA as those programs which *“have already demonstrated their effectiveness...”* The decision to create a Two-Tier system rather than expand mental health services is responsible for continued delays in distribution of county funds—communities, clients, and families do not have the benefit of expansion or improvements in mental health services.

Counties are required to spend MHSA money on various “consultants” and “specialists” to meet Department requirements for “outreach” and new programs. County and stakeholder reports support OSAE audit findings that Department actions cause unnecessary, duplicative effort, inconsistent interpretations of law, and a maze of bureaucratic procedures and forms, further blocking funds. The May 2008 OSAE Performance Audit documents these facts: *“As of March 31, 2008, approximately \$3.2 Billion has been collected and \$2.9 Billion has been allocated for county use. Of the \$2.9 Billion allocation, \$1 Billion has been approved for distribution but only \$726 million has been distributed to counties.”*

In February 2009, Director Mayberg testified before a Senate fiscal committee that approximately \$4 Billion could be held in the MHSA trust fund by the end of that fiscal year. While counties such as Sacramento are closing emergency treatment centers, the State withholds vital funds intended to serve residents with mental illnesses. (Attachment #9, Sacramento Bee report) 10/1/09)

FOUR. DMH Is Unresponsive to OAC Request to Improve Compliance and Efficiency.

OAC RECORDS. As a consultant to the Attorney General, and on behalf of the Oversight and Accountability Commission (OAC), I prepared memorandum requesting information and research to properly evaluate county plans, requesting analyses of data submitted by counties in response to DMH Requirements, and requesting modifications of DMH policies that are not consistent with the language and intent of the law enacted

by voters. In some cases, DMH management personnel, including Carol Hood, made commitments to respond, but the Department did not fulfill the commitment for unexplained reasons. I do not know which is the case. In the case of correspondence from the OAC to Director Mayberg, DMH did not respond in any manner, and did not make the modifications requested. (See Attachments #10, Agenda OAC)

DMH policies creating a Two-Tier system are the subject of complaints and official grievances. As a consultant to OAC Commissioner and then-Attorney General Bill Lockyer in 2005 and 2006, I worked with his OAC designee Patricia Wynne, other OAC Commissioners, and stakeholders throughout California, evaluating and reviewing at least 54 county plans for MHSAs. I personally participated in meetings in which objections were discussed, and prepared material for OAC meetings to brief Commissioners and communicate problems to DMH Director Mayberg and principal staff.

- **DMH was unresponsive to all requests** to modify policies, evaluate county responses, and improve compliance with MHSAs requirements and public expectations. For instance, DMH Director Mayberg and his principal aides did not respond to OAC memorandum regarding the need for integrated implementation plans. Staff did not address OAC concerns regarding the need to circulate state standards and ensure widespread understanding of Systems of Care. DMH did not provide a blueprint for integrating the new MHSAs resources with the needs of existing county systems, all of which were highlighted in OAC memorandum and direct communications to DMH lead staff.
- **DMH did not address policy questions** or respond to concerns regarding inefficient state policies—or lack of policies—that leave every county to its own devices, to independently invent its own methods, training, process, etc., for meeting state funding requirements and deadlines, which are not even consistent with the language of the law. State requirements and interpretations cause confusion, inconsistent interpretations and applications of the law, and complaints that every county is “reinventing the wheel.”
- **DMH practices continue to build a Two-Tier system and waste resources, inventing a new structure**, instead of properly funding the appropriate system. DMH “Requirements” and Regulations require counties to justify any deviation from giving preference to new clients over those who are “underserved” by their own definition of this requirement. The concept is discriminatory and arbitrary. DMH policy is inconsistent with the law, and unresponsive to county reports that virtually all current mental health clients are inappropriately served or underserved. (Attachment #11, my Memorandum of May and July 2007 mailed to principals and presented at OAC meeting)

FIVE. DMH Two-Tier System Is Primary Concern of Stakeholders and Implementation Partners.

IMPLEMENTATION PARTNERS/STAKEHOLDERS. As a consultant to the Attorney General, I attended OAC meetings from shortly after its inception in 2005 until January 2007, and served as primary staff to a committee composed of community stakeholders

throughout the State. I personally addressed many stakeholder complaints that came to OAC Commissioners, while reviewing county plans, and worked with client and family organizations in order to represent their concerns at DMH and OAC staff meetings. I initiated efforts to organize working partnerships among the parties sharing implementation responsibilities through MHSAs. After leaving DOJ in 2007, I made presentations and sent related correspondence to implementation partners. Lead DMH staff members, including Carol Hood, acknowledged stakeholder concerns. However, DMH staff affirmed the appropriateness of department procedures, despite contrary findings in its own reports. See DMH implementation studies cited below, reporting that dual system is a primary concern of stakeholders.

DMH continues to require and fund the development of a dual system, in which new MHSAs operate independent of the base system, and new clients have preferential access. This DMH policy is contrary to provisions of the MHSAs, and there is no evidence for DMH claims that the design is responsive to stakeholders.

Deceptive statements continue in 2009. Current budget crises and extreme cuts in county services may place greater pressure on the State to modify policies and comply with the law. But the most recent DMH and OAC statements perpetuate a deceptive definition of the “target population.” DMH requires that MHSAs give preference to an “unserved” target population in order to facilitate the Department’s plan requiring new programs for new clients, and a separate tier of comprehensive services.

- **Correspondence and Presentations—Stakeholders Object.** In 2007, I made presentations at OAC meetings, at stakeholder meetings, and was invited to brief the California Mental Health Planning Council on the “Two-Tier” problem. In addition, I circulated memorandum in May and July 2007 (Attachment #11) to more than 100 principal stakeholders, seeking to further compliance with the law. Dr Mayberg asserts in correspondence to me in August 2007 (Attachment #7) that his decisions were “*Informed by the MHSAs and stakeholder input...*” He states that “*we*” determined to allocate the majority of funds to those he states are “*most in need.*” DMH does not cite any process, independent study, or public or private report utilized to determine the profile of “*those most in need.*” Further, DMH and Director Mayberg do not provide any evidence that its policies are supported by constituencies. Contrary evidence includes results of a NAMI California on-line survey of constituents regarding the Two-Tier system, submitted to OAC and DMH in October 2008. DMH website posted an April 2008 NAMI survey, critical of the stakeholder process. (Attachment #12 NAMI Survey)

