LITTLE HOOVER COMMISSION

BEING THERE

Making a Commitment to Mental Health

November 2000

Little Hoover Commission

✦ ✦ ✦ ✦ ✦ ✦

Richard R. Terzian
Chairman

Michael E. Alpert*
Vice Chairman

Bill Campbell
Assemblymember

Carl D. Covitz

Daniel W. Hancock

Sally Havice
Assemblymember

Charles S. Poochigian
Senator

H. Eric Schockman*

John Vasconcellos
Senator

Sean Walsh*

Stanley R. Zax

Stanley M. Zimmerman

**Served on study subcommittee*
The Commission has one vacancy

Commission Staff

✦ ✦ ✦ ✦ ✦ ✦

James P. Mayer
Executive Director

Nancy M. Lyons
Deputy Executive Director

Toby Ewing
Project Manager

Chloe Bullard
Research Analyst

Cindy Wren
Research Analyst

Rachel Orkand
Intern

To Promote Economy and Efficiency

The Little Hoover Commission, formally known as the Milton Marks "Little Hoover" Commission on California State Government Organization and Economy, is an independent state oversight agency.

By statute, the Commission is a bipartisan board composed of five public members appointed by the Governor, four public members appointed by the Legislature, two Senators and two Assemblymembers.

In creating the Commission in 1962, the Legislature declared its purpose:

...to secure assistance for the Governor and itself in promoting economy, efficiency and improved services in the transaction of the public business in the various departments, agencies and instrumentalities of the executive branch of the state government, and in making the operation of all state departments, agencies and instrumentalities, and all expenditures of public funds, more directly responsive to the wishes of the people as expressed by their elected representatives...

The Commission fulfills this charge by listening to the public, consulting with the experts and conferring with the wise. In the course of its investigations, the Commission typically empanels advisory committees, conducts public hearings and visits government operations in action.

Its conclusions are submitted to the Governor and the Legislature for their consideration. Recommendations often take the form of legislation, which the Commission supports through the legislative process.

Contacting the Commission and Copies of Reports

All correspondence should be addressed to the Commission at:

- 925 L St., Suite 805, Sacramento CA 95814
- E-mail: little.hoover@lhc.ca.gov
- Telephone: (916) 445-2125 Fax: (916) 322-7709
- Worldwide Web: www.lhc.ca.gov

Additional copies of this report may be purchased for $5 per copy. The report is available from the Commission's Web site.

State of California

LITTLE HOOVER COMMISSION

November 20, 2000

The Honorable Gray Davis
Governor of California

The Honorable John Burton
President pro Tempore of the Senate
and members of the Senate

The Honorable James Brulte
Senate Minority Leader

The Honorable Robert Hertzberg
Speaker of the Assembly
and members of the Assembly

The Honorable Scott Baugh
Assembly Minority Leader

Dear Governor and Members of the Legislature:

Just over a year ago the Commission began to study the quality and availability of mental health services for California's adults. We discovered something that sets mental health policies apart from others: Despite programs and promises, California explicitly rations care to only those with the most extreme needs – and even then we turn people away.

California's mental health policy lacks something fundamental: a clear commitment to provide mental health services to people who need assistance. The goal of mental health reform should be that simple – ensuring that all Californians who need mental health services receive care.

The Commission also discovered that we spend billions of dollars dealing with the consequences of untreated mental illness – rather than spending that money wisely on adequate services. We pay for jail space and court costs that we incur because mental health clients do not receive care and treatment. We pay for redevelopment and struggle to revitalize our inner cities, but we pretend we cannot do anything to keep people with mental health needs from sleeping in the doorways of downtown homes and businesses.

We have, in effect, criminalized mental illness. State law instructs counties to turn away those in need because funding is limited. But law enforcement is expected to respond to every call, to keep every peace, and to ensure everyone's safety. Absent adequate mental health services, the cop has become the clinician. The jail has become the crisis center.

There is, of course, a moral imperative for caring for those who cannot care for themselves, and on that basis alone we should change our policies. But there is also a fiscal imperative to mental health reform. The public and private sectors share the costs of failed policies: lost productivity and business, lower property values and quality of life, and increased costs of criminal justice, public health and safety programs.

To curb these uncontrolled costs we must develop policies that proactively help people maintain their functionality – to keep their jobs and homes, their ambition and independence. Ensuring that everyone receives care would require a substantial up-front expenditure. It also may take years to build the public support and to build the system capacity to provide services. Still, this investment has been shown to yield a positive return: including lower criminal justice costs and healthy business districts, and more importantly a renewed hope for Californians who are too often viewed as a liability rather than an asset.

Moreover, as with the physical health care system, the value of quality mental health care is shared throughout our communities. Providing quality care therefore is a community responsibility. The State must create the foundations for stable, successful private sector mental health coverage and nurture the expansion of the private market. With a strong private system in place, the public system can be the safety net for those without private coverage. California has started down this road with the recent parity legislation. But we have not committed to providing minimum basic services to all who need care, and the consequences of inaction are tragic.

Californians have shown a willingness to spend if they see promise. Therefore, the first step to reforming mental health policy is for all Californians to understand fully the costs and consequences of failed programs and the responsibility we share to care for people with mental illness. We can then commit to building a mental health service system that emphasizes preventive care and intervention programs for all people needing services. We can ensure that no one ends up in the criminal justice system, on the streets or in the emergency room solely because treatment services were unavailable.

Too many Californians have lost their hope. Years of inadequate treatment, homelessness and jail time have stripped them of their self-esteem and their confidence that their productive lives can be restored. Too many business owners have steeled their hearts against the mentally ill individuals who scare away their customers. Too many neighborhoods have rejected treatment centers and supportive housing. Too many families have lost their sense of hope that a mentally ill child, parent, friend or neighbor will recover.

Importantly, the Commission found reason to be hopeful. We found an unwavering resolve on the part of many who have worked to provide the highest quality care possible, to push against the bureaucracy and do what they know is necessary and right. We found innovative, energized individuals who have built world-renowned models of care. They envision a California mental health system that ensures those in need can live the most fulfilling lives possible as they recover from their illnesses.

We can solve the problems facing California's mental health system. We have taken the initial steps and we are making progress. But there is more work to do. We must recognize that sound mental health policy is about compassion for human suffering and the quality of life in our communities, our neighborhoods and in our homes.

In recent months the attention on mental health reform has focused on California's involuntary commitment laws – the Lanterman-Petris-Short Act. Involuntary treatment plays an important role in providing the highest quality of mental health care. But voluntary treatment should be the initial response. California needs a continuum of care in which involuntary treatment is the last and final resort – only appropriate when no other form of treatment is effective – and implemented in a way that guarantees and respects the rights of individuals.

When we declared that people with mental illness have a right to treatment in their communities we made a promise. It's time we kept our word. We need to provide adequate housing, training, employment and counseling – services that were provided in institutions and need to be provided in our communities. People with mental illness need to be invited back from the edges of our society, out from under bridges and the margins of our conscience.

Sincerely,

Richard R. Terzian
Chairman

Being There

Making a Commitment to Mental Health

November 2000

Table of Contents

Executive Summary i

Introduction 1

Background 5

Building Public Support for the Mental Health Service System 29

Strengthening Statewide Leadership 37

Developing Comprehensive Services 45

Providing Adequate Mental Health Resources 57

Decriminalizing Mental Illness 67

Coordinating Mental Health and Criminal Justice Services 77

Creating Accountability: Monitoring the Mental Health System 85

Conclusion 91

Appendices 93

- Appendix A: Little Hoover Commission Public Hearing Witnesses 95
- Appendix B: Advisory Committee Members 97
- Appendix C: Medical Necessity Chart 101
- Appendix D: Distribution of Mental Health Funding 103
- Appendix E: Glossary of Terms 107
- Appendix F: Mental Health Information Sources and Organizations 109

Notes 113

Table of Sidebars

The Lanterman-Petris-Short Act (LPS) i
Who Needs Care ii
Living with Mental Illness iii
Immediate Steps v
Immediate Steps vi
Immediate Steps vii
Immediate Steps viii
Immediate Steps x
Immediate Steps xii
Jails Have Become Treatment Centers xiii
Immediate Steps xiv
Service Coordination Can Improve Treatment Opportunities xv
Immediate Steps xv
Immediate Steps xvi
Immediate Steps xvii
Immediate Steps xviii
Common Mental Illnesses 6
Understanding Mental Illness 7
Who is Served by the Public Mental Health Service System? 8
Estimating Unmet Need 8
Mental Illness and Suicide 10
Defining Prevention 12
Establishing Community Mental Health Services ..... 14 & 15
Who is Eligible for Medi-Cal? 14
Joint Committee on Mental Health Reform 16
The Lanterman-Petris-Short Act (LPS) 17
Where Are They Now? 18
Systems of Care 19
California Mental Health Planning Council 20
California's State Hospitals 21
Mental Health Funding 24
Clarifying Expectations 32

Immediate Steps 34
Immediate Steps 35
Defining Cultural Competency 39
Immediate Steps 42
Immediate Steps 43
Living with Mental Illness 46
Providing Comprehensive Services Requires Culturally Competent Care 47
Living in Board and Care Homes 48
Providing Adequate Housing 49
Community Organizations: Building Housing Solutions 50
Defining Employment 50
Integrating Services - The Village ISA, Long Beach, California 52
Immediate Steps 56
Program Realignment 57
Negotiating Mental Health Treatment 60
Social Security Insurance: Incentives for Participation 61
Partial Data: Distribution of Mental Health Funding Across California Counties 63
Pennsylvania's Best Practices Funding Model 64
Immediate Steps 65
Immediate Steps 66
Jails Have Become Treatment Centers 68
Lack of Community Treatment Criminalizes Mental Illness 69
MIOCR Grantees 71
Investing in Prevention, Diversion and Incarceration 73
Doing the Research: Who Ends Up In Jail? 75
Immediate Steps 76
The Need for Improved Communication 78
Custody-based vs. Community-based Treatment 79
Improving Communication Between Service Providers 80
Linking Mental Health and Criminal Justice Data 81
Immediate Steps 83
Developing Outcome Measurement Systems 88
Measuring Outcomes 89
Immediate Steps 90

Table of Charts & Graphs

Distribution of DMH Personnel 2000-01 vii
Mental Health and Substance Abuse Treatment Expenditures by Source 1996-97 9
State Hospital Inpatient Population 1990-2001 22
Distribution of DMH Personnel 2000-01 38
Historical Distribution of DMH Personnel 38
Total State and County Mental Health Expenditures 58

Executive Summary

A generation ago, California decided that people with mental illness should live in their communities rather than locked in institutions. They had a right to a more everyday life, and it was determined they would benefit from community-based treatment. It is painfully clear that we have failed to follow through with all that was required by this noble decision.

Mental health clients have in fact been integrated into our communities; we see them on the street corners and sleeping in parks. They are integrated into our jails and prisons; many are behind bars on what officers call "mercy bookings" – jailed for their protection, not the public's. They are disproportionately represented among the poor, the victims of crime, the unemployed and the homeless. A majority of people erroneously sees them as "dangerous, dirty, unpredictable and worthless" – better shunned than embraced.[1]

Many of us are uncomfortable with what we see and are not sure how to respond. We too often avert our eyes from the face of mental illness. And our public policies reflect this discomfort: Mental health programs are the chronic losers in budget debates. Community officials verbally scuffle with service providers. Neighbors complain about programs sited near their homes. And funds are increasingly siphoned away from the hundreds of thousands who want help leading productive lives to address the small minority of those who are ill and also dangerous.

The Lanterman-Petris-Short Act (LPS)

California's involuntary commitment law – the LPS Act – is one of the most controversial mental health issues of the day. But the Commission found the most important and immediate concern to be the 1.5 million Californians who need help, but do not receive it. Moreover, before meaningful reforms to the LPS Act could be considered, the Commission believes the following analyses are needed:

- An assessment of how the current LPS law is administered across counties.
- An assessment of how improved access to voluntary treatment could diminish the need for involuntary treatment.
- The dimensions of the problem that LPS reform would address.
- The capacity of state and local authorities to better serve existing clients through other "involuntary" models.
- The ability of the State to improve the quality of involuntary care.

In Finding 2, the Commission identifies a number of "leadership" challenges facing the State, including the needs to better understand the role of involuntary treatment before the Governor and the Legislature can thoughtfully and compassionately consider amending the LPS Act.

An estimated 1.5 million Californians are in need of help, but do not receive it.[2] Many of those who need help do not reflect the stereotypes. They struggle to hold jobs, maintain friends and care for children – often burdened as much by stigma as disease.

Fortunately the plight of those with mental illness – and their families and the neighborhoods where they live – are receiving renewed attention. And in these times of plenty, leaders are able to commit more resources to provide help. The neglect of the past provides the opportunity of a generation to implement fundamental reforms to the community mental health system – reforms that may outlast the current empathy and budget surplus.

The overriding goal of reform is clear: No one who needs mental health care should be denied access to high quality, tailored services. To transform this system, California needs to develop leadership capacity at two levels. First, community leaders need to define for the State a public commitment to serve those with mental illness and advocate for that commitment until it is fulfilled. What sets mental health apart from other social and medical causes is that we do not share a collective expectation or sense of responsibility – and as a result there is little outrage when mental health programs fail.

Who Needs Care

The Commission's central recommendation for reforming mental health policy is that no one who needs care should be denied access to services. California currently rations access to care, first based on the severity of an illness and then by providing services "only to the extent resources are available."

To remove the funding barrier, the public and private sectors need to commit resources to serve all of those eligible based on the severity of their illness. By urging the State to go further – to set a goal of providing care to all who need it – the Commission is acknowledging the human and fiscal benefits of preventative and early intervention services.

How to specifically limit care is an important and difficult issue that needs to be explored by policy-makers, community and business leaders, mental health professionals and, of course, clients.

Second, we need to fortify institutional leadership – at the Department of Mental Health and in communities – to create a system where barriers to improvement are identified and lowered, where the best strategies are replicated and improved, and where the public and state and local leaders are confident to invest additional resources.

Mental health clients and service providers are justifiably frustrated. For years wholesale reforms have been discussed and then shelved. In California there are model providers offering comprehensive and integrated services. Experts from around the world come to visit these operations. But California has not replicated their successes; the knowledge they have produced has not been infused into state policies.

Rather, in most communities, care is rationed to those with severe mental illness. Even then, the system seldom recognizes that some clients need a home, others need a job and all need respect – in addition to medication.

We do not tell cancer patients to come back if and when their disease has metastasized. But we turn mental health clients away and tell them to return when their symptoms are so severe and persistent that they cannot meet their own needs, and may no longer recognize that they even need care.

The commander of the Los Angeles County jail testified that he operates the largest mental institution in the nation – an indicator that the system is broken and is exacting moral, as well as monetary costs.[3] Clearly some criminals, who also have mental illnesses, warrant incarceration. But law enforcement officials are now advocating that jail and prison should not be used to house those who have not received adequate care from the mental health system.

While we need to dedicate more resources to mental health services, there is reason to believe that this investment will produce positive returns. Researchers are just beginning to tally the costs of unaddressed mental illness – lost productivity, income and tax revenues, as well as increased criminal justice and emergency medical expenditures. Evidence also is mounting that early intervention and more comprehensive services can preserve and restore functionality – providing human, as well as monetary benefits.

Living with Mental Illness

When John was 16 he tried to kill himself. He didn't lose his life, but lost his sight. While in his native Massachusetts he experienced mental health care that he found to be inhumane – so he avoided care and struggled to survive.

Homeless in California, he was encouraged to seek help, and he did. With treatment he grew stronger. He graduated from California State University, Sacramento and McGeorge School of Law.

He is practicing law, on medication and in recovery. His life is a testament to the value of appropriate, quality mental health care and the promise of recovery.

The intangible consequences must be considered: the turmoil and grief of families, friends and clients who struggle to find assistance and answers. In 1997, 3,430 Californians committed suicide, the leading cause of preventable death.[4]

Importantly, thousands of individuals are well-served. But credit goes to the dedication of compassionate staff and a growing number of policy-makers who have come to understand this public obligation. Overall, however, the State has not developed or supported management and service systems that encourage continuous improvements in the breadth and quality of services.

The challenge is to capture the growing concern, knowledge, resources and goodwill to make fundamental reform to policies and programs that have been neglected for so long that they cannot be fixed by marginal changes. Rather, we need to support fundamental change that ultimately will transform our image of people with mental illness from community liabilities into an accurate reflection of those individuals as our neighbors, family members and loved ones.

The Little Hoover Commission has identified four core areas of reform that together can move California's response to mental illness from one driven by fear, stigma and lost hope to one offering treatment, success and recovery to those living with mental illness.

- ***Expectations and Leadership***. Public policy is driven by public expectations. To raise the public's expectations for mental health services, programs must be able to communicate reliably and clearly their performance and their potential. The Department of Mental Health also needs to step up its efforts to be a statewide leader of the community-based mental health system.
- ***Comprehensive Services and Resources***. In many cases, mental health treatment is limited to medication, when what is really needed is help with housing, substance abuse and other problems. While California hosts world-renowned service providers, they are islands of success in a sea of rationed care. Mental health and related programs have been plagued by a lack of resources. Reforms should promote early intervention and more comprehensive services, as a way of preserving functionality and holding down costs for acute care. Over the long term, the State needs to capture funds now spent housing clients in jails to provide better services through the mental health system.
- ***Criminal Justice***. Law enforcement officials say they have become the safety net for the failing mental health system. California is just beginning – and needs to do much more – to make sure that people do not land in jail because of limited mental health treatment options. And when mental health clients are jailed and released, far more can be done to reintegrate them into communities and prevent their reincarceration.
- ***Accountability.*** Concern alone for the welfare of people with mental health needs is inadequate to motivate change. Clients, taxpayers, policy-makers and the public must understand how policy and funding decisions move the State closer to realizing their new expectations. Without clear and constant accountability, mental health will continue to reflect an inadequate and forsaken component of California's social service programs.

The Commission believes that successful mental health reform will require systematic change in how mental health policies are conceived, funded and administered. It will require California's community, business and political leaders to understand the costs and consequences of success and failure, and it will require them to drive the reform process.

Fundamental reform will move California toward a system of care that has as its goal ensuring access to care and tailoring mental health services for those with debilitating mental illness. But the thousands of Californians in need of services today should not have to wait for fundamental reforms to be achieved. Along with recommendations for transforming the mental health system, the Commission is urging State and community leaders to take immediate steps to expand and improve care.

The goal of ensuring that people who need care have access to high quality, tailored mental health services is achievable. It will require strategically expanding access and the capacity of the system over time – enough time to do it right, but not so long as to lose our way again.

Immediate Steps

Fundamental mental health reform will require a sustained commitment to continuously improving how mental health services are organized, managed and funded.

But long journeys begin with a single step. Beside each recommendation for fundamental reform, the Commission has identified immediate steps that would begin building the common understanding and public support necessary for California to fulfill its obligation to help people with mental illness.

These immediate steps can be taken through existing legal authority or with executive orders, by reallocating current resources or tapping into the resources of non-governmental organizations that should be part of the solutions.

Toward this end, the Commission offers the following findings and recommendations:

Building Public Support for the Mental Health Service System

Finding 1: No one who needs care should be denied access to high quality, tailored mental health services. Open access cannot be achieved until the public and policy-makers have a shared commitment to care for people with mental illness.

Mental health clients have many champions. But they have been unable to make their voices heard in the broader public and policy arena. Without a shared sense of responsibility, the public and their political leaders cannot create expectations, set goals and measure progress.

The Surgeon General asserts that stigma is a primary reason why mental health problems are not adequately funded.[5] The antidote for stigma is accurate information. The faces of those with mental illness are diverse and cross all social boundaries. Mental health clients who receive adequate treatment are no more violent than other people.[6] And failing

The faces of those with mental illness are diverse and cross all social boundaries. Mental health clients who receive adequate treatment are no more violent than other people. And failing to provide adequate mental health care leads to increased social, personal and economic costs.

to provide adequate mental health care leads to higher social, personal and economic costs.

Californians must understand the social costs and personal consequences of mental illness. They need to know that people with mental illness can lead fulfilling, productive lives and they need to recognize that mental illness affects everyone.

Defining expectations for mental health care will be a challenge. Mental health policy is complicated and reflects diverse and competing interests. The science of mental illness is also complex and continues to evolve. The policy-making process is most challenged by topics that fit this description – intricate policies based on competing interests and incomplete knowledge.

Nevertheless, the multiple interests must be brought together to develop a shared understanding of the problems and the possibilities. Creating a California Mental Health Advocacy Commission could assist policy-makers in making a commitment, providing direction and pushing for fundamental reform. The Commission should include a broad range of stakeholders, particularly interests not historically involved in mental health discussions, such as business, labor, taxpayer and education groups. The Advocacy Commission could immediately begin to raise public awareness and over time provide detailed proposals to policy-makers.

Recommendation 1: The Governor and the Legislature should ensure that no one who needs care is denied access to high quality, tailored mental health services. The first step is to establish a California Mental Health Advocacy Commission to serve as a catalyst for change, set expectations and establish responsibility for mental health services. Specifically, the Commission should:

- ❑ ***Be of limited term and funded from public and private sources.*** To ensure against unnecessary bureaucracy, the Commission should be of limited term. To improve accountability, it should be jointly funded from public and private sources. And to demonstrate clear expectations for outcomes, the Commission should issue periodic reports and a final summary of its activities and accomplishments.
- ❑ ***Develop strategies to overcome stigma.*** The public and policy-makers need an improved understanding of mental health, mental illness and the role of public policy in providing quality mental health care.

