

# **How the Ballot Brought About Funding and Changes for Mental Health Services**

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## **Abstract**

Mental Health Services in the US, and in California, one of the most diverse states in the USA, are fragmented and under-funded, especially for vulnerable populations such as the chronically mentally ill, children, members of non-dominant cultures, and lower socioeconomic status. A ballot measure (Proposition 63) was recently passed by the voters of California whereby an additional tax on millionaires was proposed to be used for designated mental health programs and education of providers. This ballot initiative is leading to a reform in expanded and more meaningful mental health service delivery, as all stakeholders (including consumers) are participating in the design and implementation of models and services brought about by Proposition 63. Cultural competence, consumer and family involvement, and linkages with educational programs for a pipeline of providers are components that are being designed now. The means to educate consumers and family members, certificated para-professionals and licensed professionals is through curriculum developed by colleges and universities and delivered through a distance format. Funds are available from various sources to offer computer hardware for those consumers who are not able to afford computers in their own household. These partnerships with institutions of higher learning for non-degree courses to include consumers and family members in the delivery of mental health services is a new and innovative approach to uses of course delivery via emerging technologies. A poster session showing the history of this ballot initiative and the consumer-driven elements that are currently being implemented to expand needed mental health services will be created.

## **Introduction**

The funding and delivery of mental health services in the United States of America is fragmented, chronically under-funded, and challenged regarding linguistically appropriate care for diverse populations. Many system-wide initiatives, both government and consumer-driven, have emerged over the past decade to address these perplexing issues. Due to a ballot initiative in 2004 (Proposition 63, now known as the Mental Health Services Act), an opportunity arose in California, one of the most population-dense diverse states in the USA, to bring an infusion of funds into the public mental health system (Mental Health Services Act, 2004).

While the usual legislative process to enact laws in California is through the State legislature, voting by the elected representatives, and a signature by the governor, a ballot initiative qualifies for the ballot by first obtaining the required number of signatures from registered voters. Once qualified, the measure can then be placed on the ballot for a regular or special election. A ballot initiative must have language that can be voted on as "yes" or "no." If approved by the voters, it is enacted into law. Proposition 63 was the result of a ballot initiative. The language of Proposition 63 read as follows, "Should a 1% tax on personal income above \$1 million to fund expanded health services for mentally ill children and seniors be established?" (<http://www.smartvoter.org>). The measure passed on November 3, 2004, with 53.7% of the voting public (6,183,119 votes) voting "yes."

## **Collaboration For Planning And Implementation Of Services**

An intentional consequence of Proposition 63 and the subsequent Mental Health Services Act (MHSA) was the establishment of a process for collaboration to bring about needed changes in the type and delivery of mental health services. A structure for collaboration was provided so that a culturally competent workforce and mental health system will be created. Collaboration to examine current needs has commenced among significant stakeholders such as consumers, agencies, consumers, advocacy groups, mental health professionals, professional and educational institutions. Stipulated in the Act is the directive to promote web-based and distance learning as a means to support education and training, inclusion of consumers and family members, and to increase the diversity of the mental health workforce. Regional partnerships with local institutions such as schools and universities will emerge so that consumers and family members can be prepared academically for active roles in service delivery as well as the creation of programs for training and re-training of the current workforce.

In addition to regional partnerships, collaboration is further promoted by language in the Act that requires treatment planning that will create programs consistent with the Recovery Vision for consumers, improve access to services for underserved populations, and establish oversight and accountability in the treatment planning process unfolds.

## **Stakeholder Input**

One mechanism for inclusion and meaningful collaboration throughout the planning process is the holding of stakeholder meetings in various locations throughout the state. Meeting announcements, minutes, and works in progress are also published on the Internet, providing open access to information such as aggregated public comments as the strategic planning and regional partnership processes take shape. Stakeholders are defined as:

a person or an organization that feels they have an active interest in the outcome of an issue or topic. The Department of Mental Health (DMH) uses the term broadly to include but not be limited to: clients, family members, community organizations, health departments, mental health providers, schools, social service agencies, law enforcement and others. (Department of Mental Health, Questions, 2005)

## **The New Recovery Vision Model**

Key elements of the Recovery Vision are explicitly stated in the Act. These elements are personal empowerment, respect, social connections, self-responsibility and self-determination. The recovery model holds at the core of its philosophy that views and goals of consumer health services are to also be incorporated into the treatment planning process. The model states that consumers and family members are involved in all stages of implementation, from assessment to delivery of services in a model true to the Recovery Vision.

To deliver the promise of the Recovery Vision, many changes are needed within the current delivery and reimbursement system as well as the current educational system where the professional scope of practice may need to be updated or changed. In order to truly address the needs of people with chronic mental illness it is absolutely necessary to create an environment where

from lack of recent opportunities for self-determination; from the negative effects of unemployment; and from crushed dreams. (Anthony, 1993a, 14)

The most important element of the recovery movement, of which the Recovery product, is the shift in focus for service delivery. Prior to the recovery model, institutions how changes in care would affect the structure of care, not how it would impact (Anthony, 1993b). In contrast, the recovery model emphasizes that the interest of the client is paramount over the interests of professionals or institutions. A dramatic shift in the focus of service is the inclusion of consumers as clinicians.

