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CLAREMONT McKENNA COLLEGE

DEINSTITUTIONALIZATION AND ITS DISCONTENTS: AMERICAN MENTAL HEALTH POLICY REFORM

SUBMITTED TO

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AND

DEAN GREGORY HESS

BY

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FOR

SENIOR THESIS

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INTRODUCTION

Mental illness is real. 10 percent of children and 25 percent of adults in America struggle with serious emotional and mental disorders which cause significant daily functional impairment.[1]

Mental illness is pervasive. 4 of the 10 leading causes of disability in the United States are mental disorders.[2] Children, adolescents and adults from all classes, backgrounds, faiths, and walks of life suffer.

Mental illness is ruinous. 31 percent of homeless adults have a combination of mental illness and addiction disorder. Adults living with serious mental illness die 25 years earlier than other Americans. Over 90 percent of those who die by suicide have a mental disorder. 24 percent of state prisoners and 21 percent of jail prisoners have mental illnesses. 70 percent of youth in the juvenile justice system have at least one mental disorder. Over 50 percent of students with a mental disorder drop out of high school.[3]

Mental illness is not a miserable ultimatum. Mental illness is treatable. Between 70 and 90 percent of individuals with mental illness experience "significant reduction" in symptoms and improved quality of life after receiving pharmacological and psychosocial treatment and

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[1] National Alliance on Mental Illness. *Mental Illnesses.* n.d. http://www.nami.org/Content/NavigationMenu/Inform_Yourself/About_Mental_Illness/About_Mental_Illness.htm (accessed April 23, 2012).

[2] U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgen General--Executive Summary.* 1999. http://www.surgeongeneral.gov/library/mentalhealth/summary.html (accessed April 23, 2012).

[3] National Alliance on Mental Illness. *Mental Illness: FACTS AND NUMBERS.* n.d. http://www.nami.org/Template.cfm?Section=About_Mental_Illness&Template=/ContentManagement/ContentDisplay.cfm&ContentID=53155 (accessed April 23, 2012).

support.[4] Yet, less than 1/3 of adults and 1/2 of children with mental illness receive mental health services. Mental illness is so widely untreated that the economic cost of untreated mental illness in America is over 100 billion dollars each year.[5]

The mentally ill have been friends; they have been family—they have been us, and we have been them. In order to understand and work with this large segment of society, reviewing the history of mental health policy and considering contemporary reform efforts is paramount.

In early Western history, the mentally ill were met with disdain and disgust. In Colonial America even the most compassionate of doctors operated under a framework of beatings and forced submission as treatment. Throughout the entire history of the United States the mentally ill have suffered at the hands of caretakers who have poked, prodded, beaten, sterilized, lobotomized, restrained, and otherwise abused them—mainly in order to render them catatonic, quiet, and out of the eyes of society. As recently as the 1970's, psychosurgery (such as the prefrontal lobotomy) was used to "treat" the mentally ill, despite terribly poor outcomes. After World War II and the rising humane portrayal of the mentally ill in popular media, wider society came to know that mental illness was common, could occur in the average person, and was not caused by the sufferer. Today the mentally ill are largely seen as a deserving and blameless group suffering from an illness like any other. Advancements in medicine have shown that mental illnesses such as schizophrenia and bipolar disorder have somatic elements and can be treated as physical illnesses, at least in part.

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[4] National Alliance on Mental Illness. *Mental Illnesses.* n.d. http://www.nami.org/Content/NavigationMenu/Inform_Yourself/About_Mental_Illness/About_Mental_Illness.htm (accessed April 23, 2012).

[5] National Alliance on Mental Illness. *Mental Illnesses.* n.d. http://www.nami.org/Content/NavigationMenu/Inform_Yourself/About_Mental_Illness/About_Mental_Illness.htm (accessed April 23, 2012).

Public mental health policy has reflected public perceptions of the mentally ill. From its earliest days, public mental health policy has been "characterized by a cyclical pattern of institutional reforms."[6] There have been four reform movements in the history of American public mental health policy, beginning first with moral management and the introduction of the asylum in the early 1800's following the Age of Enlightenment. The second movement coincided with the 1909 creation of the Department of Mental Hygiene and the psychopathic hospital during the Progressive Era. The third occurred with the growth of the community mental health movement, was demarcated by the Community Mental Health Centers Construction Act of 1963, and continued through the Great Society. The fourth and final movement, which we live in today, is yet to be certainly delineated. It is a response to the failures of community mental health and deinstitutionalization, which served the mildly mentally ill well but failed the needs of the chronically mentally ill, who often became re-institutionalized through incarceration or lost to homelessness.[7]

California has been a representative state, reflecting the national policies—both humane and terrible—since its inception as a state in 1850. In 2004, California passed Proposition 63, the Mental Health Services Act, which levied a one percent tax on taxable income above one million dollars. It receives tax revenues annually to fund community mental health services, including wraparound services such as housing and social support, which were traditionally missing from the community model. Funds are distributed to each county such that the locality can determine what is best based on its own needs. Given the failures of deinstitutionalization, the Mental Health Services Act is a potential solution to be replicated on a national scale.

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[6] Goldman, Howard H., and Joseph P. Morrissey. "The Alchemy of Mental Health Policy: Homelessness and the Fourth Cycle of Reform." *American Journal of Public Health*, 1985: 727-731.

[7] Estrada, Elaine. *The Future of Mental Health in California.* Master's Thesis, ProQuest, 2007.

The following pages review a brief history of mental health policy beginning from early Western history through the present day. Social and political movements are considered, as well as historical events of importance. The concluding chapters review the history of mental health policy in California and the passage and resulting products of Proposition 63, the Mental Health Services Act.

Perhaps most importantly, the following pages aim to humanize the plight of the mentally ill who suffered so much, for so long, so needlessly. Their histories and the failures of deinstitutionalization are not to be forgotten.

CHAPTER ONE

HISTORICALLY POOR TREATMENT IN THE EIGHTEENTH AND NINETEENTH CENTURIES

The mentally ill have long been misunderstood and mistreated, neglected and abused. In earliest history there existed no division between medicine, magic, and religion. Across most cultures in the ancient world, mental illness was considered an affliction brought on by the supernatural—God, or demons. The earliest known treatment for mental illness was trepanning, the opening of the skull, which was performed to release evil spirits.[8] Though trepanning fell out of usage, the belief that the mentally ill were divinely punished continued to thrive in Europe until the Enlightenment (1650-1789). The Enlightenment, in large part, dismissed the notion that mental illness was caused by possession of demons. Belief in evil spirits was considered superstitious. Psychiatry and the treatment of the mentally ill became an independent science during the Enlightenment, but widespread acknowledgement of mental illness continued to be missing and prejudice against the mentally ill continued to exist throughout Europe.

American colonial society was influenced greatly by Old World European superstitions. This was true in many respects but especially concerning the mentally ill. The mentally ill—considered "lunatics" –were treated inhumanely.[9] Society was comfortable with the imprisonment and punishment of the mentally ill because their illness was considered to be

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[8] Kemp, Donna R. *Mental Health in America.* Santa Barbara: ABC CLIO, 2007.

[9] Rochefort, David A. *From Poorhouses to Homelessness.* Westport: Auburn House, 1993.

brought upon by "demonological possession or moral turpitude."[10]Even the most well-meaning physicians operated under a medical framework which believed the mentally ill were devoid of that which separates man from beast. Thomas Willis, an English physician who wrote extensively on madness, wrote in his book *The Practice of Physick: Two Discourses Concerning the Soul of Brutes* that "Discipline, threats, fetters, and blows are needed as much as medical treatment…maniacs often recover much sooner if they are treated with tortures and torments in a hovel."[11] This was the treatment of the mentally ill.

The Colonies passed laws giving town councils the power to take custody of the mentally ill, including selling their property and possessions to finance the aforementioned tortures and torments. The extremely mentally ill were occasionally driven out of communities or killed. Those less extreme but violent were imprisoned; even greater numbers were placed in workhouses, almshouses, and houses of correction. The mentally ill were not considered to feel hot or cold, or to be affected by their environments, such that many were left in cold basements wearing iron shackles for restraint. Indeed, the first psychiatric hospital in America was located in the basement of Pennsylvania Hospital, where the mentally ill suffered at the hands of doctors and were put on display to the public for a price, similar to zoo animals.

The Second Great Awakening (1800-1820) espoused humanitarian reform efforts, and policies addressing mental illness and treatment of the mentally ill glaringly needed reform in light of this kinder philosophy. Moreover, the mentally ill were crowding the almshouse and the jail, which did not have the financial means to support their needs and offered little in the way of

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[10] Bell, Leleand V. "From the Asylum to the Community in U.S. Mental Health Care: A Historical Overview." In *Handbook on Mental Health Policy in the United States*, by David A. Rochefort, 89-120. New York: Greenwood Press, 1989.

[11] Whitaker, Robert. *Mad in America.* Cambridge: Perseus, 2002.

medical services. Forward-thinking American activists such as Dorothea Dix and doctors such as Benjamin Rush and Samuel B. Woodward fought to shift public opinion about mental illness, in part by creating the asylum system—the first such system developed specifically with the treatment of the mentally ill in mind—and "proving" high rates of cure through inaccurate statistics. For example, if a man came into the hospital and was released three months later, that was considered a "cure". If he relapsed, came back and was released once more? It was considered two "cures". Nevertheless, in part due to these botched statistics, in the 1830's there was a great optimism surrounding the rehabilitation of the mentally ill and the belief that asylums could cure mental illness.

By 1861, 48 mental institutions were built and made operational. Oftentimes these institutions were built in the rural countryside on farms, so that some patients could work on the farm and provide food for the asylum.[12] The treatment thought to cure the mentally ill this time was moral management.

Moral management hailed from France in 1793, when Philippe Pinel, superintendent of Bicetre (an institution reserved for the insane), ordered the unchaining of the insane.[13] Moral management was based on the belief that the mentally ill were affected by their environment, that environment could play a role in treatment, and that patients could be taught morality as the mainstay of their treatment. Treatment of the mentally ill took this benign approach and mentally ill patients experienced better conditions as well as more therapeutic relationships with their

[12] Kemp, Donna R. *Mental Health in America.* Santa Barbara: ABC CLIO, 2007.

[13] Ibid.

supervisors. In all, moral management "placed the patient in a total therapeutic milieu which accommodated the client's psychological condition."[14]

The American asylum system flourished in the 1830's and 1840's under this moral management philosophy. In particular, hospitals served the mentally ill hailing from the middle class, whose families could pay for treatment, and promoted middle-class values as the basis of moral treatment. Gerald N. Grob writes that in this early period (1830-1870) the mental institution was not yet a custodial institution and most patients were short-term (3 to 9 months). During this time states relieved local communities of any role whatever in caring for the mentally ill. Community care was considered substandard. Centralization was intended to enhance recovery and provide more humane care in state mental institutions, rather than in the almshouse or the jail—the only community services offered to the mentally ill at the time. In this spirit, a lateral transfer moved mental health patients from community-based care and almshouses (which served as home to both the elderly senile and the homeless) into asylums.[15]

However, this happy period of moral management came to a close in part due to overcrowding in asylums, in part due to the growing numbers of poor mentally ill patients which conflicted with the traditionally middle class asylum philosophy, and in part due to the Civil War. Moral management and the humane treatment of the mentally ill took an extended hiatus through the rest of the nineteenth century.

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[14] Bell, Leleand V. "From the Asylum to the Community in U.S. Mental Health Care: A Historical Overview." In *Handbook on Mental Health Policy in the United States*, by David A. Rochefort, 89-120. New York: Greenwood Press, 1989.

[15] Grob, Gerald N. "Mental Health Policy in America: Myths and Realities." *Health Affairs*, 1992: 7-22.

Following the Civil War (1861-1865), veterans returned home with violent cases of Post-Traumatic Stress Disorder. Restraints were reintroduced as necessities to maintain control of violent patients. By 1876, fifty-eight state asylums, ten city and county asylums, nine charitable institutions, and nine private asylums held 29,558 patients.[16] The decreased staff to patient ratio led to less therapeutic relationships between caretakers and their mentally ill patients. As mentally ill patients received less care and less attention, their rates of recovery suffered and faith in the ability of the mentally ill to be cured abated. By the end of the 1870's, leading medical superintendents of asylums were promulgating a message of custody rather than care due to overcrowding, the influx of patients from different socioeconomic backgrounds, and a decline in the belief in curability.[17]

The 1870's and 1880's were a transitional period for the mental institution, where the optimism of the early moral management years had faded and pessimism took its place.[18] Instead of aiming to cure, the asylum now served as a custodial facility with a strong welfare aspect—a "warehouse" for chronic patients, alcoholics, and the senile. This influx of patients into state mental hospitals caused a decline in the quality of patient care. Old procedures used to produce catatonia were reintroduced, such as ice baths and excessive physical restraint. The Second Great Awakening and the compassionate care it brought to the mentally ill fell into the depths of history.

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[16] Bell, Leleand V. "From the Asylum to the Community in U.S. Mental Health Care: A Historical Overview." In *Handbook on Mental Health Policy in the United States*, by David A. Rochefort, 89-120. New York: Greenwood Press, 1989.

[17] Ibid.

[18] Rochefort, David A. *From Poorhouses to Homelessness.* Westport: Auburn House, 1993.

As moral management waned, the concept of eugenics and Social Darwinism waxed. Social Darwinism asserted that insanity is "the end product of an incurable degenerative disease inherited biologically."[19] Eugenics, in the same thought pattern, asserted that mental illness was inheritable. The eugenics movement identified mental illness particularly as a problem of the poor, the criminal, and the sexually deviant. Many states went one step further from discrimination and implemented involuntary sterilization laws and restrictive marriage laws. Between 1907 and 1940, 18,552 mentally ill persons were surgically sterilized.[20] Mentally ill people began to be treated poorly by the psychiatric profession. Instead of personal therapy, psychiatrists spent more time diagnosing and passing off the mentally ill patient to the mental institution, where oftentimes they would become chronic patients due to poor conditions and lack of therapeutic treatment. Asylums became grossly overcrowded and state legislatures did not increase budgets neither to expand the asylum size nor to increase the pay of therapists and other personnel. Efficiency became the keyword rather than patient care.

Despite these horrors and society's enormous failure to meet the needs of the mentally ill, psychology is not totally abandoned in the late nineteenth century. In 1878, G. Stanley Hall became the first American to receive a Ph.D. in psychology. In 1890, Hall founded the American Psychological Association and six years later, the first psychological clinic was developed at the University of Pennsylvania. This marked the birth of clinical psychology.

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[19] Kemp, Donna R. *Mental Health in America.* Santa Barbara: ABC CLIO, 2007.

[20] Ibid.

CHAPTER TWO

MENTAL HYGIENE IN THE TWENTIETH CENTURY

In the wider society at the turn of the century, there was a great spirit of optimism and faith in progressivism. Achievements in science, technology, and medicine created an ideal that science was the solution for solving problems both individual and societal. This faith in progress and science, this optimism, reached the mental health community and provided an avenue for change, after 20 years of reinstated harsh treatment as the asylum overcrowded and diversified. Psychology and psychological treatment were introduced, harking back to the days of moral management when patients were treated via talk therapy. In addition to talk therapy, music therapy and photochromatic therapy were introduced, as well as family therapy.

In the first decade of the twentieth century, several notable psychologists established their own schools of thought, one immediately following the other. First, Freud established the discipline of psychoanalysis. Following Freud, John Watson created behavioral psychology, then Carl Jung founded the school of analytic psychology and Alfred Adler established the school of individual psychology. Alfred Adler was the first psychoanalyst to challenge Freud, the father of modern psychology.[21] By 1910, after much publication about psychotherapy in popular and scientific journals as well as promotion of psychotherapy by leading figures, psychology became an accepted field, changing and upgrading the treatment methods offered in asylums everywhere. Furthermore, a link was established between the problems of mental illness and delinquency. Because psychotherapy now attempted to reach the core of the problems of the mentally ill, as well as the delinquent, it newly offered understanding into social problems and tools for

[21] Ibid.

bettering the community. In the early 1900's a broad new mental health perspective embraced research, environmental etiology, and involvement in community affairs.

One important landmark marking the progressivism of the early 20th century was the creation of the National Committee for Mental Hygiene in 1909. It was brought forth after Clifford Beer published his memoir, *A Mind That Found Itself,* which detailed his experience in psychiatric hospitals. Mental hygiene promoted new trends in mental health care, notably the employment of psychologists and social workers, development of community outpatient clinics and aftercare programs, and the need for psychopathic hospitals and wards. The asylum began to be seen as an "inferior facility" which "quartered the failures of society", strengthening that institution's custodial role.[22] The mental hygiene movement sought to reform asylum conditions, improve aftercare services, and create new preventative programs.