Immediate Steps

- The Governor should appoint a personal Mental Health Advocate charged with building the networks and partnerships necessary to form the Mental Health Advocacy Commission.

- ***Detail need.*** The public and policy-makers need to understand how Californians are affected by mental health policies, the adequacy of existing programs and the magnitude of additional need.
- ***Assess costs of failure.*** The public and policy-makers need to understand the trade-off between investing in adequate mental health services and failing to provide appropriate care.

Immediate Steps

- The Governor's Mental Health Advocate should convene a series of Mental Health Summits with business, education, labor and mental health leaders to build an agenda for change.
- Draft legislation should be prepared for introduction in January to fund and formalize the Commission.

- ***Provide for on-going policy advice.*** The Commission should propose strategies for providing the Legislature and Governor on-going direction and advice on mental health policy, and in particular, strategies for understanding the complex and evolving science of mental health and mental illness.

Strengthening Statewide Leadership

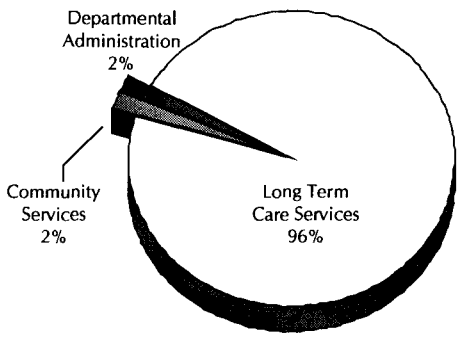
Finding 2: The state Department of Mental Health is not organized or funded to ensure that all Californians have access to mental health services when they need care.

The Department of Mental Health is charged with ensuring that targeted mental health clients have access to adequate, appropriate care through a culturally competent system within their communities.

The State faces significant barriers to improved care that require the department to exercise this leadership: Care is limited by chronic underfunding and critical shortages of mental health professionals. Stigma and fear limit support for community-based services. Local mental health agencies often do not adopt best practices. Family and client organizations battle over attempts to reform involuntary commitment laws, threatening years of good relations. There is contentious disagreement over the success or failure of managed care. Clients face an increasing shortage of affordable housing. Over 30,000 people in California's jails and prisons need mental health services – many are incarcerated because they failed to receive adequate community care.[7]

While each of these issues is challenging, the department's attention is divided between leading a statewide community-based system of care and managing a growing penal code population in state hospitals. As the chart shows, over 95 percent of the department's staff is dedicated to operating institutions; less than 2 percent is available for leadership activities.

Distribution of DMH Personnel 2000-01



California will not be able to provide adequate, appropriate mental health care to its citizens without reorganizing state resources to provide leadership and guidance to community mental health systems.

Recommendation 2: The Department of Mental Health needs to become the State's mental health champion. The department needs the resources and the political support to ensure that California's mental health system continuously improves. Specifically, the department should:

- ***Advocate and provide policy guidance.*** The department should be an advocate for mental health clients. It should provide direction and advice to the Legislature and Governor on a policy framework that results in continuous improvement in the availability and quality of mental health care.
- ***Advocate for local mental health programs.*** The department must ensure that local providers have the support they need from local, state and federal agencies to provide needed care. The department should pay particular attention to the need for housing, employment and substance abuse treatment.
- ***Identify barriers and promote change.*** The department should identify statewide and local barriers to improved care and recommend state and local strategies to overcome those barriers. The department should explore strategies to motivate improvement through funding, promote best practices and improve state and local accountability.
- ***Develop mental health workforce.*** The department must ensure that California has an adequate workforce capable of providing culturally competent, professional mental health services throughout the state. The department should partner with state and federal agencies involved in education and workforce development to meet this need.
- ***Assess options for managing state hospital system.*** The department should determine whether providing long-term care services detracts from its leadership responsibilities. It should assess alternatives for the long-term operation and management of state hospitals.

Immediate Steps

- The Governor should reassign 10 staff persons from other departments to the Department of Mental Health to immediately provide additional support for community mental health programs.
- The Department of Finance and the Legislative Analyst's Office should begin the detailed analyses necessary to redesign the Department of Mental Health.
- The department should convene a task force of county mental health officials and national mental health experts to identify barriers to improvement and strategies to promote change.
- The department should convene a summit of public and private experts in human resources and workforce development to begin assessing human resource needs and crafting short-term and long-term plans to address the shortage of qualified mental health professionals.

Developing Comprehensive Services

Finding 3: Ensuring access to high quality mental health care means that each community must provide a comprehensive array of mental health and support services. Yet the rule-bound mental health system offers fragmented and poorly coordinated care.

Like all people, mental health clients face multiple challenges every day. Some are more prepared – and some less – to provide for their housing, health care, employment and independent living needs. Some are unable to provide for themselves because of their mental illness.

Although the mental health system is organized around a rehabilitation model, the majority of people served do not receive comprehensive services. California has over 500,000 mental health clients in need of substance abuse treatment, but treatment services do not begin to meet the need.[8] Over 75,000 clients need some form of housing assistance.[9] But the mental health system and community programs have a limited supply of temporary and permanent housing. Employment presents an even greater challenge. The majority of people with serious mental illness are capable of working with support, but 80 to 90 percent are unemployed.[10]

Improving access to services often requires additional funding, but it can also be done by breaking through bureaucratic barriers. The highly regarded program offered by the Village Integrated Service Agency in Long Beach reveals the results of removing institutional barriers. Other agencies, such as Baker Places and the Progress Foundation in San Francisco, have been able to provide integrated services because administrators have the support of local authorities to work through licensing regulations. Jonathan Vernick, director of Baker Places, explains:[11]

> *The mental health system unintentionally contrives against service integration. I tried to shop around for a license that would allow the organization to provide mental health and substance abuse treatment services under one roof. There is no license that will allow me to offer both services in a single residential program.*

As the mental health leader, the State must make a concerted effort to motivate local agencies to provide comprehensive services – by lowering barriers to integrated services, promoting cost-effective strategies and encouraging innovation. California's Mental Health Planning Council, representing an array of State departments and client and family advocacy organizations, could assist the department in its efforts.

Recommendation 3: The State must assertively promote cost-effective, efficient approaches to providing care. The Department of Mental Health must ensure that local mental health programs have the tools and assistance necessary to improve the cost-effectiveness of their programs. Specifically, the department should:

Immediate Steps

- The Planning Council should convene public hearings around the state to identify and document potential best practice models.
- The department should prepare a budget change proposal to create and staff a unit charged with identifying and promoting cost-effective practices that improve outcomes.
- The department should convene a working group of mental health professionals and evaluators charged with developing a protocol for evaluating the effectiveness of service models.

❑ ***Utilize the resources of the Planning Council.*** The department should seek assistance from the Planning Council for each of the continuous improvement efforts outlined below.

❑ ***Identify barriers.*** The department should actively identify the barriers that discourage local mental health systems from providing comprehensive, integrated services that can be tailored to individual needs.

❑ ***Identify best practices.*** The refocused department should create and staff a unit charged with identifying and promoting cost-effective practices that improve individual and system outcomes.

❑ ***Explore incentives.*** The department should explore funding, reporting or other mechanisms that can create incentives for state and local mental health officials and service providers to continuously identify and remove barriers to more efficient and effective care.

❑ ***Evaluate innovate programs.*** The department should evaluate promising and innovative practices that have the potential to improve services.

❑ ***Report progress.*** The department and the Planning Council should annually report to the Legislature, local agencies and the public on their activities, progress and on-going challenges to providing comprehensive services.

Providing Adequate Mental Health Resources

Finding 4: Mental health funding is inadequate to ensure all Californians who need mental health services have access to care. Furthermore, existing resources fail to create uniform incentives for improvement and can prevent local authorities from providing cost-effective, efficient care.

Community mental health services are funded through an array of local, state and federal funds. Realignment provides dedicated revenue. Medi-Cal, Medicare and Social Security programs provide reimbursements and

direct payments for people who qualify. Categorical funds, grants and pilot projects allow some communities to provide additional services.

The result of having multiple funding streams is that local mental health authorities must patch together services, and the breadth and quality of programs vary from county to county. Overall, mental health agencies are forced to ration care to only those with the greatest needs and often cannot provide the support services needed to keep individuals stable.

One advisory committee member noted that he could not get help until he attempted suicide. Another argued that the only way she can improve the quality of her care is to move to a county that offers better services.

California should reexamine how it funds mental health programs. When funding and efficiency levels vary across the State, access and quality also vary. Some counties are able to provide a range of services to many, while others provide more limited services and place greater restrictions on access. Access to high quality mental health services should not be determined by a person's zip code.

Other states use funding to promote program effectiveness and efficiency. To promote improvements, Pennsylvania provides additional funds to local agencies willing to adopt programs that have been proven to work. The Pennsylvania funding model is based on a clear assessment of needs and the demonstrated effectiveness of a service approach. The Pennsylvania Partnership for Safe Children has used this model to support youth violence prevention programs.[12] It provides incentives to communities to adopt cost-effective programs.

California could incorporate a practice similar to the Pennsylvania model as part of an overall funding strategy. The majority of mental health funding, perhaps 90 percent, should be stable, provide incentives that promote efficiency and effectiveness and give local agencies discretion to tailor programs to meet individual needs. In addition, the State should provide incentive funding, perhaps 5 percent of all funding, that the Department of Mental Health could allocate to motivate local authorities to adopt practices proven to enhance services. A third tier of funding should promote innovation, perhaps 5 percent, as well. This funding should encourage counties to invest in approaches that hold the promise of increasing the efficiency and effectiveness of mental health programs. With three tiers of mental health funding, each with explicit incentives, the State can provide stable, discretionary funding while motivating counties to adopt best practices and continuously explore innovative approaches to improving outcomes.

Recommendation 4: California should provide adequate funding to ensure those who need care have access to services. The first step is for the Governor and the Legislature to reform the present funding streams. Specifically the legislation should:

- ***Provide stable base funding that motivates quality outcomes.*** The lion's share of mental health funding should include incentives for local mental health agencies to continuously improve services. Funding should reward local programs that improve system outcomes and generate savings associated with reduced mental health costs, as well as reductions in the costs of other public services, such as public safety and health care.

- ***Provide incentive funding for the adoption of best practices.*** In addition to base funding, the State should develop supplemental incentive funding that encourages local agencies to adopt proven best practices.

- ***Provide innovation funding to encourage new experimentation and risk taking.*** Mental health funding should also include resources in addition to base and incentive funding that promote innovation and risk taking to encourage local agencies to explore new approaches.

- ***Document the effectiveness and promote mental health parity.*** Providing all who need services unrestricted access to mental health care means expanding access through the private sector as well as expanding the safety net offered by the public sector. The effect of mental health parity legislation must be understood, and parity should be expanded to improve access to quality care.

Immediate Steps

- The Department of Finance and the Legislative Analyst's Office should analyze the cost of fully funding realignment.
- In January, the Legislature should introduce a bill to fully fund realignment and remove language that limits access "to the extent resources are available."
- The Governor should direct the Departments of Mental Health and Managed Care to assess the impact of parity legislation and constantly identify strategies for expanding access to care through public and private sector mental health programs.
- The Department of Finance and the Legislative Analyst's Office should develop a transition plan to move away from 19 major funding streams toward a more rational approach to funding mental health services.

Decriminalizing Mental Illness

Finding 5: One consequence of an inadequate mental health system is the criminalization of behavior associated with mental illness. The criminal justice system is too often the only resource – the only safety net – available to mental health clients and their families in times of crisis.

California's mental health system is designed to ensure that people have access to emergency mental health care. State and local psychiatric facilities provide round-the-clock services for individuals in need of emergency mental health services. But non-emergency services are more limited. People who need assistance, but who are not a danger to

themselves or others, are often ineligible for immediate inpatient care, and outpatient assistance may not be available.

If every community had a 24-hour assistance center, a safe haven offering care, individuals needing assistance could contact a center for immediate support, while avoiding the high cost of hospitalization or incarceration. In the majority of California communities, however, clients, family members and concerned neighbors have limited options when seeking assistance. In most cases, law enforcement is the only resource available, every day, all day.

The majority of law enforcement contacts with people with mental health needs do not result in an arrest.[13] Most client-police interactions involve officers facilitating access to mental health services, mediating disputes, calming situations or otherwise responding in ways other than to arrest and jail. Police officers, however, are not routinely trained to interact with the specialized needs and concerns of clients in crisis.[14] And when community mental health resources are not available, arrest can be the only option.

Of the 30,000 seriously mentally ill people in California's jails and prisons, the majority are thought to be nonviolent, low-level offenders who landed in the criminal justice system in part because they did not receive appropriate community treatment.[15] Unstable housing and limited substance abuse treatment are particularly associated with the likelihood clients will become involved in the criminal justice system.[16] The State needs to better understand which people are in jail or prison because they were unable to access mental health care and which should be incarcerated and receive treatment while they serve time.

Jails Have Become Treatment Centers

After several days of taking over-the-counter antihistamines, Ron was manic. His father describes him as "bouncing off the walls and slamming doors."

At one point his father called 911 because Ron was making noise, it was late and he was concerned about the neighbors and his son's safety. When the police responded Ron walked out the front door, raised his arms straight in the air and said to the police, "I will (expletive) kill you."

After spraying Ron with pepper spray and handcuffing him, the police officers called the county mental health facility to see if there was room for Ron. There was no space. They called the psychiatric hospital in the neighboring county, no space. They called a facility two counties over, no space. With no other option they charged Ron with assault and took him to jail.

California has begun to identify ways to divert people needing care out of the criminal justice system and into treatment. The Legislature has invested over $160 million in the Mentally Ill Offender Crime Reduction Grant and the Integrated Services to Homeless Adults programs. Both are designed to reduce the number of mental health clients sent to jail.[17]

But these programs are limited and may not provide the most cost-effective services to those who can most benefit. The bulk of California's

diversion and intervention efforts focus on clients after they have been arrested and jailed. Greater savings may result from providing alternatives to arrest, such as improved police training, more 24-hour assistance centers and the expansion of supportive housing programs.

Recommendation 5: The State needs to decriminalize mental illness by ensuring that no one ends up in the criminal justice system solely because of inadequate mental health care. The Governor and the Legislature should improve and expand mental health crisis interventions. Specifically, the Department of Mental Health, the Attorney General and the Board of Corrections should:

Immediate Steps

- The Department of Mental Health should query the Department of Justice database to determine how and where clients come into contact with the criminal justice system.
- The Legislative Analyst 's Office should review criminal justice diversion and intervention programs and determine if the State is making the best use of existing investments.
- Legislation should be drafted for introduction in January to expand facility funding available through the Board of Corrections and permit counties to seek funds from the Board to build 24-hour assistance centers or jails.

❑ ***Use data to improve services.*** The State should analyze criminal justice and mental health data to identify priorities, develop promising programs and inform policy decisions that will reduce the number of mental health clients who end up in the criminal justice system.

❑ ***Identify needs.*** The State should document the need in each county for services that would prevent people from ending up in the criminal justice system, such as 24-hour crisis programs, supportive and affordable housing, substance abuse treatment and other services.

❑ ***Evaluate intervention programs.*** The State should determine whether the Mentally Ill Offender Crime Reduction Grant and Integrated Services to Homeless Adults programs represent the greatest opportunities to reduce client involvement in the criminal justice system.

Coordinating Mental Health and Criminal Justice Services

Finding 6: Local and State agencies have failed to integrate and coordinate mental health and criminal justice services – and as a result people with mental health needs leaving jails and prisons do not receive adequate services and are too often rearrested.

Even if substantial efforts are made to ensure that no one is incarcerated solely because of mental illness, some persons suffering from mental illness will end up in jail or prison for crimes of survival. The criminal justice system also must continue to respond to people with mental illness who have committed serious crimes. In both cases, it must be remembered that nearly everyone in the criminal justice system will be released and re-enter their communities.

Yet clients leaving the criminal justice system face multiple barriers to community re-integration. They may require housing, employment, substance abuse treatment and independent living services to prevent their return to custody. Many communities fail to offer these services. Where these services are available, it may not be clear how to access them.

Service Coordination Can Improve Treatment Opportunities

In just one of CDC's five parole regions, 69 percent of mentally ill parolees fail to show up for mandatory mental health services. Almost 100 percent of clients paroled into Sacramento County have a history of contact with county mental health services. Yet parole and community mental health services do not coordinate care, share treatment history information or collaborate on discharge planning.

Source: California Department of Corrections.

The biggest barrier to successfully re-integrating mental health clients back into their communities is a lack of cooperation among multiple community and state agencies. The evidence is compelling that participation in treatment services is increased and recidivism is reduced when community criminal justice and mental health services are consistent and coordinated. [18] Yet the State offers limited direction or incentive to support collaboration. Resolving this problem is relatively inexpensive, but essential to improving the lives of these mental health clients.

The Texas Council on Offenders with Mental Impairments provides an example of state and community leaders from multiple service areas collaborating to identify strategies to improve services to mentally ill offenders and reduce costs. The National GAINS Center in Delmar, NY, represents a national investment in research, technical assistance and information dissemination to improve community responses to mentally ill offenders.

California should explore the potential of these models and develop strategies to realize similar goals: improving program quality, efficiency and research, enhancing education and technical assistance and increasing the ability of the State to draw upon federal resources to provide services to offenders with special needs.

Recommendation 6: The State should establish a California Council on Offenders with Special Needs to investigate and promote cost-effective approaches to meeting the long-term needs of mentally ill offenders. The council, comprised of state and local officials, should:

- ***Identify treatment strategies.*** The council should propose policies for improving the cost-effectiveness of services for offenders with special needs within jails and prisons, including service coordination and data sharing among community mental health and criminal justice programs.

Immediate Steps

- By Executive Order, the Governor should establish the California Council on Offenders with Special Needs.

Immediate Steps

- The Legislature should call for an independent evaluation of contracts between the California Department of Corrections and local mental health agencies to provide care to parolees.
- The Legislature should direct the California Department of Corrections to expand to all counties contracts proven to successfully provide quality mental health care to parolees.
- The Legislative Analyst's Office should analyze the State's response to incentive programs offered by the federal Social Security Administration and promote the use of incentive payments to fund pre-authorization efforts that speed up benefits to clients leaving jail or prison.

❑ ***Promote coordination.*** The council should document the need to coordinate mental health services and improve the ability of clients to transition successfully between corrections-based and community-based treatment programs.

❑ ***Provide technical assistance.*** The council should develop a technical assistance and resource center to document best practices and provide information and training to improve the efficiency and effectiveness of state and local programs serving mentally ill offenders.

❑ ***Develop incentives.*** The council should identify incentives that will motivate State and local agencies to coordinate mental health and criminal justice services.

Creating Accountability: Monitoring the Mental Health System

Finding 7: California will never be able to ensure that all Californians have access to mental health care without clear and continuous accountability for outcomes.

When realignment shifted responsibility for care to counties, client advocates were concerned that local agencies would limit their investment in services and the quality of care would suffer. In response, the Department of Mental Health was required to develop a reporting system to assess the performance of counties.[19] But it has struggled with the requirements and the reporting system is not fully operational.

The department envisions a data-based reporting system that tracks outcomes for all mental health clients receiving services for 60 days or more each year – some 25,000 children and 185,000 adults.[20] Data for each individual will track the services used, costs and outcomes. Despite sound planning and pilot testing, the department is challenged by the enormity of the task. There is no unequivocal agreement or standard for measuring the effects of mental health services. There is no clear measure for evaluating the impact of treatment.[21]

Supporters of the department argue it is difficult to develop a system when the science of performance measurement is still evolving. Critics contend that a lack of progress is a result of the department's interest in ensuring that the data favorably represent all county mental health agencies. The reality is likely somewhere in the middle. Similar efforts

in other states have shown that data systems often fail to capture the value of local mental health programs. Preliminary data are often suspect, and it can take years of fine tuning to build a reliable measurement and reporting system.[22]

Despite these challenges, California needs to make progress. The department needs to take first steps regardless of how unstable those steps may be. The department could bolster its efforts by involving nationally recognized experts in outcome reporting and encouraging public awareness and critique of its process and progress.

Further, the department should develop data sharing protocols with other state and local agencies to encourage collaborations that can improve the quality of services and client outcomes. Data sharing should explore potentials for organizational improvement by encouraging data-based research on the mental health service delivery system. Outcome, assessment and financial data should be widely available and permit mental health stakeholders and the general public to understand the adequacy and efficiency of local mental health programs.

Recommendation 7: Improvement, public understanding and support for mental health programs depend on an accurate assessment of California's progress toward its goals. As the State's mental health leader, the Department of Mental Health must continuously inform the public, program administrators and policy-makers on the performance of the system, whether quality and access are improving and how they could be enhanced. Specifically, the department should:

- ***Inform decision-makers.*** The department should provide information that can help the general public, policy-makers and program administrators understand the availability, quality and cost-effectiveness of mental health services.
- ***Provide benchmarks.*** The department should provide information that compares performance with expectations. It should reveal variations across programs, counties and over time.
- ***Reveal barriers.*** The department should provide data to permit administrators and researchers to identify barriers to program improvement and alert policy-makers when and where policy changes are necessary.

Immediate Steps

- The department should publicly report aggregated information for each county on the types of Californians who are being served and the unmet need.
- The department should commit to develop and publicize benchmarks that outline annual goals for expanding access to mental health care.
- The Legislature should direct the Department of Mental Health to complete the statewide performance reporting system.
- The department should provide quarterly reports to the Legislature and the public on its progress in developing the reporting system.

Immediate Steps

- The department should begin putting data on-line for easy public access.
- The department should publicize the conditions under which it will intervene to ensure mental health services are available in every community.