In correspondence with the MHSAs Oversight and Accountability Commission in 2008, I reported on the waste and inefficiency due to the failure to comply with statutory requirements. OAC Chair Linford Gayle responded, stating Commissioners are likewise concerned, and inviting me to work with a committee studying the problem of a dual system. I outlined a plan to address the problem, but there is no further indication that OAC is concerned, or that DMH intends to

change course. (Attachment #13) In August 2008, the Sacramento Bee published my “**Viewpoint**” editorial and editorial response from Dr. Mayberg. (Attachment #14)

- **OSAE Audit finds lack of documentation.** State auditors also clearly indicate that DMH does not document its claims that stakeholders are in agreement with deviations from the plan (see complete comments in Observation 1., Pages 7-8, Attachment #4). *“Although DMH indicated that all stakeholders were in agreement with the deviations, the overarching plan and vision was not sufficiently documented...goals are not known to all, and counties and stakeholders are limited from effectively planning or creating programs within their communities.”*
- **DMH Internal Reports Contradict Director’s Claim.** Stakeholders do not support deviation from the law, which is funding a Two-Tier System with MHSA revenue. The Department’s own reports state that stakeholders object to development of a “dual-system” and cite this as their primary concern. Status reports contradict Director Mayberg’s assertions. Evidence documents produced by DMH, consultant Bev Whitcomb, and its California Mental Health Planning Council are as follows:

DMH report Mental Health Services Act Implementation Study: Community Services and Supports State Planning, June 2007, Pg 17, re: “Concerns”, *“A major substantive concern is the potential for the creation of a dual system.”*

DMH report. Mental Health Services Act Implementation Study Phase II November 2007, “Executive Summary”, Pg 7, re: “Concerns...,” *“The greatest concerns expressed were that MHSA would create a dual system of care and that expectations of stakeholders may have been raised too high.”*

DMH report. Mental Health Services Act Implementation Study: Planning and Early Implementation of Community Services and Supports in Seven Counties. Phase II, November 2007, Pg 66, re: “Learning...” *“A major concern is the development of a dual system of care.”*

Two 2008 reports, and two 2009 Phase III Reports are also posted on “MHSA Publications” DMH Prop 63 website. The Phase III is described as the final implementation study. The Phase III Study and Executive Summary issued June 2009 maintains an inaccurate characterization of MHSA intent and reflects an increased emphasis on justifying the DMH plan. Where earlier studies cited major concerns about development of a dual system, the 2009 study now claims: *“The MHSA was intended to fund new programs...”* The distorted characterization was manufactured at some point by DMH personnel, and the study now shifts responsibility to counties to resolve concerns about the “dual systems of care.” The introduction to the 2009 study claims to explore county efforts to address the problem, but devotes only a paragraph in “Successes and Challenges,” reporting that the disparities between MHSA and core system

programs are becoming more pronounced and may cause a backlash against MHSAs. **DMH accepts no responsibility for creating or resolving inequities.** (Attachment #15 Complete List of Reports)

DMH executives offer no solutions to “Two-Tier” problem of its own making—and maintain posture that this is an outcome of the law, not DMH misuse of funds or failure to comply with law. The Executive Summary of the MHSAs Implementation Study in 2009 notes in the final paragraph that stakeholders and staff state the “biggest area of concern is the difficult fiscal environment, and the creation of a dual system of care.” Further, stakeholders and staff “spoke to the importance of exploring and addressing this issue in the future.”

A California State Mental Health Planning Council meeting of October 18, 2007, in Sacramento “Discussion Summary” minutes on special agenda item of Policy and Systems Development Committee. (Attachment #16 Minutes and Presentation.) Rosemarie King and DMH Executive Carol Hood are invited to make presentation to identify problems and recommendations to address growing concern among numerous constituencies about development of two-tier, dual system with MHSAs funds. DMH acknowledges problem but asserts that it is not possible to change course as too much is invested in current policies. DMH does not address any corrective actions I proposed at the request of Planning Council.

ALLEGATION #2.

DMH Lacks Capacity to Comply with Statutory Requirements for Integrated Implementation Plans. DMH Cites the Complexity of the Law as a Rationale for Imposing a Fragmented, Inefficient, and Wasteful Process on Counties.

Shortly after passage by the voters, DMH announced that the complexity of the law was such that it could not produce the Requirements for integrated county plans—a central and essential factor of successful implementation. Instead, the Department would implement one provision of the law at a time, each independent of the other, following a staggered timetable. First, this policy is contrary to provisions of the Act as placed before the voters; Second, compounding fragmentation of the system is contrary to every call for mental health reform at the state and national level for at least the last two decades; Third, fragmented, staggered implementation completely undermines MHSA prospects of cost-efficiency and replication, both promised in the Act and in ballot arguments.

Now five years after enactment, DMH continues inefficient policies wasting state and county resources, and remains incapable of issuing requirements for “Integrated Plans.” The piecemeal, fragmented implementation is a costly, repetitive, and disjointed process in which each component of the plan operates on a different timetable and budget and according to different guidelines. Six components of the plan are under discussion—in five years, only one is actually operating, and not to the satisfaction of many consumers.

OSAE Recommendations in May 2008:

“Create one set of comprehensive integrated guidelines addressing all components. The guidelines should allow for ...submittal of one integrated Plan.”

“...ensure funds are distributed to counties timely and in compliance with MHSA.”

DMH did not comply with this recommendation.

EVIDENCE:

ONE. Ballot Documents Require “Integrated” Plans.

The attached documents, including the language of the law and ballot pamphlet statements, clearly indicate that MHSA directs funds to integrated county plans for the purpose of expanding existing services and establishing new preventive and innovative programs. (Section 10. Part 3.7, Section 5847, added to Division 5 of W&I by Prop 63): “W&I Code Section 5847, **Integrated Plans for Prevention, Innovation and Systems of Care Services.**

(a.) Each county mental health program shall prepare and submit a three-year plan which shall be updated at least annually and approved by the department after review and comment by the Oversight and Accountability Commission. The plan and update shall include all of the following:...”