Despite the growth of psychology and the creation of mental hygiene, only a small number of patients were affected by the spirit of progressivism. Mental hospitals continued to grow (and to become more overcrowded and understaffed). From 1880 to 1940, the number of people within asylums increased five times as fast as the general population, to 445,000 persons.[23]

In the 1930's, the focus of public policy was on the severely and chronically mentally ill, based on the now long-accepted assumption that society had an obligation to provide mentally ill persons with care and treatment in public mental health hospitals (which continued to be the

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[22] Bell, Leleand V. "From the Asylum to the Community in U.S. Mental Health Care: A Historical Overview." In *Handbook on Mental Health Policy in the United States*, by David A. Rochefort, 89-120. New York: Greenwood Press, 1989.

[23] Rochefort, David A. *From Poorhouses to Homelessness.* Westport: Auburn House, 1993.

primary form of care offered for the mentally ill). The government also took over the care of the drug addict and in 1929, Public Law 70-672 established two "narcotics farms" and authorized a Division of Narcotics within the Public Health Service. However, due to the Great Depression (1929-1940), financial trouble haunted mental hospitals and in response, conditions in asylums continued to worsen.

A host of new therapeutic techniques came to play in the 1930's. Electroconvulsive therapy was introduced by Ugo Cerletti in 1938. Its primary aim was to render patients meek and manageable, and continues to be used in the present day on depressed patients who have not responded to other forms of treatment. Insulin-coma therapy and metrazol-shock treatment were both invented in the 1930's. Both treatments were experimental and failed to improve the lives and minds of patients, but stayed in use for at least twenty years, until the creation of antipsychotic drugs in the 1950's. Prefrontal lobotomy was introduced by Antonio Egas Moniz, but was developed by Walter Freeman and James Watts, also in the 1930's. Between 1936 and 1960, an estimated 50,000 lobotomies were performed in the United States.[24] Indeed, the creator of the lobotomy, Moniz, won the Nobel Prize for his work in 1949.This treatment failed to reduce mental illness or curb the growing custodialism of the mental institution. In the 1950's and 1960's research on lobotomized patients indicated negative results, terrible side effects and no recovery, which—coupled with the brutality of the ice pick surgery and the growth of consumer and patients' rights movements—led to the demise of the lobotomy. Many states passed laws outlawing psychosurgery in the 1960's.

[24] Kemp, Donna R. *Mental Health in America.* Santa Barbara: ABC CLIO, 2007.

After the turmoil of the Great Depression, national activism led to the demise of eugenics and the rise of funding and attention paid from the national level to the plight of the mentally ill. Two major developments of the 1930's foreshadowed the future community mental health movement. These developments were the embracing of neo-Freudian psychoanalytic theory, and the birth of national social welfare programs. The psychoanalytic approach to the mind moved the eye of psychiatry away from chronically ill cases housed in mental hospitals to people with milder, more treatable mental illness. The chronic cases were subject to previously mentioned electroconvulsive therapy, insulin-coma therapy, metrazol-shock treatment, and prefrontal lobotomy, which served to quiet them and make them more manageable within the institution. However, this patient population grew less and less appealing for psychologists and psychiatrists to work with, frustrated with their lack of progress. They became more interested in caring for patients outside of the institution; psychologists and psychiatrists exhibited a newfound interest in curing these patients' ailments through talk-therapy and psychoanalysis.

Furthermore, the national welfare programs following the Great Depression, such as the passage of the Social Security Act in 1935, established a spirit of federally mandated social welfare which encouraged future expansions in federal control over the care of the mentally ill.

Thus far, mental health and mental hygiene was of specific interest of psychologists, psychiatrists, social workers, and those who took a personal interest. It took World War Two (WWII) (1939-1945) to bring mental illness into societal focus and cause a social paradigm shift, which in turn brought great political changes. WWII provided frightening evidence of the extent

of mental illness in American society.[25] 12 percent of men screened for induction into the military were rejected on neurological or psychiatric grounds, comprising 40 percent of all rejections. Furthermore, 37 percent of Army men were discharged due to neuropsychiatric problems.[26] The enormous amount of psychiatrically disabled servicemen and veterans lessened the stigma associated with emotional breakdown and mental illness—these were, after all, the best men America had to offer.

Psychiatry's opinion of the asylum changed rapidly in the postwar era. Brought about by the aforementioned growth in Neo-Freudian psychoanalytic thought and frustration with the asylum, after 1945 psychiatrists left mental hospitals in preference of private and community practice—80% of psychiatrists registered with the American Psychiatric Association (APA) made the shift by 1955.[27] These psychiatrists now working in the community lacked contact with the severely mentally ill; they began to point to chronic patients as evidence of the inefficacy of state mental institutions and promoted community-based care. However, this was without any empirical evidence of better outcomes with community care. The assumption that patients could reside in the community with their families while undergoing rehabilitation was unrealistic because many chronically ill patients did not have homes or sympathetic families willing and able to assume responsibility for their care. Moreover, the environments which raised these mentally ill were often unfit places to rehabilitate them. Nevertheless, mental health

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[25] Cameron, James M. "A National Community Mental Health Program: Policy Initiation and Progress." In *Handbook on Mental Health Policy in the United States*, by David A. Rochefort, 121-142. New York: Greenwood Press, 1989.

[26] Rochefort, David A. "Origins of the "Third Psychiatric Revolution": The Community Mental Health Centers Act of 1963." *Journal of Health Politics, Policy and Law*, 1984.

[27] Grob, Gerald N. "Mental Health Policy in America: Myths and Realities." *Health Affairs*, 1992: 7-22.

professionals were convinced that community-oriented treatment was desirable and state mental hospital treatment was not.[28]

Another small but determined group, the conscientious objectors, moved to reform state mental hospitals. They saw first-hand the "decrepit and substandard conditions" at mental health hospitals, where they were assigned to work as attendants in alternative-service.[29]

Moreover—predicted by the growth of federal welfare programs following The Great Depression—the government began to get involved in mental health policy. Prior to WWII, mental health programs were "the domain of the states, and the principal locus of care was the large state mental institution."[30] Federal programs were limited. During the war, there was a severe shortage of trained psychiatric personnel and an enormous amount of psychiatric casualties. As a result, an "aggressive federal intervention" built psychiatric facilities and signed national legislation.[31] In 1945, General Thomas Parran requested Robert Felix—the head of the Mental Hygiene Division of the Public Health Service, who later led the National Institute of Mental Health (NIMH)—to prepare legislation that would enable the federal government to deal more effectively with the issue of mental disability revealed in the course of WWII. From this request sprung the National Mental Health Act of 1946, which created new federal grants for research into etiology, diagnosis, and care of neuropsychiatric problems; professional training;

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[28] Ibid.

[29] Rochefort, David A. "Origins of the "Third Psychiatric Revolution": The Community Mental Health Centers Act of 1963." *Journal of Health Politics, Policy and Law*, 1984.

[30] Cameron, James M. "A National Community Mental Health Program: Policy Initiation and Progress." In *Handbook on Mental Health Policy in the United States*, by David A. Rochefort, 121-142. New York: Greenwood Press, 1989.

[31] Bell, Leleand V. "From the Asylum to the Community in U.S. Mental Health Care: A Historical Overview." In *Handbook on Mental Health Policy in the United States*, by David A. Rochefort, 89-120. New York: Greenwood Press, 1989.

and development of community clinics as pilot and demonstration efforts. NIMH was given authority to supervise the grants, and the National Advisory Mental Health Council (NAMHC) was created to supervise and counsel the Surgeon General on issues of mental health.[32] Moreover, in 1955, U.S. Public Law 84-182 created the Joint Commission on Mental Illness and Health, which after research issued a report, *Action for Mental Health.* These acts were indicative of the growing federal role in mental health policy and a herald to the comprehensive community mental health centers introduced in the 1960's.

Following the return of WWII veterans, society became curious about mental illness. Movies such as *The Snake Pit* and books such as *One Flew over the Cuckoo's Nest* were produced and written, popularizing the plight of the mentally ill. In *The Snake Pit*, the mentally ill protagonist was displayed as sympathetic enough for people to relate to. There was also a boom in popular exposé articles published about mental illness and the state of asylum. It is evident that public display of mental illness had an effect on the population—an enormous growth in voluntary mental health organizations moved underway, from 50 existing organizations in the 1930's to over 200 in the 1940's. Sociologists Franklin Chu and Sharland Trotter supported Richard Rumer when he asserted that the 1950's and 1960's had "heightened public consciousness of mental health care."[33] Surveys about mental health care and public opinion were first distributed in 1950. The first survey, administered in Louisville, Kentucky, indicated that people did not appreciate mental health care treatment and thought of psychiatry as a last resort. The next year surveys taken in Canada found people to feel anxious and

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[32] Rochefort, David A. "Origins of the "Third Psychiatric Revolution": The Community Mental Health Centers Act of 1963." *Journal of Health Politics, Policy and Law*, 1984.

[33] Ibid.

antagonistic when faced with mental illness. Some continued to believe that those with mental illness were at fault, whereas others found that mental illness was not caused by the ill person. It was a slow fight for activists to convince the public that mental illness is not the fault of the mentally ill—despite WWII and the perspective it provided. Researchers also established a connection between beliefs regarding the cause of mental illness and respondents' willingness to accept social responsibility for the care of the mentally ill.[34] However, epidemiological studies began to develop a greater social consciousness towards understanding the mentally ill. August Hollinshead and Fredrick Redlich established an empirical relationship between social status and psychiatric problems, which led to a belief that mental illness was to some extent relative, based on a social dimension and connected to groups and communities. In turn, a focus on preventative psychiatry in communities arose, assisted by popular literature such as articles in Life and Reader's Digest on mental illness, as well as published social-scientific critique. As a result of the publications about the deplorable conditions in mental hospitals and the rising environmental considerations, the mental hospital itself was newly considered to be a cause of disability itself.[35] Public consciousness coupled with professional outcries against the asylum as "antitherapeutic", assisted by the invention of chlorpromazine and more effective forms of therapy, led to the increasing importance of the community mental health movement.

An enormous psychiatric revolution occurred with the introduction of the first anti-psychotic drug, chlorpromazine (Thorazine), in 1954. It introduced the field of psychopharmacology, eliminated much of the need to use physical restraints and contributed to a positive atmosphere between staff and patients. It brought optimism into the care of the

[34] Ibid.

[35] Ibid.

chronically mentally ill, who previously had no chance to avoid psychotic episodes, and strengthened the link between psychiatry and physical medicine. Thorazine had a place in deinstitutionalization because with its use, more patients—some which would have been considered chronic cases—were able to be discharged and to receive community-based treatment.

In the early 1950's, the APA and the American Medical Association (AMA) agitated for a study of mental health research and training in America. President John F. Kennedy sponsored the bill, called the Mental Health Study Act, in the Senate and it was passed unanimously in Congress on July 28, 1955. The Mental Health Study Act called for a truly comprehensive review of the mental health system in America and gave a publication which revised the public mental health system in America, substituting community care for custodialism and dependence on federal funds.[36]

Also in the 1950's, Ronald D. Laing and Thomas Szasz began an antipsychiatry movement, declaring that mental illness did not exist but was a form of social control used to manipulate those who were different. While this did not affect any national legislation, it was an important development in public thought.

David A. Rochefort, a prolific writer on mental health policy reform, summarizes the period lasting from the 1940's through 1960's as one in which public opinion shifted from the past to the present. He writes, "The psychiatric problems brought to light in WWII, the frequent exposures of mental hospitals, and the professional conflict within the mental health field created

[36] Ibid.

in combination a public mood open to change in mental health policy."[37] In the 1960's, state and federal public policies reflected back once more to the optimism and care of the moral management days of the early 1800's or the progressivism of the early 1900's. Human rights of mental patients were espoused; the movement to deinstitutionalize began; outpatient care, diagnostic services, pre-care and after-care were introduced.

[37] Ibid.

CHAPTER THREE

JFK AND THE BIRTH OF COMMUNITY MENTAL HEALTH IN 1963

President John F. Kennedy, a staunch supporter of the mentally ill and mentally retarded, asserted in 1963 that "the mentally ill and the mentally retarded need no longer be alien to our affections or beyond the help of our communities."[38] In fact, he went so far as to assert that "mental retardation ranks with mental health as a major health, social, and economic problem in this country."[39] In his presidential term, he signed the Maternal and Child Health and Mental Retardation Planning Amendment to the Social Security Act, the first major national legislation to combat mental illness and retardation. He provided planning grants to enable states to update their programs for the mentally retarded, as well as funding for the construction of community facilities related to the prevention and care for people with mental retardation. JFK's administration decided that no federal funds should go to state mental hospitals because state mental hospitals would violate the intent of a Democratic Congress, reflecting a basic shift in policy towards community mental health services. The new Democratic administration appeared to have two major objectives, given rising poverty rates following the development of big city ghettos in the 1950's and JFK's election into office in part because of the poor vote. The two objectives were to provide assistance to disenfranchised groups via economic prosperity, and to use direct federal intervention to exert influence over the behavior of those disenfranchised

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[38] John F. Kennedy Presidential Library and Museum. *Mental Retardation.* n.d. http://www.jfklibrary.org/JFK/JFK-in-History/Mental-Retardation.aspx.

[39] Ibid.

groups.[40] Mental health programs were therefore created and clinics were built within needy areas, generating community support and fostering political support among the poor for the Democratic Party. These social welfare programs had an orchestrated political strategy, and the community mental health centers proliferation of the 1960's had an antipoverty slant.

In 1962 JFK established the President's Interagency Task Force on Mental Health. The task force, composed of the leadership of NIMH and economists from the Bureau of the Budget and the Council of Economic Advisors, elected to bypass the states in favor of direct aid to communities, due to the administration's "profound distrust" of state governments during the civil rights movement and state resistance to implementing federal welfare programs.[41]

JFK started the greatest revolution in American mental health policy history when he signed into law the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (CMHCA). The CMHCA was a psychiatric revolution which sought to sweep away "a dark age of institutional confinement."[42] JFK signed the act into law less than one month before his death, issuing with the act a special message emphasizing three things: the large numbers of mentally ill persons and great costs incurred in caring for them; the horrific conditions in state hospitals; and the hope offered by new therapeutic techniques and psychotropic drugs.[43] Moreover, he stressed prevention as well as treatment. The CMHCA offered a compromise between the public health and medical model approaches and argued for

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[40] Cameron, James M. "A National Community Mental Health Program: Policy Initiation and Progress." In *Handbook on Mental Health Policy in the United States*, by David A. Rochefort, 121-142. New York: Greenwood Press, 1989.

[41] Ibid.

[42] Rochefort, David A. *From Poorhouses to Homelessness.* Westport: Auburn House, 1993.

[43] John F. Kennedy Presidential Library and Museum. *Mental Retardation.* n.d. http://www.jfklibrary.org/JFK/JFK-in-History/Mental-Retardation.aspx.

the expansion of individual-oriented and community-wide services to combat mental illness. It was the first national move toward deinstitutionalization and in fact it was a national mandate for deinstitutionalization. It envisioned 2,000 community mental health centers throughout the nation, promising a concrete alternative to the asylum and long-term custodial hospitalization. The CMHCA called for a 50 percent reduction in the number of mental health patients under custodial care.[44] It offered federal matching funds for the construction of community mental health centers based on state population and the state's financial need. There was also budgetary support to staff centers upon building.[45]

Rochefort asks, how did such a bold new approach to mental health policy pass through JFK's deadlocked Congress, which failed to make other major social welfare policy innovations? He cites two explanations and offers a third. First, the progressive view argues that community mental health legislation originated within a small oligopoly of federal officials, congressmen, and activist reformers who used legislature as a vehicle for reform of existing mental health practices. Second, the radical view, asserts that the Community Mental Health Centers Act was not a humanitarian advance but a form of community-based social control used to promote "welfare capitalism." Rochefort disagrees with both views and argues that JFK's innovative mental health legislation passed through Congress because the members listened to their constituents who saw the mentally ill through new eyes in the decades following WWII. Surveys administered in the 1960's indicate a shift in public opinion towards recognizing mental illness, believing that mental illness is curable, and feeling less social distance between respondents and

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[44] Rochefort, David A. *From Poorhouses to Homelessness.* Westport: Auburn House, 1993.