❑ ***Encourage broad access.*** All data and information on mental health programs should be readily accessible to the public, the press, researchers and others whose analyses could lead to better public understanding, program management and policy making.

❑ ***Provide standards.*** Performance data should be structured to indicate to state and local administrators and policy-makers when mental health services are so inadequate that intervention is warranted.

Introduction

Meeting the needs of people with mental illness has been a persistent challenge for individual communities and together as a State. In this report, the Commission explores some of the issues that make mental health policy unique, as well as those that burden other social services.

This report was motivated by concern and compassion for those among us whose illness is most visible. The Commission is not composed of experts in mental health, and the Commission soon recognized that it was not alone. Misunderstanding – or even just a lack of understanding – about mental illness and those who suffer with it shapes the public's often inadequate response.

Without clear expectations and obligations, policy-makers spiritedly debate involuntary treatment and separate insurance and payment systems for mental and physical health care. They are uncertain how to fix fragmented mental health policies and programs that fail to comprehensively address client needs. Everyone in California is entitled to physical health care; even those without insurance can walk into an emergency room for treatment of a relatively minor ailment. In contrast, mental health care is not always available. The law says that local mental health programs can turn away those with less severe needs. And when funds are depleted, even the most severely disabled can be turned away. The obligations of government and the expectations of the public for mental health care must be clarified before California's mental health system will dramatically improve.

Several Commission reviews have identified the role of mental health services in reaching publicly held goals. The Commission has recommended expanding mental health services for abused and neglected children.[23] It has recommended improved mental health assessments and treatment for prison inmates and those released on parole.[24] During its review of juvenile justice programs in 1994, the Commission examined the adequacy of mental health services for troubled youth.[25]

In this review, the Commission attempted to comprehensively examine the State's policies for serving those with mental illness. The Commission strived to understand the full range of service needs and the full range of available services. Whenever possible, the Commission explored these issues from the perspective of mental health clients and

what they needed to maintain or recover functionality. It probed the costs and benefits of providing adequate services, and the costs and consequences of providing inadequate care. As in the previous studies, the Commission observed that the public and private costs of mental illness reach far beyond the resources budgeted for mental health programs.

The recommendations in this report are offered to the Governor, the Legislature and the people of California. Together the recommendations call for systematic reforms to the services provided to people with mental illnesses. Most significantly, the Commission believes that fundamental reforms must begin with – and be sustained by – an expanded public understanding of mental health and the impact of mental illness. Mental illness touches the lives of all Californians, and as a result each Californian has a stake in ensuring that services are available, efficient and effective. The report contains seven findings and recommendations that would fortify the mental health system in four areas:

❑ *Expectations and Leadership*

Because of the nature of mental illness and the large number of people and institutions that must be involved to address it, extraordinary leadership is required. The leadership responsibility must be shared with an array of community leaders who historically have not been involved with this issue. They must help all Californians to understand this illness, to set clear expectations for the public response and persistently advocate for improvements in service and investment of additional resources. In turn, the State must refocus its leadership capacity to help California's communities improve services.

❑ *Comprehensive Services and Resources*

While the understanding of mental illness continues to evolve, there is general agreement on effective strategies for helping those in need. But for the most part, the State rations care to the most severely mentally ill, forsaking opportunities to intervene early. In the absence of comprehensive, efficient mental health services, mental health clients, their families, California's communities and taxpayers pay a higher price in lost potential and productivity, greater social problems and personal grief.

❑ *Criminal Justice*

California's local and state criminal justice systems have become a secondary mental health system, and state psychiatric hospitals have

become a branch of the criminal justice system. The merging of mental health and criminal justice reflects the priority given to public safety. It also reflects the mental health system's inability to adequately care for those in need and prevent the nuisance crimes of survival – vagrancy, public drunkenness, trespassing – that are actions of people with no allies and no options.

❑ *Accountability*

There is tremendous variation in the availability and quality of mental health services across California's communities. Without clear public expectations for services, some communities have invested more than others in mental health. This variation in the quality and availability of care can be addressed by improved public accountability for outcomes. The State is developing a monitoring and reporting system. It should allow the public, administrators, clients and other stakeholders to assess the adequacy of each local mental health program and identify opportunities for change.

The Commission began its work on mental health policy in September 1999 with a public hearing on the mental health service system and the challenges it faces. A second hearing was convened in October where the Commission explored the links between the criminal justice system and mental health. At a final hearing in January 2000, witnesses provided testimony on model programs, strategies for improving services and the ongoing challenges facing people with mental health needs.[26] Those hearings were complemented by site visits to Santa Barbara, Los Angeles, Indian Wells, San Bernardino, San Francisco, Sacramento, Vacaville and Napa.

The Commission also benefited from the time and energy of over 100 advisory committee members representing state departments, advocacy organizations, youth and adult mental health clients, family members, mental health researchers, public and private mental health providers, hospitals and health systems, law enforcement agencies and others. The Commission also received advice and technical assistance from the University of California, Center for Mental Health Services Research, which helped the Commission to explore specific aspects of this report. As always, the Commission greatly appreciates this assistance, but the conclusions are those of the Commission alone.

The pages that follow examine California's public mental health system and services to adult with mental health needs. Considering the differences in how children and adults experience mental illness and the distinct funding and service systems in place, the Commission will follow this report with a review of children's mental health policy.

Background

California's mental health policy has evolved through episodic changes representing large, but seldom comprehensive reforms. Policy discussions usually focus on the crisis of the day: unstable and limited funding, state versus local responsibilities for care, and the protocols for involuntary treatment. In California's communities, clients and providers struggle with limited access to care, and shortages of essential related services.

The ability of policy-makers to address these tensions is hamstrung by their complexity. The scientific understanding of mental illness and treatment options is evolving and is contentiously debated by stakeholders. Stigma, misunderstanding and inaccurate public perceptions of mental illness and those who experience it complicate efforts to solve thorny challenges. Finally, the sheer number of funding streams and agencies responsible for providing care, oversight or assistance confounds efforts to assess and improve the system.

No Bright Line between Health and Illness

Policy-makers face many challenges when crafting mental health policy – and the greatest may be the evolving understanding of mental illness. The U.S. Surgeon General reports that there is no "bright line separating health from illness, distress from disease."[27] How mental illness is defined varies for people from different age-groups, cultures and gender. Social values determine at what point distress becomes illness and those values change over time and across cultural boundaries.

There is continuous debate within the scientific and advocacy communities over how to define mental illness, the conditions under which taxpayers should fund services and the goals of treatment. These debates create a moving target for policy-makers and practitioners, particularly when they try to capture evolving and conceptual understandings into the rigid language of statutes and regulations.

It is generally agreed that illness and health are linked to social, psychological and biological factors.[28] But there is disagreement on the role that each factor plays. Social factors include the learned behavior of individuals as they respond to the events around them.[29] Psychological factors include stressful events and personality.[30] Biological influences include genetic disposition to illness. Sorting out these factors is complicated because mental illness presents itself in different ways in different people. Some experience mental illness following traumatic

events. Others might develop the same illness without such an event. This variation makes it difficult to know whether biological, psychological or social factors are the dominating influence.

Extensive research in recent years on brain development has advanced the understanding and treatment associated with biological factors. Based on this research, some have asserted the primacy of biological foundations of mental illness and treatment. Critics respond that biological factors dominate discussions only because social and psychological factors have not been adequately studied. One respected psychiatrist described the tension this way: The significance of biological, psychological and social factors as causes, consequences and correlates of mental illness ranges from complete significance to insignificance – depending on the expert, the client and the illness.

In short, the scientific community does not know with certainty what causes mental illness and treatment is not universally effective for all people. Treatment results in degrees of recovery across different people, illnesses and circumstances. The variation in how different people perceive mental illness and respond to treatment is further complicated by how the illnesses run their course. Some people overcome their illnesses. For others treatment can only help them to recover their functionality. This range of experiences, including the duration and receptiveness to treatment, has encouraged practitioners to categorize mental illnesses into degrees of severity and persistence.

Common Mental Illnesses

Schizophrenia: The most disabling mental illness. Often characterized by hallucinations and delusions, disorganized speech and behavior, and restrictions in the range and intensity of emotional expression, in the fluency and productivity of thought and the initiation of goal-directed behavior.

Panic Disorder: Panic disorder is characterized by recurrent and unexpected panic attacks. Symptoms include trembling and shaking, heart palpitations, chest pain, nausea and fear of losing control.

Obsessive-compulsive Disorder: Obsessions are recurrent and persistent thoughts, impulses or images. Compulsions are repetitive behaviors or mental acts that the person feels driven to perform. The compulsive behavior is aimed at preventing some dreaded event or outcome.

Clinical Depression: The most common psychiatric disorder. Episodes can be continuous or separated by years without reoccurrence. Symptoms include: depressed mood, little or no interest or pleasure in daily activities, significant change in weight and appetite, insomnia, fatigue, feelings of worthlessness, excessive or inappropriate guilt, diminished ability to concentrate, recurrent thoughts of death or suicide.

Bipolar Disorder – Manic Depression: Bipolar disorder is characterized by extreme changes in mood, from severe depression to severe mania, or elevated mood. During both extremes the person may be unable to make rational decisions. Mania may be characterized by several days without sleep, loss of touch with reality, and feelings of having special powers.

Source: National Institute of Mental Health (www.nimh.nih.gov) On file.

Prevalence and Adequacy of Services

Assessing the adequacy of mental health services begins with an understanding of who needs services. Because it is difficult to determine when symptoms constitute an illness or when treatment is advisable, it is difficult to measure precisely the gap between the need for treatment and the availability of treatment. County authorities assert that they serve about half the population needing public mental health care.[31]

Experts generally agree that one in five persons have a diagnosable mental disorder every given year.[32] But not all of those people need treatment. The duration and severity of symptoms vary so much that it is hard to apply treatment standards for every person and every circumstance. Many people never access treatment. Those with a diagnosable mental illness but whose symptoms do not significantly interfere with their daily lives are often referred to as the "walking worried" and generally do not need professional care.

Two national studies are widely recognized as providing the most reliable data on the prevalence of mental illness. Those estimates are still regarded as imperfect representations of the need for care and services.[33] They suggest the following rates of mental illness:

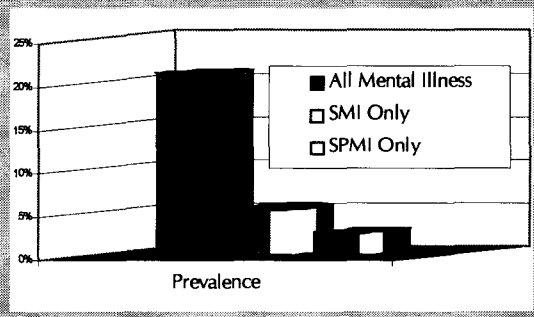
- ***Adults***. An estimated 22 to 23 percent of the adult population experience a mental illness each year. Under a third of those people, about 9 percent of all adults, have an illness that impairs their ability to function.[34] Some 5 percent have a severe illness and 2.6 percent have a severe and persistent illness. About 0.5 percent have an illness that is sufficiently disabling to qualify for disability benefits.[35]

Understanding Mental Illness

All Mental Illnesses: Disorders characterized by cognitive, emotional or behavioral anomalies. An estimated 21 percent of the adult population has a mental illness each year, or, 5,225,368 Californians.

Severe Mental Illnesses (SMI): Of those with mental illness, some have symptoms that significantly interfere with their major life activities. An estimated 5.4 percent of the adult population has a severe mental illness, or 1,343,666 Californians.

Severe and Persistent Mental Illnesses (SPMI): Of those with a severe mental illness, a significant proportion experiences symptoms that persist for an extended period of time. An estimated 2.6 percent of adults have SPMI, or 646,950 Californians.



Sources: Department of Finance. 2000. "Population Projections." U.S. Department of Health and Human Services. 1999. Mental Health: A Report of the U.S. Surgeon General. Pages 45 – 49.

Who is Served by the Public Mental Health Service System?

In 1998 over 380,000 Californians received public mental health services through Medi-Cal, up almost 20 percent from 1991. The majority of services went to adults.

Age	Persons Served	Percent of Total*
0-12	51,231	13.4
13-17	50,835	13.2
18-39	142,226	37.2
40-64	121,011	31.6
65+	16,438	4.3

Race/ Ethnicity	Persons Served	Percent of Total*
White	199,442	52.1
Latino	74,571	19.5
African Amer.	61,002	16.0
Asian/Pacific Isl.	21,926	5.7
Native American	3,683	1.0
Other	21,799	5.7

* Does not total to 100 percent because of rounding. DMH data show that 467,000 persons were served in 1997-98. Age and ethnicity data are only available on those served through the Medi-Cal program. Source: Department of Mental Health. 1999. Persons Served in County Mental Health Programs: 1990-91, 1994-95, 1997-98. Sacramento, CA: Department of Mental Health.

- ***Children and Adolescents.*** Children and adults experience mental illnesses differently.[36] An estimated 20 percent of children have mental illness with some form of functional impairment. Approximately 5 percent to 9 percent of children ages 9 to 17 have more severe impairments known as "serious emotional disturbances."[37] Having a childhood mental illness does not necessarily mean the disorder will continue into adulthood.[38]

- ***Older Adults.*** Older adults are affected differently than younger adults, and it is not clear why. Cognitive impairments associated with aging may affect the prevalence of mental illness. One study suggests that 19.8 percent of the older adult population has a mental illness in a given year, with almost 4 percent having a severe illness and 1 percent a severe and persistent illness.[39]

California provides mental health services to more than 467,000 people.[40] The Mental Health Planning Council has estimated the gap between services presently available and the number of clients in need. Estimates refer to adults with serious mental illnesses and children with serious emotional disturbances. Those estimates are presented in the box below.

Estimating Unmet Need

The California Mental Health Planning Council estimates between 500,000 and 1.7 million Californians need mental health services, but fail to receive care.

The council has established a lower limit, which reflects clients likely to receive care through publicly funded programs, and an upper limit that includes clients who could access care through sources such as private insurance. Estimates are based on age groups and reflect two sources of data. The lower estimate for each age group is based on a 1999 study that found 5.4 percent of the population experiences serious mental illness. The higher estimate is based on prevalence rates developed for California counties in 1990.

Unmet Need

Age	0-17	18-21	22-59	60+	Total
Lower Limit	160,220	31,762 - 37,094	223,086 - 274,179	97,015 - 109,433	**512,083 - 580,926**
Upper Limit	530,900	81,058 - 92,090	733,637 - 854,532	230,118 - 257,185	**1,575,713 - 1,734,707**

Estimates of unmet need provide important policy guideposts. But numerous factors contribute to an individual's ability to access services, including poverty, language and cultural background, insurance coverage and stigma. While California's public system serves approximately half of those in need, doubling services would not necessarily address the remaining need.

Source: California Mental Health Planning Council. Letter to the Assembly Budget Committee. April 7, 2000. On file.

The Costs of Mental Illness

The costs of mental illness are difficult to quantify – and the sum is much greater than the total expenditures on mental health services alone. The direct costs of mental illness represent what the public and private sectors spend to treat and respond to mental health needs. Indirect costs capture lost value, as when clients or family members take time away from work. A greater challenge is determining the intangible costs – the price that families, neighborhoods and communities pay when someone is ill.

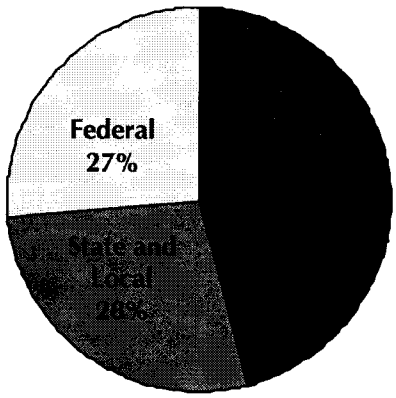
Direct Costs. The direct costs of mental illness include funding for services people receive as a result of a mental illness. Public sector funding includes state and county mental health services, as well as spending on correctional, vocational rehabilitation, substance abuse treatment, housing, employment, education and other programs serving clients. The private sector also bears direct costs of mental illness. Private sector health insurance may pay for treatment, residential programs, and assisted living or respite services. Many families without insurance may pay service providers directly through "fee for service" arrangements that must also be included in direct cost estimates.

One report estimates that the public and private direct costs of mental health care in California are $9.5 billion annually. This estimate applies a 1996 national estimate of per capita expenditures to the California population. This figure includes the cost of substance abuse treatment services and the $2 billion spent by State and local agencies for community mental health programs.[41]

Indirect Costs. Indirect costs are more difficult to measure. They include lost productivity associated with time away from work, inability to work or premature death. They can also include the cost of lost property value, tax dollars and business profits, higher insurance premiums or other costs associated with a population of mentally ill and often homeless people whose presence reduces the tranquility of a business district or neighborhood.

The U.S. Surgeon General references a national study that calculated the indirect costs of mental illness at $79 billion based on 1990 figures.[42] This amount includes lost

Mental Health and Substance Abuse Treatment Expenditures by Source 1996-97



Source: SGR Health Alliance. 2000. The State of the State of Behavioral Health in California: Alcohol, Drug, and Mental Health Services and Systems. On File.

productivity due to illness, premature death and incarceration only. California's share of those indirect costs, based on the state having 12.5 percent of the U.S. population, is roughly $9.875 billion annually, or $823 million each month.[43] Undoubtedly, costs have increased in the last decade.

Intangible Costs. More difficult to quantify, yet equally significant are the social, emotional and psychological costs when a family member is homeless, unaccounted for, commits suicide or spends time in the criminal justice system because of an illness. The intangible costs of mental illness are tremendous.

> ***Mental Illness and Suicide***
>
> The costs of mental illness include suicide. Most suicide victims have a diagnosable mental illness. Between 1990 and 1997, 29,266 Californians committed suicide.
>
> Source: Suicide Data 1997. (www.iusb.edu)

Some of these costs – such as criminal justice expenditures – are increased because of inadequate treatment and other services that can limit the severity of an illness and prevent the loss of functionality. California has not attempted to document the full range of costs associated with mental illness or the savings in corrections or other programs that could be captured if more resources were invested in treatment. Most discussions of the cost of mental illness emphasize public expenditures for mental health care alone, which are outlined later in this background.

Related Challenges

Two challenges in particular fundamentally shape public perceptions and policy responses to mental health clients: substance use and homelessness. Housing is a common problem for clients unable to work and with limited personal income. Many clients deal with substance abuse problems that are linked to their mental illness.

Substance Use. Approximately half of the clients with severe mental illness have a history of drug use.[44] And at any given time, about half of all clients receiving treatment are using illicit substances, which is often referred to as "co-occurring disorders" or "dual diagnosis."[45] Substance use complicates the ability of mental health professionals to diagnose and treat mental illness because drugs can mask or mimic the symptoms of mental illness. Treatment is complicated when people use illicit drugs that interact with powerful psychotropic medicines prescribed to treat a mental illness. And historically, treatment protocols for substance use and mental illness followed opposing philosophies. Substance abuse treatment emphasized complete avoidance of controlled substances, while mental health care embraces the use of drugs in treatment.

Different stakeholders have differing views about drug use by mental health clients. To some, drug use is illegal activity unassociated with an illness. Others see drug use as a way to self-medicate for psychotic episodes, depression, anxiety or other features of their illness. They suggest that unlike prescribed drugs, street drugs have fewer negative side effects. Others believe drug use may alter a person's chemical balance or change the structure of the brain and result in a mental illness. Some also argue that biological, social or psychological aspects of mental illness may trigger street drug use by mental health clients.

Homelessness. An estimated 57 percent of all homeless adults suffer from a mental illness.[46] The prevalence of homelessness is associated with economics and the mental illness itself. Limited income provides few housing options. As housing prices increase, more mental health clients become homeless. Many mentally ill individuals have a difficult time conforming to, or understanding rules imposed in shelter programs or by landlords. Others have a history of substance abuse that makes them ineligible for housing support. The homeless mentally ill are generally the most difficult homeless people to work with, often refusing to sleep in public shelters. They are thought to be homeless more frequently and for longer periods than other homeless individuals.

Substance abuse and the vagrancy associated with homelessness are viewed as criminal activities, coloring perceptions of mental health clients. Both factors challenge the ability of service providers to offer effective treatment. Substance abuse complicates treatment and reduces the likelihood that clients will follow a treatment regimen. Homelessness compounds the effects of mental illness by limiting the ability of clients to build social support networks or follow a treatment program.

Client substance abuse and homelessness are considered consequences of deinstitutionalization and inadequate mental health care. California over years adopted policies that moved people out of mental hospitals where they received comprehensive, integrated services for a range of needs, into community treatment programs that in many cases are limited to therapy and medication.

Few community programs could guarantee housing for people leaving state hospitals. Substance abuse services were unavailable or not integrated with mental health care. Those same conditions exist today. As a result, mental health clients enter the criminal justice system – often for drug use or crimes of survival associated with homelessness and poverty. Without comprehensive services and increased funding, providers are forced to ration care and emphasize treatment over prevention.

Prevention, Treatment Effectiveness and Recovery

Mental illness confounds common notions of illness, where the progression of a disease can be forecast and treatment prescribed. The difference complicates efforts to develop and fund treatment programs early in the onset of mental illness. Still, providers believe it is important to think about mental illness as any other illness, with opportunities for prevention, intervention and treatment with recovery as the goal.