The law lists components (1) through (7), including Preventive and Early Intervention programs, Children’s Systems of Care Services with appropriate access to wraparound program, Adult and Older Adult Systems of Care Services, Innovative programs, and investments in infrastructure supports of technological needs, capital facilities, workforce development, and prudent reserves, all of which are to be incorporated in a single county

plan, consistent with provisions (b) through (f), and with Section 5848 (a) through (d), which spell out duties of the DMH. Duties include responsibility to establish requirements for integrated county plans. Provisions also indicate role of OAC, and guidelines and procedures to be followed in the development of integrated county plans. (Attachment #1.)

TWO. Proponent's January 2005 Publication Illustrates Anticipated Timeline

The California Council of Community Mental Health Agencies published its "Focal Point" Newsletter in January 2005, including graphic illustrations of Timeline and Planning Process for Prop 63 implementation. The association's President John Buck explains how "integrated services" will be funded as best practices, recognized by the New Freedom Commission on Mental Health at the White House.

CCCMHA consists of more than 70 community mental health agencies throughout California, according to this publication. The association was a primary proponent of Proposition 63, providing a significant portion of funding for the qualification and passage of the initiative, and enlisting volunteers throughout the State. The time and money invested by individuals and organizations throughout California anticipated the outcome explained and illustrated in this January 2005 publication by CCCMHA.

Prop 63 Proponents anticipate that DMH will promote Systems of Care educational material to guide counties and stakeholders. Further, Systems of Care guidelines will be finalized in April 2005. DMH implementation policies and practices **are entirely contrary to the timeline and plans published by CCCMHA, a chief proponent of the ballot initiative.** Proponents' positions in this publication dispute DMH claims that the fragmented, Two-Tier system complies with the law. The organization's publication supports my assertion that DMH actions are arbitrary and contrary to all expectations. (Attachment #17, graphics of timeline and planning process)

THREE. OSAE Audit Calls for "Corrective Actions" to Integrate Components.

Auditors identify a chief source of waste and delays in delivering services. A chief recommendation in May 2008: ***"Create and document a strategic development and implementation plan which includes clear guidance on component integration, performance measures, and program monitoring efforts. Ensure this plan is adhered to, communicated to affected entities, and made readily accessible on DMH's MHSA website."***

- **No public actions or documents issued by DMH indicate the intent to comply with this recommended corrective action.** There is no evidence of improvement in management or implementation strategies. Instead, it appears that DMH sought legislation in 2009; the language of AB XXX5 seeks to compensate for DMH mismanagement, stating that guidelines for Integrated Plans for Prevention, innovation, and Systems of Care shall not be issued until 2012—eight years after adoption by voters. ABXXX5 also ensures the institutionalization of a Two-Tier system; language for the bill was drafted and circulated by proponent Rusty Selix and supported by proponent Senator Darrell Steinberg.

DMH asserts in its six-page response to needed “Corrective Actions,” in November 2008, that a “Framework” for integrated plans is posted on website, and guidelines will be issued in July 2009. After failing to produce an integrated or comprehensive plan of any sort, DMH updates its report in September 2009, with the news that it is now prohibited from issuing integrated plans until 2012. Advocates question the legality of amendments to such provisions of a law enacted by ballot measure, but have not yet sought a legal opinion to my knowledge.

- **Amendments Cannot Rationalize Waste, Inefficiency, Mismanagement.** AB XXX5 may or may not have legalized DMH incompetence, but DMH policies remain in violation of good sense and the provisions of existing—and amended—law. DMH policies **funding a single portion of the law, implementing each component independent of the other, with all of the associated waste and unnecessary administration at state and county levels, remain grossly out of line** with both the policy and cost-effective benefits of the law supported by voters. DMH still lacks the competency to properly and efficiently implement the MHPA in a timely manner, and generate requirements for an Integrated Plan. OSAE properly identified management failures.

Why was it necessary to give the state eight years to implement expansion of model programs? What is the underlying purpose of changing the law?

FOUR: County Administrative Burden Costly, Unnecessary and Unproductive.

As a result of DMH incompetence or poor judgment:

- Every county is required to prepare six separate implementation plans for each component of the law;
- Every county must conduct six separate, independent public reviews and extended “stakeholder” meetings;
- Each of six plans in every county has a different set of instructions from DMH, and operates according to a different timetable;
- Each of the six plans has a separate budget, and each of the six plans is subjected to separate state and local approval, accounting, and reporting procedures.
- Each of the six plans in every county is funded independent of the other.

DMH claims in report to OSAE that it has complied with recommendation to integrate several provisions, but independent county committees and process are already established; it is too late to claim effective integration of this process.

As a result of DMH waste and mismanagement:

- Counties have wasted MHPA revenues on repetitive, expensive, and unnecessary bureaucratic reports;
- Unnecessary, repetitive procedures also waste revenue on state and county administrators, contractors, consultants, and excessive meetings and conferences;
- Accountability is greatly impeded as a result of the disjointed DMH process of implementation;

- Fragmented implementation delays funding of vital services, while billions of MHSAs revenues are held in capitol account.
- Counties are still planning in 2009. As a result of DMH failure to issue Integrated Plan Requirements, counties and stakeholders continue the planning, review, and approval process for five years—with no end in sight.
- A year and more of planning for each separate component. Every county generates unnecessary administrative costs for the entire process of approval, accounting, reporting, etc., for each of six components of the law—and most take about a year to launch one of six provisions of the law.

FIVE. Drafts Integrated Plans for Four Years—NO Final Product.

For more than four years, DMH issued timetables, circulated draft Integrated Plans, conducted meetings with counties, stakeholders and other implementation partners, and announced deadlines for implementation. **Five years after enactment**, DMH is apparently unable or unwilling to complete this vital process. (Attachments #18 of drafts circulated by DMH for years 2006—2008, which illustrate the lack of clarity and coherency offered to stakeholders and the public as working documents.) Integrated plans are on hold while DMH counts on AB XXX5 provisions to further delay action.

Implementation remains fragmented. Benefits are undermined because each provision of the law functions independent of the other. Collaboration and efficiencies, vital to effectiveness, are lost at state and county levels. For lack of an integrated plan, excessive and wasteful expenditures are for process instead of direct services to mental health clients. And the excess is completely unnecessary because the mental health “Systems of Care,” an integrated service plan, is already invented, approved by stakeholders, codified in California law, tested, and proven.

