

## **Proposition 63, The Mental Health Services Act: A Research Agenda**

By Mistique Felton, MPH;  
in collaboration with Jenny Liu, BA, Tracy Finlayson, PhD,  
Neal Adams, MD, MPH, Richard M. Scheffler, PhD, and James F. Ross, MBA  
The Nicholas C. Petris Center on Health Care Markets and Consumer Welfare  
University of California, Berkeley

### **Executive Summary**

Beginning in the early 1990s, California has been moving its public mental health system towards a more integrated and outcomes oriented one, with a focus on consumer empowerment. Realignment legislation, children's system of care, Mentally Ill Offender Crime Reduction (MIOCR) grants, and funding of local mental health grants (AB34/2034) all laid the groundwork for the development and passage of Proposition 63, which is now known as the Mental Health Services Act (MHSA). Passed in November of 2004, it aims to expand access to public mental health services and restructure California's public mental health system into a more consumer-oriented one that addresses a broad continuum of prevention, early intervention, and service needs for the recovery and resiliency of mental health consumers. MHSA's provisions are funded by a 1% tax on incomes over \$1 million (affecting approximately 0.1% of California taxpayers) and was projected to generate approximately \$254 million in fiscal year 2004-05, \$683 million in 2005-06, and increasing amounts thereafter. This paper discusses a brief history of the implementation process to date, as well as a number of policy issues that have arisen, including questions on involuntary treatment, non-supplantation of existing mental health funds, and concerns with inter-agency collaborations under MHSA.

## **California Has Changed the Way Mental Health Services Are Traditionally Provided**

In the 1970s, California began its deinstitutionalization movement, which transferred care for people with mental illness away from large state-operated hospitals and into community settings. While the goal was to provide better care in the least restrictive settings, many communities lacked the infrastructure and resources necessary to provide adequate care once people were released from hospitals. Money saved from reduced hospitalizations was not reinvested into other community mental health services as had been envisioned. Consequently, many of those released from institutions did not succeed and thrive in the community. A good number became homeless and only received treatment when they came in contact with law enforcement.<sup>1</sup>

In order to address the gap in care left by deinstitutionalization and an inadequate community care system, California began to build a more effective community oriented and county-based mental health system beginning in the early 1990s. In 1991, the California legislature initiated a realignment of both administrative and fiscal responsibility for health, social, and mental health services from the state to counties to increase flexibility, stability of funding and local control.<sup>2</sup> By consolidating sources of mental health funds into a single dedicated sales tax, funding across counties was equalized through redistribution while overall costs decreased. Realignment legislation also established local mental health boards and a statewide monitoring system to ensure services were targeted to people with severe mental illness (SMI) and others most in need. Empirical research by Scheffler and colleagues show that this effort was only partially successful: utilization and costs decreased with realignment while access for consumers, particularly those with the most severe impairments, was unchanged.<sup>3</sup> California has also passed laws in 1992<sup>4</sup> and 1997<sup>5</sup> that focused on enhancing mental health services for children by promoting a *systems of care* approach to provide intensive,

individualized, family-based care across multiple agencies as an alternative to foster care. Counties were subsequently given the state's share of funding for children at risk for out-of-home placement and were encouraged to increase inter-agency collaboration, particularly among the mental health department, probation department, special education agencies, and school districts. Evidence from the California System of Care Model Evaluation Project found that children in the system of care programs were more likely to be placed in the least restrictive settings, had decreased recidivism rates, and registered significant improvements in educational attainment.<sup>6</sup> Additionally, costs for foster care fell in counties with these programs.<sup>7</sup>

For people who were homeless and mentally ill, or mentally ill and at risk of being incarcerated, pilot projects were begun in 1999<sup>8</sup> and expanded in 2000,<sup>9</sup> to provide housing and intensive services with a focus on recovery and wellness. Anchored in a “whatever it takes” philosophy and approach to meeting individuals’ needs, these programs were lauded as models for successful mental health care.<sup>10</sup> Evaluations showed that rates of homelessness, incarceration, hospitalization, and unemployment all decreased after new services were instituted.<sup>11</sup>