Prevention. Adult mental health shares a three-fold definition of prevention with the public health model.[47] Developing effective prevention programs requires some sense of who is at risk of becoming ill. Researchers have identified two types of risks. Fixed risks, such as gender and family history, cannot be changed. But other risk factors, such as lack of social supports, exposure to trauma and stress, provide opportunities for intervention and prevention.[48] Research on twins suggests that even with inheritable mental illnesses, such as schizophrenia, environmental factors may reduce risks associated with genetic factors.[49] Prevention can also emphasize strengthening "protective factors," such as housing and social supports, which can improve a person's response to risk factors.[50] Prevention involves assessing risks and changing those that are amenable to intervention, while increasing protective factors to offset potential risks.

Defining Prevention

Primary. Warding off the initial onset of an illness.

Secondary. Treatment to reduce the recurrence of symptoms and co-occurring disorders.

Tertiary. Maintenance to prevent relapse and provide rehabilitation support.

Treatment Effectiveness. Treatment involves managing or stabilizing symptoms to support the most fulfilling life possible. Treatment includes medication, counseling, skills training and social and psychological supports to increase functional capacity. Many mental health interventions also address risk factors that influence the severity, persistence and likelihood of recurrence, such as housing, employment, independent living skills, substance abuse treatment and assistance with money management.

Recovery. The mental health literature does not view a cure as the goal of treatment. Instead, it promotes recovery. But not all stakeholders agree on what constitutes recovery or the goals of treatment. According to standard treatment terminology, treatment goals include reducing the length of an episode, limiting its severity, halting reoccurrence or lengthening the time between episodes. Some advocates however, are concerned that mental illness is presumed to be a permanent disability that can at best be managed.[51] Those advocates support the notion of recovery and have built a social movement within the mental health community to promote their view.[52] There are two dominant perspectives on recovery: rehabilitation and empowerment.

Rehabilitative recovery emphasizes restoring functionality. Taking cues from physical health, rehabilitative recovery emphasizes enabling a person to live with an illness. Treatment offers support, often permanent, to help the person function despite limitations. In contrast, an empowerment recovery asserts that full recovery is possible. Mental illness can be overcome and individuals can regain control of their lives.

Rehabilitation and empowerment visions are distinct in their treatment goals. Rehabilitative recovery envisions lifelong dependency as acceptable, such as employment support, subsidized housing and assistance with living skills. Empowerment recovery envisions clients living independent of external supports. Gainful employment is a key goal of empowerment recovery.[53] Although it does not include the notion of a "cure" for mental illness, empowerment recovery emphasizes independence and self-purpose.[54]

The Public Mental Health System

California's mental health system has evolved over the last four decades. This evolution has changed the role of the State and local governments in providing care. Mental health services have moved from being predominately hospital-based and provided by the State to community-based and provided through local governments. More recently, mental health stakeholders recognize that mental health care requires an array of services that have not traditionally been available through a community-based service model. For instance, institutional care provides housing, social activity, transportation assistance, vocational rehabilitation and physical health care. Community mental health programs historically have provided more limited services.

Multiple state agencies provide health, mental health and related services. The primary agency for ensuring the provision of mental health services is the Department of Mental Health. It operates state hospitals, oversees county-based mental health services and provides leadership on issues of policy and practice. The Department of Health Services is California's lead agency for Medi-Cal, which funds the treatment of some clients. The Department of Alcohol and Drug Programs, Department of Aging, Department of Rehabilitation and multiple others offer services or coordinate programs available to mental health clients.

The primary public providers of mental health services are California's 59 local mental health agencies, the majority run by county governments.[55]

Pre-1957

State operates eight hospitals serving 36,319 (1956-57) mental health clients.

1957

Short-Doyle Act creates framework and funding for local governments to develop community mental health programs.

1966

California establishes Medi-Cal program with the State and Federal governments sharing the costs of providing some mental health services.

1967

Lanterman-Petris-Short Act changes threshold for involuntary treatment and increases state funding for community mental health programs.

1969

California turns toward more community-based mental health services and begins closing three state hospitals.

Establishing Community Mental Health Services

In 1957 California established the Short-Doyle program to encourage counties to develop community mental health services. Originally a voluntary program with no state funding, many counties chose not to participate. To spur counties into building programs, the State offered dollar for dollar match funding. Short-Doyle later became a mandatory program. The State provided 90 percent matching funds for inpatient care and 85 percent for outpatient services.

In 1965 the U.S. Medicaid program was created to reimburse states providing medical services to low-income individuals. California responded by establishing the California Medical Assistance Program (Medi-Cal). Under Medi-Cal, the federal government reimburses California 51 cents for each dollar the State spends. Some 5 million Californians participate in Medi-Cal programs.[56]

Originally, Medi-Cal only covered care in nursing facilities and hospitals and the services of psychiatrists and psychologists and was known as Fee-for-Service Medi-Cal (FFS/MC). In 1971 the Legislature folded the Short-Doyle program into the Medi-Cal program to capture federal matching dollars with the funds already dedicated under Short-Doyle. Short-Doyle Medi-Cal (SD/MC) complimented FFS/MC by paying for services provided through hospitals, therapy provided in outpatient settings, and day treatment programs. The SD/MC program added a Targeted Case Management component in 1989 and the Rehabilitation Option in 1993.[57] These two components broadened the range of services and providers covered. Medi-Cal funding now covers case management services for targeted clients and treatment for mental disorders and associated functional limitations that are barriers to living in the community.[58]

Who is Eligible for Medi-Cal?

Under Medi-Cal, federal and state dollars are available to pay for health care services to welfare recipients and other qualified individuals. County welfare agencies determine the eligibility of applicants and are reimbursed through the state Department of Health Services for services based on established rates.

People eligible for Medi-Cal fall into two categories, 1) aged, blind or disabled, or 2) families with children. Mental health clients are primarily eligible based on mental illness as a disability. Clients who receive social security income (SSI) are automatically eligible for Medi-Cal benefits. Others qualify based on low incomes. In general, eligibility is based on a monthly income of $954 or less for a family of four.

Source: Office of the Legislative Analyst. 2000. Analysis of the 2000-01 Budget. Sacramento, CA: LAO. Pages C64-65.

Program Realignment. The lean budget years of the 1980s prompted California to revamp public mental health services. In 1991, the State and counties negotiated "Program Realignment" (known as "realignment"). Prior to realignment, county programs were funded through the annual budget act. Each county program competed for limited funds, counties could not set priorities and funding was unpredictable. The State operated and financed state hospitals and provided other services. Realignment replaced more than $700 million in annual General Fund allocations with dedicated revenue from sales taxes and vehicle license fees. It also made counties responsible for providing treatment and gave them control over local programs. The legislation did not guarantee that people would have access to mental heath care. While Medi-Cal recipients are entitled to services, realignment specified that the counties must only serve other residents to the extent funding is available.

A report by University of California researchers argues that realignment improved efficiency, stabilized expenditures and increased the number of people served. Prior to realignment, the number of people served was declining by about 1.5 percent. The first year after realignment, the number served rebounded by 6.5 percent and increased 1.5 percent in the two subsequent years. Prior to realignment, per person costs were increasing by 5.3 percent each year. With realignment, costs dropped by 3.3 percent in the first three years. Under realignment, counties "buy" state hospital services from the state, an arrangement that encourages counties to develop less-expensive community-based services. [59]

Mental Health Managed Care. In 1993 California's Department of Health Services initiated a plan to provide public health services under a system of managed care. The Department of Mental Health followed suit with a "carve out" of mental health dollars, separating mental health and physical health funding. Under mental health managed care, mental health services to Medi-Cal participants are available through a single mental health plan in each county.[60]

California first implemented managed care with the Short-Doyle Medi-Cal program. Later, the State consolidated funding for Short-Doyle Medi-Cal and Fee-for-Service/Medi-Cal. The State's initial managed care plan envisioned funding local mental health plans with a fixed monthly allocation for each Medi-Cal participant regardless of service usage.[61] Known as capitation, this element of managed care has not been implemented and is controversial. Among the concerns is that capitation will not provide the counties sufficient resources to provide services that clients are entitled to under federal law.

1988
California moves toward integrated and community-based, system of care for adult mental health clients. Three pilot projects receive funding.

1991
Program realignment reforms State and local responsibilities and funding for mental health services, further supporting policy of community-based mental health services.

1995
California moves to implement Medi-Cal Mental Health Managed Care. Each county establishes a single Mental Health Plan for providing Medi-Cal services.

2000
The Legislature establishes the Joint Committee on Mental Health Reform to recommend reforms that will improve the quality of mental health services in California.

The following three pages summarize important developments, issues and opportunities:
- *The work of the Joint Committee.*
- *The debate over LPS reform.*
- *Client access to community services.*

Joint Committee on Mental Health Reform

Senate Concurrent Resolution 59 established the Joint Committee on Mental Health Reform and directed it to submit a report to the Legislature by May 1, 2000. The Joint Committee reached agreement on 13 issues but could not find common ground on the need to reform involuntary treatment laws.

Disagreement over whether to address involuntary treatment standards disrupted the Committee's work. Members were unable to identify a procedure for releasing a "minority report" and as a consequence failed to issue a report. Instead, the co-chairs of the Joint Committee each issued a version of the findings. Senator Chesbro and the Senate Select Committee on Developmental Disabilities and Mental Health issued a report with the 13 agreed upon findings and recommendations. Assemblymember Thomson along with four other members of the Joint Committee issued a similar report that included the disputed 14th finding on involuntary treatment. The findings are summarized below:

1. **Eligibility and Access to Services.** Encourages legislative review of eligibility policies, expansion of the Adult System of Care with minimum standards, extension of crisis services and parity to include substance abuse and remaining mental health diagnoses, and research on access to voluntary care.
2. **Homelessness and the Housing Shortage.** Encourages expansion of services and housing for homeless clients.
3. **Criminalization of Mental Illness.** Recommends target improved services for clients at risk of becomin involved with the criminal justice system or coming out of the criminal justice system, and expansion o law enforcement training, mental health courts, and crime prevention services.
4. **Substance Abuse Treatment and Services.** Urges expanding and integrating mental health and substance abuse services and consideration of the consolidation of State mental health and substance abuse departments.
5. **Access to Appropriate Medications for Effective Treatment.** Recommends improving access and affordability to the most effective medications, including assisting counties with medication purchasing agreements and improving the interface of public and private health care plans.
6. **Children's Services and Interventions.** Recommends expansion of Children's System of Care, improved school-based programs, services for infants and specialized services for foster care youth.
7. **Human Service Shortage.** Recommends consideration of the Mental Health Planning Council's Action Plan on human resources, improved reimbursement rates for licensed mental health providers, expanded outreach and incentives for students to enter the mental health field.
8. **Consumer Confidence, Representation and Resources.** Promotes use of "advance directives," expansion of self-help model of services, and reform of the County Patients' Rights Advocate program.
9. **Family Access and Resources.** Supports expanded respite care, improved family education programs, training in the rights of family members and expansion of County Family Advocate programs.
10. **Under-Served Populations.** Recommends support for programs targeting underserved populations, including services and programs targeting diverse cultural groups, women and older adults.
11. **Stigma and its Implications.** Recommends increased public education and outreach to reduce stigma.
12. **Suicide Prevention.** Recommends improved awareness and understanding of suicide and efforts to enhance resources and include prevention services in all mental health systems.
13. **Accountability and Oversight.** Recommends defining and streamlining oversight functions of the State, counties and local boards and improving client and family access to advocacy services.
14. **Outpatient Treatment for Involuntary Patients.** Recommends legislative support for assisted outpatient programs for involuntary patients. ***(Not uniformly adopted)***

Sources: A Report of the Public Hearings of the Joint Committee on Mental Health Reform and Findings and Recommendations as Adopted by the Senate Select Committee on Developmental Disabilities and Mental Health. June 2000. A Report of the Public Hearings held by the Joint Committee on Mental Health Reform and Findings and Recommendations. Summary Excerpt. June 2000. On File.

The Lanterman-Petris-Short Act (LPS)

California was a historic leader in moving mental health services out of state-run hospitals into community-based programs. The LPS Act – which defines the process for establishing involuntary care – was a component of the State's efforts to support community care.

The Lanterman-Petris-Short Act removed "need for treatment" from the criteria under which people could be involuntarily hospitalized. Under LPS, only those "gravely disabled" as evidenced by lack of food, shelter and clothing or a "danger to self or others" as a result of mental disorder can be involuntarily treated. Adopting the LPS act meant thousands of people could not be forcibly hospitalized. Community-based, voluntary treatment was expected to replace institutional care. But funding did not follow clients from the state hospital system and into communities to provide services.

The LPS Act changed the nature of mental health services. Fewer people received involuntary treatment and more were expected to receive voluntary care. But with limited funding, communities must ration care. The Commission heard testimony that some counties provide care only after people threaten suicide

Some people and their families feel caught in a Catch 22 between involuntary commitment laws and rationed care that helps only the most severely disabled. Clients often cannot access care when they recognize they need help. They become eligible only after they no longer recognize their needs. Once they are a threat they can be forcibly treated. At that point, treatment often involves expensive, inpatient care.

In 1999 Assemblymember Helen Thomson proposed changes in the LPS law to allow involuntary outpatient care for people who were unable to recognize they need assistance but are not yet a danger to themselves or others. The original bill would have provided $350 million to expand treatment services. The bill, AB 1800, generated significant interest in mental health reform and a bipartisan coalition of legislators supported the proposal.

Mental health clients opposed to the expansion of involuntary treatment lobbied aggressively to stop the bill. They argued that involuntary treatment laws are adequate, and that voluntary treatment is inadequate. Assemblymember Thomson's bill died in the Senate. In response to Thomson's bill, the Senate commissioned the Rand Corporation to evaluate what is known about the effectiveness of involuntary treatment and the experiences of states that have adopted involuntary outpatient treatment laws.

The Commission believes that adequate information has not been developed to fully assess the need for LPS reform. Involuntary treatment laws may need to be reformed. But involuntary treatment should be understood as the last and final resort in a continuum of care that prioritizes voluntary treatment. The Commission believes the debate over LPS reform should be guided by the following analyses:

- An assessment of how the current LPS law is administered across counties. Are due process requirements adequate and involuntary treatment decisions consistent across the state?
- An assessment of how improved access to voluntary treatment could diminish the need for involuntary treatment. The State should ensure that involuntary treatment is only an option when no other form of treatment is effective. Inadequate access to voluntary care does not warrant the use of involuntary care.
- The dimensions of the problem that LPS reform would address. Preliminary data suggest the rate of involuntary commitment is increasing; it is unclear why. How has the use of involuntary commitment changed over time? How does the law affect different ethnic groups? How would a reformed law change outcomes?
- The capacity of state and local authorities to better serve existing clients through other "involuntary" models, such as CONREP, mental health courts or probation.
- The ability of the State to improve the quality of involuntary care and decrease the level of fear clients associate with forced treatment.

Where Are They Now?

The LPS Act of 1967 resulted in thousands of clients leaving mental hospitals. In 1991 realignment created a fiscal incentive for counties to develop community-based treatment options as alternatives to expensive hospital-based care. Critics of California's mental health system argue that both decisions pushed people into the streets because mental health funding did not follow mental health clients out of the hospitals and into community programs.

To find out where clients went after they left the state hospital system, the Little Hoover Commission asked the Department of Mental Health to track people who were hospitalized on June 30, 1991. On that date, 2,509 people were in state hospitals. These "LPS" clients were receiving care under provisions of the Lanterman-Petris-Short Act. Where are they now?

- 128 did not have sufficient personal information to be tracked.
  History unknown: 5.1 percent.
- 96 were never discharged and as of June 30, 1999 remain on inpatient status.
  Never left: 3.8 percent.
- 213 left and later returned to inpatient status between June 30, 1991 and June 30, 1999.
  Left and returned: 8.5 percent.
- 171 died while they were on inpatient status at the hospital.
  Died in a hospital: 6.8 percent.
- 1,901 were discharged into community services and did not return to inpatient status.
  Discharged: 76 percent.

Realignment resulted in three out of four clients being released from state hospitals. The Department of Mental Health had a more difficult time tracking people after they were released. Detailed records are only available for people who receive Medi-Cal services. Of the 1,901 people released, the department found the following information. (Percentages calculated based on 1,901 discharged.)

- 158 died following discharge.
  Died in the community: 8.3 percent.
- 971 received Medi-Cal mental health services between July 1998 and June 1999.
  Still receiving care: 51 percent.
- 772 are unaccounted for.
  Unknown: 40.6 percent.

The 40 percent who are unaccounted for include people who may have moved out of state and those receiving mental health services through private insurance or public programs not funded by Medi-Cal. The Department of Mental Health did not query criminal justice databases to determine the percentage in jail or prison. The data suggest that a slim majority of people discharged (51 percent) received community care and continue to receive care. It also suggests the State does not comprehensively monitor public services on an individual basis. The data do not indicate how well community mental health programs serve clients.

Source: Department of Mental Health. 2000. "June 30, 1999 Follow-Up of Persons on Inpatient Status in State Hospital Programs for the Mentally Disordered on June 30, 1991." On file.

The Department of Mental Health

The organization of the Department of Mental Health reflects the evolution of its responsibilities. The department is charged by law to set overall policy for the delivery of services, oversee local mental health plans, monitor compliance with state and federal laws and administer various state-funded programs. It also runs four state hospitals and a psychiatric facility under contract with the Department of Corrections.[62] The 1999-2000 budget allocated $1.6 billion to the department. It is organized into four divisions: Systems of Care, Long-Term Care, Program Compliance, and Administrative Services.

1. Systems of Care

The Systems of Care division ensures that people have access to treatment and support services in their communities. The 103 staff in the Systems of Care unit provide technical assistance and facilitation services to local mental health programs, assist counties implementing managed care programs, conduct research, oversee special projects and offer assistance to counties dealing with Medi-Cal.[63] The division has 11 programs that are outlined in the table below.

The Research and Performance Unit within the Systems of Care division has a significant role. It is developing performance reporting requirements and monitoring procedures. Realignment requires county mental health systems to report their performance to the State. Reporting was mandated to ensure counties did not neglect their mental health system once they were given control over how resources would be spent.[64] Outcome reporting was designed to complement the department's program compliance division, which handles audits, licensing, and oversight of mental health Medi-Cal billings.

Systems of Care	
Adult Mental Health Services	The department supports two systems of care models: the Integrated Services Agency and the County Interagency Demonstration models.
Caregiver Resource Centers	The department funds 11 centers serving caregivers of brain impaired adults.
Children's Mental Health Services	Administers grants to counties for community-based children's services.
Disaster Assistance to Counties	Coordinates mental health responses to major disasters.
Dual Diagnosis Initiative	A joint project with the Department of Alcohol and Drug Programs.
Early Mental Health Initiative	Provides grants to schools for prevention and early intervention programs.
Managed Care	Oversees mental health plans of California's 59 local mental health agencies.
PATH	Program helps counties develop programs serving homeless clients.
Research and Performance Unit	Unit responsible for implementing statewide performance outcome system.
SAMHSA	Distributes federal block grants for comprehensive community services.
Traumatic Brain Injury	Pilot projects serving persons with traumatic brain injuries.

The department's reporting system will include data on all people who receive mental health services for 60 days or more each year.[65] The data are intended to permit the department to assess change in people's lives to determine if services are adequate, appropriate and cost-effective.[66] The system has encountered several challenges, some technical, such as coordinating reporting across 59 local agencies, and others based on the difficulty of devising adequate measures of treatment impact.

The department is the lead agency developing performance measures. The Legislature authorized the California Mental Health Planning Council to review and approve those measures.[67] Local mental health boards and commissions also have the authority to review and comment on local efforts to document performance and collect outcome data.[68] Both the council and local boards are intended to be independent mental health oversight entities. The council is housed within the Department of Mental Health and the director of the department appoints its members. The Mental Health Planning Council also intends to issue recommendations for improving the reporting and accountability system through its efforts to develop a mental health master plan for the state.

California Mental Health Planning Council

Federal law (PL 102-321) requires states that receive SAMHSA block grants to establish Mental Health Planning Councils. Federal law requires at least half the council members to represent mental health clients. The council is empowered by federal law to monitor and review the adequacy of mental health services. The California MHPC has 40 members who are appointed by the director of the Department of Mental Health and serve 3-year terms. Members include 8 representatives of State agencies and 32 representatives of client, family member and service providers. The council has four staff positions.

The council has the following duties:

- Advocate for effective, quality mental health programs.
- Review, assess, and make recommendations to the Legislature to improve programs and policies.
- Review program performance, including the review and approval of outcome measures.
- Document best practices.
- Direct DMH to review the performance of specific local mental health services.
- Advise the Legislature, DMH and county boards.
- Review the State's data systems and paperwork requirements.
- Recommend strategies to stimulate innovation.
- Hold public hearings.
- Assist local mental health boards in their duties.
- Advise the director of DMH.
- Assess the effect of realignment and report to the Legislature and others.
- Mediate disputes between counties and the State.

Source: Center for Mental Health Services. 1999. Substance Abuse and Mental Health Services Administration. Block Grant Application. On file.