[45] Cameron, James M. "A National Community Mental Health Program: Policy Initiation and Progress." In *Handbook on Mental Health Policy in the United States*, by David A. Rochefort, 121-142. New York: Greenwood Press, 1989.

the mentally ill. Political scientist Henry Foley credits these changes in opinion to the efforts of an elite group of policymakers and activists in the years following WWII. These elite policymakers and activists included the American Hospital Association (AHA) and the American Psychiatric Association (APA), who estimated that up to 10 percent of the population in urban areas were mentally ill—dissolving the myth that the mentally ill composed only a small, anomalous group of "bizarre deviants."[46]

The mentally ill increasingly came to be seen as a deserving group, which led naturally to less isolating and socially stigmatizing treatment and policy options. State hospitals came under attack for being grossly inadequate. Robert Felix, director of the NIMH, was the strongest fighter against centralized state mental hospitals, which held 500,000 patients in 1963.[47] Deinstitutionalization was the popular concept which almost all—activists, politicians, and the populous—bought into. Hospital populations declined rapidly and the passage of Medicaid and Medicare in 1966 hastened the shift of aged patients from state hospitals to nursing homes, stimulating the use of community psychiatric services. As these community psychiatric services grew, they began to serve populations previously not receiving services—people who, while certainly mentally ill, were not chronic or severe enough to warrant full hospitalization. Many of the changes in the mental health system occurred because of the expansion of services and recruitment of new patients, creating a decentralized and heterogeneous system of services which

[46] Rochefort, David A. "Origins of the "Third Psychiatric Revolution": The Community Mental Health Centers Act of 1963." *Journal of Health Politics, Policy and Law*, 1984.

[47] Ibid.

was no longer solely concerned with the severely and chronically mentally ill, but also other groups who needed psychological services.[48]

These decentralizing, deinstitutionalizing policies, though effective on paper, did not work as planned. The distinction between "care" and "treatment" became distorted. While community policies paid rhetorical homage to the need for care, their primary focus was on providing therapeutic treatment. The social and human needs of patients were often ignored, or overlooked. This raised a host of concerns over the deinstitutionalizing legislation of the 1960's, as many chronically mentally ill persons no longer had state hospitals in which to reside and became reinstitutionalized from state hospitals to nursing homes, jails and prisons, or into homelessness. Though sometimes offered therapeutic services, their placement (if not with caring family and friends) left them vulnerable to social ostracism, without necessary social services. Sociologist David Mechanic blames the unfortunate initial results of deinstitutionalization on a lack of empirical evidence. He maintains that "the operation of mental health programs has proceeded more on an ideological thrust than on any empirically supported ideas concerning the feasibility and the effectiveness of particular alternatives."[49]

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[48] Grob, Gerald N. "Mental Health Policy in America: Myths and Realities." *Health Affairs*, 1992: 7-22.

[49] Rochefort, David A. "Origins of the "Third Psychiatric Revolution": The Community Mental Health Centers Act of 1963." *Journal of Health Politics, Policy and Law*, 1984.

CHAPTER FOUR

DEINSTITUTIONALIZATION AND ITS DISCONTENTS

From 1963 to 1980, the CMHCA went through a series of amendments to extend its life. After the passing of JFK, President Lyndon B. Johnson committed to fulfilling the social programs agenda he inherited. The general political strategy of the Democratic administration under LBJ was to bypass the states, and this was reflected in funding for community-based social programs under the direction and control of federal leaders who were themselves committed to social change (while state governments were not).[50] In 1965, Congress passed the Health Insurance for the Aged Act (Medicare) and the Grants to the States for Medical Assistance Programs Act (Medicaid), which provided some assistance to the mentally disabled. The Narcotic Addict Rehabilitation Act of 1966 established national legislation for the long-term treatment and rehabilitation of narcotic addicts, and alcoholism was recognized as a major public health problem with the establishment of the National Center for Prevention and Control of Alcoholism.

There was also a vote-acquiring tilt about it all, where communities receiving federal funds from the CMHCA and its amendments would be informed that these were Democratic monies coming in and being spent on them. To garner public support, Congress passed the Alcoholic and Narcotic Addict Rehabilitation Amendments of 1968, which integrated services for the prevention and treatment of alcohol and drug addiction with the CMHCA. This was another broadening of federal purview over the mental health system. The Community Mental

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[50] Cameron, James M. "A National Community Mental Health Program: Policy Initiation and Progress." In *Handbook on Mental Health Policy in the United States*, by David A. Rochefort, 121-142. New York: Greenwood Press, 1989.

Health Centers Amendments of 1970 did quite the same thing, identifying children this time as needing special mental health programs. The CMHCA, originally enacted for five years, was expanded to eight years. These expansions were seen by Congress as "a long-term national commitment designed to replace traditional public mental hospitals and to establish community mental health centers."[51]

However, the Nixon administration following LBJ was not fond of these goals and strongly opposed the CMHCA, leading to hostility and a protracted period of confrontation between the Executive branch and Congress over the CMHCA. The Nixon administration resisted spending the money allocated to community mental health centers and between 1970-1973, only 50.5 million dollars were allocated out of the authorized $340 million dollars—less than 15 percent.[52] The Nixon administration similarly refused to expend other funds congressionally authorized by the Great Society programs during the 1960's. However, the CMHCA survived because it had developed a strong national constituency. While public support for other federally initiated community programs decreased in the 1970's, community mental health advocates maintained strong support.

President Gerald Ford, following Nixon, also attempted to block the moves of Congress to expand the CMHCA. Ford continued to refuse to approve acts via pocket veto. However, Congress continued to pass acts such as Title III of the Health Revenue Sharing and Health Services Act by overriding presidential veto, which extended CMHC funding for two years. The CMHCA was renewed once more in 1977, and again in 1978 for two years—indicating

[51] Ibid.

[52] Ibid.

continued Congressional support of the community-based care and continued public support for the community mental health movement. By 1975, the movement was so effective that the number of patients in mental hospitals had declined by 62 percent from JFK's address in 1963, which originally aimed for a 50 percent reduction.[53]

Idealists of the community mental health movement believed that state and local resources would follow patients after their discharge from state institutions, as funds would be redirected from state hospitals to community-based care. This proved to be a false assumption, however. States were not pleased to support mental health programs and little more than custodial care was provided. Major gaps in service were never addressed, particularly the lack of rehabilitative and aftercare services for the chronically mentally ill. Poor coordination between state hospitals and community mental health centers also made continuous care for the chronically mentally ill patchy at best. Worse yet, states divested themselves of responsibility for the mentally ill by transferring patients to private nursing homes or board-and-care facilities away from state facilities as a result of Supplemental Security Income (SSI) and Medicaid offering financial support. The chronic mentally ill patient was often left homeless or forced to live in "substandard unregulated for-profit accommodations."[54] The seriously mentally disabled were quietly ignored (despite evidence that they were in large part, neglected, and "fell through the cracks" in the community system). There existed a "procrustean determination to make the evidence fit the theory."[55] These underserved patients were noticed in the late 1970's by the

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[53] Rochefort, David A. *From Poorhouses to Homelessness.* Westport: Auburn House, 1993.

[54] Cameron, James M. "A National Community Mental Health Program: Policy Initiation and Progress." In *Handbook on Mental Health Policy in the United States*, by David A. Rochefort, 121-142. New York: Greenwood Press, 1989.

[55] Ibid.

Carter administration and Congress, and 1975 amendments to the CMHCA acknowledged that community mental health centers must coordinate with other agencies, but no authority was established to ensure coordination.

By 1980, deinstitutionalization is in full swing. United States mental asylum populations plummeted from 560,000 to just over 130,000, leaving many of the chronically mentally ill homeless or incarcerated due to a lack of community follow-up care and housing. One-third of homeless people were believed to be seriously mentally ill.[56] Deinstitutionalization, beginning with the growth of community mental health centers following the passage of JFK's CMHCA, was "one of the era's most stunning public policy failures."[57] The CMHCA failed to provide adequate treatment for the chronically mentally ill. Programs focused too much on treating the mildly mentally ill and not enough on providing services to the chronically and seriously mentally ill. The chronically mentally ill were deprived of the all-encompassing social support offered in state mental hospitals and community mental health centers were not adequately funded by the states. Federal funding was provided to the states for the initial establishment of community mental health centers, with the provision that those funds would be discontinued in favor of state funding. However, in legislature, the states failed to allocate adequate funding, leading to a mental health system bereft of resources. While many changes occurred between 1963 and 1980, no coherent national policy emerged.

When President Jimmy Carter was elected into office in 1976, the CMHCA was surviving—but the program was in dire straits. In February 1977, as a result of the trouble that the CMHCA was in, President Carter established the President's Commission on Mental Health.

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[56] Kemp, Donna R. *Mental Health in America.* Santa Barbara: ABC CLIO, 2007.

[57] Rochefort, David A. *From Poorhouses to Homelessness.* Westport: Auburn House, 1993.

A four-volume report was delivered to the President in 1978, but offered little in the way of corrective courses of action. The commission did, however, reaffirm the basic original tenants of community mental health, reiterating that public mental health care should be available to all of the population who need it and that all pathologies, including problems of daily living, should fall within the purview of mental health. In 1978 Congress passed and funded a national plan for the treatment of the chronically mentally ill. The Mental Health Systems Act was signed into law in 1980, which appeared to be a long-awaited update to the CMHCA in light of its failures. The Mental Health Systems Act provided federal funding for community mental health programs, focusing particularly on the chronically mentally ill, children and youth, the elderly, rural and minority populations. The states were given additional purview in review and management of federal grant programs. Provisions were set out for protection of mental patients' rights, and greater coordination was demanded between health and mental health planning.

President Carter's Mental Health Systems Act of 1980, though it seemed like a potential panacea for community mental health advocates, turned out to be of no effect. It was not implemented due to President Ronald Reagan's Omnibus Budget and Reconciliation Act of 1981. President Reagan, espousing a "new federalism," substantially repealed the Mental Health Systems Act, and "turned over to the states all responsibility for the provision of mental health services".[58] This was in an effort to re-enfranchise the states by a Republican perspective; to "restore them to their rightful constitutional authority and responsibilities in the federal

[58] Cameron, James M. "A National Community Mental Health Program: Policy Initiation and Progress." In *Handbook on Mental Health Policy in the United States*, by David A. Rochefort, 121-142. New York: Greenwood Press, 1989.

system."[59] The block grant was a favorite tool of the Reagan administration, used to distribute federal dollars in a way that allowed states administrative flexibility. The block grant combines multiple categorical programs that already had detailed requirements and regulations (as in categorical grants) and strips them of such requirements and regulations. It stands somewhere between the most extreme federal control (the categorical grant, exemplified by the Great Society) and the most state control (general revenue sharing). In the Omnibus Budget Reconciliation Act of 1981, fifty seven existing federal aid programs were packed together into nine block grants—one of which was the alcohol, drug abuse, and mental health services block grant. The alcohol, drug abuse, and mental health services block grant was placed under the management of the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) .

The changeover from categorical to block grant funding transferred responsibility for community mental health to state governments, reversing one of the most fundamental principles of the CMHCA. Mental health advocates of the 1960's purposely passed over the heads of state authority to promote federal objectives and to broaden the scope of mental health services. Now, in the 1980's, the alternative system of mental health care created by the CMHCA was under the control of the states, which had new ability to pursue their own programmatic objectives with their funding. Surprisingly, the once-unwilling states, in the years following the creation of the Reagan block grants, expanded total state outlays for alcohol, drug abuse, and mental health programs from 3 percent to 24 percent.[60]

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[59] Rochefort, David A., and Bruce M. Logan. "The Alcohol, Drug Abuse, and Mental Health Block Grant: Origins, Design, and Impact." In *Handbook on Mental Health Policy in the United States*, by David A. Rochefort, 143-171. New York: Greenwood Press, 1989.

[60] Ibid.

Furthermore, management performance improved in the states after receiving block grants. One advantage espoused by block grant theory is that the consolidation of fragmented categorical programs will result in improved management performance using state-level administration. Evaluation studies of the Reagan block grants indicate that administrative improvements and efficiencies were realized in most states. However, the ones which already had the strongest administrative capacity and the most fully developed mental health systems best utilized the ADAMH block grant.[61]

Perhaps most importantly, the delegation of prioritizing from the federal government to the states allowed for states to determine what is in their best interest. New concepts of organization, financing, management, and delivery of services became possible because of the expanded supervision of state government. In particular, the chronically mentally ill were better served by state oversight than by federal oversight, due to the difficulty of servicing such a population from the national level.

Another result of the Reagan administration's shift from categorical to block grants was the diversification of services between states. With no unifying national policy, state mental health programs varied to represent local values and conditions but critics feared that the lack of single purpose would cause the abandonment of previously established national objectives, such as access for all and service for diverse social groups.[62] Insufficient oversight, another problem in the tension between permissiveness and control within the intergovernmental system, was made evident in surveys administered between 1990 and 1991. Independent and government reports found that as many as 249 community mental health centers received federal funding but

[61] Ibid.

[62] Rochefort, David A. *From Poorhouses to Homelessness.* Westport: Auburn House, 1993.

failed to provide basic services required by law—by some estimates, $100 million was used for purposes in violation of the CMHCA.[63]

The introduction of block grants and dissolution of the CMHCA categorical grants received mixed reviews. Some mental health professionals saw the ADAMH block grant as a crisis—a lack of federal oversight, no unifying national mental health policy, and perhaps most terrifying of all: trusting the states to manage their own mental health programs. Others viewed the grant as a great opportunity—the states could finally take care of their mentally ill in a way which made sense based on their needs, rather than what the federal government mandated. Retrospectively, the states did demonstrate a "willingness and capacity to accept the new responsibilities they acquired under the program."[64]

Despite this state willingness to serve its mentally ill, mental health policy in America continues to fail its neediest. Mental health policy since the 1980's has had little to do with legislation, and much more to do with insurance. Medical insurance began covering mental health much later than physical health, and even when coverage has existed, it was less extensive. Private group health insurance originated during the 1930's, after the Great Depression. At this time, public authorities were the established payers for mental health care, through state and county asylums. As insurance spread during and after WWII, insurance coverage became more complete and included mental health services. The first mental health insurance was offered by Blue Cross and Blue Shield, pushed forward by the expansion of office-based service delivery and increased use of general hospitals and outpatient clinics. Blue

[63] Ibid.

[64] Ibid.

Cross and Blue Shield's mental health coverage only covered technical procedures, such as electroshock therapy and psychosurgery (such as the prefrontal lobotomy). Commercial insurers in the 1960's offered inpatient care and outpatient psychotherapy in an attempt to attract customers, using deductibles and coinsurance provisions to control costs. In 1965, Medicare provided "generous" psychiatric benefits which became a "benchmark" which other insurers, Blue Cross and Blue Shield included, were expected to measure up to.[65]

In the 1970's and 1980's, as the CMHCA passed through the stages of development until the Reagan administration's switch to the ADAMH block grant, states passed legislation mandating a minimum set of mental health care benefits from private insurers. By 1990, a majority of states had minimum benefit mental health legislation.

The 1990's were designated as the "Decade of the Brain" by Congress, signed by President George W. Bush.[66] Indeed, much advancement occurred in the 1990's for the mentally ill. The Americans with Disabilities Act is passed, providing protections for people with any disability—mental or physical. The Public Health Service Act is passed in 1991 and it set requirements for state comprehensive mental health service plans. In 1992 the ADAMHA Reorganization Act abolished Reagan's ADAMHA and created the Substance Abuse and Mental Health Services Administration in its stead.

Yet, despite these advances and expansions in insurance for the mentally ill, in 1990 only one fifth of those with mental illness received treatment.[67]A 1992 survey of American jails

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[65] Ibid.

[66] Kemp, Donna R. *Mental Health in America.* Santa Barbara: ABC CLIO, 2007.

[67] Ibid.

reported that 100,000 seriously mentally ill people are in jails and prison—7.2 percent of inmates. "Over a quarter of them are held without charges, often awaiting a bed in a psychiatric hospital."[68]

A 1990 report by the Public Citizen Health Research Group and the National Alliance for the Mentally Ill found that public psychiatric services were in "near-total breakdown". Only one in five of the 2.8 million people with serious mental illness were receiving adequate care. The federal budget for mental health research was only a fraction of the billions spent on AIDS, cancer, and heart disease—only $515 million. Not since the 1830's had so many people with mental illness been living on the streets. The report found eight specific crises in the American mental health system:

1) More than twice as many people with schizophrenia and bipolar disorder lived in public shelters or on the streets than in public mental hospitals (at least 150,000).

2) There were more people with schizophrenia and bipolar disorder in prison and jails than in public mental hospitals (about 100,000).

3) Increasing violent episodes by seriously mentally ill persons were a consequence of not receiving adequate treatment.

4) Mental health professionals left the public sector to work in the private sector.

5) Most community mental health centers have been failures.

6) Funding of public services for individuals with serious mental illness was chaotic.

[68] Ibid.

7) An undetermined portion of public funds for services for people with mental illness was stolen.

8) Administrators with no experience created guidelines for serving people with mental illness.

