

THE MENTAL HEALTH SERVICES ACT: AN IMPORTANT STEP TOWARDS TRANSFORMATION



Proposition 63 presents a once-in-a-lifetime opportunity to transform our mental health system...California can lead the way by developing a system that keeps individuals in their communities with treatment and supports from a variety of sources, rather than in institutions or on the street. A satisfying quality of life in the community is possible with integration, proven programs...and most of all, better and earlier access.

Dr. Stephen Mayberg, 2004

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In 2000, the California Healthcare Foundation sponsored a **report** on the state's behavioral healthcare system. The authors did not mince words in their assessment. "Many of the services for treatment both of substance abuse and mental health...are still fragmented, lack appropriate resources, are often out-of-date...(and) lack sufficient effective quality controls," they wrote. Consequently, the services offered to Californians with mental health and substance abuse problems were "not as effective...as they could otherwise be," and major changes were in order.

Four years later, voters in California took a major step towards fixing the problems of fragmentation and **under-funding** when they approved Proposition 63, the Mental Health Services Act (MHSA). The key features of the MHSA included the creation of a devoted pool of money for mental health services funded by a tax on the extremely wealthy, the expansion of services for the most chronically and severely mentally ill, an increased emphasis on consumer-driven services, and the reorientation of the state's mental health system towards the **recovery model**. Through new programs and funding designed to fill in gaps in the existing mental health system, the MHSA held the promise not only of improving the way California provided services to its mentally ill population, but also of transforming it.

The Need for Something New

For decades leading up to the passage of the MHSA, policymakers, clinicians, family members and consumers had been pushing for major reforms to California's mental health system. And with good reason. Dating back to the 1960s, when California released thousands of severely mentally ill from state hospitals, **the state had failed to follow through on its promise** to provide adequate and comprehensive services in the community. While **legislation in the 1950s** had created mechanisms to fund community-based services for the mentally ill, Governor Ronald Reagan vetoed provisions that would have utilized savings from state hospital discharges to enhance community mental health programs. In the 1970s and 1980s, lack of resources continued to plague the system, and though a major overhaul to the way county mental health services were funded in the early 1990s helped, it still **failed to adequately address the problem**.



Poor financing, not surprisingly, led to poor services. Many who were most in need of mental health services were simply warehoused in inexpensive board and care facilities, and a good number received little more than basic food, clothing, shelter, and medication. Outreach was particularly lacking, and many who would have benefited from mental health services probably did not even know where to go. As J.R. Elpers, the Director of the Los Angeles County Department of Mental Health (1978-1982) recalls, the outpatient system in the 1970s was not very involved in providing services for those who could have used them the most. “The whole idea (with anybody with a serious mental illness,” he says, “was to put them in a hospital someplace... All they [outpatient clinics] did was evaluate the seriously ill, give them a diagnosis, and send them off to the hospital.”



Thus the seriously mentally ill were in a serious bind. There was little room for them in the inpatient system thanks to dramatic cuts to state hospitals, and the outpatient system was either unable or unwilling to provide the services they needed. Consequently, a large number of Californians with severe mental illness were unable to get help in the 1970s, and many wound up incarcerated or homeless. Beyond the lack of outpatient services for the most seriously ill, the state’s mental health system was in a **general state of crisis**, with treatment facilities becoming overcrowded, state hospitals being decertified, and a dearth of services being offered to children, the elderly, and minorities. By the mid-1980s, California had dropped to 42nd nationally in a survey of state mental health programs.

In Los Angeles County, the situation was particularly dire. In 1991, some within the county’s Department of Mental Health had diagnosed an endemic and “pernicious cycle” of indifference to the plight of the community’s most mentally ill citizens. “The lack of resources allowed existing programs to pick, choose, and skim off the easier-to-treat patients,” **lamented two concerned members of the Department’s administration.** “This, coupled with an incessant round of budget cuts wherein the more expensive services were cut, produced a further loss of treatment for the severely ill.” The end result, they warned, was “the near demise of the public mental health system in Los Angeles” altogether.

Clearly, a change was needed. Administrators and providers were frustrated with the lack of resources they needed to do their job well, while consumers and family members grew justifiably eager to change a system that was supposed to help them, but rarely did. Taking matters into their own hands, the mental health community began organizing and working on plans to fix the system.