Furthermore, treatment of the mentally ill within law enforcement was addressed in 1998 through the Mental Ill Offender Crime Reduction Grants (MIOCR) that funded multi-agency pilot projects aimed at reducing recidivism among mentally ill offenders.<sup>12</sup> Early evaluation data of the first MIOCR grants show that programs lowered rates of recidivism, decreased jail bookings and average number of days in jail, and decreased self-reports of substance abuse problems.<sup>13</sup>

Taken together, these programs and initiatives began to build support for the introduction of Proposition 63. The positive outcome data tied to these service approaches made clear that the strategic dedication of money and resources could substantially improve access and

effectiveness of services and improve the quality of life for those served. In other words, these successes supported the belief that the mental health system could be improved if not transformed with the availability of additional resources.

### **What Does the 2004 Mental Health Services Act (MHSA) Do?**

In an effort to expand access and restructure California's mental health system towards a more consumer-driven system, focused on resiliency and recovery, for people with mental illness, the 2004 Mental Health Services Act includes components or funding strategies to target different aspects of mental health care:

- 1) **Community Planning Process:** provides funding for counties and the state Department of Mental Health (DMH) to engage consumers, family members and other stakeholders, including providers, law enforcement, county mental health officials, organized labor and others, in a planning process
- 2) **Community Services and Supports:** provides funding for direct services to people with serious mental illness<sup>14</sup>
- 3) **Capital facilities and technological needs:**<sup>15</sup> provides funding for housing and increased technological capabilities in order to provide better services for people with mental illness
- 4) **Education and training (workforce development):** calls for a statewide needs assessment for mental health professionals and the development of a five-year plan to address the shortage of qualified personnel
- 5) **Prevention and early intervention:** develops outreach programs for families, providers, and others to recognize early signs of mental illness, improve early access to services, and develop programs to reduce stigma and discrimination

- 6) **Innovation:** funds new programs that increase access to the underserved, promote interagency collaboration and increase quality of services

### **Implementation of MHSA**

Following passage of Proposition 63 in November of 2004, implementation has taken longer than the originally anticipated six months for a number of reasons. Perhaps most significantly, DMH sought the active participation of all stakeholders—particularly mental health clients and their families—in the development of administrative regulations needed for implementation of all sections of MHSA. For example, it took many months to convene twelve stakeholder meetings across the state to obtain and integrate both general input as well as recommendations pertaining to specific areas of the MHSA legislation. Thirteen conference calls with stakeholders were also conducted.

DMH has made Community Services and Supports (CSS) the first priority in the implementation of MHSA. Money for direct services is expected to account for approximately 50% of all MHSA funding requests. Planning for the remaining five components of MHSA are currently in development.

The final draft of the Three Year Program and Expenditure Plan Requirements for the CCS plans was released in August, 2005. Forty-four of the fifty-eight counties in California have submitted their plan proposals to DMH as of March 2006 and the first county plan was approved (with funding released for programs) in January 2006. Although DMH aimed to respond to county plan submission within three months, only six counties have been approved for funding; other counties are working with DMH to revise their plans before receiving approval. A detailed timeline of MHSA implementation events is provided in Table 1.

## **MHSA Policy Issues**

As DMH began to translate MHSA into policy and regulation, a number of sensitive issues have surfaced that sparked much debate among stakeholders about both legislative intent as well as best policy. Three of perhaps the most critical or difficult issues are discussed below.

### *MHSA Funding of Involuntary Treatment*

During the first DMH stakeholder and the Mental Health Services Oversight and Accountability Commission meetings, concern over the use of MHSA funds for involuntary treatment were raised. This is a sensitive issue for many consumers and advocates who are concerned about the loss of autonomy and the mistreatment that some consumers have experienced during involuntary treatment that can hinder recovery and exacerbate mental health problems. In response, MHSA regulations were amended to require all funded programs to be voluntary in nature;<sup>16</sup> this however does not exclude individuals with involuntary legal status from accessing MHSA funded programs.