In the 1990's, community mental health services involved 2,965 organizations providing services to 3 million people, or 1.22 percent of the population.[69] However, despite the vast amount of organizations, only one fifth of mentally ill people were being adequately served in 1990. Nevertheless, President George H. W. Bush continued deinstitutionalizing with the vision to eliminate the national role in providing services to the mentally ill, delegating that role to the states.

In 1992, the Department of Health and Human Services reorganized mental health programs into the Substance Abuse and Mental Health Services Administration (SAMHSA), consisting of the Center for Mental Health Services, the Center for Substance Abuse Prevention, and the Center for Treatment Improvement. The institutes on mental health, drug abuse, and alcohol and alcohol abuse were shifted to the National Institutes of Health.

President Bill Clinton attempted to radically alter healthcare during his term of office with the Health Security Act of 1993, but it was defeated by a Republican Congress. Modest, incremental changes marked the rest of President Clinton's term. In 1995, the Social Security Administration became an independent agency. In 1996, Congress passed the Mental Health Parity Act, which required that annual and lifetime dollar limits on mental health care be not stricter than for other medical care. But in 1997 the Balanced Budget Act reduced funding for

[69] Ibid.

Medicaid and Medicare, which cut back funding for many public mental health programs.[70] In 1999, the first White House Conference on Mental Health is held—in the same year, the Surgeon General's report on mental health was released. Regardless of pressure from the executive branch on Congress to reform, no coherent national policy emerged despite President Clinton's commitment to healthcare.

In 2001, the World Health Organization released a landmark publication aimed to raise public and professional awareness of mental disorders titled *The World Health Report 2001:Mental Health: New Understanding, New Hope*.[71] The report sought to decrease stigma around mental illness, report accurate and recent statistics about mental illness, and to encourage governments to take their roles as national leaders in the treatment of the mentally ill.

In 2002, President George W. Bush created the President's New Freedom Commission on Mental Health, which acknowledged that the mental health system had problems which allowed the chronically mentally ill to fall through the cracks. It recommended Americans to better understand mental health and that mental health care should be community-driven. California's Assembly Bill 34 was identified as an excellent program using resources effectively while producing positive outcomes, which turned the national eye of mental health professionals onto the west coast.

In 2008, Congress passed the Mental Health Parity and Addiction Act with the Emergency Economic Stabilization Act of 208, which eliminated higher deductibles for mental

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[70] Ibid.

[71] Kemp, Donna R. *Mental Health in America.* Santa Barbara: ABC CLIO, 2007.

health care and restrictions of treatment. Federal law mandated that all states and group health plans were to comply by 2010.

In short, JFK's CMHCA was the first and last piece of legislation which offered a national solution to mental health care policy problems. While it was unsuccessful at treating the chronically mentally ill, it did succeed in expanding mental health care services to the non-institutionalized moderately and mildly mentally ill. It stood for 17 years on amendments, but when President Reagan came into office a "new federalism" altered the national vision for mental health care policy. Instead of federal mandate and oversight, state control was espoused. At first, the states did not respond enthusiastically but in time did accept responsibility for the mentally ill and implemented policies uniquely helpful to their residents. After 1990, mental health care policy was closely interwoven with insurance policy and mental/physical health parity legislation helped more insured people gain access to mental health services.

However, mental health care treatment remained disjointed for the chronically mentally ill, and in that way the American mental health system has failed and continues to fail its neediest. Without support 24 hours a day, 7 days a week—required for 25% of the severely mentally ill population—many mentally ill people become homeless or incarcerated.[72] In that way, the penitentiary is the new American asylum, and the system continues to need a better solution.

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[72] PBS Frontline. *Deinstitutionalization: A Psychiatric "Titanic"*. May 10, 2005. http://www.pbs.org/wgbh/pages/frontline/shows/asylums/special/excerpt.html.

CHAPTER FIVE

CALIFORNIA, A LABORATORY OF POLICY

The concept of federalism is encapsulated by the metaphor that the states are the laboratories of democracy. Nowhere is this truer than in California. California has been at the forefront of mental health policy since its admission as a state. This has not always been positive, for mental health policy both in California and in the United States has had several eras of darkness. Nevertheless, California is a worthwhile state to study especially since the passage of Proposition 63, the Mental Health Services Act of 2004, which could preclude the next national move in mental healthcare legislation.

In 1850, California was admitted into the Union and from the outset the state assumed responsibility for the mentally disabled. San Francisco Marine Hospital, Sacramento State Hospital, and Stockton State Hospital were established to treat both the physically ill and the "insane."[73] By 1853, Stockton State Hospital was recommitted exclusively to mental health care and renamed the California Asylum for the Insane--it became the first such hospital in the western United States. Moral management and principles of compassionate care were practiced at the California Asylum for the Insane, as well as other insane asylums located in the rural Californian countryside. Through the 1850's, 60's, and 70's, the population at the California Asylum for the Insane skyrocketed from 62 patients to 1,047. Staff shortages and overcrowding caused a movement away from practices of moral management (a decrease in medical, moral and

[73] Department of Mental Health Office of Public Affairs. "Caring for Californians: An Overview of the State Department of Mental Health." Sacramento, 1990.

recreational activities) and more emphasis on custodial care. By 1875, Napa Asylum was opened to ease overcrowding.[74]

By 1920, California legislature was discussing community placement, decades ahead of the rest of the nation. This early consideration of community treatment was a cost-saving move rather than an action to provide better treatment. At the time, community mental health services were considered to be sub-par but cheaper than full-time asylum treatment. Like the rest of the nation, just the discussion of community-based care did not lead to an immediate transition of patients—in 1938 there were still 22,000 patients in Californian mental hospitals.[75]

In the early twentieth century California took part in an enormous violation of the civil rights of mentally ill persons. Between 1907 and 1940, 18,552 mentally ill persons were surgically sterilized in the United States following the development of the monstrous philosophy of eugenics. More than half of these sterilizations were performed in California.[76] Furthermore, pressed by increasingly crowded asylums and financial imbalances, the Department of Institutions (previously known as the Commission on Lunacy) saw fit to deport immigrants found to have mental illness, and reported a savings of $8.5 million by deporting 4,160 mentally ill persons and 2,987 delinquent persons between 1923 and 1929. Lobotomy was a procedure frequently used in Californian asylums. Over time, the civil rights of the mentally ill were upheld, and in 1976 psychosurgery was outlawed in California.

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[74] Ibid.

[75] Kemp, Donna R. *Mental Health in America.* Santa Barbara: ABC CLIO, 2007.

[76] Ibid.

In California as in the rest of the nation, the Great Depression cut mental health budgets tremendously. Following the Great Depression, the first program in California aiming to help patients return to their home communities was designed in 1939.[77] As previously mentioned, this policy was aimed to reduce costs rather than to provide improved care in the community. Community care was still considered substandard. In 1950, the first family care program in America is formalized in California, where the state would pay citizens $25 monthly to provide homes and foster care for state hospital patients.[78]

California was the second state, after New York, to legislate for community treatment, passing the Short-Doyle Act in 1957. It created the funding structure for a community mental health system where cities and counties received reimbursement from state funds to cover part of the cost of locally operated mental health programs.[79] Short-Doyle also transferred responsibility for hospital admissions to the county mental health authority, making county mental health directors in charge of involuntary and voluntary admissions. This led to California having one of the lowest state hospital utilization rates, but a growing community mental health system.[80] Medi-Cal was established in 1966 and by 1972 the Short-Doyle community mental health services were added to the scope of benefits of the Medi-Cal program, growing the community mental health movement once more. Of course the deinstitutionalization of chronic cases led to

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[77] Department of Mental Health Office of Public Affairs. "Caring for Californians: An Overview of the State Department of Mental Health." Sacramento, 1990.

[78] Kemp, Donna R. *Mental Health in America.* Santa Barbara: ABC CLIO, 2007.

[79] State of California Department of Mental Hygiene. "Progress Report." 1963.

[80] Luna, Angela C. *Analysis of the California Mental Health Services Act.* Master's Thesis, ProQuest Dissertations and Theses, 2009.

homelessness and poor outcomes for these patients, mostly because the assumption that mentally ill people could return to loving families and communities was inaccurate.

Yet despite the failures of deinstitutionalization, during the 1960's California led the nation in community mental health development. Governor Edmund G. "Pat" Brown was elected governor in 1959 and in his first inaugural address he advocated "responsible liberalism" in California, which included expanding funding for public services.[81] In 1961 California developed a ten-year plan, leading to a state decision to stop building state hospitals, reduce the length of treatment, and enable rapid return to the community—which supported the development of local mental health programs.[82] The California state hospital population of mentally ill patients peaked at 33,757 in 1963, at the time of the passage of the CMHCA.

Governor Ronald Reagan was elected into office in 1967. In the same year, the Lanterman-Petris-Short Act was passed. It aimed "to end the inappropriate, indefinite, and involuntary commitment of mentally disordered persons…to provide prompt evaluation and treatment…individualized treatment…[and] to encourage full use of all existing agencies, professional personnel and public funds."[83] Following the national pattern, the Lanterman-Petris-Short Act started the process of converting California's hospital-based mental health system to community care and was primarily espoused by politicians Art Bolton and Steve Thompson.[84] The intent of the reform was to link involuntary treatment to the community mental health

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[81] Estrada, Elaine. *The Future of Mental Health in California.* Master's Thesis, ProQuest, 2007.

[82] Kemp, Donna R. *Mental Health in America.* Santa Barbara: ABC CLIO, 2007.

[83] Official California Legislative Information. *Welfare and Institutions Code Section 5000-5120.* n.d. http://www.leginfo.ca.gov/cgi-bin/displaycode?section=wic&group=04001-05000&file=5000-5120.

[84] Mental Health America of California. *History: Proposition 63: How Did It Happen?* n.d. http://www.mhac.org/mhservices/history.cfm.

system, remove financial obstacles to using community rather than state hospital services, and set up an involuntary commitment process which balanced civil rights and public safety.[85] It created a series of holds for people who were dangerous to themselves or others, but also aimed to protect individual rights through judicial review and individual treatment.[86] It also increased state funding to 90 percent for local community mental health programs, further encouraging deinstitutionalization and promoting community-based care and treatment.

By 1973, 80 percent of California's state hospital population had been deinstitutionalized. A Senate committee considered closing the state hospitals entirely, but hearings indicated that the community mental health programs were not effective in providing care for the chronically mentally ill—as was the case nationally, and continues to be the case today. By 1980 the number of residents living in state hospitals was under 4,000, a nearly 90 percent decline; by 1990 the number of residents was under 1,800.[87]

However, Reagan took steps to decrease funding for community clinics. He made significant cuts to the Department of Mental Hygiene in an attempt to balance the state budget. Consequently, mentally ill people oftentimes became the responsibility of their families and local communities, and community clinics were often overwhelmed by the need. In California, deinstitutionalization left patients and families having to cope with a lack of outpatient programs for reintegration and rehabilitation. The mentally ill who were not lucky enough to have families

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[85] Department of Mental Health Office of Public Affairs. "Caring for Californians: An Overview of the State Department of Mental Health." Sacramento, 1990.

[86] Nguyen, Connie. *Exploring California's Mental Helath Services Act of 2004: A Policy Analysis.* Master's Thesis, ProQuest LLC, 2010.

[87] Luna, Angela C. *Analysis of the California Mental Health Services Act.* Master's Thesis, ProQuest Dissertations and Theses, 2009.

to return to, or community mental health centers to receive treatment from, often were incarcerated or became homeless.[88]

Assembly Bill 1288 was passed in 1991, known as the Bronzan-McCorquodale Act. This reform, referred to as "realignment," included programmatic, governance, and fiscal changes and became the groundwork for future reforms under California's Medicaid Managed Mental Health Plan. Under realignment, mental health was no longer funded as part of the state's general fund but instead was funded from a state trust. The trust was funded by a half-cent increase in sales tax and by an increase in vehicle license fees. Realignment created a common vision and philosophy of service, set target populations, established systems-of-care treatment approaches, put in place a minimum array of services, increased participation in decision making by consumers and advocates, set responsibility for program design at the local level, created incentives for restructuring at the state hospitals, and tied accountability to performance outcome measures. Moreover, realignment transferred responsibility for all of these things to counties rather than to the state, allowing counties to be flexible with their allotted funding.[89]

In 1999 Governor Gray Davis, passed mental health parity legislation requiring insurance companies to provide insurance coverage for mental health comparable to that for other medical conditions. This was a follow-up to the Mental Health Parity Law, a national parity law passed in 1996. Parity laws acknowledged that certain mental illnesses at least had an element of biology to them, and were not purely constructs of the mind. Schizophrenia, schizoaffective disorder, bulimia nervosa, anorexia nervosa, bipolar disorder, panic disorder, autism, and obsessive-

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[88] Estrada, Elaine. *The Future of Mental Health in California.* Master's Thesis, ProQuest, 2007.

[89] Nguyen, Connie. *Exploring California's Mental Helath Services Act of 2004: A Policy Analysis.* Master's Thesis, ProQuest LLC, 2010.

compulsive disorder were covered.[90] In 2001, a study was completed to examine the implementation of California's Mental Health Parity Law. It did not seem to have adverse consequences, such as premium increases or decreases in health insurance coverage, but there were administrative challenges caused by limitations set by professionals who diagnosed patients. There was also a lack of consumer education; many did not realize that they had expanded mental health benefits. But of course, the insurance parity laws only affected those with insurance, and certainly many of the chronically mentally ill were lacking coverage.

In 1999, as a response to the failures of deinstitutionalization and the high rates of mental illness among homeless populations, Assemblyman Darrell Steinberg (the later Senator and author of Proposition 63, the Mental Health Services Act) introduced Assembly Bill 34, Integrated Services for Homeless Adults. 10 million dollars were allocated for pilot programs which intended to treat people who were mentally ill and homeless or at risk of being incarcerated, and later to offer housing and intensive recovery services. The pilot programs were so effective in reducing homelessness, incarceration, hospitalization and unemployment, that Assembly Bill 2034 expanded the pilot programs. The expansion increased funding to 55 million dollars, growing the service area from 3 counties to 31 additional counties, and offering additional cultural- and linguistic-competent services.

Assembly Bills 34 and 2034 sought to address specifically those populations which were underserved as a result of deinstitutionalization following the CMHCA in 1963, using a "whatever it takes" approach.[91] These populations, particularly the chronically mentally ill, oftentimes wound up homeless or incarcerated. Their primary mode of (very costly) treatment

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[90] Ibid.

[91] Estrada, Elaine. *The Future of Mental Health in California.* Master's Thesis, ProQuest, 2007.

was emergency hospitalization, which far exceeded the costs of preventative care. Assembly Bill 34 was identified by President George W. Bush as a model program in the President's New Freedom Commission on Mental Health in 2003. The commission reported that the bill resulted in a 66 percent decrease in days of psychiatric hospitalization, 82 percent decrease in days of incarceration, and 80 percent decrease in days of homelessness.[92] Because preventative care was shown to work in the pilot project Assembly Bill 34, the road was paved for another piece of legislation, Proposition 63. Proposition 63, the Mental Health Services Act, was passed in 2004 and levied a one percent tax on taxable income above on million dollars, guaranteeing a dedicated revenue source of approximately 700 million dollars per year for community mental health programs determined by the needs of each individual county.

[92] Ibid.

CHAPTER SIX

CALIFORNIA'S PROPOSITION 63: THE MENTAL HEALTH SERVICES ACT OF 2004

Proposition 63, the Mental Health Services Act, was drafted by Senator Darrell Steinberg and was introduced to the public in September 2004. It was long-awaited by mental health providers and policymakers who, since the 1960's, watched mental health services funding grow smaller and smaller after the deinstitutionalization which started in 1963. The Mental Health Services Act (MHSA) was ultimately intended to fulfill the promises of President John F. Kennedy's Community Mental Health Centers Act of 1963, which included deinstitutionalization from asylums but increased and adequate community mental health services for all chronically, moderately, and mildly mentally ill people.[93] Proposition 63 circumvented the legislative process via a ballot measure, which was hotly debated in the press leading up to the passage of the act. The MHSA was funded by a one percent tax increase on taxable income over one million dollars, held in the Mental Health Services Fund.

There were seven focus areas in the MHSA: children's care, adult care, prevention and early intervention, wraparound services for families, innovative program development, mental health workforce education and training, and capital facilities and technology.[94] To reach its goals in each focus area, the MHSA implements "innovative, prevention-focused, client-centered, community-based, culturally competent, and integrated services programs, based on the

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[93] Estrada, Elaine. *The Future of Mental Health in California.* Master's Thesis, ProQuest, 2007.