The 1980s and 1990s: An Era of Experimentation

Our challenge is to infuse our public service systems with the sense of duty and responsibility—out of love—that we have for our own children. Anything less will fail...But the system we have created is badly flawed. It is not driven by love to be swiftly responsive to the changing and long-term needs of the client and the family. It is driven by bureaucratic and economic considerations to be fragmented, unresponsive, and wasteful...We must create a system, driven by love, that will serve the whole person and the family.

California Lieutenant Governor Leo McCarthy, 1987

In 1979, State Assemblyman Thomas H. Bates appointed a coalition of stakeholders, led by representatives from the Mental Health Association (now Mental Health America) to draft a new design for California's mental health system. The document that emerged from the group's work— ***The Model for California Community Mental Health Programs*** (also known simply as *The California Model*)— emphasized the importance of quality care, community participation, attention to the special needs of rural and minority populations, and adequate resources. In particular, the California Model highlighted that a complete mental health system had to include more than just hospital beds on inpatient units and medication support in outpatient clinics. A whole menu of options, ranging from acute, emergency, and out-of-home placement programs to day treatment, outpatient, case management, community support, and outreach services was necessary if the mental health system was to serve all consumers, at different stages of recovery, adequately and appropriately. The creation of such a system would be not only challenging, but also expensive. Based on Fiscal Year 1979-1980 budget numbers, California would have needed to increase its mental health expenditures by nearly 87% in order to meet the minimum standards suggested in the report.



While some were working to create a more well-rounded and complete system for all who needed mental health services, others focused their efforts on the population that was the most neglected at the time—the chronically and severely mentally ill who needed intensive services, but did not seem to benefit from institutionalization. What could be done to help these individuals not just survive – but actually thrive – in the community? In 1986, California Lieutenant Governor Leo McCarthy appointed a Task Force to explore the options. In the **preliminary report it issued in June of 1987**, the Task Force had already come to some striking conclusions. First, it found that money alone would not solve the problem. “Whatever the level of funding,” the Task Force charged, “the dollars seem to support the ‘system’ instead of the people in need.”



Though increased funding may have helped improve mental health services, it would not have necessarily made them more effective. The existing mental health infrastructure failed consumers, the Task Force found, because it was “a poorly designed system that offers only fragments of service to people who require continuing and comprehensive attention.” Social service programs and bureaucracies were not user-friendly, and many severely mentally ill individuals had difficulty jumping the administrative hurdles that lay between them and access to quality services. Furthermore, since no one agency was responsible for assuring individuals’ quality of life improved, it was easy for the task of guaranteeing consumers’ well-being to become lost in the bureaucratic shuffle; since nobody was “in charge” of helping consumers improve their lives, nobody produced results.

To address these problems, the Task Force envisioned a new way of delivering services for people with serious, long-term mental disabilities. Both philosophically and structurally, it wanted to create a system that worked not just to provide symptom relief for the mentally ill, but to help them lead better lives. Calling for a system that could give consumers “a life of good quality,” the Task Force advocated for interventions that would help the mentally ill get decent housing, adequate income, a level of work that they themselves deemed appropriate, education, friendships, good physical health, freedom, independence, and responsibility. This was a tall order, and one that went well above and beyond the narrow range of medically-oriented services offered in most of California’s public mental health clinics at the time. Though revolutionary, and perhaps daunting for some, the idea was actually quite straightforward. “It sounds almost too simple,” **recalls Ed Nathan**, a social worker who served on the Task Force, “but (we) believed that placing a high value on caring and respect would help restore the dignity that so many clients in the mental health system had felt they had lost.”



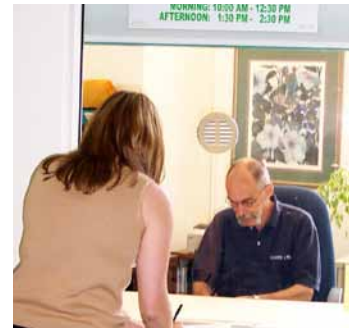
To empower consumers, the Task Force wanted to provide them with a different kind of service—one that was much more personal, and personalized—than what they knew before. The group called for service agencies to act as “single points of entry” that would provide consumers with the 24/7 access, personal services, and assistance with housing, employment, recreation, education, health, and socialization if they wanted it. Such services, modeled loosely on **Assertive Community Treatment** programs, would require very small caseloads, which were a rarity in California’s overburdened mental health system.