## **OVERSIGHT AND ACCOUNTABILITY**

### **Oversight and Accountability Commission**

The state of California has a number of agencies that provide oversight for mental health services. The Department of Mental Health (DMH) has a federally mandated oversight agency, the California Mental Health Planning Council (CMHPC). The CMHPC oversees the delivery of mental health services in the public mental health system. The meetings are open to the public. The Master Plan is also available at the CMHPC (<http://www.dmh.ca.gov/MHPC/default.asp>). The MHSOA has another oversight body designed to aid in implementing the Act. Part 3.7 of MHSOA requires that an accountability commission, Mental Health Services Oversight and Accountability Commission (MHSOAC), be established for the new law. The DMH, MHSOAC, and the CMHPC collaborate to stay current on each other's progress, roles, recommendations, and data.

### **Mental Health Services Oversight and Accountability Commission (MHSOAC)**

The primary responsibility of MHSOAC is as follows: to provide support, accountability for the implementation of MHSOA, to ensure that the direction of the new law, prevention and early intervention, to ensure that the needs and voices of people with illness will be taken into consideration when planning for the implementation of MHSOA. MHSOAC will promote a systemic approach to mental health services, develop programs to reduce stigma, promote programs that maximize MHSOA funding, and keep the public informed of the progress of MHSOA (Department of Mental Health, 2006). MHSOAC meets at least once at least quarterly in a location that will be as accessible as possible. All meetings of MHSOAC are to be open to the public (MHSOAC, 2006).

### **The California Mental Health Planning Council (CMHPC)**

The California Mental Health Planning Council provides a very special role in the implementation of MHSOA. The Planning Council is an autonomous body that operates independently of DMH. The Planning Council is a federal and state mandated or advocates for the needs of seriously mentally ill persons in the state of California (42 USC). As outlined by section 1911 of federal statute 106-310, any state that receives federal funding must have a Mental Health Planning Council to provide oversight of policy and implementation. The Planning Council has a number of committees and task forces that are aligned with the process and topic in specific areas relating to mental health services. The Planning Council has three standing committees: the Human Resource committee, the Quality Improvement (Quality) committee, and the Policy and System Development Committee, and the System of Care Committee (SCC). Currently the main focus for the Policy and System Development Committee is the implementation of MHSOA. The Planning Council will ultimately issue recommendations to the state based on information gathered at the stakeholder meetings and the plans that have been developed. Because the CMHPC has so much influence on DMH procedures, most of the CMHPC recommendations will be implemented into their system of care procedures.

## **SUCCESSFUL INCLUSION OF MARGINALIZED COMMUNITIES**

The Department of Mental Health (DMH) Master Plan has identified underserved populations, such as linguistic and ethnic minorities, rural versus urban dwellers, severely disturbed children and transition age (17-25) youth, and individuals with co-occurring conditions such as chemical dependency and mental illness. In fiscal year 1999-2000, in California the need for mental health services was estimated to be 600,000 persons, where 300,000 are children and youth, and 100,000 are adults over the age of 18 (<http://www.dmh.ca.gov/MHPC/masterplan.asp>). In 1997-98 the total number of people in need through the State of California public mental health system was 460,000, so the need for building to meet current need in addition to capacity expansion to meet growing need is apparent (CMHPC Master Plan).

between 30-55% indigent, depending on location of service (CMHPC Master Pla disproportionately higher utilization by this lowest socio-economic group when co population of California as a whole.

Mental health clients are also underserved in terms of cultural and linguistic conte. There is a shortage of mental health workers overall, and this shortage is especia examined against client ethnicity. The need for culturally and linguistically compet apparent. Table 1 compares the percentage of clients served to the population of whole, Los Angeles County which is the most population-dense geographic region of the composition of mental health personnel who are currently delivering services.

**Table 1  
Comparison of Utilization by Ethnicity to Population and Workforce: Mental H in California**

Race/Ethnicity	% clients served – public mental health system 2002-03 ***	% California State population 2003 ****	% Los Angeles County population 2003 *****	% H W (€ 2)
White	43	42	28	8:
Hispanic/Latino	24	35	46	4
Black	17	7	10	8
American Indian/Alaskan	1	1	1	0.
Asian/Pacific Islander	6	12	13	2.