[94] California Deparment of Mental Health. "Mental Health Services Act." April 24, 2009. http://www.dmh.ca.gov/Prop_63/mhsa/docs/MHSAafterAB100.pdf.

model established by [Assembly Bill 34]."[95] The difference between the MHSA and CMHCA was that the CMHCA advocated community support, but not a continuum of services (including housing, social services, et cetera.) The MHSA is a hybrid system using community support as well as a continuum of care approach, described as the community-based integrated services approach. The MHSA attempts to be the best of both worlds.

The MHSA was a response to the historical dearth in mental health service provision in California. In the 1980's following deinstitutionalization, "thousands ended up on the streets homeless and incapable of caring for themselves. [In 2004,] thousands of suffering people remain on our streets because they are afflicted with untreated severe mental illness." The MHSA text asserted that "people who become disabled by mental illness deserve the same guarantee of care already extended to those who face other kinds of disabilities," indicating a gross injustice in the current system of care.[96]

The MHSA text claimed that not only are people left homeless and hungry, but they are also left hurt and unheard. Mental illness is extremely common and affects almost every family in California. Mental illness is no discriminator—it affects people of all backgrounds and all ages. Yet, mental illness often goes untreated and destroys individuals and families in the absence of timely rehabilitation. "For too many Californians with mental illness", the MHSA held, "the mental health services and supports they need remain fragmented, disconnected, and often inadequate, frustrating the opportunity for recovery."[97]

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[95] Estrada, Elaine. *The Future of Mental Health in California.* Master's Thesis, ProQuest, 2007.

[96] California Department of Mental Health. *Mental Health Services Act (Proposition 63).* n.d. http://www.dmh.ca.gov/Prop_63/mhsa/.

[97] Ibid.

Perhaps the greatest injustice the MHSA found was that "recovery from mental illness is feasible for most people." In 1999, Assembly Bill 34 was passed and was recognized in 2003 as a model program by the President's Commission on Mental Health. This model program was "culturally and linguistically competent… [and] provided in an integrated services system."

Many of the assertions of the introductory MHSA text continue to hold today. As an ongoing problem, true both in 2004 and in 2012, mental illness is the leading cause of disability and suicide. It results not only in homelessness and despair for the chronically afflicted, but also in disability and dysfunction for mentally ill people in all walks of life. Not only is there an enormous human cost, but there's also an enormous economic cost of mental illness, and these costs are ultimately paid by the taxpayer. Costs include emergency medical care (in the case of a psychotic episode or suicidal ideation, for example); long-term nursing home care (as in dementia); unemployment (as in any chronic mental illness); housing; and law enforcement including juvenile justice, jail, and prison. Instead of those destinations for the mentally ill, MHSA offered that by expanding programs that have demonstrated their effectiveness, California could save lives and money. Early diagnosis, a very effective tool, prevents disability and according to the MHSA was another method by which to balance the Californian budget. But the initial costs were something to be considered—and later debated on both sides of the political spectrum.

In the short-term, a source of revenue to pay for the MHSA was necessary. "To provide an equitable way to fund these expanded services while protecting other vital state services from being cut, very high-income individuals should pay an additional one percent of that portion of

their annual income that exceeds one million dollars."[98] The MHSA pointed out that due to changes in federal income tax law and savings on Californian property taxes, the additional tax paid pursuant to the act would not affect take-home income for millionaires due to its small fraction of tax addition.

Taxes are levied as a means to an end, not as a pointless exercise, argued the MHSA. The purpose and intent in enacting the Mental Health Services Act was firstly to define serious mental illness as a condition deserving attention, including prevention and early intervention services and medical and supportive care. By taking these actions and treating mental illness, the long-term adverse impact of mental illness on individuals and families will abate, and state and local governments (and ultimately, the taxpayer) will experience lowered costs in the hospital and prison systems. Children, adults, and seniors (including underserved populations) will receive care from "successful, innovative service programs…including culturally and linguistic competent approaches."[99] In order to provide enough funding to adequately meet the needs of all mentally ill persons who are identified and enrolled in such aforementioned programs, but lack current funding or insurance coverage for the mentally ill, the one percent tax on millionaires was levied. Lastly, the MHSA held that all funds are to be used in the most cost-effective manner possible and services are to be provided in accordance with best practices. Oversight was to come from local and state governments to ensure accountability.

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[98] Ibid.

[99] Ibid.

The MHSA's primary purpose was to strengthen direct care and rehabilitation for the chronically mentally ill through integrated community-based services.[100] Other objectives included preventing mental illness from becoming severe and disabling; reducing stigma associated with mental illness; decreasing homelessness and incarceration related to mental illness; and reducing the duration of untreated severe mental illness.[101] While previous acts attempted to accomplish some or all of these objectives, the MHSA was unique in creating a dedicated fund with which to fund programs. It created the Mental Health Services Fund, which was filled by millionaire taxpayer dollars. The MHSA is a true "Robin Hood" tax, where taxable income over one million dollars is taxed at one percent and redistributed to the counties to serve the neediest populations. This was not lost on the citizens of California as they debated the merits and drawbacks of Proposition 63.

In the passing days and weeks after the release of the text of Proposition 63, the Mental Health Services Act, small and large news publications alike gave their take on the ballot initiative and strongly encouraged voters to vote. Whether they encouraged voters to vote yes or no was dependent on how necessary the publication saw mental health services to be—was it worth going to any length to fund these programs?

For those arguing for the measure, considering the history of mental health services in California was an important step to take when evaluating Proposition 63. The San Francisco Chronicle wrote that in the late 1960's, deinstitutionalization moved mentally ill people from state institutions with the intention of providing them holistic community-based care. There

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[100] Luna, Angela C. *Analysis of the California Mental Health Services Act.* Master's Thesis, ProQuest Dissertations and Theses, 2009.

[101] California Deparment of Mental Health. "Mental Health Services Act." April 24, 2009. http://www.dmh.ca.gov/Prop_63/mhsa/docs/MHSAafterAB100.pdf.

existed a theory that mentally ill patients would have better outcomes if they were able to live at home, surrounded by friends and family, or at minimum live outside of asylum walls. "This state made a solemn pledge that the mentally ill would continue receiving treatment in smaller, community-based settings," wrote the Chronicle.[102] Yet, the state of California has reneged on that promise and the "effects of this neglect have been devastating." As a result, "all Californians pay more," wrote Steinberg, Najera and Blanas in the Sacramento Bee, "our county jails and state prisons have become the country's largest de facto mental institutions."[103] Lynda Gledhill wrote that the Los Angeles County Jail is the largest mental health ward in California; Joan Ryan asserted that it's the largest in the world.[104] The San Francisco Chronicle concluded the historical argument when it set the claim that "California can no longer afford the cost, in dollars and human anguish, of its broken promise."[105]

The Alameda Times-Star cited one more broken promise, one made not in the late 1960's but in 1991. In 1991, counties were promised a portion of money collected from state sales taxes and vehicle license fees. But oftentimes, mental health programs were passed over for caseload-driven social service programs. It therefore became necessary not only to have a source of funding for mental health programs but a clause which states that the funds cannot be appropriated for other causes, which Proposition 63 included.

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[102] San Francisco Chronicle. "Why Prop. 63 is essential." San Francisco, September 27, 2004.

[103] Steinberg, Darrell, Albert Najera, and Lou Blanas. "Prop. 63: Treat the state's mentally ill." Sacramento: The Sacramento Bee, October 13, 2004.

[104] Ryan, Joan. "One woman takes sides on Prop. 63." San Francisco: San Francisco Chronicle, October 17, 2004.

[105] San Francisco Chronicle. "Why Prop. 63 is essential." San Francisco, September 27, 2004.

Regardless of broken promises, those who voted "yes" on Proposition 63 thought that whatever the past may be, the present moment was proof that government action was necessary immediately to help the mentally ill. Burnham Matthews, police chief of Alameda, argued that "Proposition 63 deserves support because it is the only real hope for making mental health care a priority in California." He cited that police officers spend 20% of their time dealing with untreated mental illness, and that this time would be better spent on "real crimes."[106] Hanh Quach cited that 50,000 people with mental illness are homeless in California. This was, and continues to be, a real need, and the homeless mentally ill need everything from medication to housing to counseling—but the state only provides beds for 4,500 people. "It is barely the tip of the iceberg," Steinberg pointed out.[107] Furthermore, Proposition 63 would save taxpayer money not only for millionaires but also for the common person. The San Francisco Chronicle cited amazing statistics in pilot projects similar to those that would be funded by Proposition 63: 56% reduction in hospital stays, 72% reduction in jail stays, and 65% increase in full-time jobs.[108]

There were two points on which both sides could agree: ballot-box budgeting is not ideal, and there should be a logical link between revenue source and purpose. Ballot-box budgeting is a method used to fund programs without going through the tricky, sometimes slow legislative process. It is a way of "bringing it to the people." Assemblyman Darrell Steinberg, who spearheaded Proposition 63, admitted that "In a perfect world, or even a better world, you would not fund a government program by going to the ballot." As a member and chairman of the

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[106] Matthews, Burnham E. "Prop. 63 makes mental health priority." Alameda: Alameda Times-Star, October 31, 2004.

[107] Quach, Hanh Kim. "Banking on 'Millionaire Tax' to help mentally ill." Santa Ana: The Orange County Register, October 23, 2004.

[108] San Francisco Chronicle. "Why Prop. 63 is essential." San Francisco, September 27, 2004.

Assembly's Budget Committee, Steinberg was well aware of how to balance a budget. However, he continued by saying that "for the mentally ill, it has not been close to a perfect world, and it has not even been a better world. For every rule, there should be an exception, and this is the exception."[109] Proponents of Proposition 63, such as Joan Ryan, conceded that the Proposition is not a perfect law. Ryan wrote, "It is not a magic carpet…but it is an essential, logical step."[110]

Opponents countered that it is not. Ballot-box budgeting is irresponsible, they argued practically unanimously. An editorial in Mercury News stated that: "California's record on mental health is abysmal. Spending more on treatment and housing would save on prisons, police and emergency care. But putting "do not touch" signs on slices of revenue on Election Day is no way to solve the state's budget problems."[111] It encouraged a "no" vote on Proposition 63.

Proponents countered this argument by pointing out that federal tax cuts passed by President George W. Bush decreased taxes significantly for millionaires and, moreover, the Proposition 63 tax was federally deductible, making the true tax value for millionaires small if not negligible.[112]

Dan Walters, for the Fresno Bee, used a piece of history to argue that Proposition 63 is a "lousy" fiscal policy. He recanted that George Deukmejian, the conservative Republican governor of California in the 1980's, frustrated any attempts liberal political groups tried to make in legislature. Jerry Meral of the Planning and Conservation League thought up the idea to use

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[109] Gledhill, Lynda. "Campaign 2004." San Francisco: San Francisco Chronicle, October 22, 2004.

[110] Ryan, Joan. "One woman takes sides on Prop. 63." San Francisco: San Francisco Chronicle, October 17, 2004.

[111] Mercury News Editorial. "Prop. 63: No." San Jose, September 21, 2004.

[112] Rojas, Aurelio. "Mental health funding at issue." Sacramento: The Sacramento Bee, October 7, 2004.

the ballot initiative process to financially benefit those who would do signature-gathering and offer campaign money. While this would be an illegal exchange in Legislature, it was "perfectly legal" in initiative bonds. In June 1988 the technique was first used and had been adopted ever since. Proposition 63 was one such example where the major financial contributors benefitted from the passage of the law. Many financial contributors to Proposition 63 ran mental health clinics. These contributors experienced great benefits from public mental health service funding.[113]

Furthermore, opponents argued that there should be a logical correlation between the revenue source and the recipient. Sara Steffens wrote for the Contra Costa times: "there's no logical correlation between the very wealthy and the problems of mental illness…the tax would be a volatile funding source that could dry up as high-wage earners move elsewhere or the economy sours."[114] If millionaires moved elsewhere, it could severely damage the Californian budget, which is already crippled in 2004. The average millionaire in California in 2004 had a taxable income of $5 million a year, equating an average tax revenue of about $465,000 per year. Losing one of these millionaires would mean losing $505,000—the average tax plus the $40,000 added by Proposition 63. That is equivalent to 367 taxpayers, with average incomes of $31,666.[115]

Steinberg admitted that there is no "nexus" between millionaries and the mentally ill, but he frankly gave his reason for proposing such a tax: "Frankly," he said, "it's politically

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[113] Mercury News Editorial. "Prop. 63: No." San Jose, September 21, 2004.

[114] Steffens, Sara. "Prop. 63 - Mental Health." Walnut Creek: Contra Costa Times, October 17, 2004.

[115] Quach, Hanh Kim. "Banking on 'Millionaire Tax' to help mentally ill." Santa Ana: The Orange County Register, October 23, 2004.

doable."[116] And proponents argued that passing the act is the most important thing—doability was necessary, whatever the budgetary repercussions.

Less widely-accepted arguments against Proposition 63 included that paternalistic government action prevented people from taking care of themselves, and that creating more bureaucracy was not the answer to mental health issues.

One point is clear: all admitted that Proposition 63 addressed a critical need, except perhaps for "No on 63" spokesperson Jon Coupal. Coupal asserted, "If these mental health programs are that valuable, then they should have a priority on existing revenues, not a higher tax increase."[117] Coupal also claimed that singling out millionaires to foot the bill is "the ultimate form of discrimination."[118] But that was not the majority opinion from other news sources around the state. Lynda Gledhill wrote that "opponents do not question the goals of the initiative but believe a tax increase on the ballot is the wrong approach."[119] The Daily News of Los Angeles found that Proposition 63, alongside its fellow healthcare initiatives, was "good intentions gone wrong."[120]

There were strong voices on both sides of the debate in newspapers and publications throughout California. However, "money talks", and there was an enormous tilt in the scales for

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[116] Quach, Hanh Kim. "Banking on 'Millionaire Tax' to help mentally ill." Santa Ana: The Orange County Register, October 23, 2004.

[117] Alameda Times-Star. "Proposition 63: Good idea, bad tax." Alameda, October 19, 2004.

[118] Mesfin, Bilen. "Proposition 63 Expands Mental Health Services." San Luis Obispo: The Tribune, October 4, 2004.

[119] Gledhill, Lynda. "Campaign 2004." San Francisco: San Francisco Chronicle, October 22, 2004.

[120] The Daily News of Los Angeles. "Editorial; No, No and No; Props. 61, 63, and 67 Aren't the Answer." Los Angeles, October 19, 2004.

the proponents in terms of financial support. Gledhill pointed out that by October 22, 2004, opponents raised only $7,000 compared to proponents' $3,000,000 (three million). County mental health associations and labor organizations were the biggest donors.

DiCamillo and Field took polls from August through November. Democrats were overwhelmingly in favor of Proposition 63, by a four to one margin. Non-partisans supported the measure nearly three to one. A small plurality of Republicans opposed the measure.[121] Yes votes slowly crept down from August, 59 percent yes, to late October, 56 percent yes. No slowly crept up from 29 percent to 31 percent. Undecided hovered at 12-13 percent. [122]

Proposition 63, the Mental Health Services Act, was passed in November of 2004. The final tally was 53.8 percent to 46.2 percent.

It was called a "stunning electoral victory."[123] After many years of the mentally ill being ignored and their needs not being met, approximately $800 million dollars per year were allocated specifically for the mentally ill—with the counties able to use their discretion and focus on the issues that were most needed at the local level, such as help for the chronically mentally ill homeless.

California Governor Arnold Schwarzenegger, as a response to the enormous amount of revenue generated by the MHSA tax, attempted to redirect $227 million to basic mental health

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[121] DiCamillo, Mark, and Mervin Field. "Voters Sharply Divided." *The Field Poll.* San Francisco: Field Research Corporation, August 15, 2004.

[122] DiCamillo, Mark, and Mervin Field. "Health Related Propositions." *The Field Poll.* San Francisco: Field Research Corporation, October 12, 2004.

[123] Peck, Richard L. "Proposition 63: California's Mental Health Miracle." *Behavioral Health Management*, 2005: 42-46.

services originally offered under Medi-Cal, which would have completely dismissed the state's obligation to the mentally ill. This never came to fruition.

In 2006, the National Alliance for the Mentally Ill reviewed California's mental health care system and gave it a "C" grade. In 2009, California received the same grade. It acknowledged that California has been able to innovate, but cites that California has "failed to meet major challenges." [124] Unintended consequences of Proposition 63 were among the failures in California, including the creation of a two-tiered system wherein new clients enter new, updated programs but old clients are trapped in antiquated programs without wraparound services, due to a clause restricting MHSA funds from being used for existing programs. Though the MHSA has generated three billion dollars, only 724 million dollars have reached the counties.[125]

The first official review of the MHSA Community Supports and Services (CSS), one aspect of the MHSA bureaucratic structure, came in 2011. It was written by the UCLA Center for Healthier Children, Youth, and Families.[126] They found that:

- Participation in CSS programs was strongly associated with improved residential outcomes, including reductions in homelessness and increases in independent or residential living situations

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[124] National Alliance on Mental Illness. *California.* 2009. http://www.nami.org/gtsTemplate09.cfm?Section=Grading_the_States_2009&Template=/contentmanagement/contentdisplay.cfm&ContentID=74847 (accessed April 23, 2012).