To ensure results, the Task Force also wanted the new service to be capitated—with agencies being prepaid to provide for a consumer for a fixed period of time for a set amount of money, and being responsible for all services provided. This scheme promised to bring a level of accountability to the service delivery system: if consumers improved, they would utilize less costly services, and the providing agency would thrive; if, on the other hand, the agency provided low-quality services, consumers would need to use more costly services (such as the hospital), at direct cost to the agency. Thus the success of the consumer and the fate of the provider were to be intimately linked, as providers were now to be fiscally accountable for how they utilized funds and the outcomes they were able to achieve.

In 1988, California lawmakers decided to test these ideas, and approved **Assembly Bill 3777 (AB 3777)**—the Wright, Bronzan, and McCorquodale Act—which authorized the creation of pilot projects following the “integrated service” philosophy that the Task Force recommended. Statewide, three contracts were awarded, **including one for The Village**, a Long Beach program that was to be run by the Mental Health Association of Los Angeles. In the early days of The Village, there were some anxious moments, **but the program eventually found its stride**: some consumers would experience major setbacks, **but with perseverance and encouragement from staff, their lives improved**; the capitation scheme sometimes forced staff to make difficult decisions regarding client care and the allocation of resources, but the agency stayed afloat; perhaps the biggest challenge was, as a recreational specialist who worked there recalled, to **“get out of the way”** and overcome the natural tendency to try to shield and protect consumers instead of encouraging them and empowering them. But in spite of these difficulties, both consumers and staff continually landed on their feet, even with a few slips along the way.



Within a few years, The Village proved to be a success. Anecdotaly, **consumers and family members** said they were pleased with the unique approach towards services offered at The Village, while an **independent audit** conducted a few years after the program began reported positive outcomes. Consumers at The Village were more likely to live independently and find work than those receiving traditional services, and they were less likely to wind up institutionalized. Furthermore, they reported improvement in their mental health problems, and also more hope and optimism than their counterparts in regular outpatient clinics. Thus it seemed that the programs succeeded not only in reducing the deficits associated with mental illness, but also in the more challenging task of improving consumers’ quality of life and restoring their dignity.



The village...has shown me that there are effective, alternative methods of providing services to persons with serious mental illness. The village has been able to achieve what I had been told was impossible; providing quality services which are relevant and meet the needs of persons with serious mental illness and their families without sacrificing cost effectiveness!



Camille DiRienzo-Callahan, California Alliance for the Mentally Ill, 1993



Soon, policymakers took notice. In Los Angeles County, the Department of Mental Health **examined the feasibility of starting similar programs locally**, and decided to **create** the People Achieving Rehabilitation Together Need Empowering Respectful Support (PARTNERS) program in 1993, and the Adult Targeted Case Management Services (ATCMS) program in 1997. Convinced that the integrated services approach **could be effective both clinically and fiscally**, the state also expanded on the concept behind AB 3777 with the passage of Darrell Steinberg's Assembly Bill 34 (AB 34) in 1999—which devoted \$10 million to similar programs—and his Assembly Bill 2034 (AB 2034)—which expanded funding to \$55 million statewide—in 2000.

The AB 34 and AB 2034 programs focused on providing intensive, recovery-oriented, community-based services to severely mentally ill individuals who were homeless or involved with the criminal justice system. Like the AB 3777 programs that preceded them, the AB 34 and AB 2034 programs **focused on much more than just symptom reduction**; providers worked closely with consumers to help them avoid the pitfalls of hospitalization and incarceration, and they also guided them on the road to recovery with services that helped them find housing and work. Outcomes data seemed to show that the new way of doing business that the Task Force had recommended could work, even on a large scale. **According to a study conducted by the state in 2003**, the consumers who participated in the AB 2034 program were better able to handle their mental health problems without inpatient care, as rates of psychiatric hospitalization dropped over 55%. More importantly, indicators that consumers' quality of life improved spoke to the program's success—participants saw their number of days incarcerated drop over 72%, their days homeless drop over 67%, days employed part-time increase over 53%, and days of full-time employment increase over 65%.

Not only were the programs effective, but they were also efficient. State data showed that nearly half of the costs of the program were offset by savings that came from reduced rates of hospitalization and incarceration, and decreases in emergency room utilization. Thus not only did consumers benefit from these programs, but so did the taxpayers. Before long, these successes gained recognition nationwide, with the **2003 President's New Freedom Commission on Mental Health** recognizing the AB 34 programs as models that should be emulated across the country.



