



## Basics of the Mental Health Services Act (MHSA)

Championed by consumer, family member and parent or caregivers of children and youth with mental health issues, Proposition 63, the Mental Health Services Act (MHSA) was passed by California voters in November, 2004. The MHSA taxes all California residents' income that is over \$1 million at 1%. This tax money has gone to the MHSA fund to expand and develop multi-cultural, innovative, integrated services. Services must reflect the cultural, ethnic, and racial diversity of consumers and families served. (MHSA, 2013)

### MHSA Roots & Core Values

The Department of Mental Health understood this when they developed a Vision Statement and Guiding principles for the implementation of the Mental Health Services Act soon after its passage by the people of California:

**“Planning for services shall be consistent with the philosophy, principles and practices of the Recovery Vision for mental health consumers:**

- To promote concepts key to the recovery for individuals who have mental illness -- hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.
- To promote consumer-operated services as a way to support recovery.
- To reflect the cultural, ethnic, and racial diversity of mental health consumers.
- To plan for each consumer's individual needs.” (CA WIC Section 7, 5813.5 (d))

**“Mental health care is consumer and family driven ... (It is crucial to) involve consumers and families fully in orienting the mental health system toward recovery.”** - *President's New Freedom Commission on Mental Health Final Report, July, 2003*<sup>1</sup>

Consumer values are explicitly or implicitly embedded in the MHSA:

- Designed for voluntary participation.
- Promotion of self-help/peer support programs
- Involvement of consumers at all levels of mental health systems
- Services that deal with the whole human being
- Involvement of consumers as part of, and in training of, the mental health work force
- Promotion of recovery as a goal<sup>1</sup>

<sup>1</sup> Section 3, MHSA and Section 11010.5, Government Code., Article 4: GENERAL FUNDING PROVISIONS (2)



## MHSA Components & Program Examples

MHSA funding is earmarked for components based on the law's priorities. Most innovative, recovery and resiliency-based programs that exist today are funded under one of the MHSA five funding program components:

**1. Community Service & Supports (CSS)** are programs and strategies improving access to underserved populations, bringing recovery approaches to current systems, and providing "whatever it takes" services to those most in need. Programs offer integrated, recovery-oriented mental health treatment; outreach and engagement and linkage to essential services; housing and vocational support; and self-help.

**CSS Status**—ongoing, most county programs are already set up, periodically some updates and changes may be made

**CSS Example programs:** wellness or recovery centers, wrap-around services, Assertive Community Treatment or Full Service Partnerships.

**2. Prevention and Early Intervention (PEI)** supports the design of programs to prevent mental health issues from becoming severe and disabling, with an emphasis on bringing about positive mental health outcomes either for individuals and families who are at risk of, or showing early signs of serious mental illness, and improving timely access to services to underserved populations.

**PEI Status**—ongoing—

**PEI Example Programs:** suicide prevention programs, stigma reduction programs, transition age youth centers and outreach, mental health consultation in schools

**3. Workforce Education & Training (WET)** has an overall mission of developing and maintaining a sufficient workforce capable of providing client and family driven, culturally competent services, that promotes wellness, recovery and resiliency, and lead to evidenced-based, value-driven outcomes. Outcomes include to develop training curricula in accordance with MHSA values; to promote employment of clients and family members in the mental health system; promote meaningful inclusion of client and family members in training and education programs; to fill gaps in the mental health workforce.

**WET has five separate funding categories:**

1. Workforce Staffing Support
2. Training and Technical Assistance



3. Mental Health Career Pathway Programs
4. Residency and Internship Programs
5. Financial Incentive Programs

**WET Status** is temporary, **sunsetts in fiscal year 2017/18**

**WET Example Programs:** peer and family employment training, Mental Health Loan Assumption Program (MHLAP).

**4. Capital Facilities/Technological Needs (CF/TN)** improve the infrastructure of California's mental health system. This is one component with two sections:

**Capital Facilities (CF)** projects acquire and develop land and/or construct or renovate buildings to house recovery programs within the community and to create cost-effective improvements to data processing and communications that support services provided through CSS and PEI.

**Technological Needs (TN)** support the MHSA objectives through cost effective and efficient improvements to data processing and communication to bring health records up to legal requirements electronically, and to provide consumers and family members education and access to services.