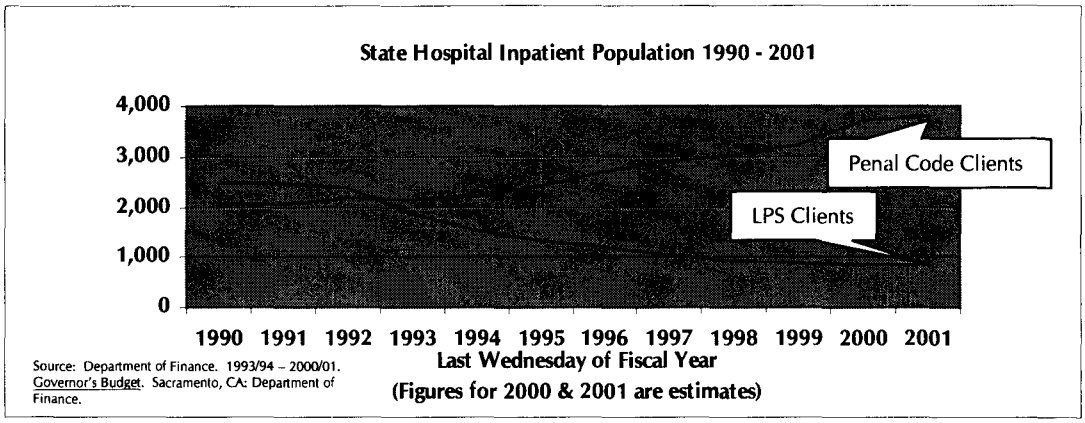
2. Long-Term Care Services

The Long-Term Care Services Division administers four state hospitals, the Acute Psychiatric Program at the California Medical Facility at Vacaville and the Forensic Conditional Release Program (CONREP). Over 8,241 (96 percent) of the department's 8,547 employees work in the Long-Term Care Services Division.[69] People treated in state hospitals fall into two general categories:

- ***LPS clients.*** Civilly committed individuals determined to be dangerous to themselves or others, or severely disabled. In 1999 the Department of Mental Health served 929 LPS clients in state hospitals. That figure is expected to drop to 850 for the year 2000.
- ***Forensic or penal code clients*** (also referred to as judicially committed). The criminal justice system directs people into state hospitals for a variety of reasons. Some are sent to a hospital for treatment while they serve a criminal sentence. Others have been found not guilty by reason of insanity or incompetent to stand trial. They are hospitalized until they are able to stand trial or until they can be released back into their communities. The total forensic population numbered 3,217 in 1999 and is expected to grow to 3,805 for the year 2001.[70]

Penal code clients make up a growing percentage of state hospital patients, approximately 82 percent. Just 18 percent of state hospital patients are LPS clients.[71]

California's State Hospitals	
Atascadero State Hospital	• Maximum security. Serves penal code clients. • Security is controlled by Department of Mental Health.
Patton State Hospital	• Maximum security. Services penal code clients. • Department of Corrections controls security.
Metropolitan State Hospital	• Mixed facility – approximately 1/3 penal code clients (low to medium security), 2/3 LPS clients. • Only hospital with programs for children.
Napa State Hospital	• Mixed facility – majority of patients are penal code clients.
California Medical Facility	• Department operates program within a prison run by California Department of Corrections. Serves penal code clients only. The prison has two Department of Mental Health programs: ✓ Intermediate Treatment Program (ITP) ✓ Acute Psychiatric Program (APP)



Source: Department of Finance. 1993/94 – 2000/01. Governor's Budget. Sacramento, CA: Department of Finance.

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Percentage LPS	0.55	0.54	0.52	0.47	0.41	0.35	0.31	0.27	0.24	0.21	0.19	0.18
Percentage PC	0.45	0.46	0.48	0.53	0.59	0.65	0.69	0.73	0.76	0.79	0.81	0.82
Total	**4,530**	**4,510**	**4,582**	**4,013**	**3,768**	**3,739**	**3,940**	**3,961**	**3,941**	**4,095**	**4,585**	**4,655**

The Department of Mental Health also operates the Forensic Conditional Release program (CONREP). CONREP provides enriched oversight and treatment services to a select group of mentally ill offenders on parole. The department contracts with mental health providers for direct services to people enrolled in CONREP.

3. Program Compliance

The program compliance unit handles licensing and certifications, Medi-Cal oversight and audits. The unit has 51 staff positions.[72]

4. Administrative Services

The department maintains an administrative unit that supports county financial systems, is a liaison with Medi-Cal staff and administers the financial and personnel needs of the department. The administrative services unit has 134 personnel.[73]

Community Mental Health Systems

For the most part, locally elected county boards of supervisors are responsible for oversight of mental health services.[74] State law requires counties to establish a mental health board or commission to advise the local governing board and oversee mental health policies and programs.[75]

Local mental health authorities – mostly counties – are charged with providing or arranging for public mental health care for county residents, including: pre-crisis and crisis services, comprehensive evaluation and assessment, individual service planning, medication management, case management, 24-hour treatment services, rehabilitation and support

services, vocational rehabilitation, residential services, services for homeless persons, group services, and wrap around services.[76]

Realignment established criteria for providing services. Mental health care would first be made available to people with severe mental illnesses. Specifically, realignment funding gave priority to the following groups:

- Seriously emotionally disturbed children and adolescents;
- Adults and older adults who have a serious mental disorder;
- Adults or older adults who require or are at risk of requiring acute inpatient care, residential treatment, or outpatient crisis services because of psychosis or the likelihood of suicide or violence; and,
- Persons needing treatment due to a natural disaster or emergency.[77]

The State also established a service delivery philosophy to guide local programs – Systems of Care (SOC). Under SOC, services are client-directed, available 24 hours a day, integrated and culturally appropriate. Counties are expected to track performance under Systems of Care.[78]

The target population established under realignment limits the diagnoses that are covered under local plans. (Appendix C outlines the specific criteria.) People may be denied services on the following grounds:

- The diagnosis does not meet eligibility requirements.
- Functional impairment does not meet the thresholds for services.
- The condition is unlikely to improve with services.
- A physical health care provider can treat needs.[79]

Some local programs provide services to people who do not qualify under Medi-Cal or realignment. Sacramento County, for instance, serves an expanded population by working with its service providers. In some cases the county covers the additional costs, in others it does not.

Once eligibility is established, clients are directed to service providers. Many counties employ community clinics to provide services. Prior to 1993, Medi-Cal reimbursement was generally limited to care directed by a physician and provided in clinics. Since 1993, Medi-Cal has reimbursed providers for services delivered throughout communities.

Clients also may receive services based on their needs and eligibility for benefits under specialized programs funded through the Veterans Administration, Medicare, pilot programs or special grants.

Mental Health Funding

Mental health funding is available from federal, state, local and private sources. Services are funded through reimbursements such as Medi-Cal and Medicare. Some clients receive stipends such as Social Security Insurance/State Supplemental Program payments for living expenses. Additional funding is provided through categorical and discretionary funding. Not all counties participate in all funding programs.

The distribution of funding reflects historical policies. Some counties receive significant resources while others receive much less. Historical inequities are exacerbated when well-funded counties capture categorical and grant dollars that are not available to counties lacking matching funds or staff to complete complex applications.[80] Although realignment created a stable and growing source of funds for local programs, advocates argue that realignment funding has not kept pace with need, nor has it kept pace with funding for other social services. During the 1980s mental health funding was cut. During the 1990s mental health funding growth lagged behind support for similar programs.

Federal Funding	
Short-Doyle/Medi-Cal	Funds to serve disabled individuals who meet income requirements.
Medicare	Serve persons who are 65 years of age or older or who are permanently disabled.
SAMHSA	Federal grant to provide comprehensive community mental health services to adults.
PATH	Federal grant targeting clients who are homeless or at risk of becoming homeless.
SSI	Monthly stipend of $44 to $647 for eligible disabled individuals.
Veterans Services	Mental health clients who are veterans may be eligible for VA services.

State Funding	
Medi-Cal Managed Care	State share of funding to local agencies providing services to eligible recipients.
CalWORKs	Funding supports clients with conditions that present barriers to employment.
SSP	State payment to supplement federal SSI, payments range up to $335 per month.
Integrated Services to Homeless Adults	General Fund support for pilot projects serving clients at risk of becoming homeless.
MIOCR Grants	General Fund support for a continuum of responses for mentally ill offenders.
Adult SOC Pilots	General Fund money to promote a system of care approach to providing services.
Homeless Mentally Disabled	General Fund allocation to augment federal PATH grants.
Caregiver Resource Ctrs.	General Fund allocation serving people who are caregivers to brain impaired adults.
AIDS	General Fund allocation to support programs serving clients living with AIDS/HIV.
Traumatic Brain Injury	Special fund allocation for services to adults with acquired traumatic brain injury.

Local Funding	
Realignment	Dedicated revenue from sales tax and vehicle licensing fees.
Grants	Includes grants obtained from private and non-profit sources.
Patient Fees	Counties collect service fees on a sliding-scale, fee-for-service basis.
Patient Insurance	Counties bill private insurers for services when clients have coverage.
County Match	A limited county match is required for a small portion of state funding.
County Overmatch	County funds dedicated to mental health programs above the required match.
Conservatorship Fees	Public guardians collect fees to offset the costs of providing services.
Other Revenues	A catch-all category that includes miscellaneous sources, including reimbursements from schools or other local agencies, endowments, donations or other sources.

Mental Health and the Criminal Justice System

Much of California's mental health policy is driven by concerns for public safety. Despite evidence that people with mental health needs are no more violent or dangerous than others, the public perceives mental illness as linked with violence and criminal activity.[81] As stated earlier, the prevalence of homelessness and substance abuse contributes to this perception.

Research suggests that 10 to 20 percent of people who enter state and local criminal justice systems are mentally ill or suffer some form of functional impairment. About 15 percent of the prison population requires mental health treatment on any given day.[82] The California Department of Corrections (CDC) incarcerates 160,000 inmates. Using a rate of 15 percent, there are 24,000 mentally ill prisoners in California. CDC reports that it serves 18,500 inmates with serious mental illnesses, or approximately 11.4 percent.[83] The discrepancy can be attributed to mentally ill inmates who fail to receive care because they have gone unnoticed or actively mask the symptoms of their illness.

The Board of Corrections reports that local jails book an average of 96,834 individuals per month, or about 1,162,000 persons annually. Again, based on the 15 percent figure, some 145,251 annual bookings involve mental health clients, many of them repeat offenders.

In other words, California's jails and prisons have evolved to become a secondary – and for many individuals an unintended and unnecessary – mental health system. In its review, the Commission looked at efforts to divert non-serious offenders with mental illness out of the criminal justice system, and to help those in jails and prisons transition safely back into their communities.

Policy Challenges

The large number of clients in jails and prisons and the high costs of incarceration and corrections-based treatment present a number of policy challenges for the State, including:

1. ***Criminalization of Mental Illness.*** A significant number of people with mental illness – although no one knows how many – end up in jails and prisons because of inadequate mental health services. Client advocates condemn the "criminalization of mental illness" in which untreated mental illness leads to crimes of survival – trespassing, vagrancy, petty theft – and imprisonment. Correctional officials struggling with overcrowded jails recognize that many mental health clients end up in jail for lack of other community facilities. While

access to community mental health services are limited by eligibility criteria and funding, law enforcement officials cannot turn away clients who violate the law – even if only because they are mentally ill.

2. ***Difficulty Providing Treatment in Jails and Prisons.*** Law enforcement officials widely recognize that officers often lack the training and awareness to effectively deal with mental health clients. Paranoid, delusional people often react violently in confrontational settings. The harsh confines of jails and prisons challenge the ability of mental health providers to build therapeutic relationships with clients and improve their functionality and recovery.

3. ***Costs of Incarceration and Treatment.*** Providing mental health services in jails and prisons is expensive and difficult. The CDC reports difficulty hiring mental health staff willing to work in prisons. On average the annual cost of incarceration in prison is $21,243 per inmate.[84] Mental health services cost an additional $880 and $9,600 for general outpatient and enhanced outpatient care, respectively.[85] In total, CDC spends $400 million annually to incarcerate and treat mentally ill prisoners.[86] Local jails have an easier time recruiting qualified personnel but also face difficulties. Los Angeles County reports spending nearly $5 million on psychotropic medications each year.[87] The Pacific Research Institute estimates that state and local agencies spend between $1.2 billion and $1.8 billion annually on law enforcement, court, jail, prison, parole and processing costs associated with serving seriously mentally ill people.[88]

4. ***Providing Follow-Up Services.*** Mental health clients coming out of jail or prison have inadequate access to community mental health services and they often cycle right back into custody. State and community mental health and criminal justice officials do not routinely share information on the people they jointly serve. They do not routinely coordinate care or capture the savings associated with keeping clients from entering or returning to the criminal justice system.

California's Responses

Select state and local agencies have responded to the high cost and increasing number of mental health clients in the criminal justice system in a variety of ways. Some efforts intend to prevent criminality by improving access to high quality services, or to divert clients into treatment programs. Other efforts emphasize coordination between local and state law enforcement and mental health agencies.

Diversion and Intervention Services. Successful diversion and intervention programs reduce the incidence and length of incarceration or re-incarceration by providing enhanced mental health services. Some counties have adopted formal diversion programs, such as mental health courts. Others employ less formal approaches, such as coordinating services with non-profit organizations such as Volunteers of America (VOA). VOA staff respond to calls from law enforcement, business owners and others and arrange services for mental health clients as an alternative to arrest for activities such as vagrancy, trespassing or public drunkenness.[89] California's formal diversion and intervention efforts include the following programs:

- ***Mental Health Courts.*** Mental health courts provide a single point of contact where a defendant with a qualifying mental illness may receive court-ordered treatment and support services in connection with a diversion from prosecution, a sentencing alternative, or a term of probation. Modeled after drug courts, specialized mental health courts allow the judicial system to better tailor programming and sentencing to the needs of offenders.

- ***Crisis Response Teams.*** Crisis response teams often pair law enforcement and mental health staff to respond to people in crisis. Traditionally, law enforcement officials who confront a mental health client can transport the individual to a treatment center, release them to a responsible adult such as a spouse or parent, or make an arrest. In contrast, crisis response teams divert clients from costly jail or psychiatric hospitals by providing immediate services to stabilize a situation.

The State has funded these and other efforts through the Mentally Ill Offender Crime Reduction (MIOCR) grants. The Board of Corrections has awarded MIOCR grants to 15 counties to develop diversion and intervention programs. Some counties have used the funding to establish mental health courts or crisis response teams. Others have pursued specialized programs that improve the identification of mentally ill offenders and emphasize reducing re-arrest or time spent in jail. The MIOCR program is discussed in greater detail in Finding 5.

The State also has developed and funded the Integrated Services for Homeless Adults program under AB 34 (Steinberg). AB 34 (Chapter 617, Statutes of 1999) provided funding for counties to provide enhanced services to clients who are homeless or likely to be incarcerated. Three counties have received AB 34 funding. Each has developed a distinct approach to reducing incarceration rates, including increased housing support, better coordination between law enforcement and mental health staff and improved outreach to clients who are homeless.

Improving Coordination of Community Reintegration Services. Federal and state laws require jail and prison staff to provide mental health clients with necessary treatment. This treatment is intended to stabilize the person during his or her incarceration. Upon release, many clients encounter difficulty obtaining continuous services as they transition back into their communities. People who were ineligible for county treatment before their incarceration generally remain ineligible. Even when eligibility is established, law enforcement and mental health staff do not routinely share information or coordinate treatment services. The need for improved service coordination is discussed in detail in Finding 6.

California has a long way to go to improve its response to mental health clients, particularly those who become involved with the criminal justice system. Ongoing efforts to improve mental health care signal increasing recognition that improving mental health services, particularly early intervention or prevention services, can reduce the costs associated with mental health treatment and incarceration.

Building Public Support for the Mental Health Service System

Finding 1: No one who needs care should be denied access to high quality, tailored mental health services. Open access cannot be achieved until the public and policy-makers have a shared commitment to care for people with mental illness.

For many policy areas, the public obligation is clear. All agree that protecting children from abuse is important and all young people deserve a public education. But communities are less clear about their responsibility for people – who as a result of mental illness – cannot meet their own needs. Importantly, many more people than is commonly realized are affected by mental illness. And public understanding is limited and often inaccurate. Before real improvements can be made in California's mental health system – before the state can even establish a vision and set a course for reform – the public and policy-makers need to clarify public expectations for mental health care. They need to establish the responsibility of communities for providing services. And they must call for public leadership to improve mental health services.

Mental Illness is a Community Issue

Mental health services have traditionally been considered a concern of clients, their families and service providers – but not society at large. Despite evidence that mental illness-related costs approach $20 billion a year in California, concern for the effectiveness of mental health care has not captured the attention of main street.[90]

One in five Californians experiences some form of mental illness. One in 20 Californians experiences a debilitating disease.[91] Every California community, every neighborhood and every family stands to benefit from improved mental health care. Clients, families, employers and taxpayers pay the price of mental illness. Although often unrecognized, the true constituents of mental health reform are neighborhood and community leaders, employers and unions, taxpayer advocates and the general public as well as the people who experience mental illness and their families.

The community response to residents with mental health needs vary across the state. California does not have a uniform commitment to providing high quality mental health care. The State has not made it

clear what it hopes to accomplish through mental health policies, who is responsible for ensuring care and what the costs and consequences of inaction may be. As a result, it is hard to build consensus for additional mental health resources or how that money should be invested.

Without expectations and a vision to drive mental health agendas, policy-makers do not know when the system is broken until a crisis occurs. And they have limited access to meaningful information on how the system should be fixed or who should fix it.

To create expectations and a vision for mental health policy, the public and policy-makers need to understand the personal and social costs and consequences of mental illness. They need to be aware of opportunities for clients to recover and lead fulfilling, productive lives. And they need to recognize that the consequences of mental illness affect everyone. The public and policy-makers must understand the goals of a successful mental health policy and take responsibility for the challenge. They must understand that mental health is a business issue, a workforce issue and a community and family issue.

Policy-makers have made the connection between investment in transportation systems and improved quality of life and productivity for all Californians. They have not made a similar connection for mental health.

The Governor's 2000-01 budget pointed out that congestion on California roadways costs an estimated $7.8 million a day. The budget included $7.5 billion for transportation projects.[92] Mental illnesses are leading causes of disability and lost productivity.[93] National estimates suggest that mental health and related substance abuse costs an estimated $79 billion each year.[94] California's share equals $9.875 billion, or $27 million each day. Public mental health funding in California is about $2.5 billion annually.[95] Policy-makers have made the connection between investment in transportation systems and improved quality of life and productivity. They have calculated the costs of inaction and have responded with measured investment. Policy-makers have not made a similar connection for mental health. The costs of inaction are not self-evident.

Stigma – Barrier to Improving Mental Health Services

Mental health advocates argue that society's reluctance to take responsibility for mental health care is the result of stigma. Recognized as a mark of shame or discredit, stigma is based on limited awareness of mental illness and its origins. The Surgeon General argues that stigma represents one of the greatest challenges to mental health policy:[96]

Stigmatization of people with mental disorders has persisted throughout history. It is manifested by bias, distrust, stereotyping, fear, embarrassment, anger, and/or avoidance. Stigma leads others to avoid living, socializing or working with, renting to, or employing people with mental disorders, especially severe disorders such as schizophrenia. It reduces patients' access to resources and opportunities (e.g. housing, jobs) and leads to low self-esteem, isolation, and hopelessness. It deters the public from seeking, and wanting to pay for, care. In its more overt and egregious form, stigma results in outright discrimination and abuse. More tragically, it deprives people of their dignity and interferes with their full participation in society.

Stigma deprives people of their dignity and interferes with their full participation in society.

The public's support for mental health programs is shaped by their understanding of mental illness and the effectiveness of treatment.[97] Limited public awareness and concern over the quality of programs restricts support for funding, policy reform and overall attention to the needs of clients and their families.[98]

Stigma has historically been addressed through education. As public understanding of particular illnesses has improved, inaccurate stereotypes have dissipated and public compassion and support for treatment has improved.[99]

Yet the public views people with mental illness with fear. A greater percentage of people associated mental illness with violence in the 1990s than did so in the 1950s.[100] Despite research showing that mental health clients are responsible for only a small fraction of violence, they are labeled as violence prone and feared.[101] One study found that people typified a mentally ill man as "dangerous, dirty, unpredictable and worthless."[102]

The more people understand its origins and symptoms, the more they equate mental illness with physical illness. Reframing and improving public understanding of mental health can increase the public's support for programs and raise expectations for their effectiveness.[103]

One study found that people typified a mentally ill man as "dangerous, dirty, unpredictable and worthless."

Reframing public understanding is difficult. But it can be done. The public should understand that mental illness does not reflect moral weakness, poor parenting or an inherent inclination for violence.[104] The public needs to understand that mental illness is treatable; people can and do recover, and they contribute to their communities. People who experience mental illness are valued members of California's communities.

Reframing Mental Health Care

Reform discussions in the year 2000 parallel conversations from the 1970s. Advocates have made little progress. Steve Fields, executive director of the Progress Foundation, testified that he has discussed the same mental health reforms with legislative leaders in California for four decades. Client advocates and service providers have spent many years seeking stable and adequate funding for mental health services. They have championed increased access to substance abuse treatment, supportive housing, rehabilitative care and employment services. They have had little success. Each decade presents a renewed interest in mental health reform, but little change. The San Diego Union Tribune cited mental health as the "perennial loser" of budget negotiations.[105]

Mental health funding has lagged behind support for other public services, including funding for transportation, education and public safety. Tax relief has been given a higher priority than ensuring that mental health programs are effective and make the best use of public resources. These policy areas receive public and political support because they are well understood. The impact of failed policies is calculated and the need for investment and the potential returns are understood.

The Senate Select Committee on Developmental Disabilities and Mental Health and the Assembly Select Committee on Mental Health held a joint hearing in February 1999. The Little Hoover Commission held three public hearings on mental health later that year, and the Joint Committee on Mental Health Reform held four more. Client and family

Clarifying Expectations

Sacramento County shares a problem with most counties. Because of inadequate care, too many mental health clients end up in the county jail. And the cost of custody and psychiatric services in jail exceeds the cost of community mental health services.