[125] National Alliance on Mental Illness. *California.* 2009. http://www.nami.org/gtsTemplate09.cfm?Section=Grading_the_States_2009&Template=/contentmanagement/contentdisplay.cfm&ContentID=74847 (accessed April 23, 2012).

[126] UCLA Center for Healthier Children, Youth and Families. "Summary and Synthesis of Findings on CSS Consumer Outcomes." Evaluation Brief, 2011.

- Participation in CSS programs was strongly associated with reductions in acute psychiatric hospitalizations and arrests
- There existed an overall trend toward reduced physical health emergencies among those participating in CSS
- Positive trends appeared in education for children and youth in CSS programs, but did not have a strong correlation
- Positive trends appeared in mental health functioning and quality of life for adults and older adults participating in CSS programs, but did not have a strong correlation
- There were no trends in employment outcomes

Which is to say that the UCLA Center for Healthier Children, Youth, and Families found largely positive outcomes in association with the MHSA seven years after its passage.

However, in 2012, the MHSA is under fire for failing to follow its own priorities. Mary Ann Bernard writes that "California continues to ignore the dangerous mentally ill, while squandering millions in mental health dollars earmarked for "severe mental illness" on the worried well, whose voices are much louder in local politics."[127] Bernard points out that the MHSA earmarks 20% of funding for effective, successful programs for severe mental illness and mental illness that may become severe. However, counties are given flexibility to do practically anything with that money and in turn; $133,571,200 was spent on a host of programs in a single

[127] Bernard, Mary Ann. "Legislative Fix Needed to Stop Waste of Millions Earmarked For Severe Mental Illness." *The California Progress Report*, 2011.

2011 summer, none of which necessarily had to do with treating the mentally ill or reducing severity of mental illness.

Bernard's proposed solution is two-fold—firstly, for legislators to use the "clarification" power specified under Section 18 of the MHSA to eliminate programs which do not abide by the spirit of MHSA, which is to treat the severely mentally ill or the mentally ill which could become severe. Secondly, to make Laura's Law mandatory in each California county and to fund Laura's Law through Proposition 63. Laura's Law allows for court-ordered assisted outpatient treatment or forced anti-psychotic use on the severely mentally ill who are a danger to themselves or others.

One limitation of studying the effects of Proposition 63, the Mental Health Services Act, is that there is very little in the way of nonpartisan literature reviewing the act. The Health Policy Monitor has placed the MHSA in the "implementation" stage, not yet ripe for evaluation.[128] The California Department of Mental Health performs qualitative internal evaluations, but without accurate statistics a fair appraisal is difficult to assert.

In summation, California's Mental Health Services Act, while widely accepted as an innovative solution, has not been entirely successful. The National Alliance on Mental Illness gives California a "C" grade in mental health policy, asserting that California's mental health care system is "hostage to the state's massive budget crisis."[129] Furthermore, critics argue that

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[128] Schulz, Anke Therese, and Carol Medlin. *Mental Health Services Act (Proposition 63).* April 6, 2006. http://www.hpm.org/en/Surveys/IGH_-_USA/07/Mental_Health_Services_Act_(Proposition_63).html.

[129] National Alliance on Mental Illness. *California.* 2009. http://www.nami.org/gtsTemplate09.cfm?Section=Grading_the_States_2009&Template=/contentmanagement/contentdisplay.cfm&ContentID=74847 (accessed April 23, 2012).

the MHSA, like so many community-based acts before it, provides services to the mildly mentally ill at the expense of the chronically mentally ill, who continue to slip through the cracks. However, the Department of Mental Health continues to be optimistic in self-review and no amendments have been made to the MHSA since its passage eight years ago.

CONCLUSION

After much consideration of mental health policy affecting millions, consider one girl: Marsha Linehan. She was seventeen years old in 1961. Using sharp objects, Marsha would slice her arms, legs, and midsection and burn her wrists with cigarettes. Diagnosed with schizophrenia, Marsha was given powerful drugs and administered a total of thirty rounds of electroshock therapy. Marsha continued harming herself. Seeing no alternative, the staff at the Institute of Living, a psychiatric hospital in Hartford, Connecticut, placed her in a seclusion room in the unit Thompson Two, which held the most severely mentally ill patients at the hospital. Seeing no alternative, Marsha bashed her head against the wall, and then the floor. After 26 months, in her discharge summary, Marsha was identified as one of the most disturbed patients in the hospital.

Today a Professor of Psychology and Adjust Professor of Psychiatry and Behavioral Studies at the University of Washington, Dr. Linehan is most famously known for developing Dialectical Behavior Therapy (DBT), which combines Eastern contemplative practices such as acceptance and mindfulness with Western cognitive-behavioral techniques for emotion regulation and reality-testing. DBT is primarily used in the treatment of borderline personality disorder, which is Dr. Linehan's accurate diagnosis.

Of course it is evident—Marsha Linehan is recovered from a serious mental disorder and she has dedicated her life to helping others find recovery. She is proof positive that not only is recovery possible but so is a full, meaningful life after mental illness.

Yet, a known 30 percent of homeless people suffer from mental illness—approximately 1,155,000 people. 24 percent of state prisoners and 21 percent of jail prisoners have a recent

history of a mental health disorder—approximately 1,806,450 people. 70 percent of youth in juvenile justice systems have at least one mental disorder—approximately 60,848 youth.[130] To be homeless and incarcerated is not to be recovered. It is to be fully in the clutches of mental illness, unable to control one's own actions, causing self-harm and harm to others.

From tortures and torments in the eighteenth century to wraparound community-based care in the twenty-first, psychiatry and psychology have made enormous strides. With proper psychotherapeutic techniques and effective medication, recovery from mental illness is possible today. However, as the aforementioned statistics indicate, recovery is not guaranteed.

Who recovers? Those who are able and willing to receive community-based treatment such as the mildly and moderately mentally ill will recover, if given the proper medication and consistent therapy. Between 70 and 90 percent of individuals with mental illness experience "significant reduction" in symptoms and improved quality of life after receiving pharmacological and psychosocial treatment and support.[131] However, for those who need constant care, a community clinic will not suffice. Chief of the Bureau of Mental Health, Debbie Nixon-Hughes, asserts that 25-30 percent of those suffering with one or more chronic mental illness will always need assistance with taking medication, interacting socially, and living in the world without

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[130] National Alliance on Mental Illness. *Mental Illness: FACTS AND NUMBERS.* n.d. http://www.nami.org/Template.cfm?Section=About_Mental_Illness&Template=/ContentManagement/ContentDisplay.cfm&ContentID=53155 (accessed April 23, 2012).

[131] National Alliance on Mental Illness. *Mental Illnesses.* n.d. http://www.nami.org/Content/NavigationMenu/Inform_Yourself/About_Mental_Illness/About_Mental_Illness.htm (accessed April 23, 2012).

harming themselves or others.[132] Without this support, they end up homeless, incarcerated, or dead.

One criteria of borderline personality disorder is "black and white thinking." Also known as splitting, it is a logical fallacy in which only two alternatives—polar opposites—are considered. It seems that contemporary American mental health policy has suffered from a sort of splitting, remembering only the horrific asylums of the eighteenth century and imagining only the idealized notion of the community mental health center of 1963. There is no simple, elegant, Gordian solution. Some of the mentally ill will recover after receiving services from a community-based mental healthcare center; others will need intensive wraparound social support but can live in the community; and still others will require constant assistance and supervision to live in recovery. To best address the needs of all the mentally ill, policymakers will have to work closely with a diverse array of mental health professionals treating patients privately, in community clinics, for nonprofits, and in the penitentiary system. Moreover, policymakers will have to remember the history of mental health policy and look toward innovative states such as California, to determine best practices old and new.

Perhaps most importantly, policymakers will have to remember the humanity of the mentally ill and consider that physical and political freedom is worthless without the ability to be free in one's own mind.

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[132] PBS Frontline. *Deinstitutionalization: A Psychiatric "Titanic"*. May 10, 2005. http://www.pbs.org/wgbh/pages/frontline/shows/asylums/special/excerpt.html.

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APPENDIX A

PROPOSITION 63: THE MENTAL HEALTH SERVICES ACT

MENTAL HEALTH SERVICES ACT

SECTION 1. Title

This Act shall be known and may be cited as the "Mental Health Services Act."

SECTION 2. Findings and Declarations

The people of the State of California hereby find and declare all of the following:

(a) Mental illnesses are extremely common; they affect almost every family in California. They affect people from every background and occur at any age. In any year, between 5% and 7% of adults have a serious mental illness as do a similar percentage of children — between 5% and 9%. Therefore, more than two million children, adults and seniors in California are affected by a potentially disabling mental illness every year. People who become disabled by mental illness deserve the same guarantee of care already extended to those who face other kinds of disabilities.

(b) Failure to provide timely treatment can destroy individuals and families. No parent should have to give up custody of a child and no adult or senior should have to become disabled or homeless to get mental health services as too often happens now. No individual or family should have to suffer inadequate or insufficient treatment due to language or cultural barriers to care. Lives can be devastated and families can be financially ruined by the costs of care. Yet, for too many Californians with mental illness, the mental health services and supports they need remain fragmented, disconnected and often inadequate, frustrating the opportunity for recovery.

(c) Untreated mental illness is the leading cause of disability and suicide and imposes high costs on state and local government. Many people left untreated or with insufficient care see their mental illness worsen. Children left untreated often become unable to learn or participate in a normal school environment. Adults lose their ability to work and be independent; many become homeless and are subject to frequent hospitalizations or jail. State and county governments are forced to pay billions of dollars each year in emergency medical care, long-term nursing home care, unemployment, housing, and law enforcement, including juvenile justice, jail and prison costs.

(d) In a cost cutting move 30 years ago, California drastically cut back its services in state hospitals for people with severe mental illness. Thousands ended up on the streets homeless and incapable of caring for themselves. Today thousands of suffering people remain on our streets because they are afflicted with untreated severe mental illness. We can and should offer these people the care they need to lead more productive lives.

(e) With effective treatment and support, recovery from mental illness is feasible for most people. The State of California has developed effective models of providing services to children, adults and seniors with serious mental illness. A recent innovative approach, begun

under Assembly Bill 34 in 1999, was recognized in 2003 as a model program by the President's Commission on Mental Health. This program combines prevention services with a full range of integrated services to treat the whole person, with the goal of self-sufficiency for those who may have otherwise faced homelessness or dependence on the state for years to come. Other innovations address services to other underserved populations such as traumatized youth and isolated seniors. These successful programs, including prevention, emphasize client-centered, family focused and community-based services that are culturally and linguistically competent and are provided in an integrated services system.

(f) By expanding programs that have demonstrated their effectiveness, California can save lives and money. Early diagnosis and adequate treatment provided in an integrated service system is very effective; and by preventing disability, it also saves money. Cutting mental health services wastes lives and costs more. California can do a better job saving lives and saving money by making a firm commitment to providing timely, adequate mental health services.

(g) To provide an equitable way to fund these expanded services while protecting other vital state services from being cut, very high-income individuals should pay an additional one percent of that portion of their annual income that exceeds one million dollars ($1,000,000). About 1/10 of one percent of Californians have incomes in excess of one million dollars ($1,000,000). They have an average pre-tax income of nearly five million dollars ($5,000,000). The additional tax paid pursuant to this represents only a small fraction of the amount of tax reduction they are realizing through recent changes in the federal income tax law and only a small portion of what they save on property taxes by living in California as compared to the property taxes they would be paying on multi-million dollar homes in other states.

SECTION 3. Purpose and Intent.

The people of the State of California hereby declare their purpose and intent in enacting this act to be as follows:

(a) To define serious mental illness among children, adults and seniors as a condition deserving priority attention, including prevention and early intervention services and medical and supportive care.

(b) To reduce the long-term adverse impact on individuals, families and state and local budgets resulting from untreated serious mental illness.

(c) To expand the kinds of successful, innovative service programs for children, adults and seniors begun in California, including culturally and linguistically competent approaches for underserved populations. These programs have already demonstrated their effectiveness in providing outreach and integrated services, including medically necessary psychiatric services, and other services, to individuals most severely affected by or at risk of serious mental illness.

(d) To provide state and local funds to adequately meet the needs of all children and adults who can be identified and enrolled in programs under this measure. State funds shall be available to provide services that are not already covered by federally sponsored programs or by

individuals' or families' insurance programs.

(e) To ensure that all funds are expended in the most cost effective manner and services are provided in accordance with recommended best practices subject to local and state oversight to ensure accountability to taxpayers and to the public.

SECTION 4. Part 3.6 (commencing with Section 5840) is added to Division 5 of the Welfare and Institutions Code, to read:

PART 3.6 PREVENTION AND EARLY INTERVENTION PROGRAMS

5840. (a) The State Department of Mental Health shall establish a program designed to prevent mental illnesses from becoming severe and disabling. The program shall emphasize improving timely access to services for underserved populations.

(b) The program shall include the following components:

(1) Outreach to families, employers, primary care health care providers, and others to recognize the early signs of potentially severe and disabling mental illnesses.

(2) Access and linkage to medically necessary care provided by county mental health programs for children with severe mental illness, as defined in Section 5600.3, and for adults and seniors with severe mental illness, as defined in Section 5600.3, as early in the onset of these conditions as practicable.

(3) Reduction in stigma associated with either being diagnosed with a mental illness or seeking mental health services.

(4) Reduction in discrimination against people with mental illness.

(c) The program shall include mental health services similar to those provided under other programs effective in preventing mental illnesses from becoming severe, and shall also include components similar to programs that have been successful in reducing the duration of untreated severe mental illnesses and assisting people in quickly regaining productive lives.

(d) The program shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness:

(1) Suicide.

(2) Incarcerations.

(3) School failure or dropout.

(4) Unemployment.

(5) Prolonged suffering.

(6) Homelessness.

(7) Removal of children from their homes.

(e) In consultation with mental health stakeholders, the department shall revise the program elements in Section 5840 applicable to all county mental health programs in future years to reflect what is learned about the most effective prevention and intervention programs for children, adults, and seniors.

5840.2 (a) The department shall contract for the provision of services pursuant to this part with each county mental health program in the manner set forth in Section 5897.

SECTION 5. Article 11 (commencing with Section 5878.1) is added to Chapter 1 of Part 4 of Division 5 of the Welfare and Institutions Code, to read:

Article 11. Services for Children with Severe Mental Illness.

5878.1 (a) It is the intent of this article to establish programs that assure services will be provided to severely mentally ill children as defined in Section 5878.2 and that they be part of the children's system of care established pursuant to this part. It is the intent of this act that services provided under this chapter to severely mentally ill children are accountable, developed in partnership with youth and their families, culturally competent, and individualized to the strengths and needs of each child and their family.

(b) Nothing in this act shall be construed to authorize any services to be provided to a minor without the consent of the child's parent or legal guardian beyond those already authorized by existing statute.

5878.2 For purposes of this article, severely mentally ill children means minors under the age of 18 who meet the criteria set forth in subdivision (a) of Section 5600.3.

5878.3 (a) Subject to the availability of funds as determined pursuant to Part 4.5 (commencing with Section 5890), county mental health programs shall offer services to severely mentally ill children for whom services under any other public or private insurance or other mental health or entitlement program is inadequate or unavailable. Other entitlement programs include but are not limited to mental health services available pursuant to Medi-Cal, child welfare, and special education programs. The funding shall cover only those portions of care that cannot be paid for with public or private insurance, other mental health funds or other entitlement programs.

(b) Funding shall be at sufficient levels to ensure that counties can provide each child served all of the necessary services set forth in the applicable treatment plan developed in accordance with this part, including services where appropriate and necessary to prevent an out of home placement**,** such as services pursuant to Chapter 4 (commencing with Section 18250) of Part 6 of Division 9.

(c) The State Department of Mental Health shall contract with county mental health programs for the provision of services under this article in the manner set forth in Section 5897.

SECTION 6. Section 18257 is added to the Welfare and Institutions Code, to read:

18257. (a) The State Department of Social Services shall seek applicable federal approval to make the maximum number of children being served through such programs eligible for federal financial participation and amend any applicable state regulations to the extent necessary to eliminate any limitations on the numbers of children who can participate in these programs.

(b) Funds from the Mental Health Services Fund shall be made available to the State

Department of Social Services for technical assistance to counties in establishing and administering projects. Funding shall include reasonable and necessary administrative costs in establishing and administering a project pursuant to this chapter and shall be sufficient to create an incentive for all counties to seek to establish programs pursuant to this chapter.