### *Non-Supplantation and MHSA Funds*

The new influx of funds into the mental health system raised concerns about the potential for the re-direction of existing/historical funding sources away from mental health services. To prevent this, DMH established a policy of non-supplantation for the expenditure of MHSA funds, requiring that (1) mental health programs be officially authorized under MHSA,<sup>17</sup> (2) MHSA funds be used only for new programs or expanding existing programs, and (3) non-MHSA funds for mental health services in fiscal year 2004-05 cannot be replaced with MHSA funds.<sup>18</sup>

### *Inter-Agency Collaborations under MHSA*

The need for increased collaboration with agencies and departments outside of mental health has brought about a number of questions on how MHSA funds can be used in these partnerships. There is concern that MHSA monies may be used for services traditionally provided by agencies outside of mental health.

For example, Mental Health Court initiatives, where defendants carry out court-supervised treatment instead of criminal sentences, cannot be entirely funded through MHSA. The California Attorney General's Office concluded that MHSA funds cannot be used because direct mental health services are not provided by court personnel. However, MHSA funds can be used to cover costs associated with additional mental health staff (e.g. health case managers and clinicians), the mental health system liaison functions of court administrators, and the evaluation of mental health courts in new or expanded programs.<sup>19</sup>

Another concern about inter-agency collaboration arose regarding the use of MHSA funds to support services such as mobile crisis teams which pair police officers with mental health professionals. A preliminary decision about the division of financial responsibility was made in February 2006 by the Attorney General's Office stating that "law enforcement services, including costs for officers' salaries and equipment" is not allowed under MHSA. As a result, law enforcement officials must be funded through their respective departments, although, salaries for mental health professionals, law enforcement training costs and evaluation of services are eligible for MHSA funding.

### **Measuring the Impact of MHSA**

The provisions within MHSA will institute changes within California's mental health system that includes administrative reorganization, new funding channels, and new or expanded

programs and services with a more person-centered recovery/resiliency oriented approach.

Measuring these changes over time will be essential to understand the social and fiscal impacts of MHSA on individuals and families, their communities and the service delivery system. In response to the need for research on MHSA, the California HealthCare Foundation has funded a three-year study by the Petris Center to address the need for measurement and assessment. This study will focus on economic implications of this increase in funding for mental health.

Specifically, future research will need to focus on uncertainties regarding the impact of MHSA on the market for mental health care services:

- How has funding of mental health services changed at the county level because of MHSA?\*
- How much have MHSA funds been used as leverage to increase total mental health dollars through matching from other funding sources (like Medicaid)? How will additional funding and training of mental health professionals affect the future workforce needs in California?

Additionally, because MHSA specifically targets a number of social indicators (rates for suicide, incarceration, school failure/dropout, unemployment, out-of-home placements, and prolonged suffering), the impact of MHSA and of specific programs that it funds will need to be evaluated:

- Are MHSA and its programs having a measurable improvement in mental health outcomes?\*
- Has MHSA been effective in reaching out to targeted populations, including children, transition age youth, adults, older adults and families, racial/ethnic minorities, and the previously unserved?
- How have disparities, particularly for racial/ethnic minorities, between and within counties shifted?\*

\*Research questions that will be addressed in the Petris Center research project



**Table 1: Timeline of MHSA Implementation Events**

<b>Timeline for MHSA implementation</b>	
<b>2004</b>	
November 2, 2004	California Proposition 63 (now known as the Mental Health Services Act or MHSA) passed with 54% of the vote.
December 17, 2004	California Department of Mental Health (DMH) holds first general stakeholder meeting
<b>2005</b>	
January 1, 2005	MHSA becomes law
January 18, 2005	DMH released its guidelines for the County Funding Request for Mental Health Services Act (MHSA) Community Program Planning.
March 15, 2005	Deadline for counties to turn in funding requests for Community Program Planning
April 22, 2005	DMH releases funding for Community Program Planning to counties
June 1, 2005	Funding criteria for Community Services and Supports (CSS) released by DMH
July 7, 2005	First meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC)
July 18, 2005	DMH releases its policy on non-supplantation of MHSA funds
August 1, 2005	The Three Year Program and Expenditure Plan Requirements for CSS plans is released
August 22, 2005	MHSOAC holds two day retreat to outline vision and priorities
September 9, 2005	Performance Measurement Advisory Committee (PMAC) holds its first meeting.
September 30, 2005	Fresno is the first county to turn in its CSS plan
October 25, 2005	Informational Technology (IT) workgroup holds its first meeting
<b>2006</b>	
January 24, 2006	Stanislaus is the first county to have its CSS plan approved