Sacramento County MHSAs meetings, in progress for five years, illustrate a thriving planning, consulting and meeting industry, consuming millions of MHSAs dollars. At the same time, Sacramento County is closing its mental health emergency facility, mental health services were discontinued for 4,500 mental health clients in July 2009, law enforcement personnel are delivering “5150” clients to unprepared private emergency rooms, and county personnel predict a rise in suicides, according to news reports. Sacramento County is typical of every other county in the State; waste, delays, and unnecessary administrative expense is replicated in every community.

While Sacramento County was slashing clinic budgets, and service centers were making massive personnel cutbacks, the county followed DMH requirements to spend \$3 million in MHSAs dollars on a year-long process of meetings, focus groups, et al, to study the nature of workforce shortages. The process adds insult to injury, illustrated by the attached announcement of wasted time and money, when consumers wait five months for a doctor visit, or are denied care altogether. (Attachment #19.)

SIX. DMH ignored Systems of Care provisions from the start of implementation.

While DMH has not produced a documented implementation plan, it has generated requirements and regulations with no context, no state guidelines, and no public

understanding of a beginning or end point. There is no record of DMH management policies or public documents that explain integrated Systems of Care in W&I codes. For instance, this information was not provided to stakeholders at initial meetings in 2005. At the first official public meeting of the Oversight and Accountability Commission meeting, DMH executive Carol Hood provided a briefing on MHSA to Commissioners, which did not reference any information about integrated services and the Systems of Care for children, adults, and older adults. (OAC July 2005 meeting Minutes)

The willful failure of the State to promulgate any information or guidelines to comply with the central provision of the law creates massive waste, and misleads counties and public constituencies. The DMH willful failure undermines the core values in the MHSA, while it creates widespread misunderstanding, misinterpretations, and inconsistent applications of the law.

ALLEGATION #3. DMH policies create opportunities for conflicts-of-interest and special interests at both state and local levels, and obstruct accountability. The process suggests there are unexplained motives for pursuing a persistently inefficient and ineffective course of action.

Who does it benefit, what is the payoff, what is the unstated objective?

A blatantly dysfunctional design diverts tax revenue for unproductive and questionable purposes, and creates bureaucratic obstacles to funding community mental health. MHSA monies sit in a capital Trust Fund, while community services deteriorate and people are denied treatment. In June 2007, I summarized my concerns about MHSA unethical practices and waste in correspondence with a Schwarzenegger Administration executive whose expertise is in health care management. (Attachment #20) The following includes excerpts from that letter:

“Every report from that of the World Health Organization to California’s Little Hoover Commission points to ‘fragmentation’ as the central problem in mental health access, quality, and delivery. California is reinforcing this longstanding weakness of the system. Overall, problems arise from:

- *No strategic plan that would protect against special interest invasion, bureaucratic overload, corruption of purpose and expenditures;*
- *Failure to assert Standards and Best Practices, which could expedite service delivery and cost-effectiveness, and impose ethical guidelines for expending millions of dollars in contracts; and*
- *Unexplained policies that lead to two-tier system and increased paperwork burden, as well as conflict-of-interest, undue influence of politically connected, and questionable contracts.”*

EVIDENCE

ONE: DMH Implementation Structure and Process Invites Conflicts-of-Interest and Special Interest Influence.

In a public mental health system unable to adequately serve its consumers, virtually any added service can meet the test of need when there is no defined context. Absent an MHSA implementation plan, the door is open to private deal-making. There are no parameters to prohibit distortion of the law and diversion of funds. Programs may proceed without a rationale for decisions or any basis in “best practices.”

MHSA Funding decisions and program preferences by state and local leaders:

- Do not flow from public knowledge of system conditions, or strengths and weaknesses;
- Are not always informed by useful policy research, though abundantly available from respected and accepted sources;
- Are not confined by an overall sequential, standardized strategy, which defines progress; and

- Are not required to meet a test of efficacy or relevancy, in terms of demonstrating how a chosen program contributes to fulfilling an end goal—a finished product—a defined successful service system.

The entire policymaking process operates without a defined context.

The Steps to a Process and Structure Inviting Diversion of Funds and Purpose.

The conditions cited above are a result of DMH policies. This complaint questions the professional judgment, ethical sense, and competence of policymakers in charge of implementing this law. Why did the State take these steps?

First, DMH rejected the codified Systems of Care specified by Prop 63, and created its own design of unknown origin. (There is no evidence to support DMH claims that “stakeholders” preferred this new design.) Systems of Care, Adults and Older Adults, W&I Code Sections 5801-5802, declare the benefits to client, family, and community, and list 11 specific points of the system’s underlying philosophy. Further, these sections explain the need for comprehensive and coordinated systems of care, and cite the guidelines and principles developed under demonstration projects beginning with 1989 Bronzan-McCorquodale legislation. Sections 5806-5807 include a very specific and lengthy explanation of “**service standards.**” 5600.1 through 5600.7 further elaborate on treatment options and “client-centered, culturally competent, and fully accountable” systems of care for adults, older adults, and Systems of Care for Children and Youth; these codes describe target populations, and list the “minimum array of services” which should be available to each age group in this population. (Attachment #5)

- **In sum, the work of defining a functioning, desirable system was completed, but underfunded.** Components of the Systems of Care had been developed over a period of many years, with extensive stakeholder participation at every point and reflect all of the values of the Mental Health Planning Council Master Plan (Attachment #5), likewise reviewed and approved by diverse stakeholders in 2003. The work of 2005 might have refined and complemented the work that came before.
- **According to the provisions of Prop 63, the MHSA stakeholder process** required an informed community and county leaders to determine priorities and steps necessary to measure up to “service standards” in Systems of Care, and update those standards as deemed necessary.
- **The MHSA stakeholder process did not require five years of planning,** continuing today without end in sight, millions in tax revenue wasted on six separate, continuing committees in each county, consultants, events, reports, etc., etc., millions in unproductive planning which could fund direct services.

Second, DMH launched a new, disjointed system with extensive Requirements, NO service standards, and “Blank Slate” community planning.

It is necessary to understand the complete coverage of “Systems of Care” (briefly outlined above) to understand the complete lack of necessity for DMH actions creating new programs.

DMH did not brief state and local implementation partners, communities, and press on the established Systems of Care model, and promulgated inaccurate interpretations and information about the provisions and intent of the MHSA law.

DMH decided to implement one provision of the law at a time, and to invest a significant majority of MHSA revenue in a new, Two-Tier mental health system.