What we are trying to achieve and have already accomplished with AB 2034 programs has never been done before in the history of California's adult community mental health system...one of California's goals is to incorporate what we learn from AB 2034 programs into traditional adult mental health services for those populations who may frequently use public healthcare services in ways that do not result in positive outcomes.

Thus it seemed California's mental health community had found a new model that worked. Documents such as the **Assembly Bill 904 Planning Council's 1991 Master Plan**, the **California Mental Health Directors Association's 2000 Adult System of Care Framework**, and **Los Angeles County's 2000 Comprehensive Community Care (CCC) Report** show that mental health policymakers were hoping to reorient the system towards the "system of care" approach, with services becoming more client and family-centered, culturally competent, and focused on improving consumers' overall quality of life. The CCC was particularly ambitious, as beyond a reorientation of services, it also called for their reorganization to become more efficient and consumer-friendly.

Yet in spite of plans for action, little changed in the system as a whole. As the **Little Hoover Commission** wrote in 2000, California did have "model providers offering comprehensive and integrated services...But California has not replicated their successes; the knowledge they have produced has not been infused into state policies" on a large scale.

A main reason why was lack of resources. To make the vision articulated in the 1991 Master Plan a reality, an extra \$766 million would have needed to be invested in the system, and that would have only addressed the needs of those in need of the most intensive services. In Los Angeles County, in spite of the creation of a solid plan, the redesign of the system was derailed by a lack of funding to see it through. Even proven programs such as AB 2034 were having trouble securing funding so they could serve more consumers when California's budget woes began escalating in the early 2000s. It was at that point that the idea of bypassing the legislature, and taking the issue of mental health funding directly to the voters, grabbed the attention of mental health advocates in Sacramento.

Proposition 63: Taking the Case to the People

Starting with Governor Reagan, we have had 36 years of broken promises: broken promises to provide quality mental health services and supports in the community, but then inadequate resources to fulfill the promises...we have a once in a lifetime opportunity to correct the injustices of inadequate resources that have been our plight for the last 36 years. Just as hope is a key for a person's recovery, we need to have hope for our ailing mental health system.

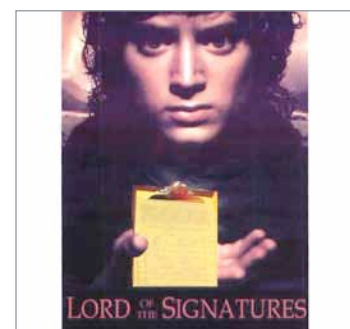


Jay Mahler, speaking to the California Network of Mental Health Clients, June 2004

Frustrated by failed attempts to procure more funding for innovative investments in the mental health system through the legislature, the mental health community—led by California Council of Community Mental Health Agencies Executive Director Rusty Selix—began deliberating how they could bypass the legislative and budgetary impasses that were stifling progress. In 2002, as advocates around the state were considering the idea, Selix gained the support of Assemblyman Steinberg. By early 2003, **Selix and his colleagues began doing research to test out the feasibility** of putting an initiative to expand mental health services on the ballot. They **drafted an initial set of ideas**, envisioning a funding source that would expand AB 34 programs, provide treatment to individuals who are no longer in need of such intensive services, and also create programs aimed at prevention. Unsure of how they would pay for these new and expanded programs, Selix and his colleagues considered either financing them out of the state’s general fund, or creating a new devoted source of tax revenue.

In March of 2003, they sponsored **a poll**, which revealed that an initiative would fare well at the ballot box – even though it would have increased state costs, 69% of respondents said they would support the initiative. Many reported having been touched by mental illness, as 44% of respondents said they either had or personally knew someone who had suffered from serious mental illness at some point in their lives. When asked how they would fund such an initiative, 72% said they would support a tax on individuals with incomes over \$1 million per year. It was clear that a ballot initiative that promised to expand services by raising taxes on millionaires would appeal to the electorate, so advocates went ahead and wrote a **first draft** of what would eventually become Proposition 63. That summer, **they refined the details of their proposal**, outlining the services to children, adults, and older adults that it would provide, as well as specifics on provisions that would facilitate programs aimed at prevention, education and training, and capital facilities and technology development, as well as assurances for oversight and accountability. All of these programs would be funded by a 1% surtax on all annual incomes over \$1 million earned in California, without having any adverse effect on the state budget or the vast majority of taxpayers.