## References

- Mayberg SW. "Effectiveness of integrated services for homeless adults with mental illness; A report to the California Legislature." May 2003. [http://www.dmh.cahwnet.gov/AOAPP/Int\\_Services/docs/AB2034\\_may2003.pdf](http://www.dmh.cahwnet.gov/AOAPP/Int_Services/docs/AB2034_may2003.pdf). Last accessed 4/4/06.
- Ridgely MS, Borum J, Petralia J. "Involuntary Treatment in California: Who is potentially affected by a change in the Lanterman-Petris-Short Act." *The Effectiveness of Involuntary Outpatient Treatment: Empirical Evidence and the Experience of Eight States*, MR-1340-CSCR, 2001. [http://www.rand.org/pubs/monograph\\_reports/MR1340/mr1340.ch7.pdf](http://www.rand.org/pubs/monograph_reports/MR1340/mr1340.ch7.pdf). Last accessed 4/4/06.
- Snowden L, Scheffler R, Zhang A. "The impact of realignment on the client population in California's public mental health system." *Adm Policy Ment Health*. 2002 Jan;29(3):229-41.
- Scheffler R, Zhang A, Snowden L. "The impact of realignment on utilization and cost of community-based mental health services in California." *Adm Policy Ment Health*. 2001 Nov;29(2):129-43.
- Scheffler RM, Wallace NT, Hu TW, Garrett AB, Bloom JR. "The impact of risk shifting and contracting on mental health service costs in California." *Inquiry*. 2000 Summer; 37(2):121-33.
- Scheffler RM, Wallace NT, Hu TW, Garret AB, Bloom JR. "The effects of decentralization on mental health service costs in California." *Mental Health Research Review*. 1998; 5:31-32.
- California Board of Corrections; "Mentally Ill Offender Crime Reduction Grant Program" Annual Legislative Report; June 2002. <http://www.bpt.ca.gov/DivisionsBoards/CSA/docs/june01final.pdf>. Last accessed 4/4/06.
- Solis. SB 163; Children's Wrap-around Services. 1997. [http://www.leginfo.ca.gov/pub/97-98/bill/sen/sb\\_0151-0200/sb\\_163\\_bill\\_19971009\\_chaptered.pdf](http://www.leginfo.ca.gov/pub/97-98/bill/sen/sb_0151-0200/sb_163_bill_19971009_chaptered.pdf)
- DMH. "A Draft Readers Guide to Mental Health Services Act, Community Services and Supports Three-Year Program and Expenditure Plan Requirements." [http://www.dmh.ca.gov/mhsa/docs/A\\_Draft\\_Readers\\_Guide\\_to\\_Mental\\_Health\\_Services\\_Act.pdf](http://www.dmh.ca.gov/mhsa/docs/A_Draft_Readers_Guide_to_Mental_Health_Services_Act.pdf)
- 
- <sup>1</sup> Center for Mental Health Services Research. "History of Public Mental Health in California and the U.S." <http://ist-socrates.berkeley.edu/~cmhsr/history.html>. Last accessed 4/4/06.
- <sup>2</sup> AB 1288, 1991, known as Program Realignment
- <sup>3</sup> (Scheffler, et al, 1998 and 2000; Scheffler, Zhang, & Snowden, 2001; Snowden, Scheffler, & Zhang, 2002)
- <sup>4</sup> AB 3015, passed in 1992, is now known as the Children's Mental Health Services Act. It expanded a system of care for children with serious emotional and behavioral problems. Children's system of care provides comprehensive services through interagency cooperation for children and their families and requires outcome measurements and accountability for each program.
- <sup>5</sup> SB 163, passed in 1997, extends the children "wrap-around" services in a pilot program in Santa Clara to all counties who wished to participate. "Wrap-around" services provide comprehensive services through interagency cooperation for children and their families. This law also requires outcome measurements and accountability for each program. Eligible children included those at risk or currently in out-of-home placement.
- <sup>6</sup> CSOC PERFORMANCE OUTCOME MEASURES. [http://www.dmh.cahwnet.gov/CFPP/csoc\\_initiative.asp](http://www.dmh.cahwnet.gov/CFPP/csoc_initiative.asp). Last accessed 4/4/06.
- <sup>7</sup> California System of Care Model Evaluation Project. "Evaluation of the California Model System of Care for Children with Severe Emotional Disturbance as Enabled under AB377 and AB3015." Attkisson, Rosenblatt. <http://ist-socrates.berkeley.edu/~cmhsr/organize.html>. Last accessed 4/4/06.