In 1999, the county received $4.7 million from the State for Project Redirection to reduce homelessness and prevent clients from ending up or returning to jail. The program provides services not readily available through community mental health, including housing, substance abuse treatment and intensive case management. After months of negotiations, county mental health officials have convinced residents the project is necessary. But they cannot convince neighbors that the project should be near their homes.

The irony of community opposition is that mentally ill offenders already live in the community. They are released from jail every day without services, without follow-up and they re-offend. County efforts to provide them with structured services, to prevent crime and improve public safety are often blocked by the "Not in My Backyard" sentiment. Limited public understanding of the causes, consequences and costs of mental illness and the effectiveness of services restricts the ability of the county to improve outcomes for mental health clients, neighborhoods and the community.

advocates turned out in force. County, service providers and law enforcement representatives testified. Participation by the business and labor community was limited or absent. Yet a single form of mental illness, depression, results in more workplace disability claims than any other ailment.[106] The views of taxpayer advocates also were underrepresented, even though mental health care represents a significant investment of public dollars.

Reframing mental health policy requires making it explicit that providing adequate mental health care benefits all members of society. Mental health is a business, labor and taxpayer issue. It is also a policy area affecting clients, family members and service providers. Mental health policy impacts everyone.

Promoting Investment in Mental Health Policies

While lawmakers can increase expenditures and make incremental changes to specific programs, wholesale change will require the commitment of community leaders. For these improvements to be sustained when the spotlight moves to another crisis, the public commitment to cost-effective and compassionate care must be firmly in place. To build a solid foundation for fundamental reform, four issues need to be addressed:

- ***Stigma.*** Improved information on the effectiveness of adequate mental health care and the policy choices available to the state are essential to improving services. California should educate, inform and improve public awareness of the challenges of mental illness and the benefits of mental health treatment.

- ***Inadequate advocacy.*** By themselves, mental health advocates have pushed for reform unsuccessfully. New advocates – including business and labor, faith and other community leaders – must join existing stakeholders and define policy goals. Their challenge is to develop a framework for understanding mental health policy that can guide policy decisions.

- ***Costs are high and diffused.*** The public and private sectors spend billions of dollars each year to provide mental health care, respond to unaddressed mental illness through the criminal justice system or otherwise cover the direct and indirect costs of mental illness. Policy-makers and the public need to understand these costs and the trade-off of providing adequate versus inadequate care.

- ***Science is evolving.*** Mental health policy is complex. Political decisions require a negotiation of competing interests, often with

contradictory understandings of the science of mental health, the problems to be solved and the solutions available. Policy-makers struggle the most with decisions laced with uncertainty, confusion, complexity and contradictory direction.[107] Mental health policy presents these very challenges.

Policy-makers draw upon multiple tools when they need to understand complex policy issues. Advisory bodies can provide compelling and reliable information on complex issues, particularly those where scientific understanding is evolving. Congress chartered the National Academy of Sciences specifically to advise the federal government on complex and contentious scientific and technical matters related to public policy.[108] Similarly, advisory bodies can be used to build common understanding and agreement among an array of interest groups.

A California Mental Health Advocacy Commission could assess and establish expectations for mental health care and outline strategies for realizing those expectations. It could be non-partisan, funded with public and private resources to create broad interest and accountability. Broad-based funding could promote oversight, collaboration across the public and private sectors and interest in the committee's labors. Membership could include traditional mental health advocates, including client, family member and service provider representatives, and non-traditional stakeholders representing labor, business and taxpayer organizations. California's foundation community has a role in building public leadership and should be part of this partnership to create a civic agenda for mental health policy.

Some of the barriers to reform can be lowered quickly – others will take time. What the State needs is to create a catalyst for change that can guide policy-makers immediately and over the next five years.

Recommendation 1: The Governor and the Legislature should ensure that no one who needs care is denied access to high quality, tailored mental health services. The first step is to establish a California Mental Health Advocacy Commission to serve as a catalyst for change, set expectations and establish responsibility for mental health services. Specifically, the Commission should:

Immediate Steps

- The Governor should appoint a personal Mental Health Advocate charged with building the networks and partnerships necessary to form the Mental Health Advocacy Commission.

❑ ***Be of limited term and funded from public and private sources.*** To ensure against unnecessary bureaucracy, the Commission should be of limited term. To improve accountability, it should be jointly funded from public and private sources. And to demonstrate clear expectations for outcomes, the Commission should issue periodic

reports and a final summary of its activities and accomplishments.

- ***Develop strategies to overcome stigma.*** The public and policy-makers need an improved understanding of mental health, mental illness and the role of public policy in providing quality mental health care.
- ***Detail need.*** The public and policy-makers need to understand how Californians are affected by mental health policies, the adequacy of existing programs and the magnitude of additional need.
- ***Assess costs of failure.*** The public and policy-makers need to understand the trade-off between investing in adequate mental health services and failing to provide appropriate care.
- ***Provide for ongoing policy advice.*** The commission should propose strategies for providing the Legislature and Governor ongoing direction and advice on mental health policy, and in particular, strategies for understanding the complex and evolving science of mental health and mental illness.

Immediate Steps

- The Governor's Mental Health Advocate should convene a series of Mental Health Summits with business, education, labor and mental health leaders to build an agenda for change.
- Draft legislation should be prepared for introduction in January to fund and formalize the Commission.

Strengthening Statewide Leadership

Finding 2: The state Department of Mental Health is not organized or funded to ensure that all Californians have access to mental health services when they need care.

The Department of Mental Health (DMH) is entrusted with leadership of California's mental health system. It is charged with ensuring the availability of effective, efficient, culturally competent, community-based mental health services. Yet the department is not organized or funded to lead a statewide system of community-based care. It needs new direction from California's policy-makers to focus its staff, resources and efforts on returning California's mental health system to a national model.

California's mental health system faces many tough issues that require focused leadership, consistent attention and aggressive effort. The Department of Mental Health has demonstrated those capacities. Yet the State faces many more hurdles than the department can manage given its present organization: oversight of Medi-Cal mental health managed care, identifying an expanded funding base, negotiating calls to reform California's involuntary commitment laws, solving human resource crises and implementing a statewide performance reporting system.

The department's resources and its mission are divided between providing direct services through the State's hospital system and providing leadership for California's community mental health programs. Its role as a direct service provider threatens to overwhelm its ability to inspire and guide community-based programs. Over 95 percent of DMH staff provide direct services to people in the state hospital system, a population that includes a growing percentage of penal code clients. Less than 2 percent of the department's staff is available for leadership activities.

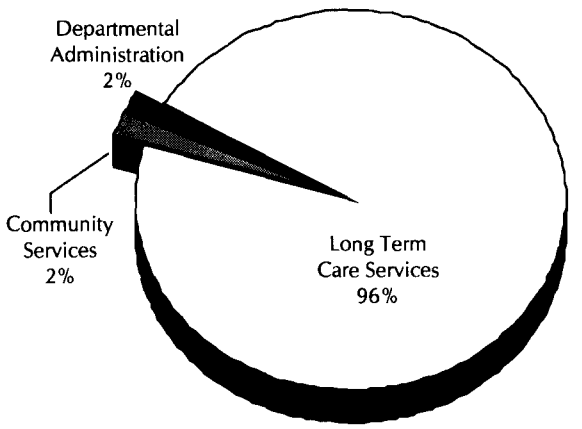
The challenge for the Department of Mental Health is to implement a vision for community mental health care.[109] Its leadership function should not be compromised by the need to provide direct services to a growing and politically sensitive penal code population. The department should be reorganized to reinforce its efforts on setting standards for services, improving the cost-effectiveness of local mental health programs and driving the debate on how to build a continuously improving mental health service system.

Department of Mental Health Resources

While dozens of State entities serve mental health clients in some way, the Department of Mental Health is the only state entity charged with leading California's community-based mental health system. The department is expected to ensure that county programs are effective, efficient and take advantage of every opportunity to improve services. Yet the department's personnel are overwhelmingly dedicated to serving the growing number of penal code clients in state institutions.

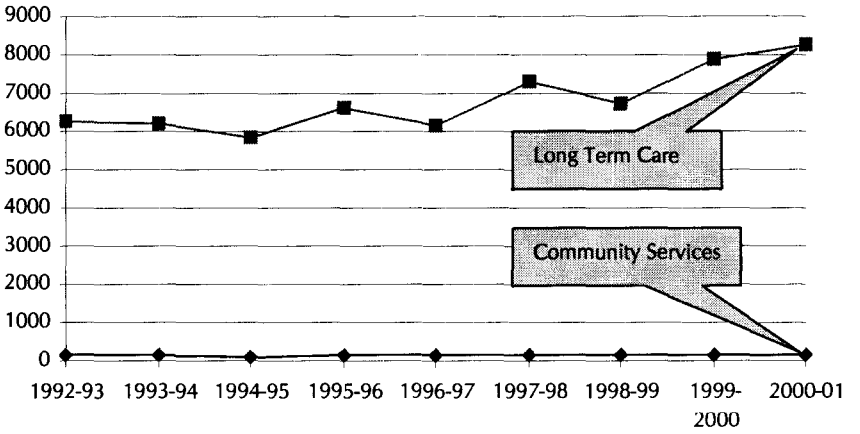
The department has 8,547 staff positions: 8,241 (96.4 percent) provide long-term care in institutions; 51 (0.6 percent) ensure compliance with state and federal statutes, 103 (1.2 percent) assist counties with mental health services; and, 152 (1.8 percent) administer the department. The department has almost an equal number of staff available to monitor and assist California's community mental health programs as are available to administer department offices in Sacramento.[110]

Distribution of DMH Personnel 2000-01



The 103 personnel available to assist local mental health agencies divide their time between 11 separate community service programs. Just 10 positions are dedicated full-time to providing technical assistance and training for community programs.[111] Few resources are available to document best practices, identify barriers to improved services and support county programs.

Historical Distribution of DMH Personnel



Between 1991-92 and 2000-01, the number of department personnel has increased by 23 percent – 1,591 new positions. Nearly all (1,586, 99.7 percent) have been dedicated to long-term care operations. The size of the Community Services program, which includes both Systems of Care and Program Compliance divisions has actually been reduced.[112]

California Faces Numerous Leadership Challenges

In addition to supporting local programs, the department's leadership role requires it to address statewide issues affecting the availability and quality of mental health services. The challenges are numerous and significant:

1. Providing Adequate Funding and Promoting Efficient Spending. Mental health services in California are believed to be seriously underfunded. The California Association of Mental Health Directors asserts that mental health funding provides sufficient resources to meet approximately half of all mental health needs. Services are rationed as a result. No one is sure how many people access mental health services through private insurance plans or how that number may expand under newly enacted state and federal insurance parity laws. Mental health funding is detailed in Finding 4.

2. Addressing Human Resource Needs. According to the California Mental Health Planning Council, the vacancy rates for mental health professional positions exceeds 30 percent. Los Angeles County has a 30 percent vacancy rate for psychiatrists. The Bay Area has a 30 percent vacancy rate for licensed clinical social workers and spends 4 months filling each position. In the Central Valley, it can take 10 months to fill similar positions. In the northern region, it can take almost a year and a half to fill vacancies for psychiatrists and psychologists.[113]

It is even more difficult to find multilingual, multi-cultural mental health professionals. Providing culturally competent care in the primary languages of clients is a significant challenge. Local agencies cannot resolve this problem individually. A statewide response involving California's higher education and workforce development agencies will be required.

3. Focusing on Prevention and Reducing Stigma. Stigma is a leading barrier to improved use of mental health programs and public support for

Defining Cultural Competency

Cultural competency refers to providing mental health services that reflect and respect the culture of clients and their families. The challenge that providing culturally competent care presents is seen in the number of languages spoken by clients accessing public mental health services in Los Angeles County.

	1999-2000		
Language Group	Clients	Language Group	Clients
Afghan	24	Lithuanian	1
Afrikaans	2	Mandarin	678
Arabic	49	Native American	2
Armenian	1,031	Pakistani	4
Bengali	6	Persian/Farsi	186
Bulgarian	3	Pilipino/Tagalog	292
Burmese	2	Polish	7
Calo	2	Portuguese	14
Cambodian	842	Punjabi	5
Cantonese	483	Romanian	10
Chinese	264	Russian	243
Choctaw	3	Samoan	60
Czech	3	Serbo-Croatian	5
Danish	2	Sign	204
English	102,330	Singhalese	3
Ethiopian	11	Spanish	15,558
French	23	Swahili	1
German	19	Swatow	16
Greek	5	Swedish	3
Hebrew	12	Taiwanese	7
Hindi	5	Telegu	2
Hindustani	1	Thai	32
Hmong	5	Toisan	n/a
Hungarian	10	Tonga	6
Ilocano	3	Turkish	2
Italian	5	Urdu	2
Japanese	140	Vietnamese	1,160
Korean	940	Visayan	1
Lao	80	Yiddish	1
Lingala	8	Unknown/Other	820
		Total Languages	59+

Source: Los Angeles County Department of Mental Health.

mental health services. Public education can improve the public's awareness of unmet needs and reduce the effects of stigma. But a successful campaign will require enormous collaboration with nonprofit organizations, community leaders and the media and entertainment industries.

4. Developing, Documenting and Disseminating Best Practices. Local mental health programs face an array of competing priorities. They have few resources that allow them to explore practices elsewhere. Yet the lessons learned in one part of the state can inform the work of others. The Department of Mental Health has a statewide vantage point. Its responsibilities include developing, documenting and disseminating best practices in the provision of mental health services. The department recognizes this responsibility and is building partnerships with local and national leaders. But the staff and resources dedicated to this effort are limited.

5. Meeting the Need for Comprehensive Community Services. Mental health clients have a variety of daily living challenges. Providing mental health care requires attention to housing, counseling, substance abuse treatment, vocational rehabilitation and independent living needs. Too often local mental health agencies cannot muster the resources or the political capital to integrate services provided by multiple state and local agencies. The department must assist agencies in this effort. It must ensure that local mental health agencies receive the support and services they require from State agencies and it must promote the capacity of local agencies to integrate and coordinate their services.

6. Growing Penal Code Client Population. California has a growing population of penal code clients in the state hospital system. The demands of this population often differ from those of civilly committed people with no history of crime. State and local agencies have developed multiple approaches to preserving public safety while providing appropriate mental health care. The Department of Mental Health has a leadership obligation to ensure the coordination and integration of state and local efforts to preserve public safety and address the mental health needs of penal code clients reintegrating into their communities. Mental health and the criminal justice system are discussed in detail in Findings 5 and 6.

7. Addressing Demands for LPS Reform. Assemblymember Helen Thomson has made a forceful and passionate plea to improve the ability of seriously mentally ill individuals to receive mental health services. Her efforts unearthed a long-standing concern over the need to reform California's involuntary commitment laws and expand opportunities for

outpatient involuntary treatment. The Department of Mental Health, along with other mental health stakeholders, convened a series of community dialogues to explore the need for mental health reform. The Legislature established the Joint Committee on Mental Health reform and included the charge of investigating the need to reform LPS. But the committee was unable to reach consensus on how to approach this issue. Policy-makers can benefit from a clear and detailed assessment of the need to reform the LPS Act.

8. Implementing Managed Care. The State's federal waiver of Medicaid requirements allows it to pursue innovative ways to reduce costs, increase access and improve services. Recent analyses disagree on the value mental health managed care has brought to the State. An independent evaluation commissioned by the department lauded the State's efforts.[114] In contrast, an independent review commissioned by a client advocacy organization, Protection and Advocacy Inc., raised many concerns. It argues that under managed care people have been denied access to a full range of mental health services and they have not been adequately informed of their treatment options. The report found that California's oversight system lacks enforceable standards, meaningful reporting, the means to ensure compliance and equitable funding.[115]

9. Supporting Mental Health Parity. AB 88 (Thomson) established mental health insurance parity under California law. The 1999 law requires health insurers to cover nine severe mental illnesses, and pay for services for seriously emotionally disturbed children. It is unclear how many people will receive mental health services through private insurance programs. Increased coverage could impact the already severe human resource shortage in the mental health field. Private insurance companies may provide mental health coverage through carve outs that some contend do not create parity.[116] While the newly formed Department of Managed Care will enforce mental health coverage, the Department of Mental Health could help the new department understand how parity will affect access and quality of care.

10. Improving Oversight and Accountability Mechanisms. Realignment mandated the development of a performance outcome monitoring system. Since 1994 the department has been implementing a statewide information system that can monitor access and participation across all local mental health systems.[117] The department reports less than 10 counties are linked to the system. Its leadership responsibility requires the department to complete the work. Accountability and monitoring are discussed in greater detail in Finding 7.

Refocusing the DMH on Statewide Leadership

Each of the leadership challenges mentioned above requires focused attention, long-term planning and aggressive action for breakthrough change to occur. The department can realize solutions to each of these challenges given adequate support, resources and direction from the Legislature and the Governor.

Historically the department was California's primary provider of institutional care. Under realignment California made the decision to shift the attention of the department away from providing institutional services and to lead a community based service system. Through various policy decisions, the role of the department has evolved back into providing institutional care, primarily for penal code clients. Responsibility for nearly 3,800 penal clients should not detract from the department's responsibility for the nearly 500,000 people in the community based system – and the nearly equal number of Californians who need help from the public system, but are not receiving it.[118]

The department's leadership role includes providing policy direction to the Legislature and Governor, directing data gathering and research, and advocating on behalf of clients and local mental health systems. It includes identifying barriers to success and strategies for overcoming them.

Recommendation 2: The Department of Mental Health needs to become the State's mental health champion. The department needs the resources and the political support to ensure that California's mental health system continuously improves. Specifically, the department should:

Immediate Steps

- The Governor should reassign 10 staff persons from other departments to the Department of Mental Health to immediately provide additional support for community mental health programs.
- The Department of Finance and the Legislative Analyst's Office should begin the detailed analyses necessary to redesign the Department of Mental Health.

❑ ***Advocate and provide policy guidance.*** The department should be an advocate for mental health clients. It should provide direction and advice to the Legislature and Governor on a policy framework that results in continuous improvement in the availability and quality of mental health care.

❑ ***Advocate for local mental health programs.*** The department must ensure that local providers have the support they need from local, state and federal agencies to provide needed care. The department should pay particular attention to the need for housing, employment and substance abuse treatment.

- ***Identify barriers and promote change.*** The department should identify statewide and local barriers to improved care and recommend state and local strategies to overcome those barriers. The department should explore strategies to motivate improvement through funding, promote best practices and improve state and local accountability.
- ***Develop mental health workforce.*** The department must ensure that California has an adequate workforce capable of providing culturally competent, professional mental health services throughout the state. The department should partner with state and federal agencies involved in education and workforce development to meet this need.
- ***Assess options for managing state hospital system.*** The department should determine whether providing long-term care services detracts from its leadership responsibilities. It should assess alternatives for the long-term operation and management of state hospitals.

Immediate Steps

- The department should convene a task force of county mental health officials and national mental health experts to identify barriers to improvement and strategies to promote change.
- The department should convene a summit of public and private experts in human resources and workforce development to begin assessing human resource needs and crafting short-term and long-term plans to address the shortage of qualified mental health professionals.

Developing Comprehensive Services

Finding 3: Ensuring access to high quality mental health care means that each community must provide a comprehensive array of mental health and support services. Yet the rule-bound mental health system offers fragmented and poorly coordinated care.

Many mental health clients face daunting challenges that prevent their successful recovery. Homelessness, unemployment, substance abuse, and debilitating physical and mental illnesses can thwart the recovery of even tenacious individuals. In contrast, many others face a serious mental illness, but have a home, a job, supportive family members and good physical health. They require much less intervention to stabilize their illness or promote recovery.

The public mental health system must respond equally well to everyone in need. Ideally, a spectrum of services would be available – just as the physical system provides residential care to Alzheimer's patients and rehabilitative services to accident victims.

Mental health care means more than medication and emergency services. Adequate care may require housing, counseling, substance abuse treatment, vocational rehabilitation and independent living skills training. Every client does not need each of these services, but every client does need tailored services that will provide her or him with the stability necessary to promote recovery.

Homelessness and substance abuse can undermine treatment and recovery efforts. Yet we ration care and often leave it to the people who are struggling the most to piece together these ingredients of their recovery. In contrast, "tailored" services provide what is needed, when it is needed, in ways that respect culture, language and other individual attributes.

In most instances, doctors, counselors and social workers know what it takes to enable people to manage their illnesses and lead productive lives. Yet policies and programs are not structured to provide the necessary supports and services. Model programs around the country demonstrate that best practices can cost-effectively enable people with mental illness to lead productive lives. And many people successfully transition from a life of despair and homelessness to hope and stability.

The Best Form of Therapy is...

Dr. Mark Ragins, director of medical services for the Village Integrated Service Agency in Los Angeles, has stated that the best form of therapy is a job. Steve Fields, director of the Progress Foundation in San Francisco, has stated that the best form of therapy is adequate housing.

Both testified that providing employment and housing are key elements of comprehensive services for many clients. In other words, the best form of care is to assemble the supports and services each person needs. For some, treatment will involve medication alone. These individuals will meet their other needs through other means. Others have needs either related to their illness or the product of their disability that they cannot

Living with Mental Illness

I want to echo the importance of having a compassionate and humanistic-oriented community-based mental health support system. I am from Massachusetts originally. I lost my sight as the result of a suicide attempt when I was 16 years old. I ended up in a locked psychiatric hospital for roughly two months, and I got to know firsthand the terror and the feeling of powerlessness and helplessness of being thrown into a mental health system that treats people as a diagnosis and not as a human being.