SECTION 7. Section 5813.5 is added to Part 3 of Division 5 of the Welfare and Institutions Code, to read:

5813.5. Subject to the availability of funds from the Mental Health Services Fund, the State Department of Mental Health shall distribute funds for the provision of services under Sections 5801, 5802 and 5806 to county mental health programs. Services shall be available to adults and seniors with severe illnesses who meet the eligibility criteria in subdivisions (b) and (c) of Section 5600.3 of the Welfare and Institutions Code. For purposes of this act, seniors means older adult persons identified in Part 3 (commencing with Section 5800) of this division.

(a) Funding shall be provided at sufficient levels to ensure that counties can provide each adult and senior served pursuant to this part with the medically necessary mental health services, medications and supportive services set forth in the applicable treatment plan.
(b) The funding shall only cover the portions of those costs of services that cannot be paid for with other funds including other mental health funds, public and private insurance, and other local, state and federal funds.
(c) Each county mental health programs plan shall provide for services in accordance with the system of care for adults and seniors who meet the eligibility criteria in subdivisions (b) and (c) of Section 5600.3.

(d) Planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers:
(1) To promote concepts key to the recovery for individuals who have mental illness: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.

(2) To promote consumer-operated services as a way to support recovery.
(3) To reflect the cultural, ethnic and racial diversity of mental health consumers.
(4) To plan for each consumer's individual needs.

(e) The plan for each county mental health program shall indicate, subject to the availability of funds as determined by Part 4.5 (commencing with Section 5890) of this division, and other funds available for mental health services, adults and seniors with a severe mental illness being served by this program are either receiving services from this program or have a mental illness that is not sufficiently severe to require the level of services required of this program.
(f) Each county plan and annual update pursuant to Section 5847 shall consider ways to provide services similar to those established pursuant to the Mentally Ill Offender Crime Reduction Grant Program. Funds shall not be used to pay for persons incarcerated in state prison or

parolees from state prisons.

(g) The department shall contract for services with county mental health programs pursuant to Section 5897**.** After the effective date of this section the term grants referred to in Sections 5814 and 5814.5 shall refer to such contracts.

SECTION 8. Part 3.1 (commencing with Section 5820) is hereby added to Division 5 of the Welfare and Institutions Code, to read:

PART 3.1 HUMAN RESOURCES, EDUCATION, AND TRAINING PROGRAM

5820. (a) It is the intent of this Part to establish a program with dedicated funding to remedy the shortage of qualified individuals to provide services to address severe mental illnesses.

(b) Each county mental health program shall submit to the department a needs assessment identifying its shortages in each professional and other occupational category in order to increase the supply of professional staff and other staff that county mental health programs anticipate they will require in order to provide the increase in services projected to serve additional individuals and families pursuant to Part 3 (commencing with section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division. For purposes of this part, employment in California's public mental health system includes employment in private organizations providing publicly funded mental health services.

(c) The department shall identify the total statewide needs for each professional and other occupational category and develop a five-year education and training development plan.

(d) Development of the first five-year plan shall commence upon enactment of the initiative. Subsequent plans shall be adopted every five years.

(e) Each five-year plan shall be reviewed and approved by the California Mental Health Planning Council.

5821. (a) The California Mental Health Planning Council shall advise the State Department of Mental Health on education and training policy development and provide oversight for the department's education and training plan development.

(b) The State Department of Mental Health shall work with the California Mental Health Planning Council so that council staff is increased appropriately to fulfill its duties required by Sections 5820 and 5821.

5822. The State Department of Mental Health shall include in the five-year plan:

(a) Expansion plans for the capacity of postsecondary education to meet the needs of identified mental health occupational shortages.

(b) Expansion plans for the forgiveness and scholarship programs offered in return for a commitment to employment in California's public mental health system and make loan forgiveness programs available to current employees of the mental health system who want to obtain Associate of Arts, Bachelor of Arts, masters degrees, or doctoral degrees.

(c) Creation of a stipend program modeled after the federal Title IV-E program for persons

enrolled in academic institutions who want to be employed in the mental health system.

(d) Establishment of regional partnerships among the mental health system and the educational system to expand outreach to multicultural communities, increase the diversity of the mental health workforce, to reduce the stigma associated with mental illness, and to promote the use of web-based technologies, and distance learning techniques.

(e) Strategies to recruit high school students for mental health occupations, increasing the prevalence of mental health occupations in high school career development programs such as health science academies, adult schools, and regional occupation centers and programs, and increasing the number of human service academies.

(f) Curriculum to train and retrain staff to provide services in accordance with the provisions and principles of Part 3 (commencing with Section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with 5840), and Part 4 (commencing with 5850) of this division.

(g) Promotion of the employment of mental health consumers and family members in the mental health system.

(h) Promotion of the meaningful inclusion of mental health consumers and family members and incorporating their viewpoint and experiences in the training and education programs in subdivisions (a) through (f).

(i) Promotion of the inclusion of cultural competency in the training and education programs in subdivisions (a) through (f).

SECTION 9. Part 3.2 (commencing with Section 5830) is added to Division 5 of the Welfare and Institutions Code, to read:

Part 3.2 INNOVATIVE PROGRAMS

5830. County mental health programs shall develop plans for innovative programs to be funded pursuant to paragraph (6) of subdivision (a) of Section 5892.

(a) The innovative programs shall have the following purposes:

(1) To increase access to underserved groups.
(2) To increase the quality of services, including better outcomes.
(3) To promote interagency collaboration.
(4) To increase access to services.

(b) County mental health programs shall receive funds for their innovation programs upon approval by the Mental Health Services Oversight and Accountability Commission.

SECTION 10. Part 3.7 (commencing with Section 5845) is added to Division 5 of the Welfare and Institutions Code, to read:

PART 3.7. OVERSIGHT AND ACCOUNTABILITY

5845. (a) The Mental Health Services Oversight and Accountability Commission is hereby established to oversee Part 3 (commencing with Section 5800), the Adult and Older Adult Mental Health System of Care Act; Part 3.1 (commencing with Section 5820), Human Resources, Education, and Training Programs; Part 3.2 (commencing with Section 5830),

Innovative Programs; Part 3.6 (commencing with Section 5840), Prevention and Early Intervention Programs; and Part 4 (commencing with Section 5850), the Children's Mental Health Services Act. The commission shall replace the advisory committee established pursuant to Section 5814. The commission shall consist of 16 voting members as follows:

(1) The Attorney General or his or her designee.

(2) The Superintendent of Public Instruction or his or her designee.

(3) The Chairperson of the Senate Health and Human Services Committee or another member of the Senate selected by the President pro Tempore of the Senate.

(4) The Chairperson of the Assembly Health Committee or another member of the Assembly selected by the Speaker of the Assembly.

(5) Two persons with a severe mental illness, a family member of an adult or senior with a severe mental illness, a family member of a child who has or has had a severe mental illness, a physician specializing in alcohol and drug treatment, a mental health professional, a county sheriff, a superintendent of a school district, a representative of a labor organization, a representative of an employer with less than 500 employees and a representative of an employer with more than 500 employees, and a representative of a health care services plan or insurer, all appointed by the Governor. In making appointments, the Governor shall seek individuals who have had personal or family experience with mental illness.

(b) Members shall serve without compensation, but shall be reimbursed for all actual and necessary expenses incurred in the performance of their duties.

(c) The term of each member shall be three years, to be staggered so that approximately one-third of the appointments expire in each year.

(d) In carrying out its duties and responsibilities, the commission may do all of the following:

(1) Meet at least once each quarter at any time and location convenient to the public as it may deem appropriate. All meetings of the commission shall be open to the public.

(2) Within the limit of funds allocated for these purposes, pursuant to the laws and regulations governing state civil service, employ staff, including any clerical, legal, and technical assistance as may appear necessary. The commission shall administer its operations separate and apart from the State Department of Mental Health.

(3) Establish technical advisory committees such as a committee of consumers and family members.

(4) Employ all other appropriate strategies necessary or convenient to enable it to fully and adequately perform its duties and exercise the powers expressly granted, notwithstanding any authority expressly granted to any officer or employee of state government.

(5) Enter into contracts.

(6) Obtain data and information from the State Department of Mental Health, or other state or local entities that receive Mental Health Services Act funds, for the commission to utilize in its oversight, review, and evaluation capacity regarding projects and programs supported with Mental Health Services Act funds.

(7) Participate in the joint state-county decisionmaking process, as contained in Section 4061, for training, technical assistance, and regulatory resources to meet the mission and goals of the state's mental health system.

(8) Develop strategies to overcome stigma and accomplish all other objectives of Part 3.2 (commencing with Section 5830), 3.6 (commencing with Section 5840), and the other provisions of the act establishing this commission.

(9) At any time, advise the Governor or the Legislature regarding actions the state may take to

improve care and services for people with mental illness.

(10) If the commission identifies a critical issue related to the performance of a county mental health program, it may refer the issue to the State Department of Mental Health pursuant to Section 5655.

5846. (a) The commission shall annually review and approve each county mental health program for expenditures pursuant to Part 3.2 (commencing with Section 5830), for innovative programs and Part 3.6 (commencing with Section 5840), for prevention and early intervention.

(b) The commission shall place a county expenditure plan for consideration on a meeting agenda no later than 60 days after receipt.

(c) The commission shall issue guidelines for expenditures pursuant to Part 3.2 (commencing with Section 5830), for innovative programs, and Part 3.6 (commencing with Section 5840), for prevention and early intervention, no later than 180 days before the fiscal year for which the funds will apply.

(d) The department may provide technical assistance to any county mental health plan as needed to address concerns or recommendations of the commission or when local programs could benefit from technical assistance for improvement of their plans submitted pursuant to Section 5847.

(e) The commission shall ensure that the perspective and participation of members and others suffering from severe mental illness and their family members is a significant factor in all of its decisions and recommendations.

5847. Integrated Plans for Prevention, Innovation and System of Care Services.

(a) It is the intent of the Legislature to streamline the approval processes of the State Department of Mental Health and the Mental Health Services Oversight and Accountability Commission of programs developed pursuant to Sections 5891 and 5892.

(b) Each county mental health program shall prepare and submit a three-year plan which shall be updated at least annually and approved by the department after review and comment by the Mental Health Services Oversight and Accountability Commission. The plan and update shall include all of the following:

(1) A program for prevention and early intervention in accordance with Part 3.6 (commencing with Section 5840).

(2) A program for services to children in accordance with Part 4 (commencing with Section 5850), to include a program pursuant to Chapter 4 (commencing with Section 18250) of Part 6 of Division 9 or provide substantial evidence that it is not feasible to establish a wraparound program in that county.

(3) A program for services to adults and seniors in accordance with Part 3 (commencing with Section 5800).

(4) A program for innovations in accordance with Part 3.2 (commencing with Section 5830).

(5) A program for technological needs and capital facilities needed to provide services pursuant to Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850). All plans for proposed facilities with restrictive settings shall demonstrate that the needs of the people to be served cannot be met in a less restrictive or more integrated setting.

(6) Identification of shortages in personnel to provide services pursuant to the above programs and the additional assistance needed from the education and training programs established

pursuant to Part 3.1 (commencing with Section 5820).

(7) Establishment and maintenance of a prudent reserve to ensure the county program will continue to be able to serve children, adults and seniors that it is currently serving pursuant to Part 3 (commencing with Section 5800*),* the Adult and Older Adult Mental Health System of Care Act, Part 3.6 (commencing with Section 5840), Prevention and Early Intervention Programs, and Part 4 (commencing with Section 5850), the Children's Mental Health Services Act, during years in which revenues for the Mental Health Services Fund are below recent averages adjusted by changes in the state population and the California Consumer Price Index.

(c) The State Department of Mental Health shall not issue guidelines for the Integrated Plans for Prevention, Innovation and System of Care Services before January 1, 2012.

(d) The department's review and approval of the programs specified in paragraphs (1) and (4) of subdivision (b) shall be limited to ensuring the consistency of such programs with the other portions of the plan and providing review and comment to the Mental Health Services Oversight and Accountability Commission.

(e) The programs established pursuant to paragraphs (2) and (3) of subdivision (b) shall include services to address the needs of transition age youth ages 16 to 25.

(f) Each year the Department of Mental Health, in consultation with the California Mental Health Directors Association, the Mental Health Services Oversight and Accountability Commission, and the Mental Health Planning Council, shall inform counties of the amounts of funds available for services to children pursuant to Part 4 (commencing with Section 5850), and to adults and seniors pursuant to Part 3 (commencing with Section 5800). Each county mental health program shall prepare expenditure plans pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850), and updates to the plans developed pursuant to this section. Each expenditure update shall indicate the number of children, adults and seniors to be served pursuant to Part 3 (commencing with Section 5800) and Part 4 (commencing with Section 5850), and the cost per person. The expenditure update shall include utilization of unspent funds allocated in the previous year and the proposed expenditure for the same purpose.

(g) (1) The department shall evaluate each proposed expenditure plan and determine the extent to which each county has the capacity to serve the proposed number of children, adults and seniors pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850); the extent to which there is an unmet need to serve that number of children, adults and seniors; and determine the amount of available funds; and provide each county with an allocation from the funds available. The department shall give greater weight for a county or a population which has been significantly underserved for several years. The department shall approve, deny, or request information on a county expenditure plan or update no later than 60 days upon receipt.

(2) The department shall only evaluate those programs in a county expenditure plan or update that have not previously been approved or that have previously identified problems which have been conveyed to the county. The department shall distribute the funds for renewal of the previously approved programs contained in the county expenditure plan or update prior to approval of the county expenditure plan or update.

(h) A county mental health program shall include an allocation of funds from a reserve established pursuant to paragraph (6) of subdivision (b) for services pursuant to paragraphs

(2) and (3) of subdivision (b) in years in which the allocation of funds for services pursuant to subdivision (e) are not adequate to continue to serve the same number of individuals as the county had been serving in the previous fiscal year.

5848. (a) Each plan and update shall be developed with local stakeholders including adults and seniors with severe mental illness, families of children, adults and seniors with severe mental illness, providers of services, law enforcement agencies, education, social services agencies and other important interests. A draft plan and update shall be prepared and circulated for review and comment for at least 30 days to representatives of stakeholder interests and any interested party who has requested a copy of such plans.

(b) The mental health board established pursuant to Section 5604 shall conduct a public hearing on the draft plan and annual updates at the close of the 30–day comment period required by subdivision (a). Each adopted plan and update shall include any substantive written recommendations for revisions. The adopted plan or update shall summarize and analyze the recommended revisions. The mental health board shall review the adopted plan or update and make recommendations to the county mental health department for revisions.

(c) The department shall establish requirements for the content of the plans. The plans shall include reports on the achievement of performance outcomes for services pursuant to Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840, and Part 4 (commencing with Section 5850) of this division funded by the Mental Health Services Fund and established by the department.

(d) Mental health services provided pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) of this division, shall be included in the review of program performance by the California Mental Health Planning Council required by paragraph (2) of subdivision (c) of Section 5772 and in the local mental health board's review and comment on the performance outcome data required by paragraph (7) of subdivision (a) of Section 5604.2.

SECTION 11. Section 5771.1 is added to the Welfare and Institutions Code, to read:

5771.1 The members of the Mental Health Services Oversight and Accountability Commission established pursuant to Section 5845 are members of the California Mental Health Planning Council. They serve in an ex officio capacity when the council is performing its statutory duties pursuant to Section 5772. Such membership shall not affect the composition requirements for the council specified in Section 5771.

SECTION 12. Section 17043 is added to the Revenue and Taxation Code, to read:

17043. (a) For each taxable year beginning on or after January 1, 2005, in addition to any other taxes imposed by this part, an additional tax shall be imposed at the rate of 1% on that portion of a taxpayer's taxable income in excess of one million dollars ($1,000,000).

(b) For purposes of applying Part 10.2 (commencing with Section 18401) of Division 2, the tax imposed under this section shall be treated as if imposed under Section 17041.

(c) The following shall not apply to the tax imposed by this section:

(1) The provisions of Section 17039, relating to the allowance of credits.

(2) The provisions of Section 17041, relating to filing status and recomputation of the income

tax brackets.
(3) The provisions of Section 17045, relating to joint returns.

SECTION 13. Section 19602 of the Revenue and Taxation Code is amended to read:

19602. Except for amounts collected or accrued under Sections 17935, 17941, 17948, 19532, and 19561, and revenues deposited pursuant to Section 19602.5, all moneys and remittances received by the Franchise Tax Board as amounts imposed under Part 10 (commencing with Section 17001), and related penalties, additions to tax, and interest imposed under this part, shall be deposited, after clearance of remittances, in the State Treasury and credited to the Personal Income Tax Fund.