---

<sup>8</sup> AB34 passed in 1999, which allotted a \$10 million grant for a pilot project in three counties.

<sup>9</sup> Early success of the pilot programs led to the passage of AB2034, which set aside another \$55 million to begin programs in other counties.

<sup>10</sup> In the President's New Freedom Commission Report on Mental Illness, the AB34/2034 programs were recognized as a model program for treating homeless with mentally illnesses.

<sup>11</sup> Data from the 2003 Legislative Report "Effectiveness of integrated services for homeless adults with mental illness" showed that AB34/2034 programs resulted in a 67% decrease in the number of days spent homeless, 72% decrease in the number of days incarcerated, 56% decrease in the number of days hospitalized, 53% increase in the number of days employed part-time, and 65% increase in the number of days employed full-time.

<sup>12</sup> SB 1485 passed in 1998 and authorized the Board of Corrections to initially fund 30 projects in 26 counties. Additionally, MIOCR requires the Board of Corrections to evaluate outcome measures, identify interventions with the largest impact on outcomes and annually report the findings to the Legislature. Fifteen grants began in July 1999 (MIOCR I) and the other 15 grants (MIOCR II) began in 2001 as a result in an augmentation of the 2000/01 State Budget Act. The MIOCR programs provide "enhanced services addressing in-custody and/or post-custody needs identified by counties during a comprehensive local planning process required by SB 1485."<sup>12</sup>

<sup>13</sup> 2001 Annual legislation report on the Mentally Ill Offender Crime Reduction Grant

<sup>14</sup> DMH requirements for CSS Plans

<sup>15</sup> The division of funds between capital facilities and technological needs has not yet been determined.

<sup>16</sup> Amendment to Chapter 14. Mental Health Services Act Article 4. Allowable Costs and Expenditures, Section 3400 [http://www.dmh.ca.gov/Admin/regulations/docs/MHSA-rulemaking/Amendment\\_to\\_Emergency.pdf](http://www.dmh.ca.gov/Admin/regulations/docs/MHSA-rulemaking/Amendment_to_Emergency.pdf)

<sup>17</sup> Section 5892 of the W&I code

<sup>18</sup> DMH letter no. 05-04. DMH letter 05-08 specifically lays out the funding that cannot be supplanted by MHSA monies which include the following funds from fiscal year 2004-05: realignment base funding (composed of state tax revenues and matching county funds), DMH state general fund allocations, Projects for Assistance in Transition from Homelessness (PATH) and Substance Abuse and Mental Health Services Administration (SAMHSA) funding, Early Periodic Screening, Diagnosis, and Treatment state general fund settlement. Counties are required to comply with existing regulations and statutes on funds used for mental health services. MHSA funds cannot be used to cover inflationary increases in costs but can be used to expand programs to a larger population. However, county overmatch, funds provided for mental health services above the obligations outlined in realignment legislation, can be reduced under DMH's interpretation of MHSA.

<sup>19</sup> Opinion 05-1007