After I was released from the hospital, I was forced to seek treatment from psychiatrists who were trained in the old school way of thinking. It was just very degrading and humiliating. When I came to California roughly 17 or 18 years ago, I refused to have anything to do with the mental health system. I continued to suffer from extreme depression, suicidal thinking. I was a – I had a very difficult time continuing with my life. However, at some point, I ended up trying to seek treatment again after some encouragement from people who had had some positive experiences with the mental health system here. I began to receive treatment for my depression, began to receive medication, and received counseling services.

I graduated from California State University, Sacramento with a bachelor's degree in political science. After that I attended the McGeorge School of Law and graduated with my juris doctorate degree in 1996 and was admitted to practice law in December of 1996. I continue to receive psychiatric services. I continue to take the medication that helps me to stay emotionally out of the active depression. Had I not done that – had I let the fear of being locked up for speaking truthfully about how I really felt, I never would have received the treatment. I would have probably ended up killing myself or I may have ended up just staying in the house, not having the courage to go out and do anything. I would not be a productive member of society. So I think it is very important to have the rehabilitation services that were talked about so much today. ...

– John, formerly homeless
Thursday, January 27, 2000
Testimony before the Little Hoover Commission

meet on their own. For them, stability and recovery may depend on publicly provided housing, psychosocial therapy, day treatment services, physical health care, money management, employment and transportation assistance, crisis support and self-help services. As with physical health care, mental health care can require more than medication.

Dr. Ragins asserted that when California scaled back state hospitals and moved mental health clients into community programs, the State failed to provide the range of services that were provided in hospitals. Hospital care included then – as it does now – housing, physical health care, social interaction and employment services. In contrast, too often community care is equated with medication and counseling.

He called for a new approach to providing community care:

> *There needs to be a widespread understanding of, and commitment to, the creation of a community integration system to replace the present one. The present system is about as good as an institutional/medical model can be. If we want substantial improvement we have to replace our system.*[119]

Providing Comprehensive Services Requires Culturally Competent Care

As California's population has grown in size and diversity, the mental health system has strained to keep up with the need for care. Cultural and language barriers to mental health care are particularly significant. The U.S. Office of Civil Rights is investigating claims against Fresno County that Spanish-speaking people do not have access to services because the county does not employ adequate Spanish-speaking staff. An increase in the population of Laotian, Hmong and Cambodian residents in the county presents similar concerns. The barriers to care are as simple and as intractable as not being able to communicate because no county staff who speak these languages are available when a crisis occurs.

Cultural differences also present barriers to adequate care. The Los Angeles County Department of Mental Health serves people from hundreds of cultural groups, many with distinct communication styles, attitudes toward mental illness and mental health care. The counties have difficulty finding staff with the language and other skills to offer culturally competent care. The dimension of this challenge expands as counties move to offer crisis services throughout large communities, such as Los Angeles, and make it available on demand, 24 hours a day, every day.

Building successful mental health programs requires local mental health authorities to offer services in ways that respect and reflect the languages and cultural identities of each client.

The mental health field is embracing programs that offer a continuum of community care to promote stability and reduce hospitalization, symptom severity and relapse. Continuum models, such as the Integrated Service Agency, offer a single point of responsibility for a range of treatment and services. Among those services:

1. Housing. Stable housing improves mental health outcomes by reducing stress, decreasing victimization and allowing people to participate in other treatment opportunities, including employment. Housing is often the linchpin of mental health services. Yet many of California's communities struggle to provide adequate, affordable housing.

In Sacramento County, for instance, outpatient mental health services are organized into four residential zones. Clients are directed to service providers based on where they live. Those who are homeless receive services through a separate agency that specializes in working with homeless clients, but offers a more limited array of services. Homeless clients face long waiting lists for public housing programs. One Sacramento County facility has a list of 600 waiting for one of 65 spaces.[120]

Nationally, an estimated 57 percent of people who are homeless experience mental illness.[121] The California Statewide Supportive Housing Initiative Act reports that 75,000 mental health clients are homeless in California.[122]

Client housing needs range from independent housing to assisted-living facilities. At one end of the spectrum are low-cost apartments and homes and unsupervised room and board arrangements. In a room and board home, people rent beds from homeowners and receive meals. They often share the room with others.

Board and care homes also rent beds to individuals. But they are licensed by the State because operators provide assistance with money management, medications support and other services. The federal Social Security program augments Social Security Insurance

Living in Board and Care Homes

Less than 5 percent of Sacramento County's mental health client population lives in board and care facilities, but the quality of board and care life dominates the attention of client advocates. The Commission toured a variety of board and care facilities to understand how B&Cs operate. The Commission asked to see the best and brightest as well as the most challenging facilities for advocates and licensing staff.

The Commission visited wonderful facilities in which clients had private rooms in cheery residences. The homes paralleled high quality assisted living facilities.

The Commission also visited large, dreary Victorian homes where clients slept two and three to a room. Bare and worn wood floors, scuffed hole-pocked walls and worn out furniture filled common areas. Residents congregated around the hazy television or in front of the house, smoking around coffee can ashtrays.

The "challenging" board and care homes met minimum licensing standards. But few people would choose to live there. Minimum standards do not mean desirable conditions. It is hard to imagine how sharing a room with one or two other people while spending each day with little or no constructive activities can contribute to successful recovery.

payments to clients living in board and care facilities to cover the cost of additional services. Under licensing rules, board and care operators typically receive full social security payments to cover the cost of the board and care, less a monthly allowance of about $40 that is given to the client for personal expenses.

At the other end of the spectrum is supportive housing. This model offers long-term housing with support services, including physical and mental health care, substance abuse treatment, family support, counseling, employment assistance and other programs.

Supportive housing helps clients establish themselves in communities and decreases demands on high cost emergency and acute care services.[123] Supportive housing is particularly important for people with substance abuse problems who are poorly served by less structured housing options.[124]

Few communities have an adequate supply of low cost independent and supported housing. Limited public funding and acceptance for large facilities restrict opportunities to expand housing options. Meanwhile, licensing authorities are concerned that rigorous enforcement of regulatory and oversight requirements will drive providers out of the licensed housing market into the unregulated room and board business. As a result, regulators told the Commission they strive to maintain adequate standards while ensuring that homes do not close, which often pits them against client advocates who believe the quality of board and care homes is declining.

Providing Adequate Housing

An inadequate supply of appropriate housing is a leading barrier to client recovery. Yet finding affordable housing is a perennial issue. The supply of low-cost housing – particularly board and care homes, room and board homes, supportive and transitional housing – is driven by a complex array of market, regulatory, financial and other forces.

To address housing challenges, communities need to understand where mental health clients are living, the appropriateness of their housing arrangements and strategies for improving access to high quality housing.

The State, county authorities and mental health advocates in each community should consider the following steps to document, analyze and improve the quality of client housing.

1. **Create an inventory.** County mental health staff should understand the housing options available to mental health clients in their communities.

2. **Develop standards and assess quality.** The immediate and long-term success of local mental health programs will require county authorities to have reliable information on the quality and appropriateness of client housing.

3. **Build strategies to influence the housing market.** Local authorities need to call upon state and federal authorities to assist them by addressing fiscal, regulatory and other policies that restrict the supply of high quality, affordable housing for clients.

The best client housing is often provided by community and non-profit organizations that have worked to patch together funding, build relationships with neighbors, and pressure regulators to adjust rules so that they can provide high-quality housing that meets the needs of individuals.

Community Organizations: Building Housing Solutions

Two innovative community organizations display the potential for providing quality living situations:

Pine Tree Gardens (PTG), Yolo County
A non-profit, long-term residence for mentally disabled adults, PTG provides housing, social and daily living skills and supported employment for 13 residents in a quiet residential neighborhood. PTG has been successful using a social rehabilitation approach and works closely with area neighbors, businesses and community organizations.

Placer County NAMI Housing Program
Local National Alliance for the Mentally Ill (NAMI) members have leased residential housing under service agreements with Placer County Mental Health. County employees provide mental health and supportive services, while NAMI coordinates and organizes rent, food and insurance payments. The housing program is self-supporting, using client SSI/SSP reimbursements. NAMI charges clients less than board and care homes.

2. Vocational Rehabilitation. After years of neglect vocational rehabilitation is being recognized as an important part of mental health treatment. The Americans With Disabilities Act provides federal protection from discriminatory practices to workers with mental disabilities. And the Social Security Administration has revised policies to permit recipients of Supplemental Security Income to work part time without incurring financial penalties.

Defining Employment

Supported employment: Offers ongoing, flexible assistance to enable clients to join the workforce.

Competitive employment: Unsubsidized, unassisted employment.

Sheltered/Segregated employment: Provides structured, isolated employment opportunities.

These policies, in part, recognize that holding a job can improve a person's recovery. In addition to providing income, employment allows clients to build relationships within their communities. Vocational rehabilitation leads to supported employment and even competitive employment that is free of subsidies. Both forms of employment are thought to be better at helping clients maintain long-term employment than sheltered or segregated job programs.[125]

Despite evidence that vocational rehabilitation and employment can improve treatment outcomes, clients do not routinely receive vocational services.[126] Unemployment among persons with schizophrenia is estimated to be 75 to 80 percent, yet only 10 percent are permanently or totally disabled.[127] CalWORKs funding is available to reduce employment barriers for qualified clients, but differing service philosophies and competing priorities limit the number of people who benefit.

3. Substance Abuse Treatment. Approximately half of the population with severe mental illnesses also have substance use disorders. At any given time, about half of all people receiving mental health treatment are

using illicit substances.[128] Some argue that substance use reflects attempts to self-medicate. Illegal drugs are thought to have fewer negative side effects while calming anxieties, masking the "voices" that indicate psychotic episodes, or otherwise helping clients to cope. While the actual reasons for high rates of co-occurring mental illness and substance use are unclear, others suggest that biological, psychological or social aspects of their illness trigger street drug use.[129] Still others see no connection and view substance abuse as illegal activity unassociated with an illness.

Regardless of the relationship to mental illness, substance-using clients need treatment that is coordinated with their physical and mental health care and which compliments their living and employment arrangements. For instance, research suggests that outpatient substance abuse treatment may not be effective for homeless mentally ill clients because they lack a stable living situation that is important to recovery efforts.[130]

4. Physical Health Care. Many clients suffer co-occurring physical and mental illnesses, one often masking signs of the other. It is estimated that between 24 percent and 60 percent of clients have related physical and mental health needs with about half receiving treatment for acute physical disorders.[131] HIV among the mentally ill is of particular concern.

Identifying physical health needs in mental health clients is key to building successful treatment plans. Physical disease can cause mental illness and can worsen symptoms or promote the progression and severity of a mental illness. Many clients may be unable to recognize that they are experiencing a physical disease because of their mental illness and therefore do not seek treatment.[132]

5. Independent Living Skills. Many mental health clients do not grow up with the luxury of learning to live independently over the course of many years, with a supportive family and the transition years of college and young adulthood. Young adults may be forced to transition out of foster care, group homes or other facilities, which they depended on during their youth, into independent living situations. Older adults may also face changes in their living situations through the loss of a spouse, guardian or other caretaker.

Research demonstrates that mental health clients who receive focused assistance learning the skills necessary to live in communities have a higher success rate for independent living than others who do not receive that training.[133] Teaching the skills of independent living includes all the training an individual needs to function in a way that does not endanger their safety and facilitates their day-to-day activities, including: using and balancing a checkbook, cooking, cleaning, navigating public

transportation systems, shopping, applying for employment, working responsibly, using mail and banking systems, etc.

6. Other Services. Each client will present a range of needs that may require providers to offer additional services, such as money management, transportation and assistance with medical needs. Promoting recovery entails providing an individualized package of services necessary for recovery to be successful.

Integrating Mental Health Services

Service integration refers to bringing together services and funding from multiple sources. It provides a single point of entry and improves the coordination and continuity of care. Proponents of service integration argue that it results in more cost-effective treatment by reducing duplication and allowing organizations to focus on what they do best. But there is conflicting evidence about how or whether integrated services improve outcomes for clients.

Two studies have failed to show convincingly that service integration actually results in cost savings. Although access and service coordination improved with integration, outcomes did not necessarily improve and costs did not necessarily decrease. Some suggest that integration has not been adequately explored, particularly in California.[134]

Dr. Ragins with the Village Integrated Services Agency testified that institutional care not only provided comprehensive, but integrated

Integrating Services
The Village ISA, Long Beach, California

The Village Integrated Services Agency is a comprehensive program for 276 people with serious mental illnesses. Its mission is to "empower adults with psychiatric disabilities to live, learn, socialize and work in the community." The Village integrates services and support, opportunity and encouragement.

The Village's service philosophy centers on strengthening the abilities of members while lessening their disabilities. Services are based on needs, not the limitations of a service system. Services are tailored to address each client's distinct employment, housing, psychiatric, health, recreation and financial choices. Village staff are "coaches," they stand supportively with members who make decisions and take responsibility for moving into their own apartments, starting new jobs or returning to school.

At the Village, services are built around a team concept. Staff teams are made up of a psychiatrist, social worker, psychiatric nurse and three psychosocial staff who can tap the expertise of specialists in employment, recreation, money management and substance abuse services.

Employment is a cornerstone of the Village. All members are encouraged to work and are supported on the job by Village staff. The Village helps members create opportunities for competitive jobs in the community as well as offering paid job experience at Village-run businesses.

services. When institutional care was replaced with community-based care, integration was left behind. Clients in need of services outside the mental health system, such as substance abuse or housing, are referred to separate providers. Comprehensive and integrated institutional care was replaced with limited, competing and often uncoordinated care.

Research on clients with mental health and substance abuse needs argues that integrated treatment produces better outcomes than coordinated but separate mental health and substance abuse treatment. Traditional substance abuse treatment that is not integrated with mental health care is ineffective.[135] Similarly, supported employment that is integrated with mental health treatment is more effective than non-integrated services.[136] Integration is also important for mental and physical health care. Screening, treatment and support services can be combined to ensure effectiveness and reduce complications, such as those associated with taking multiple prescription medicines.[137]

Barriers to Integrated, Comprehensive Services

Integrated and comprehensive services allow clients to succeed in employment, reduce reliance on expensive hospital care, and improve participation in treatment.[138] Yet integrating services is complicated by differing philosophical approaches of key service providers, limited cross-training, poor communication and coordination, and political barriers between agencies that historically competed for funding.[139] These challenges undermine efforts to provide the best treatment practices.[140] But barriers can be overcome. Administrators of comprehensive, integrated services argue that successful programs require tremendous commitment to identify and lower legal and political hurdles.

Unfortunately California offers no incentives and no rewards for those who take on this challenge. State and local regulatory and oversight mechanisms can actually discourage providers from integrating services. Two Bay Area providers explained their difficulty in obtaining licenses to operate integrated residential programs. In the first instance, no single licensing category covers substance abuse and mental health programs. In the second instance, licensing categories did not allow for programs serving parents and their young children.

Baker Places in San Francisco provides integrated substance abuse and mental health services through a residential treatment program. It offers services to clients who are coming out of the hospital or jail and require ongoing treatment.

Jonathan Vernick, the director of Baker Places, explains:[141]

> *The mental health system unintentionally contrives against service integration. I tried to shop around for a license that would allow the organization to provide mental health and substance abuse treatment services under one roof. There is no license that will allow me to offer both services in a single residential service program. Services may be available in a hospital setting. But where do clients go when they leave the hospital? They have to go into two very different systems of care for their mental health needs and their substance abuse needs. They would benefit much more from an integrated program. Instead Baker Places has dual programs with separate mental health and substance abuse funding. Each source of funding has its own reporting requirements and limitations.*

Steve Fields, the executive director of the Progress Foundation, expressed similar frustrations. The Ashbury House is a licensed, 24-hour adult community care facility. Some of the clients are single parents with custody of young children. But when Ashbury House was established, the State did not have a category for supported residential programs where parents and children can live together.[142]

> *For five years I looked for funding that would support a comprehensive service model. I needed a funding stream that was able to break down the traditional categorical barriers to providing a comprehensive response to client needs. The federal government came out with McKinney funding that was so general – it covered services to homeless mentally ill adults – that it could work. They said I could use the funds to pay for program staff. Once I got federal money, it was much easier to talk with state licensing authorities. But without federal funding no one would listen to my idea of providing comprehensive services through a 24-hour residential model.*
>
> *At the time, community care licensing categories did not address the notion of housing children with their parents. The regional coordinator from the Department of Social Services and I sat down and figured out how we could make this program work without triggering a licensing problem. DSS allowed me to provide social rehabilitation for programs for mothers as long as they were the caretakers of their children. I could not provide child care. If I was required to obtain a child care license as well, this program would not be here today.*

Without Ashbury House, residents would be forced to relinquish their children to the overcrowded and expensive foster care system.

Conflicting treatment philosophies among providers also complicate integration efforts. Officials of Santa Barbara County's mental health court are frustrated in their efforts to find housing for clients with substance abuse problems. In one case, court officials wanted to send a client to a substance abuse residential facility, but the gentleman was on medication. The facility initially resisted because of its policy prohibiting the use of any drugs, even those prescribed to treat mental illness.

The Challenge of Improving Services

The success of individual programs throughout the State suggests that mental health providers often know how to best serve people with mental health needs. But that success rarely transfers across communities or across the state. The challenge for California is to increase the number of service providers employing the most effective practices. Given adequate resources and expertise, more mental health clients would receive tailored, integrated services.

Mental health providers know that clients need more than medication. Unfortunately, practitioners do not routinely use, and policies do not encourage the use of, the best available treatment opportunities.[143] The Village ISA succeeds in part because it was legislatively exempted from funding and administrative barriers that hamper the integration of services.[144] Similarly, the Progress Foundation negotiated a solution to a licensing hurdle that would otherwise divide families. But the State has not used those examples to examine practices and craft reforms to remove those barriers for other communities.

California must identify, document and promote effective and efficient approaches to comprehensive services. As the leader, the state Department of Mental Health should show the way. The Village ISA has hosted site visits from the Governor's Office, from New Zealand and many other U.S. states. But many California communities have yet to understand how The Village operates.

In Recommendation 2 the Commission proposed that the Department of Mental Health be refocused on its leadership role. The department should more assertively investigate, document and promote best practices. The unit should network with local, state, national and world mental health leaders to provide the information local mental health authorities need to improve client outcomes and motivate and challenge them to move ahead. The department should call upon the Mental Health Planning Council to assist it in these efforts.

Recommendation 3: The State must assertively promote cost-effective, efficient approaches to providing care. The Department of Mental Health must ensure that local mental health programs have the tools and assistance necessary to improve the cost-effectiveness of their programs. Specifically, the department should:

Immediate Steps

- The Planning Council should convene public hearings around the state to identify and document potential best practice models.
- The department should prepare a budget change proposal to create and staff a unit charged with identifying and promoting cost-effective practices that improve outcomes.
- The department should convene a working group of mental health professionals and evaluators charged with developing a protocol for evaluating the effectiveness of service models.

❑ ***Utilize the resources of the Planning Council.*** The department should seek assistance from the Planning Council for each of the continuous improvement efforts outlined below.

❑ ***Identify barriers.*** The department should actively identify the barriers that discourage local mental health systems from providing comprehensive, integrated services that can be tailored to individual needs.

❑ ***Identify best practices.*** The refocused department should create and staff a unit charged with identifying and promoting cost-effective practices that improve individual and system outcomes.

❑ ***Explore incentives.*** The department should explore funding, reporting or other mechanisms that can create incentives for state and local mental health officials and service providers to continuously identify and remove barriers to more efficient and effective care.

❑ ***Evaluate innovate programs.*** The department should evaluate promising and innovative practices that have the potential to improve services.

❑ ***Report progress.*** The department and the Planning Council should annually report to the Legislature, local agencies and the public on their activities, progress and on-going challenges to providing comprehensive services.

Providing Adequate Mental Health Resources

Finding 4: Mental health funding is inadequate to ensure all Californians who need mental health services have access to care. Furthermore, existing resources fail to create uniform incentives for improvement and can prevent local authorities from providing cost-effective, efficient care.

Realignment created incentives for local mental health agencies to pursue efficient, effective service approaches. But the majority of mental health funding is not distributed in ways that promote innovation or cost-effective treatment. Further, the variety of mental health funding sources creates inequities among counties in the availability and quality of care. And multiple funding streams force local authorities to patch together services based on the eligibility and use restrictions of categorical, pilot and reimbursement funding sources. The result is a mental health service system defined by funding streams rather than people's needs. Local programs are unable to offer tailored services when they are most needed and wanted – potentially increasing the demand for costly acute care and the anguish associated with mental illness.