SECTION 14. Section 19602.5 is added to the Revenue and Taxation Code to read:

19602.5 (a) There is in the State Treasury the Mental Health Services Fund (MHS Fund). The estimated revenue from the additional tax imposed under Section 17043 for the applicable fiscal year, as determined under subparagraph (B) of paragraph (3) of subdivision (c), shall be deposited to the MHS Fund on a monthly basis, subject to an annual adjustment as described in this section.
(b) (1) Beginning with fiscal year 2004-2005 and for each fiscal year thereafter, the Controller shall deposit on a monthly basis in the MHS Fund an amount equal to the applicable percentage of net personal income tax receipts as defined in paragraph (4).
(2) (A) Except as provided in subparagraph (B), the applicable percentage referred to in paragraph (1) shall be 1.76 percent.

(B) For fiscal year 2004-2005, the applicable percentage shall be 0.70 percent.

(3) Beginning with fiscal year 2006-2007, monthly deposits to the MHS Fund pursuant to this subdivision are subject to suspension pursuant to subdivision (f).
(4) For purposes of this subdivision, "net personal income tax receipts" refers to amounts received by the Franchise Tax Board and the Employment Development Department under the Personal Income Tax Law, as reported by the Franchise Tax Board to the Department of Finance pursuant to law, regulation, procedure, and practice (commonly referred to as the "102 Report") in effect on the effective date of the Act establishing this section.
(c) No later than March 1, 2006, and each March 1 thereafter, the Department of Finance, in consultation with the Franchise Tax Board, shall determine the annual adjustment amount for the following fiscal year.
(1) The "annual adjustment amount" for any fiscal year shall be an amount equal to the amount determined by subtracting the "revenue adjustment amount" for the applicable revenue adjustment fiscal year, as determined by the Franchise Tax Board under paragraph (3), from the "tax liability adjustment amount" for applicable tax liability adjustment tax year, as determined by the Franchise Tax Board under paragraph (2).
(2) (A) (i) The "tax liability adjustment amount" for a tax year is equal to the amount determined by subtracting the estimated tax liability increase from the additional tax imposed under Section 17043 for the applicable year under subparagraph (B) from the amount of the

actual tax liability increase from the additional tax imposed under Section 17043 for the applicable tax year, based on the returns filed for that tax year.

(ii) For purposes of the determinations required under this paragraph, actual tax liability increase from the additional tax means the increase in tax liability resulting from the tax of 1% imposed under Section 17043, as reflected on the original returns filed by October 15 of the year after the close of the applicable tax year.

(iii) The applicable tax year referred to in this paragraph means the 12-calendar month taxable year beginning on January 1 of the year that is two years before the beginning of the fiscal year for which an annual adjustment amount is calculated.

(B) (i) The estimated tax liability increase from the additional tax for the following tax years is:

Tax Year	Estimated Tax Liability Increase from the Additional Tax
2005	$ 634 million
2006	$ 672 million
2007	$ 713 million
2008	$ 758 million

(ii) The "estimated tax liability increase from the additional tax" for the tax year beginning in 2009 and each tax year thereafter shall be determined by applying an annual growth rate of 7 percent to the "estimated tax liability increase from additional tax" of the immediately preceding tax year.

(3) (A) The "revenue adjustment amount" is equal to the amount determined by subtracting the "estimated revenue from the additional tax" for the applicable fiscal year, as determined under subparagraph (B), from the actual amount transferred for the applicable fiscal year.

(B) (i) The "estimated revenue from the additional tax" for the following applicable fiscal years is:

Applicable **Fiscal Year**	Estimated Revenue from Additional Tax
2004-05	$ 254 million
2005-06	$ 683 million
2006-07	$ 690 million
2007-08	$ 733 million

(ii) The "estimated revenue from the additional tax" for applicable fiscal year 2007-08 and each applicable fiscal year thereafter shall be determined by applying an annual growth rate of 7 percent to the "estimated revenue from the additional tax" of the immediately preceding applicable fiscal year.

(iii) The applicable fiscal year referred to in this paragraph means the fiscal year that is two years before the fiscal year for which an annual adjustment amount is calculated.

(d) The Department of Finance shall notify the Legislature and the Controller of the results of the determinations required under subdivision (c) no later than 10 business days after the determinations are final.

(e) If the annual adjustment amount for a fiscal year is a positive number, the Controller shall transfer that amount from the General Fund to the MHS Fund on July 1 of that fiscal year.

(f) If the annual adjustment amount for a fiscal year is a negative number, the Controller shall suspend monthly transfers to the MHS Fund for that fiscal year, as otherwise required by paragraph (1) of subdivision (b), until the total amount of suspended deposits for that fiscal year equals the amount of the negative annual adjustment amount for that fiscal year.

SECTION 15. Part 4.5 (commencing with Section 5890) is added to Division 5 of the Welfare and Institutions Code, to read:

PART 4.5. MENTAL HEALTH SERVICES FUND

5890. (a) The Mental Health Services Fund is hereby created in the State Treasury. The fund shall be administered by the State Department of Mental Health. Notwithstanding Section 13340 of the Government Code, all moneys in the fund are continuously appropriated to the department, without regard to fiscal years, for the purpose of funding the following programs and other related activities as designated by other provisions of this division:

(1) Part 3 (commencing with Section 5800), the Adult and Older Adult System of Care Act.

(2) Part 3.6 (commencing with Section 5840), Prevention and Early Intervention Programs.

(3) Part 4 (commencing with Section 5850), the Children's Mental Health Services Act.

(b) Nothing in the establishment of this fund, nor any other provisions of the act establishing it or the programs funded shall be construed to modify the obligation of health care service plans and disability insurance policies to provide coverage for mental health services, including those services required under Section 1374.72 of the Health and Safety Code and Section 10144.5 of the Insurance Code, related to mental health parity. Nothing in this act shall be construed to modify the oversight duties of the Department of Managed Health Care or the duties of the Department of Insurance with respect to enforcing such obligations of plans and insurance policies.

(c) Nothing in this act shall be construed to modify or reduce the existing authority or responsibility of the State Department of Mental Health.

(d) The State Department of Health Services, in consultation with the State Department of Mental Health, shall seek approval of all applicable federal Medicaid approvals to maximize the availability of federal funds and eligibility of participating children, adults and seniors for medically necessary care.

(e) Share of costs for services pursuant to Part 3 (commencing with Section 5800) and Part 4 (commencing with Section 5850) of this division, shall be determined in accordance with the Uniform Method for Determining Ability to Pay applicable to other publicly funded mental health services, unless such Uniform Method is replaced by another method of determining co-payments, in which case the new method applicable to other mental health services shall be applicable to services pursuant to Part 3 (commencing with Section 5800) and Part 4 (commencing with Section 5850) of this division.

5891. (a) The funding established pursuant to this act shall be utilized to expand mental health services. These funds shall not be used to supplant existing state or county funds utilized to

provide mental health services. The state shall continue to provide financial support for mental health programs with not less than the same entitlements, amounts of allocations from the General Fund and formula distributions of dedicated funds as provided in the last fiscal year which ended prior to the effective date of this act. The state shall not make any change to the structure of financing mental health services, which increases a county's share of costs or financial risk for mental health services unless the state includes adequate funding to fully compensate for such increased costs or financial risk. These funds shall only be used to pay for the programs authorized in Section 5892. These funds may not be used to pay for any other program. These funds may not be loaned to the state General Fund or any other fund of the state, or a county general fund or any other county fund for any purpose other than those authorized by Section 5892.

(b) Notwithstanding subdivision (a), the Controller may use the funds created pursuant to this part for loans to the General Fund as provided in Sections 16310 and 16381 of the Government Code. Any such loan shall be repaid from the General Fund with interest computed at 110 percent of the Pooled Money Investment Account rate, with interest commencing to accrue on the date the loan is made from the fund. This subdivision does not authorize any transfer that would interfere with the carrying out of the object for which these funds were created.

5892. (a) In order to promote efficient implementation of this act allocate the following portions of funds available in the Mental Health Services Fund in 2005-06 and each year thereafter:

(1) In 2005-06, 2006-07, and in 2007-08 10% shall be placed in a trust fund to be expended for education and training programs pursuant to Part 3.1.

(2) In 2005-06, 2006-07 and in 2007-08 10% for capital facilities and technological needs distributed to counties in accordance with a formula developed in consultation with the California Mental Health Directors Association to implement plans developed pursuant to Section 5847.

(3) 20% for prevention and early intervention programs distributed to counties in accordance with a formula developed in consultation with the California Mental Health Directors Association pursuant to Part 3.6 (commencing with Section 5840) of this division. Each county's allocation of funds shall be distributed only after its annual program for expenditure of such funds has been approved by the Oversight and Accountability Commission established pursuant to Section 5845.

(4) The allocation for prevention and early intervention may be increased in any county which the department determines that such increase will decrease the need and cost for additional services to severely mentally ill persons in that county by an amount at least commensurate with the proposed increase. The statewide allocation for prevention and early intervention may be increased whenever the Mental Health Services Oversight and Accountability Commission determines that all counties are receiving all necessary funds for services to severely mentally ill persons and have established prudent reserves and there are additional revenues available in the Fund.

(5) The balance of funds shall be distributed to county mental health programs for services to persons with severe mental illnesses pursuant to Part 4 (commencing with Section 5850), for the children's system of care and Part 3 (commencing with Section 5800), for the adult and older adult system of care.

(6) Five percent of the total funding for each county mental health program for Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4

(commencing with Section 5850) of this division, shall be utilized for innovative programs pursuant to an approved plan required by Section 5830 and such funds may be distributed by the department only after such programs have been approved by the Mental Health Services Oversight and Accountability Commission established pursuant to Section 5845.

(b) In any year after 2007-08, programs for services pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) of this division may include funds for technological needs and capital facilities, human resource needs, and a prudent reserve to ensure services do not have to be significantly reduced in years in which revenues are below the average of previous years. The total allocation for purposes authorized by this subdivision shall not exceed 20 percent of the average amount of funds allocated to that county for the previous five years pursuant to this section.

(c) The allocations pursuant to subdivisions (a) and (b) shall include funding for annual planning costs pursuant to Section 5848. The total of such costs shall not exceed 5 percent of the total of annual revenues received for the fund. The planning costs shall include funds for county mental health programs to pay for the costs of consumers, family members and other stakeholders to participate in the planning process and for the planning and implementation required for private provider contracts to be significantly expanded to provide additional services pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) of this division.

(d) Prior to making the allocations pursuant to subdivisions (a), (b) and (c), the department shall also provide funds for the costs for itself, the California Mental Health Planning Council and the Mental Health Services Oversight and Accountability Commission to implement all duties pursuant to the programs set forth in this section. Such costs shall not exceed 5% of the total of annual revenues received for the fund. The administrative costs shall include funds to assist consumers and family members to ensure the appropriate state and county agencies give full consideration to concerns about quality, structure of service delivery or access to services. The amounts allocated for administration shall include amounts sufficient to ensure adequate research and evaluation regarding the effectiveness of services being provided and achievement of the outcome measures set forth in Part 3(commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division.

(e) In 2004-05 funds shall be allocated as follows:

(1) 45% for education and training pursuant to Part 3.1(commencing with Section 5820) of this division.

(2) 45% for capital facilities and technology needs in the manner specified by paragraph (2) of subdivision (a).

(3) 5% for local planning in the manner specified in subdivision (c) and

(4) 5% for state implementation in the manner specified in subdivision (d).

(f) Each county shall place all funds received from the State Mental Health Services Fund in a local Mental Health Services Fund. The Local Mental Health Services Fund balance shall be invested consistent with other county funds and the interest earned on such investments shall be transferred into the fund. The earnings on investment of these funds shall be available for distribution from the fund in future years.

(g) All expenditures for county mental health programs shall be consistent with a currently approved plan or update pursuant to Section 5847.

(h) Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which have not been spent for their authorized purpose within three years shall revert to the state to be deposited into the fund and available for other counties in future years, provided however, that funds for capital facilities, technological needs or education and training may be retained for up to 10 years before reverting to the fund.

(i) If there are still additional revenues available in the fund after the Mental Health Services Oversight and Accountability Commission has determined there are prudent reserves and no unmet needs for any of the programs funded pursuant to this section, including all purposes of the Prevention and Early Intervention Program, the commission shall develop a plan for expenditures of such revenues to further the purposes of this act and the Legislature may appropriate such funds for any purpose consistent with the commission's adopted plan which furthers the purposes of this act.

5893. (a) In any year in which the funds available exceed the amount allocated to counties, such funds shall be carried forward to the next fiscal year to be available for distribution to counties in accordance with Section 5892 in that fiscal year.

(b) All funds deposited into the Mental Health Services Fund shall be invested in the same manner in which other state funds are invested. The fund shall be increased by its share of the amount earned on investments.

5894. In the event that Part 3 (commencing with Section 5800) or Part 4 (commencing with Section 5850) of this division, are restructured by legislation signed into law before the adoption of this measure, the funding provided by this measure shall be distributed in accordance with such legislation; provided, however, that nothing herein shall be construed to reduce the categories of persons entitled to receive services.

5895. In the event any provisions of Part 3 (commencing with Section 5800), or Part 4 (commencing with Section 5850) of this division, are repealed or modified so the purposes of this act cannot be accomplished, the funds in the Mental Health Services Fund shall be administered in accordance with those sections as they read on January 1, 2004.

5897. (a) Notwithstanding any other provision of state law, the State Department of Mental Health shall implement the mental health services provided by Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division through contracts with county mental health programs or counties acting jointly. A contract may be exclusive and may be awarded on a geographic basis. As used herein a county mental health program includes a city receiving funds pursuant to Section 5701.5

(b) Two or more counties acting jointly may agree to deliver or subcontract for the delivery of such mental health services. The agreement may encompass all or any part of the mental health services provided pursuant to these parts. Any agreement between counties shall delineate each county's responsibilities and fiscal liability.

(c) The department shall implement the provisions of Part 3 (commencing with Section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division through the annual county mental health services performance contract, as specified in Chapter 2 (commencing with Section 5650) of Part 2 of Division 5.

(d) When a county mental health program is not in compliance with its performance contract, the department may request a plan of correction with a specific time-line to achieve improvements.

(e) Contracts awarded by the State Department of Mental Health, the California Mental Health Planning Council, and the Mental Health Services Oversight and Accountability Commission pursuant to Part 3 (commencing with 5800), Part 3.1 (commencing with 5820), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), Part 3.7 (commencing with Section 5845), Part 4 (commencing with Section 5850), and Part 4.5 (commencing with Section 5890) of this division, may be awarded in the same manner in which contracts are awarded pursuant to Section 5814 and the provisions of subdivisions (g) and (h) of Section 5814 shall apply to such contracts.

(f) For purposes of Section 5775, the allocation of funds pursuant to Section 5892 which are used to provide services to Medi-Cal beneficiaries shall be included in calculating anticipated county matching funds and the transfer to the department of the anticipated county matching funds needed for community mental health programs.

5898. The department shall develop regulations, as necessary, for the department or designated local agencies to implement this Act. In 2005, the director may adopt all regulations pursuant to this Act as emergency regulations in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. For the purpose of the Administrative Procedure Act, the adoption of regulations, in 2005, shall be deemed an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. These regulations shall not be subject to the review and approval of the Office of Administrative Law and shall not be subject to automatic repeal until final regulations take effect. Emergency regulations adopted in accordance with this provision shall not remain in effect for more than a year. The final regulations shall become effective upon filing with the Secretary of State. Regulations adopted pursuant to this section shall be developed with the maximum feasible opportunity for public participation and comments.

SECTION 16

The provisions of this act shall become effective January 1 of the year following passage of the act, and its provisions shall be applied prospectively.

The provisions of this act are written with the expectation that it will be enacted in November of 2004. In the event that it is approved by the voters at an election other than one which occurs during the 2004-05 fiscal year, the provisions of this act which refer to fiscal year 2005-06 shall be deemed to refer to the first fiscal year which begins after the effective date of this act and the provisions of this act which refer to other fiscal years shall refer to the year that is the same number of years after the first fiscal year as that year is in relationship to 2005-06.

SECTION 17

Notwithstanding any other provision of law to the contrary, the department shall begin implementing the provisions of this act immediately upon its effective date and shall have the authority to immediately make any necessary expenditures and to hire staff for that purpose.

SECTION 18

This act shall be broadly construed to accomplish its purposes. All of the provisions of this Act may be amended by a 2/3 vote of the Legislature so long as such amendments are consistent with and further the intent of this act. The Legislature may by majority vote add provisions to clarify procedures and terms including the procedures for the collection of the tax surcharge imposed by Section 12 of this act.

SECTION 19

If any provision of this act is held to be unconstitutional or invalid for any reason, such unconstitutionality or invalidity shall not affect the validity of any other provision.