I have asked questions in correspondence to DMH and OAC principals and stakeholder organizations, and directly questioned principals in public and private meetings. What is the purpose of the “Blank Slate” planning process, in which stakeholders are not briefed on the law, nor informed of any parameters in planning? What is the explanation for the dual system and transparently wasteful decisions?

Noted earlier, DMH Director Mayberg explained that an abstract “we” decided who would receive preferential service, and OAC Chair Linford Gayle explained that the OAC shared my concern about the dual system, and will be addressing this problem, but Commissioners have not expressed further interest. No one has answered the substantive questions I posed over a period of several years. No one has explained the benefits, revealed the objectives, or demonstrated that policies are founded upon any known model of effectiveness. Aside from Dr. Mayberg’s assertions, no one has answered my question: ***“Who supports this policy and what is the unstated rationale for excluding underserved and inappropriately served consumers..?”*** (Attachment # 11)

There is simply no reasonable explanation for failure to comply with the law, as understood by the authors (including myself), and as it was analyzed by the State’s Legislative Analyst in November 2004. The arbitrary, inexplicable, inefficient, noncompliant, and grossly wasteful policy contrived by the State DMH is not based upon public demand or expectations, and is not responsive to any kind of public or private study. DMH stakeholder meeting records, posted on the Prop 63 website, as well as the OSAE auditors, dispute Dr. Mayberg’s assertion that this policy was a result of stakeholder conferences.

Finally, DMH implemented the law without a public implementation plan. There is no confining structure or guideline, incorporating all provisions of the Act. An implementation plan would likely require DMH to conduct needed research and synthesis of available data, would provide a frame of reference to inform the Administration, the Department, and the public of progress toward goals. An objective standard would measure compliance. None of these elements are present in the structure and process created by DMH.

Absent an implementation plan:

- **Waste and inefficiency flows from ad-hoc planning and policymaking at state and local levels;**
- DMH and OAC are not restrained by the need to demonstrate that policies contribute to a known, declared end result;

- Decision-makers may negotiate programs and policies favoring special interests that are familiar, politically influential, or affirm their personal experience.

Whether by design or gross incompetence, the structure facilitates special interest access and potential conflicts-of-interest. Individuals from numerous counties have affirmed similar problems at the local level, and I will invite their direct testimony to be forwarded to the California State Auditor in relation to this allegation.

The Results of DMH Implementation Steps. I believe an objective analysis would lead the public to question the objectives of the state DMH, inasmuch as implementation policies do not comply with the law, deviations are not justified by any body of compelling evidence or public declarations, and the arbitrary decisions of the state DMH and Director Mayberg have substantially impaired the intended enhancement of community mental health services. For all of the reasons noted above, it appears that creation of a Two-Tier system and other DMH practices have motives unrelated to successful implementation, motives which may be known to some witnesses but have never been publicly revealed. The suspect policies warrant investigation in a State Audit.

TWO: Examples of Questionable DMH and OAC Practices and Policies and Funding Decisions.

- **Context, baseline, and concrete objectives** are not available to policymakers in other state agencies or in local entities. Because there is no expressed starting point or finish line, decisions about implementation, regulation, and evaluation of county plans are made in an information vacuum. DMH and OAC lack knowledge of existing systems. No government entity has described what factors are present in a successful, final product.
- **Vision and Principles** substitute for actual, functioning standards. Operating with vague vision statements and principles, DMH and OAC leaders may favor policies or programs of their own choosing, and they offer the same opportunity to local entrepreneurs. The record of DMH/OAC can appear to foster the appearance of conflicts-of-interest and undue influence of special interests because the Department and the Commission set funding priorities, contract with selected organizations, and approve programs unrestrained by a documented, and widely understood context.

Limits are so ill-defined or undefined that arbitrary decisions at the state and local levels cannot be challenged. Special interests with established resources have a competitive advantage, and may advance any objectives where they can demonstrate a track record. Stakeholders complain that every “bright idea” is on the table, and lack of guidance wastes time and money.

I described this waste in a presentation at the invitation of the California Mental Health Planning Council. Part of my presentation addresses the failure to provide context to stakeholders, and the resulting waste of their time and money. Absent defined purpose, stakeholder efforts make little contribution to the process, and

some complain they have been exploited for mere theatre. (Attachment #21 NAMI Survey)

The lack of clarity in guidelines was discussed in a 2006 meeting I attended as consultant to the AG, which was conducted by OAC Executive Director Jennifer Clancy and a policy/mediation consultant under contract to the Commission. We met to discuss development of guidelines for the “Innovation” component of the MHSA. The consultant, who had also advised OAC on other matters, characterized the “Prevention” component parameters as “large enough to drive a truck through,” indicating that virtually any favored project could qualify as a “Prevention/Early Intervention” program.

I learned from the discussion that this was both intentional and a result of the wide range of special interests that weighed in on setting priorities. DMH and PAC failed to provide guidelines and parameters for volunteers who may have been placed in awkward situations. While the report delivered substantive scholarship and guidance, the final broad parameters could be interpreted to serve many interests. The OAC report states that language of “PEI policies is intentionally broad” and explains “15 Areas of Policy Direction for County Plans.”

Waste of time and money in Prevention and Early Intervention programs is so extensive it warrants a separate complaint. I summarize here a few results of operating without defined parameters, and the possibility of waste. Confusion is now generated by the ABXXX5 law, as well as DMH declarations confounding OAC Commissioners and counties that have already proposed their own prevention plans, following earlier requirements.

