Origins of California's Mental Health Services Act

April 28, 2023

Toby Ewing, PhD, Executive Director
Mental Health Services Oversight and Accountability Commission

Summary

The Mental Health Services Act, championed by community advocates statewide and enacted by voters in 2004, expresses a powerful commitment to meeting the mental health needs of Californians.

The act was informed and inspired by the emergence of effective practices for dealing with serious mental health conditions and legislatively sponsored pilot projects in comprehensive services that improved outcomes, including reductions in homelessness, criminal justice involvement and hospitalizations for individuals with serious mental health conditions.

Proposition 63, the citizen's initiative enacting the Mental Health Services Act, also incorporated recommendations from two Little Hoover Commission reports that were developed through two years of public hearings, advisory committee meetings, consultations, and site visits. The unanimous recommendations by the bipartisan Little Hoover Commission called for an end to rationed services – and for transforming the system by providing tailored and comprehensive care and investing in prevention, early intervention, and innovation as essential to reducing human suffering.

That transformation is underway and incomplete. Implementation efforts are improving, and inadequate. While the act can be strengthened, key elements of the law have matured into first principles for fundamental improvements -- especially community engagement and empowerment, and a commitment to prevention and early intervention, innovation, and continuous improvement.

The Mental Health Services Oversight and Accountability Commission – an independent panel comprised of community and government perspectives – has proven to be essential to elevating public voice and catalyzing system-level transformation.

The MHSA was a milestone in a community-based movement and state-responsiveness.

By the late 1980s, communities throughout California were grappling with the heartaches associated with untreated mental illness. Peers, family members, social workers, health professionals, law enforcement officers and others were united by their frustration, compassion, and apparent helplessness.

The Legislature in 1988 passed AB 3777, which created a pilot program that gave three communities the chance to test comprehensive wraparound services for high-risk individuals. The pilot program provided fixed but flexible funding and discretion in how to meet human needs. Evaluations documented that within three years participants in the

program were more stable, healthy, and connected. Two of these models continued to develop into what today are referred to as Full Service Partnerships.

In 1999, the Legislature enacted AB 34, which funded three counties to increase outreach and services to people with mental health needs who were experiencing homelessness. The program was expanded in 2000. The programs further demonstrated improved outcomes for individuals and cost avoidance that exceeded the investment in services.

The Little Hoover Commission viewed inadequate mental care as a public failure.
During this same period, the Little Hoover Commission conducted a series of reviews of California's child welfare and state prison systems.

Those projects focused on abused and neglected children and examined the extreme challenges facing the state and counties when they tried to restore families and provide safe and nurturing homes for children who had experienced trauma, including the implications of inadequate mental health care and substance abuse services.

Simultaneously the rapidly expanding prison system was grappling with a surge of inmates with serious mental health issues, often after enduring years in county jails or living on the streets.

The costs of both systems were increasing even faster than caseloads, compounding the urgency to develop more cost effective as well as more compassionate responses.

The Commission consulted deeply with peers, advocates, and system leaders.
As with other projects, the Little Hoover Commission turned to Californians to understand challenges and identify potential improvements. The Commission empaneled advisory committees, conducted public hearings, and made site visits. The Commission relied deeply on people with lived experience, practitioners, and researchers to understand where the system was failing and what could be done differently and better.

The Commission was profoundly moved by what it was told.

- The general public did not understand the scope and scale of mental health challenges and mental health advocates and providers had little political capital in budget and policy decisions.
- While the consequences of unaddressed mental health needs were driving costs, budget allocations for services were inadequate and inconsistent.
- Fragmented governance, programs and funding thwarted any ambition to provide the package of services required for stability and recovery.
- State and local agencies narrowly defined their responsibilities to ration care and avoid costs. And state and local agencies were overwhelmingly concerned with complying with federal funding rules that restrict who could receive which services.
- Care was often rationed to those in crisis when services are most expensive and least effective.
- Funding and services varied so greatly across the state that families were encouraged to move their homes and lives to improve access to care for loved ones.

- The public mental health system was stuck in a doom loop --- not benefiting from emerging evidence on effective care or administrative practices for improving outcomes.

The Commission called on Californians to care for each other and for urgent public action.
The Little Hoover Commission's recommendations are contained in two reports:

Being There: Making a Commitment to Mental Health, November 2000
Young Hearts & Minds: Making a Commitment to Children's Mental Health, October 2001

The Little Hoover Commission's recommendations focused on system-level improvements.