\*\*\* California Mental Health Planning Council, personal communication

\*\*\*\*US Census obtained from <http://quickfacts.census.gov/qfd/states/06000.html>

\*\*\*\*\*US Census obtained from <http://quickfacts.census.gov/qfd/states/06037.html>

### Marginalization and Inclusion

The Mental Health Services Act seeks to address the marginalization of mental h several ways [MHSA, Section 5813.5 (d)] The Recovery Vision named in the Act p personal empowerment, respect, social connections, self-responsibility, and sel [MHSA, Section 5813.5 (d)(1)]. Further, the Act states that planning for services cultural, ethnic and racial diversity of mental health consumers [MHSA, Section 581: Act includes dedicated funding to address the overall shortfall of service providers mental health [MHSA WIC Section 5820 (a)], where this planning will include a nee [MHSA, Section 5820 (b,c)] by occupational category along with a 5-year educatic development plan. The plan will include many aspects of community and client including inclusion and employment of mental health consumers and family member health system [MHSA, Section 5822 (d, g, h)]. Curriculum to train existing staff and t training for new jobs will commence [MHSA, Section 5822 (f)] and the use technologies and distance learning techniques will be used [MHSA, Section 5822 (d)]

Even for marginalized populations and communities, availability of comp Internet is a feasible means of communication and a way to sustain communication a endeavors, since many public buildings such as libraries have computers with I available to the public (Table 2).

**Table 2  
Internet usage by Age and Household in the United States 2003**

<b>Uses Internet at School</b>	
- age 6-9	47%
- age 10-14	77%
- age 15-17	91%
<b>Uses Internet at Work</b>	
- age 18-64	84%
- age >65	63%
<b>Internet Usage by Ethnicity</b>	<b>3-17 years</b>
- White	65.4%
	<b>18 and over</b>
	83%

The Recovery Vision that is infused throughout the Mental Health Services Act training services, including the education and training component, emphasizes the importance of individual experience and context of the human experience. Interestingly, and coincidentally, this world view also describes constructivist conceptions of learning. Knowledge is individually and socially constructed by each learner, based on personal interpretations and experiences. Constructivist curriculum design, therefore, is highly consistent with the aims of the Act and can serve as a basis, at least in part, for new curricula to be developed.

Constructivist components (Jonassen, in Riegeluth, ed., 1999) are especially important in training programs that build upon experiences of consumers and family members, and are sensitive to cultural relevance for populations, sub-groups, and groups with special needs based on language, socioeconomic variables, lifestyle, and many other aspects that express individual and group affinities in daily life. Using the framework of problem-based learning and active learning strategies such as exploration through modeling, articulation and creation of meaning, coaching, and reflection as a synthesis to create meaning through scaffolding, an engaging environment for diverse groups of learners can be created. The element of authenticity, an important component of therapeutic relationships as well as educational contexts, is important in the construction of curriculum – real problems or personally relevant issues can be incorporated into construction activities and is also congruent with a core value in mental health support systems.

#### **Mental Health Services Act – Special Topics Workgroups**

As part of the development process for short- and long-term education and training opportunities, a series of planning sessions are being held. Leadership from stakeholder groups and individuals with interest and expertise in the specialized areas are invited, and consumer and family member participation is incorporated as part of the recruitment. These special topics are needed to address training and technical assistance, consumer/Family member employment, regional stipends and scholarships, distance learning, human service academies, post secondary education and training, and licensing and certification. Subject matter experts are invited from representative populations with special needs, and contributions from the (California) Ethnic Health Network to assist in ensuring a culturally diverse working group (Communication, Human Resources Committee, CMHPC).

The operating principles of the special topic workgroups include that recommendations be applicable and available to local mental health programs and agencies that will be involved in the delivery of services according to the MHSA. In this way, no one agency or group will be developed in their own interests, and all stakeholders will be able to participate in the development and feasibility of implementation. All viewpoints and experiences of mental health consumers and family members are to be incorporated, and principles and practices of cultural competence are to be incorporated (personal communication, Special Topic Workgroup, 2006).

#### **CMHPC Plans for Distance Education Curricula**

There are several curricula that are being adapted for distance delivery under the leadership of the CMHPC's Distance Education subcommittee. The five-year plan for education and training is intended to include distance learning as a means to train or re-train existing workers in mental health professions, as well as construct new programs to train new workers, including consumers and family members, for new positions in the mental health system.

A kick-off curriculum planning meeting was held with the CMHPC's Distance Education subcommittee in February of 2006 to establish the target populations for the four online courses to be developed as the first offerings for all Californians. Information gathering and planning, including learner capabilities and intended course outcomes was established at this kick-off meeting (personal communication, HR subcommittee February 2006)

Subsequent meetings will be held with each of the sponsoring agencies and stakeholders to further develop the curriculum. The California Association of Social Workers (CASRA) has a psychosocial rehabilitation counselor certificate curriculum adapted for online delivery. The Department of Mental Health/Department of Industrial Relations Cooperative Program is based on a model designed to retrain disabled individuals in the workforce in productive jobs, and this cooperative program will be used as a prototype for training mental health and dual-diagnosis clients. Pacific Clinics is a not-for-profit community organization that has developed a paraprofessional mental health certificate program that will be made available via distance delivery. United Advocates for Children of California is a community network organization that has developed a curriculum for mental health

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