1. The OAC and Executive Director Clancy conducted a costly, three-day “In-Service” educational forum on prevention and early intervention programs in 2006 at a Burlingame hotel. The OAC and MHSA budgets subsidized many participants, and hosted expert presenters on “best practices” from around the country. The sessions were very informative but completely irrelevant to the final approved Prevention/Early Intervention statement issued by the OAC.
2. Today, in November 2009, counties continue to conduct stakeholder meetings, review options, and prepare Prevention/Early Intervention plans, based upon a complicated division of spending authority between state and counties. Counties are now contemplating preferences for state programs on three priorities. DMH fiscal reports indicate that allocations have been approved for numerous county prevention plans; each county conducted, and continues to conduct, a “reinvent the wheel” process to determine appropriate prevention measures. The state DMH did provide counties with a commendable, lengthy list of recommended “best practice” programs for consideration—within parameters of the broad-based OAC “drive a truck through it” guidelines, “15 Areas of Policy Direction for County Plans” and “Five Key Community Mental Health Needs.”
3. The OAC “Prevention/Early Intervention Policy Direction” plan was adopted by the Commission in 2007, and developed with consultation services from the

Director of the UC Davis (UCD) Center for Reducing Health Disparities, employed under contract by DMH/OAC. Ultimately, “Disparities in Access to Mental Health Services” was determined to be the first of “Five Key Community Mental Health Needs” in the OAC document guiding county plans. The UCD Director was also the National Chairman of the Board of Directors of the Mental Health Association of America. Associated with this document, I asked if DMH considered the contract with UCD a conflict-of-interest, given that local and state Mental Health Associations and UCD were recipients of state grants, and given that the particular priorities of UCD and MHA were reflected in the OAC funding priorities. In a meeting with DMH executive Carol Hood and OAC Acting Executive Director Sheri Whitt, Ms Hood answered “No,” she did not believe there was a conflict-of-interest. From the public and my perspective, there is a potential for conflicts-of-interest, primarily because DMH does not provide a context for such decisions.

4. DMH support for UCD and the Center for Reducing Health Disparities continues. A “**California Reducing Disparities Project**” is now a component of the DMH statewide MHSA Prevention plan; RFP’s issued in 2009. DMH via MHSA sponsorship, collaborated with UCD Health System, to convene a two-day conference on Mental Health Disparities at the Sacramento Convention Center in May 2009.

5. “Reducing Disparities” is now “*an overarching goal of the MHSA*” according to the Prevention and Early Intervention Component Guidelines (revised 8/08) issued by DMH, although the term is not found in the language of the MHSA. A lengthy “*Findings and Declarations*” Section 2. introduces the need for the Mental Health Services Act and does not reference “disparities.” Further, the “*Purpose and Intent*” Section 3. does not reference disparities. Assuredly, throughout the Act, and in the pre-existing Systems of Care code sections, the need to further develop and invest in culturally and linguistically competent approaches is recognized. In the Innovation Component of the MHSA, “*increasing access to underserved groups*” is an emphasis, which recognizes the shortage of culturally competent personnel and services, but not disparities.

6. The 2009 MHSA Implementation Study cited above (Attachment #15) asserts that “*reduction in ethnic disparities is one of the primary goals of the MHSA.*” This manufactured assertion is a new addition to primary goals, and, again, not found in any material related to “Findings and Declaration” or “Purpose and Intent” in the law. This emphasis is also curiously asserted despite a report by the Rand Corporation on Health in the New England Journal of Medicine, which found that the quality of health care in the U.S. is uniformly inadequate, and, contrary to popular opinion, residents of all races and ages, insured and uninsured, are equally likely to receive inappropriate or inadequate medical treatment. As to California mental health system data, counties report that virtually everyone in the system is poorly treated, regardless of age, ethnicity, or culture. There is abundant documentation that inadequate human resources is the central problem in providing culturally and linguistically competent services—there may be no documented need to spend more fiscal resources studying the problem. There is a documented urgent need to recruit, train, and employ people to correct the

inadequacies.

7. CIMH continues to conduct MHSA seminars and training conferences on the various aspects of Prevention/Early Intervention for the various stakeholders and counties that might participate in development of a program for one of the 15 Areas of Policy Direction for County Plans, among the “Five Key Community Mental Health Needs.”

8. The 2009 legislation altering the ballot proposition delays state guidelines for integrated Prevention programs until 2012.

There is not evidence or documentation of waste in all of the above instances. They are questionable because there is no declared purpose for the investment of MHSA dollars, within a known context. The “Disparities” investments are an example of a DMH priority that can appear to be a personal preference of Director Mayberg or others making program decisions, because there is no statement of how this priority contributes to progress of the overall design. Operating without a context, this funding decision is not required to demonstrate its relevance to success.

- **No knowledge of existing county systems.** In countless meetings in 2005 and 2006, as a consultant to OAC Commissioner and then-Attorney General Lockyer, I met with DMH executives and data management personnel. Commissioners and OAC and AG staff attended some of these meetings. We experienced a great deal of resistance from DMH to requests for developing county-by-county baselines, to providing a profile of known information for each county, and to summarizing sources of known data tracked by DMH. I prepared correspondence from the OAC, and proposed a method of reviewing research. (OAC Agenda 9/06 and 11/06) Memorandum I prepared in consultation with Commissioners described the importance of acquiring county baselines.

Carol Hood at DMH agreed to pursue development of material on three specific OAC requests. OAC Commissioners and stakeholders were informed at a public meeting of the agreement we had reached with DMH, but no data reports were ever produced. (See Attachment 28.) In my experience, DMH actions block access to knowledge of the demographics and conditions described in the 50+ county plans, submitted in response to DMH funding Requirements. All OAC attempts to pursue another research project to acquire more baseline information were met with resistance from DMH personnel. I do not know the Department’s purpose in compiling this county data, but it is not intended to inform decision-makers, the press, or public. OAC no longer demonstrates any interest in the information.

- **Demographics and Data Are Ignored.** DMH and OAC operate from ignorance of county systems and current conditions. The data in county plans (300 to 1,000 pages of data requested by DMH) is not synthesized or utilized. Even if processed, the data would not provide a complete baseline, but the wealth of demographics available could better inform state actions. Absent this foundation, DMH and OAC projects are funded independent of knowledge of county

demographics. All specialties or personal preferences of management or officials may be considered for funding. Special Interests or Conflicts-of-Interest are not restrained by a broad understanding of community needs.

- **Housing.** Millions in MHSA revenue are contributed to the Governor's Homeless Initiative and at least \$400,000 is now diverted to a housing construction program. I believe a thorough audit should seek opinions on the legality of these expenditures. Related documents propose that in the future the MHSA Trust Fund will transfer \$75 million a year to this housing construction program. AG opinions cited earlier, and attached to this complaint, affirm the restriction that revenue should be directed to expansion of county mental health services. While counties may approve housing subsidies as part of a comprehensive mental health service program, there does not appear to be any authority for the state to directly transfer funds to homeless or housing construction programs.
- **Anti-Stigma Campaign.** Anti-Stigma campaign documents, meetings, options, and recommendations are as dense and prolific and complicated as those for primary Prevention/Early Intervention. Anti-stigma efforts are a part of the Prevention plan at the state and county levels, many experts have contributed to guidelines, and I trust that some wise decisions are included in some investments. It is difficult to reach any conclusion in this regard. DMH and OAC have not sought to employ the experience of other state agencies that have conducted effective educational and public service campaigns.