In the fall of 2003, mental health advocates took to the streets, gathering the signatures necessary to get the initiative on the ballot and then **raising funds** for the campaign. Along the way, the Proposition gained **significant support from the California Network of Mental Health Clients**, and by the summer of 2004, **a wide coalition** of individuals and organizations representing children, seniors, veterans, teachers, organized labor, and public safety, had officially endorsed the measure. As mental health advocates and their allies **made the case for the initiative**, there was limited opposition since the proposition did not call for taxes on any businesses or consumer goods, but only on the extremely rich. As Selix recalls in **a report on the campaign**, “our belief was that the very wealthy could afford to pay a small amount in extra taxes and that this would not do any harm to them or to the state as a whole...we checked with major business interests to make sure they would not see this as an



attack, and indeed, they did not.” On November 2, 2004, the campaign achieved its goal, with **53.4% of California voters** approving Proposition 63, and **making the MHSA a reality**.

Estimates at the time predicted that the MHSA would add an **additional \$2.36 billion into the health system by the end of the 2007-2008 fiscal year**. After nearly fifty years of neglect, California’s public mental health system finally had a chance to fulfill its promise.



The MHSA and the Task of Transformation

Thanks to the MHSA, we can do something far more fundamental and effective than simply treat “mental illness”: we can improve the quality of life of the “whole” person — helping him or her overcome an addiction to drugs, for instance, develop resilience, attain a higher level of education or land a better job. Our hope is to help people and their families not only rebound from crisis but achieve the full promise of living productive, fulfilling and meaningful lives.

Marvin J. Southard, D.S.W.

The California Department of Mental Health’s **vision** for the MHSA was ambitious. According to the state, the MHSA held the promise to “create a state-of-the-art, culturally competent system...where access will be easier, services are more effective, out of-of-home and institutional care are reduced and stigma towards those with severe mental illness or serious emotional disturbance no longer exists.” **As Selix and Steinberg** wrote in the wake of Proposition 63’s passage, “complete transformation” of the mental health system “from fail-first to help-first” was the MHSA’s main goal.

At the state level, there were five guiding principles underlying the implementation of the MHSA. First and foremost, consumers and families were to drive the process, playing leading roles in policy planning and development, as well as service delivery and evaluation. On the ground, this meant that consumer-operated services were to increase dramatically, and all service plans would be individualized, based on each consumer’s goals, strengths, and motivations. Second, the state wanted programs and services to be improved, with increased accessibility, the elimination of administrative barriers, and the integration of services for clients with substance abuse problems into mental health services. Third, services were also to be tailored to the needs of specific age groups, and a renewed focus on cultural competence was designed to eliminate disparities in services to minorities and other underserved populations. Fourth, the state wanted to enhance community partnerships between mental health providers in hopes of creating opportunities for consumers to pursue quality education, work, and housing. Finally, oversight and accountability were priorities, as the state wanted to ensure that the programs put into place actually worked.

Though policymakers in Sacramento hoped that the MHSA would bring about these changes across the state, there was also recognition that different communities had different needs. As such, MHSA programs were to be designed at the local level, by county mental health authorities in collaboration with consumers, families, and other community stakeholders. Once counties came up with plans for how they would utilize their MHSA dollars, they then submitted proposals to the state, where a Mental Health Services Oversight and Accountability Commission would review them. After MHSA plans were approved, the state then dispersed funds to the counties to create and run their MHSA programs. MHSA funding was divided into five different categories—Community Supports and Services (CSS), Prevention and Early Intervention (PEI), Capital Facilities and Technology, Workforce Education and Training (WET), and Innovations (INN).