1. The Commission called for a public commitment to provide high quality care to all of those in need, and for the creation of a Mental Health Commission to persistently engage Californians, reduce stigma, catalyze system change and advocate for those who need care.
2. The Commission called for comprehensive services to meet the complex needs of individuals and for fortified state leadership to systematically reduce barriers to improvement, facilitate adoption of cost-effective services, evaluate innovations, and publicly report outcomes.
3. The Commission called for adequate and stable funding with incentives for innovation and continuous improvement. This was the first time in over a decade that the bipartisan Commission advocated for additional funding as a prerequisite to improving outcomes.
4. The Commission called for "decriminalizing mental illness" by establishing better responses to individuals in crisis and for greater coordination between jails, prisons, and community service providers to reduce reincarceration among individuals with mental health needs.
5. "Young Hearts and Minds" went further in recommending dedicated funding for prevention and early intervention, whole-person care, and system coordination.
6. The report elevated the need to invest in the workforce and leadership needed to transform the system and deliver effective care and services.

Prop 63 was true direct democracy, and the Mental Health Services Act is community owned.
Leading up to the campaign, advocates and people with lived experiences expressed relief and hope – that they had been heard by the Little Hoover Commission and by the authors of the initiative. They rallied support for the measure and have participated in its implementation.

"Many of us know someone who has suffered from a severe mental illness," the proponents concluded in their ballot argument. "It is time to stop the suffering."

While that goal has not yet been achieved, many of those advocates, and the next generation they have mentored, are empowered within their communities and through the Mental Health Services Oversight and Accountability Commission to have a voice and to be part of the solution.

To this day, the mental health community speaks with pride about the law they helped to create and express responsibility for making sure the money is well spent, that communities are involved, and that the unserved be made a priority.

Successes and setbacks affirm the imperative of the MHSA's values.
The authors of Proposition 63 intentionally provided for the measure to be amended because they wanted the law to incorporate new knowledge and experience. Still, they set super-majority thresholds to protect the core values – what have matured as first principles of the MHSA.

Community engagement: The MHSA requires counties to engage with their communities to develop three-year plans, prevention and early intervention plans, and innovation plans. Local mental health boards are required to review these plans and county boards of supervisors are required to approve them.

Community empowerment: The MHSOAC was structured to explicitly empower people with lived experience, family members, and private and public sector leaders to drive transformational change. The Commission was established to build public support, address stigma, advocate for better results, and hold the system accountable to the community and California's taxpayers.

Comprehensive and wholistic care: The MHSA established in policy the imperative to provide "wraparound services" and to do "whatever it takes" to meet the complex needs of individuals and to focus on recovery. As a ballot proposition, the MHSA was offered to the public as the right next step in building the long-neglected community service system that was promised when locked institutions were dramatically reduced some 40 years before. A system focused on healing and recovery, self-reliance, personal connection, and hope.

Prevention: The act established a flexible funding stream – in addition to and separate from restrictive Medi-Cal funds – to support activities that can improve the social and economic determinants of health, including housing, education, employment, safety, and healthy family connections; with the goal of reducing homelessness, justice involvement, suicide, and suffering, while also tackling the disparities that pervade public services.

Early intervention: Mindful of the tragic consequences of rationing care to those with the most serious conditions, MHSA dedicated funding to programs that can detect and respond more effectively to mental health conditions. This provision has been essential to deploying research discoveries that can significantly reduce the progression of, and as a result, the consequences of serious mental health conditions.

Flexible funding: While the Act requires counties to invest in specific categories – including Full Service Partnerships, innovation and prevention and early intervention – the act provides counties with valuable flexibility to pay for services and supports that are not covered by other public funding sources, and to meet the distinct needs of their communities.

Focus on outcomes. The Prevention and Early Intervention provisions specifically identified seven negative outcomes that the act seeks to reduce: out-of-home placement for children, school failure or dropout, unemployment, incarceration, homelessness, prolonged suffering, and suicide.

Innovation: In an unprecedented way, the MHSA made a commitment to innovation as an essential mechanism to finding better ways to achieve desired outcomes. Counties use 5 percent of MHSA funds, less than 1 percent of public mental health funding, to explore ways to improve services and results.

These MHSA values work together to inform and support the transformational change that is necessary to achieve a dynamic mental health system that is community owned, cost-effective, and reflects the best of California.

MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION
1812 9th Street, Sacramento, CA 95811 • Phone: 916. 500.0577 • Fax: 916.623.4687 • mhsoac.ca.gov