In March 2007, I expressed my concerns in correspondence to Prop 63 proponents Senator Darrell Steinberg, then serving as an OAC Commissioner and Chair, and Rusty Selix, advocate for mental health coalitions, community providers, and state and local mental health associations. I communicated my concerns that professionals in marketing, communications, opinion research, etc., were not among those making recommendations. My points in the letter included:

- “(1.) most important, there is no indication that principals are seeking to coordinate with, learn from, or contact public and private organizations already conducting anti-stigma advertising and testing messages in at least eight other states, based upon extensive research, including SAMHSA-funded, professional campaigns.*
- (2.) skills in marketing, influencing opinion, changing behavior, etc., etc., etc., are absent from the team of people crafting the plans (advertising professionals are the first stop, not the follow-up).*
- (3.) evidence and experience demonstrate that a pre-ordained objective of targeting messages led by the Center for Reducing Health Disparities, absent an overarching message and context, is strategically and fatally flawed and will prove to be a waste of money.*

- *NAMI national, the National Mental Health Association, the Ad Council, SAMHSA's Resource Center to Address Discrimination and Stigma (ADS) et al have compiled research and packaged anti-stigma campaigns. The OAC hosted*

Bill Lichtenstein from Boston; experts and advertising expertise are clearly available. Failure to utilize these resources seriously questions the Commission's credibility and motives. Get the information and a presentation from those who know how to spend the money."

- **Education Initiative.** The Education Initiative, like stigma efforts, was developed as part of the Prevention/Early Intervention component of the MHSA. The author/s of the first proposal approved by the Commission is unknown; it was presented to the OAC by Executive Director Jennifer Clancy in June 2007. It is similar to the anti-stigma campaign recommendations in that the plan does not rely upon or cite appropriate sources that might guarantee effectiveness—the proposal does not explain how services produce the results sought by the OAC or their experts. The proposal, which includes grant programs, is not grounded in evidence that the expenditures would produce results—or that decisions are responsive to experienced sources of sound knowledge—or that priorities are based upon public demand or maximum return for a maximum number of people.

The Education Initiative is an example of policymaking absent a known context, and absent a defined requirement to demonstrate how investments contribute to overall success. After its initial adoption by the OAC, the Commission sought stakeholder input and produced a revised plan in September 2007. DMH website announces that funding of the initiative is on hold.

THREE: DMH and OAC policies have no cited foundation in research, law, or evidence-based reports of this decade, but are designed to facilitate Two-Tier System.

DMH and OAC policies on the various components of the MHSA do not reference California leadership reports such as the California Mental Health Planning Council Master Plan, the Report of the Joint Legislative Committee on Mental Health Reform, or the two Little Hoover Commission investigative studies on California mental health systems. The Target and Priority Populations devised by DMH exclude clients poorly served today; counties are required to spend money on “outreach” to find new clients for new programs, when clinic waiting rooms are filled with underserved clients. There is no public explanation for defining “target/priority populations” in a manner that sets up a parallel mental health system for new clients.

- **Appearance of special interest or political influence is illustrated by the ill-conceived “Two-Tier” policy, creating a parallel, dual system.** Given the absolute lack of justification from any source—and the continuing, widely-reported complaints from stakeholders—this DMH policy raises many questions, suspicions, and speculative theories about motives. Is there a private motive for the appalling magnitude of the wasted revenue, delays, unnecessary state and local bureaucracies, and general display of incompetence. For instance, this “Two-Tier” policy may be intended to meet objectives of some Prop 63 supporters who favored language that gave preference to individuals who have a mental illness and are homeless. DMH strategy may be obscure in the manner of

implementation, but its policies are meeting this objective. I do not have the information to determine whether there is some massive incompetence or coordinated deception in the state actions.

DMH official “Requirements” and “Regulations” cited in my memorandum instruct counties to give preference to “unserved” individuals, providing a back-door to preference for those who are homeless. The term “unserved” is not in the code sections identifying the MHSA target population. Yet, DMH and Director Mayberg have inserted the term in reference to the code sections and directions to counties. It is possible that this objective is the underlying motive for leading counties and stakeholders to believe that MHSA money must be spent on new programs for new clients (requiring the tremendous waste of time and money and neglect of underserved clients now in the system).

I suggest this possibility because the issue of “target populations” and preference to homeless individuals was a subject of extended discussion by a Prop 63 drafting committee representing many mental health advocates and interests. Proponent Rusty Selix and some other drafting committee members supported a draft giving first preference for service to homeless individuals. I opposed the drafted language because it lacked clarity, believed it could be widely misinterpreted, and that housing status was an unnecessary and unworkable qualification for MHSA services.

I suggested a target population already defined in W&I codes, developed in association with Systems of Care, which does not rely upon housing status as an adequate measure of urgent need for mental health services. I also explained to the drafting committee that NAMI California would not support that language. Selix and others agreed that the existing, narrow definition in the codes met their objective of cost control. Today, however, DMH and Director Mayberg foster funding requirements that give preference to homeless individuals, effectively modifying the law to accommodate motives unknown to the public.

- **Standards and Best Practices** are not established and promulgated by the State. While DMH invested extensive MHSA revenue in training programs operated by California Institute of Mental Health, it has not promulgated standardized, uniform definitions of terms and principles. Counties, providers, and stakeholders may or may not participate in CIMH training, and the fee schedule may exclude prospective participants. DMH issued a catalogue of training sessions, but attendance is optional. Thus, uniform standards are not promulgated.

While DMH implementation policies generate excessive bureaucratic reporting and forms, the Standards are fluid and entrepreneurial. Various public and private entities define terms such as “recovery model,” and many “non-profit” businesses contracting with the State define their own notions of proper service delivery; counties also are free to invent or contract for their ideas of “recovery.” The material is at hand, but the State of California does not adequately direct the terms

of spending millions of dollars on everything from training to advertising for anti-stigma campaigns.