Starting in December 2004, Los Angeles County began its MHSA planning process. In a four month period, over 2,000 individuals produced over 930 pages of analysis and recommendations, which were **then considered by over 11,000 citizens**, who participated in 355 workgroups conducted in 14 languages across the county. The **CSS Plan that emerged** focused on the creation of Full Service Partnerships (FSPs), which were intensive case management programs similar to those created by AB 3777, AB 34, and AB 2034. The county’s stakeholders decided to tailor the programs to the needs of different age groups, and authorized the creation of separate FSPs for children under fifteen, transition age youth between sixteen and twenty-five, adults age twenty-six to fifty-nine and adults over sixty. Designed to offer consumers “whatever it takes” to improve their quality of life, FSPs featured a team approach to service delivery, highly individualized care, and round-the-clock access to services if consumers needed them. For individuals who did not need the intensive services offered by FSPs, Los Angeles County created other services with its MHSA funding, including family support and family crisis services for children, drop-in centers for transition age youth, Wellness and Client Run Centers for adults, and Field Capable Clinical Services (FCCS) for older adults. In addition to these specific programs, the CSS plan also authorized the financing of Service Area Navigator Teams, Alternative Crisis Services, and Outreach and Engagement Services.

Beyond enhancing services for individuals within the mental health system, Los Angeles County stakeholders have also authorized the use of MHSA funds to make further enhancements to the local mental health system. The County’s **WET Plan** laid out 22 action plans designed to improve mental health workforce staff and support, provide training and technical assistance, and create residency and internship programs. The County’s **PEI Plan** created ten new initiatives to provide services for individuals who are not yet suffering from severe mental illness, but may be having problems, with programs designed for individuals of all ages. The **INN Plan** focused on identifying new practices that could be effective in the delivery of mental health services, and will fund four new mental health service delivery models.

You know, what MHSA is based on is whatever it takes. And honestly, it's not brain surgery. It's true of every human service. You do an individualized plan for this individual and then you provide services to meet the needs of the individual.

Bruce Saltzer

In the first four years of operation, nearly 67,000 individuals in Los Angeles County received services funded by the MHSA. According to **initial data gathered by the County**, FSPs have built upon the successes of the AB 3777, AB 34, and AB 2034 programs, as they have reduced the number of days spent in psychiatric institutions by over 80%, decreased the number of days incarcerated by over 25%, cut days homeless by over 50%, and also increased the number of days consumers have been able to live independently. Furthermore, field based and client run services have expanded throughout Los Angeles thanks to MHSA funding, enabling more consumers to receive more services outside of the clinical setting, and from their peers, than before. Allowing the Los Angeles Department of Mental Health to offer an increased array of services for consumers at different stages of recovery, MHSA programs have helped **begin the transformation** of the County's mental health system altogether.

Remolding the mental health system to fit the vision of the MHSA, however, has not been an easy process. When it has come to both **planning** and **service delivery**, some have claimed that not enough has been done to include consumers in a meaningful way. As a **study sponsored by the California Department of Mental Health** has shown, lack of space, labor, and systematic data collection was problematic in the first few years of the MHSA.



However, the obstacle that has done the most to limit the positive impacts of the MHSA has been the one problem area that the Act was supposed to remedy once and for all—lack of funding. Originally, the MHSA was supposed to create services that enhanced the existing mental health system, and the state made it clear that **MHSA funds could not go towards the maintenance or expansion of pre-existing services**. Yet the at the same time MHSA dollars were starting to flow in, other major sources of funding for mental health were **shrinking and failed to keep up with unavoidable cost increases**. As a result, while MHSA programs have grown, regular outpatient programs have been operating with declining revenues. As the state-sponsored study of the MHSA admitted, this has created inequality between MHSA and non-MHSA programs and services. In some counties, there is fear this may lead to “the creation of dual systems of care”—one that is well-funded thanks to MHSA money, and one that is facing devastating cuts due to the inconsistency of other

funding sources.

But the budgetary problems outside of the MHSA have not by any means diminished its impact; rather, they have made it all the more important. MHSA programs have provided a cushion that has helped keep the system whole in spite of dramatic budget reductions. Many of the individuals whose regular outpatient services have had to be cut back have been able to receive new, recovery-oriented services in MHSA programs, thus mitigating the potentially disastrous effects that the recent economic downturn could have had on the public mental health system. More importantly, beyond allowing the system to continue serving those in need, the MHSA has given mental health providers an opportunity to serve them differently, with peer-to-peer, wellness, and field-based services becoming more the rule than the exception in the public mental health system. Thus for many consumers, the MHSA truly has changed the kind of services they receive, making it truly transformative, well before many imagined it would be.

As Marvin Southard D.S.W., the director of the Los Angeles County Department of Mental Health explained in an interview, mental health services have “been transformed by the infusion of MHSA – its resources, its ideology, and its community planning process.” Thus the process of transformation continues, both within MHSA programs, and throughout all of California’s public mental health system.