**CF/TN Status** is temporary

**CF/TN Example Programs:** Tele-psychiatry, electronic health records, investing in facilities which will provide mental MHSA services to individuals diagnosed with mental illness and their families

Note: Counties may choose to use CSS funds to continue funding WET or CF/TN programs but the amount dedicated to these efforts in combination with either and the Prudent Reserve cannot exceed 20% of the average county allocation for the previous 5 years.

**5. Innovation (INN)** goal is to develop and implement promising and proven practices to increase access to mental healthcare. These are short-term programs, for two to five years, to "try-out" novel creative and/or ingenious mental health practices/approaches that are expected to contribute to learning rather than a primary focus on providing a service. If what is learned proves effective, an INN program could be funded under CSS or PEI in the future.

**INN Status** is ongoing

**INN Example Programs:** Many programs which test outreach and service strategies that target cultural specific populations, programs that pilot



behavioral health training to sectors of the community, such as religious leaders.

**Community Program Planning (CPP)** is the MHSAs mandate involvement of the public in identifying local funding priorities and ensures that a meaningful stakeholder process guides the planning of the programs under the MHSAs components. This is an ongoing inclusive stakeholder process involving consumers, families, caregivers and partner agencies to identify community issues related to mental illness resulting from gaps in community services and support, and stigma and discrimination. The CPP process assesses the current capacity, defines the populations to be served, and determines the strategies for providing effective services. From this process the MHSAs work plan is developed. (Up to 5% of the annual amount of the County MHSAs funding allocation can be used for this component.)

**MHSAs Values** are also mandated in the regulations.

**Community Collaboration:** A process by which clients and/or families receiving services, other community members, agencies, organizations, and businesses work together to share information and resources in order to fulfill a shared vision and goals.<sup>2</sup>

**Client Driven:** The client has the primary decision-making role in identifying his/her needs, preferences and strengths, and a shared decision-making role in determining the services most effective and helpful for him/her. Client-driven programs use clients' input as the main factor for planning, policies, procedures, service delivery, evaluation, and the definition and determination of outcomes.<sup>3</sup>

**Family Driven:** Families of children and youth with serious emotional disturbance have a primary decision-making role in the care of their own children, including the identification of needs, preferences, and strengths, and a shared decision-making role in determining the services most effective and helpful for their children. Family-driven programs use the input of families as the main factor for planning, policies, procedures, service delivery, evaluation, and the definition and determination of outcomes.<sup>4</sup>

**Cultural Competence:** Incorporating and working to achieve each of the goals listed below into all aspects of policy-making, program design, administration,

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<sup>2</sup> Title 9, California Code of Regulations, §§3320 and 3200-060

<sup>3</sup> Title 9, California Code of Regulations, §§3320 and 3200-050

<sup>4</sup> Title 9, California Code of Regulations, §§3320 and 3200-120



and service delivery. Each system and program is assessed for the strengths and weaknesses of its proficiency to achieve these goals. The infrastructure of a service, program, or system is transformed, and new protocol and procedures are developed, as necessary to achieve these goals.

- 1) Equal access to services
- 2) Services effectively engage and retain individuals of diverse racial/ethnic, cultural, and linguistic populations.
- 3) Identify, measure and eliminate service disparities.
- 4) Understand diverse belief systems on mental illness, health, healing and wellness among different racial/ethnic, cultural, and linguistic groups.
- 5) Understand the impact historical bias, racism, and other discrimination upon each racial/ethnic, cultural, and linguistic population/community.
- 6) Understand the impact bias, racism, and other discrimination on the mental health of each individual served.
- 7) Services utilize the strengths and forms of healing that are unique to an individual's racial/ethnic, cultural, and linguistic population or community.
- 8) Workforce training to effectively address the needs and values of the racial/ethnic, cultural, and/or linguistic population or community served.
- 9) Equal opportunities for administrators and providers who share the diverse racial/ethnic, cultural, and linguistic characteristics of individuals served.<sup>5</sup>

**Wellness, Recovery and Resilience Focused:** Planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers: To promote concepts key to the recovery for individuals who have mental illness: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination. To promote consumer-operated services as a way to support recovery.<sup>6</sup>

**Integrated Service Experiences for Clients and their Families:** The client, and when appropriate the client's family, accesses a full range of services provided by multiple agencies, programs and funding sources in a comprehensive and coordinated manner.<sup>7</sup>

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<sup>5</sup> Title 9, California Code of Regulations, §§3320 and 3200-100

<sup>6</sup> MHSA Section 7, W&I §5813.5(d)

<sup>7</sup> Title 9, California Code of Regulations, §§3320 and 3200-190