- **Contract Services.** DMH and OAC have relied heavily upon private contracts to manage implementation of MHSA. Today, information regarding the purpose and benefits of such contracts is illusive and virtually inaccessible to private citizens, particularly so for the OAC. Initially, DMH offered explanations in reports to the Legislature regarding contracts with California Institute for Mental Health for a wide range of training programs, which has continued through these five years of implementation; DMH further explained the purpose of initial contracts with advocacy organizations and agencies with statewide constituencies. This transparency was commendable and beneficial to public interests.
- **State Contracts.** Today, the purpose of state contracts is not public information. DMH implementation requirements, inappropriate policies, and bureaucratic structures benefit private consultants, event planners, and independent contractors. At the state level, DMH spent more than half of its MHSA administrative budget on private contracts in the first years of implementation. The May 2006 DMH accounting to the Legislature reports an augmentation since January of that year, due to an additional \$1.2 million in DMH staff costs and \$10.8 million for additional contracts. The May 2007 Revision lists \$7.6 million for private MHSA contracts.

What Is the Return on State Expenditures? In fiscal years 2008-09 and 2009-10, reports to the Legislature list approximately \$35 million for DMH administrative costs and more than \$4 million for the OAC administrative costs. The report no longer appears to advise legislators of how much of the budget is allocated for private contracts. MHSA also funds activities reported by DMH in 14 other state departments and branches of government. Total administrative costs projected were \$45.5 and \$48.2 million respectively. The return on the investment of these funds may well be found on the DMH website. However, a review of the site and its associated links would lead any private citizen to understand that a coordinated team of auditors and attorneys is necessary to determine the utility and use of these funds. Transparency is not there.

County Expenditures? The same density of information—and lack of transparency—can be found on county MHSA websites. When searching the Sacramento County Behavioral Health Department for MHSA information, a county link led me to 1,046 items listed by Google and posted by Sacramento County MHSA administration. The Contra Costa County MHSA Family Steering Committee reported to its County Mental Health Commission and Supervisors in February 2009 that the committee is still seeking an answer to the question: *“How much has actually been spent on programs and services to date? This is information that we asked for a year ago and have never received in a format that is understandable.”*

FOUR: DMH, OAC, and Counties do not provide proper ethical guidelines, format, or tools for effective stakeholder contributions.

Role of Providers, Grantees. The state DMH routinely contracts with organizations it identifies as “stakeholders,” the legitimate representatives of service providers, mental health clients, family members, and professional associations, among others. The leadership of these organizations also may be in a position to make an important and legitimate contribution to the implementation process. These special interests/stakeholders, however, also have a clear “stake” in DMH decisions. Their organizations may be dependent upon government grants and contracts to maintain an affiliated non-profit program. Their organization is probably invested in a particular philosophical and/or practical approach to providing mental health services. Their contribution as “stakeholders” is unquestionably influenced by the aims of their organizations.

At the same time, on the state and local level, the direct service providers and professionals have an essential role in setting priorities and developing policies. The individuals on the front lines of mental health services, both those administering programs and those making client contacts, are a primary source of accurate insights on the system and its challenges. The consumers on the receiving end of services, their family support systems, and their organized advocates, likewise, have unique knowledge of system functions and unique perspective to contribute to wise decisions.

The state DMH, in cooperation with counties, should offer ground rules and model partnership agreements to take advantage of stakeholder expertise, while ensuring outcomes aim to maximize effective investments, and sound priorities are based upon known factors such as local conditions. Sacramento County provides an example of a process in need of improvement in this regard. According to the county data submitted in response to DMH Community Support and Service (CSS) Requirements, less than four percent of youth were “fully served.” Yet, the county plan did not include a proposed program for Transition Age Youth. When questioned at the DMH Review meeting, the Mental Health Director stated that a youth program was not included because a voting committee of stakeholders decided it was not a priority. The members of the committee casting votes included program managers and others with county contracts or a “stake” in the funding priorities.

The state fostered an open-ended, fluid process of enlisting stakeholder contributions. The state started by ignoring the known parameters of Systems of Care. State and county policies—and lack of them—may place some stakeholders in a compromised or awkward position. Providers do not have to seek an influential position in setting priorities—the state or local process can recruit them for this role, but does not protect their interests.

Conditions and Operating Procedures for Community Input. Stakeholders have complained from the start that meetings to consider MHSA spending or program priorities are dominated by organizations with an agenda. Almost universally, “stakeholder” meetings are held Monday thru Friday, 9:00 to 5:00; as a result, the

majority of attendees are often people paid to be there to look out for employer interests, or seek pre-ordained objectives. The time and place of meetings does not always invite a diverse audience.

In many counties, stakeholders are not properly briefed on objectives, and the state does not provide informative material to guide discussion or consideration of options. Of great importance in the beginning of the stakeholder process, the state DMH did not explain the parameters of Systems of Care. The state and counties did not explain that MHSA funds certain services—every bright idea is not on the table. This initial failure is the source of community complaints.

I was informed at a National Alliance for Mental Illness meeting in Contra Costa County that a consultant to the county Mental Health Commission was paid \$300 an hour for MHSA consulting services to the County Commission. Volunteer Steering Committee members, Commissioners, and NAMI members also stated at a NAMI Contra Costa meeting that special interests dominate the “stakeholder” groups, which influence the use of MHSA funds.

CONCLUSION:

The state did not comply with a requirement to fund model Systems of Care to provide better services to more people. The state did not manage a coordinated implementation, but created a disorganized, fragmented, and wasteful process requiring counties to submit six different plans. The state ignored guidelines—and operated with no known structure, and no definition of the starting point, progress, or success. Entrepreneurial ideas were invited without established objectives. Some individuals were placed in a compromised position by the state’s failure to guide policymaking and provide a context for setting program and funding priorities.

The waste of time and money continues as counties cannot even hire sufficient physicians or maintain crisis clinics. Counties make massive budget cuts, resulting in staff layoffs at every level and reduced services for all clients. Plans to accommodate the fiscal crisis open another entire area of poor planning and policies. The Upper Tier “Cadillac” programs funded by MHSA are not constrained by evidence-based practices, or specific service standards such as those codified in Systems of Care. There is no guarantee of proper service for individuals in these programs—and now the state and counties discuss methods of expanding these “comprehensive” programs to serve more people with the same amount of money. There is no measure of the possible outcome.

Thank you for your consideration. I will continue to seek and forward any other evidence to support my allegations.