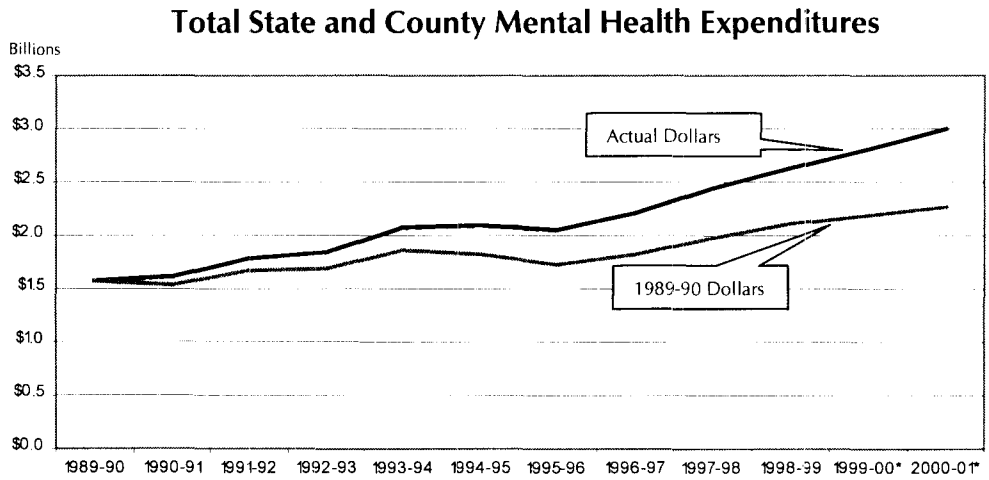
Inadequate Mental Health Funding

Between 1989 and 1999 State and local mental health funding grew from $1.57 billion to $2.99 billion, a 90 percent increase.[145] But funding has not kept pace with demand. In 1989, the public mental health system provided services to 1.4 percent of the state population – about half of those estimated to need public services. While funding has increased, so has the population. And so despite increases, the system continues to serve about 1.4 percent of the state population, or about half of those estimated to need help.[146]

In 1991 realignment fundamentally changed mental health funding and the relationship between the State and counties. Annual General Fund allocations for mental health services were replaced with dedicated revenue from sales taxes and vehicle license fees. Local mental health agencies were given responsibility and authority for providing mental health care. The State's role was focused on leadership and oversight of the statewide network of community mental health programs.

Program Realignment

In 1991 the State and counties negotiated to replace annual state budget allocations with dedicated revenue from sales tax and vehicle license fees. Realignment gave counties control over spending decisions and provided consistent funding across budget years.



Source: Legislative Analyst's Office. 2000. "California's Mental Health System: Selected Data." Presented to Joint Committee on Mental Health Reform. Figure 1. Mental Health Expenditures in California State Hospitals and Community Mental Health All Funds." 1999-2000 figures estimated, 2000-01 figures proposed.

Realignment was intended to replace the annual and unpredictable way the State allocated mental health funding to counties with a stable and growing revenue source. While revenues have increased, realignment also required counties to use that same source of funds to cover expanding caseloads in other social service programs before additional money can be spent on mental health programs.

Realignment also allows counties to transfer up to 10 percent annually between local mental health, public health and social service accounts to reflect local priorities. The first three years following realignment, counties shifted more money into mental health accounts than out. But since then mental health programs have lost $72 million to other local programs.[147] The money has gone to worthy causes – indigent health care, foster care or other social services. But in the long run, local mental health programs have not benefited from adequate growth.[148]

Realignment also acknowledged that the system is chronically under-funded in two ways. First, the legislation made it clear that services are only required to the extent resources are available. Second, it defined a target population that would be given priority service – severely mentally ill and disabled individuals.[149] Target criteria and the need to ration care limit the ability of providers to offer intervention and prevention services to clients before their needs become acute, even though such programs have proven to prevent the recurrence of symptoms and prolong time between psychotic episodes.[150] Instead, counties often require clients with limited needs to wait until the severity of their symptoms escalate before they can access services.

Some 70 percent of the people served through public mental health programs are covered by Medi-Cal, which means the federal government

pays 52 percent of the cost of serving them. Unlike realignment, Medi-Cal is not capped. The remaining 30 percent of public mental health clients are not on Medi-Cal and California covers the full cost of their care.[151]

The central challenge for California is to increase the number of people served. First, the State needs to make sure that all existing clients who are eligible for Medi-Cal are enrolled, thus taking advantage of additional federal reimbursements. Second, the State must also identify Medi-Cal eligible individuals who need mental health services, but are not receiving them. Both initiatives would stretch state money to provide more services to Californians.

Comprehensive Services are Not Funded

Limited mental health funding typically results in counties rationing care to only those most in need of assistance. But counties must also struggle to patch together resources to provide support services that can make or break client efforts to recover.

In general, clients eligible for services under Medi-Cal or realignment have access to basic mental health care. But that eligibility does not necessarily open doors to other services, such as housing assistance, vocational rehabilitation services or drug abuse treatment. Many of those programs serve even larger populations and have waiting lists of their own. Individuals may qualify for some of these supports through programs intended specifically to provide them to mental health clients and funded through categorical, pilot or grant programs. But many do not.

The result is a community mental health system that cannot provide comprehensive care tailored to individual needs. While agencies often know how to provide high quality, low cost services, including intervention and prevention programs, they are limited by eligibility rules, service criteria or funding constraints.

In Sacramento County, for instance, when new clients meet with a service coordinator, housing needs are assessed. Clients receiving social security income can generally afford to live in an apartment or in a board and care facility if they need a structured living environment. Those without social security may find space in county housing programs, such as the AB 34 program. But most without income are referred to homeless shelters. One staff person commented that the best he can do for people without personal income is to encourage them to arrive at homeless shelters before 5 p.m. to improve their chances of finding a bed. Otherwise they sleep on the streets.

Negotiating Mental Health Treatment

California's local mental health programs have access to some 19 major local, state, federal and private funding sources. While most funds strictly limit how they can be spent, some allow greater discretion.

1. Assess client
2. Determine program eligibility
3. Determine program capacity
4. Prepare treatment plan

1. The first step in providing mental health services is to assess the needs of clients.
2. Clients are also assessed to see if they are eligible for specialized programs or if they must be covered with limited discretionary funding.
3. Before program staff can prepare a treatment plan, they must also determine the capacity of community programs. Housing programs in particular fill quickly.
4. Treatment plans therefore are based on a negotiation between client needs, program eligibility and available space. Because of these limitations, providers are often unable to tailor services or provide care when it would be most effective and most efficient.

One consequence of underfunding the mental health system is the increased costs imposed on other public programs. Those costs have not been well defined, but are mounting. Law enforcement officials in particular have argued that the thousands of mental health clients ending up in county jails would be better served in local mental health programs.

Assistant Sheriff Sean McDermitt of Sonoma County testified before the Legislature that the number of mental health clients in the Sonoma County jail doubled between 1996 and 1999.[152] Dr. Barry Perrou, Los Angeles County Deputy Sheriff, testified that the Los Angeles County Sheriff's department is the safety net for the mental health system. Los Angeles County Sheriff's Mental Evaluation Teams (MET) received 15,000 calls since 1993, an average of 7 mental health calls each day.[153]

Commander Taylor Moorehead, Los Angeles County Sheriff's Department, testified that the Twin Towers Correctional Facility provides acute mental health services to 2,300 clients. The jail facility spends over $16 million on mental health services each year, nearly $5 million on psychotropic medications alone, and costs are growing.[154]

Social Security Insurance: Incentives for Participation

The U.S. Surgeon General reports that about 0.5 percent of adults are sufficiently disabled by a mental illness to qualify for disability benefits. A primary source of disability payments is the social security program. Mental health clients may be eligible for two sources of funding. The Social Security Disability Insurance (SSDI) program covers clients who have paid into a trust fund through qualifying employment. The Supplemental Security Insurance (SSI) program covers disabled individuals with limited income.

Clients who are unable to work because of a persistent condition qualify for payments that range from $44 to $647 per month. California augments SSI payments with a state supplemental payment (SSP) that ranges from $0 to $355 per month. Payment amounts vary based on income, living situation and other factors. Most people who are eligible for SSI are automatically enrolled in Medi-Cal. Thus SSI participation opens the door to medical coverage, as well as providing federal assistance to cover housing, food, personal needs and other expenses.

Some California communities aggressively pursue enrolling seriously mentally ill clients in the SSI/SSP program. The average processing time for a new application is 60 days in California. The federal Social Security Administration (SSA) will reimburse local agencies that cover a client's living expenses prior to an application being approved, although officials say some counties are unaware of this policy.

While the average SSA approval is processed within 60 days, mental health service providers report that clients often must wait longer than a year before benefits become available. The delays are caused by the appeals process. Many clients are initially denied access to SSI/SSDI because they lack the proper documentation. Homelessness compounds the difficulty of maintaining documentation, staying in touch with employers or public medical clinics that can provide backup records, or following-up with the application process.

When an SSI recipient enters jail, prison or a state hospital on a penal code status, SSI/SSP payments are suspended. When benefits are suspended for more than a year they are terminated. Clients must reapply once they are released.

The SSA does not automatically know when an enrollee loses eligibility. To reduce the number of inappropriate payments, the SSA pays an incentive to state and local authorities that report when clients are incarcerated or are in state hospitals. Incentive payments are $200 or $400 per case. There is no cap on the number of incentive payments a facility can receive.

The SSA reports that California institutions have received over $6 million in incentive payments since 1997. Although California's State hospitals already share data with the SSA, California has not signed agreements qualifying the state for incentive payments. The Department of Corrections has received $725,800 in payments. The balance went to 40 of California's 58 counties.

The State of Texas reports that participation in the incentive payment program enables it to speed the process of re-enrolling clients in SSA programs upon release from jail or prison. Data sharing allows Texas institutions to establish eligibility prior to clients being released, making it easier for those clients to become re-established in their communities.

California needs to maximize the incentive payments received by state and local institutions and increase the number of clients re-enrolled in SSDI/SSI. The State must also explore strategies for reducing the processing time to speed benefits to new applicants and re-enrollees.

Sources: Sandra D. Moore. Regional Public Affairs Specialist, U.S. Social Security Administration. 2000. Personal Communication. On file.

Mental Health Funding Lacks Incentives

Under realignment, each county receives a set amount of funding regardless of how much it spends or how it spends it. Under realignment, some counties have developed innovative and efficient ways to use funds and improve care. In particular, local mental health agencies have found ways to move clients out of expensive, acute inpatient care into stable, community-based programs that draw down additional state and federal dollars. The majority of mental health funding programs, however – particularly Medi-Cal and many categorical programs – do not encourage counties to invest in cost-effective program changes.

By combining responsibility for services and a dedicated funding stream, realignment allowed counties to benefit from improved efficiency. Analysis of pre-realignment and post-realignment services found that inpatient expenditures dropped, the number of people served increased and the overall cost of providing care decreased. Counties also were able to expand their use of revenue from federal and other sources, and county administrative costs decreased. One researcher commented that prior to realignment local administrators spent their time in Sacramento negotiating for funding. Since realignment they spend their time responding to local needs.[155] However, the incentives in place under realignment do not extend to other forms of mental health funding.

For instance, under the AB 34 program, some clients receive help with housing. But most do not qualify and funding levels limit services to those who do. AB 34 provided $10 million to three counties and provided services to 1,027 clients.[156] While the program drew attention to the plight of the mentally ill, highlighted the potential to bolster services, and improved care for about 1,000 people, it perpetuated a state practice of establishing new funding streams, most which narrowly define how resources can be used.

Access to Services Varies by Zip Code

AB 34 – again, despite its important benefits – also is an example of how limited categorical funding has contributed to a funding system that creates inequities among counties. Since realignment, the State has created multiple categorical programs that are only available to some of the 59 local mental health authorities. As a result, the quality and availability of mental health services varies depending on one's address.

The disparity actually began with realignment, which locked in historical inequities that have become exaggerated by nearly a dozen specialized

programs. Counties with more resources tend to capture still more money by crafting proposals and investing in innovative programs that attract grants. Appendix D displays mental health funding for each county by funding source. While all mental health plans receive realignment and Medi-Cal funding, specialized pilot, grant and categorical funds are available on a limited basis. The following table displays just some of the inequities among counties.

While specialized funding sources are small in comparison to managed care and realignment funding, they provide the opportunity to meet particular needs and stretch other mental health resources. The disparity in funding levels creates wealthy programs in some communities and impoverished or non-existent services in others.

Using Funding to Improve Services

The structure of mental health funding can motivate programmatic change. Pilot and discretionary funding can encourage local agencies to identify and evaluate promising new approaches to improving outcomes. Funding of proven approaches or "best practices" can motivate agencies to adopt strategies proven to deliver efficient, effective services.

Partial Data: Distribution of Mental Health, AB 34 and MIOCR Funding Across California Counties, 1997-98 (unless otherwise noted)

County	Realignment	Short-Doyle Medi-Cal	Community Svcs Other Treatment	Adult SOC	Dual Diagnosis	AB 34	MIOCR Grants	PATH Grants
Alameda	44,858,886	26,154,475	0	0	0	0	0	74,701
Alpine	177,750	0	0	0	0	0	0	0
Amador	672,799	168,121	0	0	0	0	0	2,526
Butte	5,731,551	3,810,060	0	0	0	0	0	12,376
Calaveras	787,011	244,108	0	0	0	0	0	0
Colusa	637,633	147,119	0	0	0	0	0	0
Contra Costa	24,418,626	11,818,555	20,505	0	250,000	0	0	39,982
Del Norte	857,793	665,465	0	0	0	0	0	2,848
El Dorado	2,800,892	1,334,874	20,505	0	0	0	0	10,000
Fresno	23,475,532	6,865,911	20,505	0	0	0	0	45,278
Glenn	809,617	353,974	0	0	0	0	0	3,486
Humboldt	4,445,559	2,653,271	0	0	0	0	2,268,986	10,000
Imperial	3,918,926	1,904,581	0	0	0	0	0	10,000
Inyo	895,433	115,298	0	0	0	0	0	2,217
Kern	16,505,115	9,249,297	20,505	0	0	0	3,098,768	31,013
Kings	3,068,558	1,001,044	0	0	0	0	0	10,000
Lake	1,726,043	514,157	0	0	0	0	0	7,162
Lassen	849,678	273,644	0	0	0	0	0	3,003
Los Angeles	266,206,290	69,832,334	61,515	1,883,430	0	4,800,000	5,000,000	577,271
Counties Funded	*57*	*57*	*15*	*3*	*4*	*3*	*15*	*51*

California's Pilot Programs. Since realignment the Legislature has created numerous mental health pilot projects. But in general, the State has not used the experience gained in pilot projects to reshape policy statewide. For example, the Adult System of Care program has demonstrated effectiveness, but has not become state policy.

Pilot and discretionary funding can provide mental health agencies with wide latitude in how to spend resources. With limited or no strings, discretionary funding allows agencies to take risks as they pursue promising, innovative approaches to improving care. Pilots can inform policy-makers on the effectiveness of new service approaches. They should be designed to experiment with and evaluate new programs, such as the Integrated Services for Homeless Adults program funded through AB 34 and the Mentally Ill Offender Crime Reduction (MIOCR) grant program. But more commonly, they represent incremental expansion of funding that benefits a few counties and gradually erodes the strategy of local control established under realignment.

Best Practice Funding. Funding can also be structured to encourage local agencies to adopt proven practices. The State of Pennsylvania has adopted a funding approach that provides resources to support programs that have been demonstrated to address local needs. State funding provides the incentive for local agencies to explore programs that have worked elsewhere and determine whether they would apply locally.

Pennsylvania's Best Practices Funding Model

Pennsylvania has developed an innovative funding program designed to accomplish four key challenges:

- Change institutional responses to addressing community needs.
- Mobilize community leaders to become involved in addressing needs.
- Adopt data-driven research-based programs as community policy.
- Provide local agencies with appropriate tools to improve community programs.

Under the Partnership for Safe Children, Pennsylvania provides grants to communities that adopt programs known to address specific community needs. The State's criteria for funding include:

- The community has conducted an assessment to identify specific problems to be addressed.
- Community leaders demonstrate evidence of broad community involvement in developing proposals.
- Community leaders have identified a service approach that has been empirically tested and shown to effectively address the specific needs identified in their assessment.
- The community has consulted with experts who can assist them to ensure they implement the program as it has been designed and evaluated.
- The community has committed itself to completing the program and any requirements it may have for success, such as staff training, service coordination, etc.

Source: Pennsylvania Partnership for Children.

Reforming California's Mental Health Funding System

Improving California's mental health system requires policy-makers to understand the incentives and limitations inherent in its funding structure. The bulk of mental health funding does not allow local agencies to tailor programs to needs or pursue cost-effective service approaches. Limited funding forces local decision-makers to ration care and piece together a patchwork of services. Service providers are then required to negotiate eligibility criteria based on fund sources. Providing services means finding the overlap between client needs, program space and funding availability. Needs that fall outside that overlap often go unaddressed. When problems become acute across the state, a new categorical program is created to cover the particular need.

Realignment created a basis for mental health programs to benefit from a stable, growing revenue source. It provides flexibility and incentives to scale services to needs and invest in prevention and intervention programs. California needs to reinvest in that funding approach.

Mental health funding should be restructured to motivate counties to pursue efficient, effective service approaches that improve client outcomes. Mental health funding could be tiered, with the majority having built-in incentives for efficiency and effectiveness. The State could also develop supplemental funding designed to motivate counties to adopt proven approaches to solving particular needs. A third tier of funding could be used to encourage innovation and risk taking as local agencies explore ways to improve access, quality and efficiency.

Recommendation 4: California should provide adequate funding to ensure those who need care have access to services. The first step is for the Governor and the Legislature to reform the present funding streams. Specifically the legislation should:

- ❑ ***Provide stable base funding that motivates quality outcomes.*** The lion's share of mental health funding should include incentives for local mental health agencies to continuously improve services. Funding should reward local programs that improve system outcomes and generate savings associated with reduced mental health costs, as well as reductions in the costs of other public services, such as public safety and health care.

Immediate Steps

- The Department of Finance and the Legislative Analyst's Office should analyze the cost of fully funding realignment.
- In January, the Legislature should introduce a bill to fully fund realignment and remove language that limits access "to the extent resources are available."

Immediate Steps

- The Governor should direct the Departments of Mental Health and Managed Care to assess the impact of parity legislation and constantly identify strategies for expanding access to care through public and private sector mental health programs.
- The Department of Finance and the Legislative Analyst's Office should develop a transition plan to move away from 19 major funding streams toward a more rational approach to funding mental health services.

❑ ***Provide incentive funding for the adoption of best practices.*** In addition to base funding, the State should develop supplemental incentive funding that encourages local agencies to adopt proven best practices.

❑ ***Provide innovation funding to encourage new experimentation and risk taking.*** Mental health funding should also include resources in addition to base and incentive funding that promote innovation and risk taking to encourage local agencies to explore new approaches.

❑ ***Document the effectiveness and promote mental health parity.*** Providing all who need services unrestricted access to mental health care means expanding access through the private sector as well as expanding the safety net offered by the public sector. The effect of mental health parity legislation must be understood, and parity should be expanded to improve access to quality care.

Decriminalizing Mental Illness

Finding 5: One consequence of an inadequate mental health system is the criminalization of behavior associated with mental illness. The criminal justice system is too often the only resource – the only safety net – available to mental health clients and their families in times of crisis.

Santa Barbara County Sheriff Jim Thomas said law enforcement officials have few options when dealing with mental health clients who need help. Limited mental health resources force them to arrest individuals who otherwise might be directed into mental health services. Other law enforcement leaders expressed similar concerns. Law enforcement has become the mental health safety net. The police respond when no one else will, although they may lack the resources and training to provide the most appropriate care.

Law enforcement officials and others agree that serious and violent offenders with mental illness should continue to be arrested, convicted and incarcerated. Mental health treatment is available in California jails and prisons for this population of offenders. Their concerns are with mental clients who commit nuisance crimes associated with their illness: trespassing, vagrancy, disturbing the peace or other infractions that allow a police officer to exercise discretion over whether to arrest and jail or to help the person receive care.

Few California communities offer 24-hour stabilization or crisis centers. Thus officers are often forced to abandon clients they encounter or make an arrest knowing the individual will qualify for mental health services in jail. The number of clients in county jails has led to overcrowding and increased demands on law enforcement budgets. Several county Sheriffs are taking the lead to reduce the number of mentally ill people who end up in jail solely because of inadequate mental health services. The State has also begun to invest in programs that divert non-serious offenders from the criminal justice system and prevent criminal activity by improving access to mental health care.

Community treatment programs have greater flexibility than jail mental health settings and clients can qualify for Medi-Cal, federal reimbursements or other programs unavailable while they are in jail. Research suggests it is also cheaper to serve people in the community than to arrest them and serve them in jail.

The Criminal Justice System is Serving More Clients

The number of mental health clients in the criminal justice system is increasing. Two factors are credited for this trend: First, as institutional care was reduced, more clients with serious mental illness returned to communities – often homeless, medicating with street drugs and unable to access mental health services. Second, the overall number of people in jails and prisons has increased as public safety policies have sought to incarcerate a wider range of offenders, including petty offenders.[157]

Researchers in Vermont, for instance, found that mental health clients were more likely to be arrested than the general population, 7.2 percent for clients versus 1.7 percent in general. Clients with substance abuse histories were even more likely to be arrested, 14.4 percent.[158]

Advocates assert that mental illness has been "criminalized" – as clients who cannot access services commit "crimes of survival" or are arrested for displaying in public the symptoms of unaddressed mental illness. Camping in public, urinating on private property and "felony mouth" – aggressive confrontations with police – are crimes committed by people with no place to live, suffering from paranoia and other symptoms.

The Mental Health Consumer Network is concerned that California's adoption of a managed care approach to providing mental health services will aggravate this trend by limiting services and further shifting costs from community mental health to the criminal justice system.[159] Others suggest that the higher threshold for involuntary commitment enacted in the 1960s resulted in more arrests of people who otherwise would be directed into inpatient treatment programs.[160]

A number of factors may contribute to the circumstances when mental health clients commit criminal acts. The response of the criminal justice system to those activities depends upon the awareness that individual decision-makers have of mental illness and its symptoms. There is widespread lack of knowledge regarding mental illness on the part of law enforcement officials, prosecuting and defense attorneys, judges, probation and parole officers, jail and corrections staff.[161]

Jails Have Become Treatment Centers

After several days of taking over-the-counter antihistamines, Ron was manic. His father describes him as "bouncing off the walls and slamming doors."

At one point his father called 911 because Ron was making noise, it was late and he was concerned about the neighbors and his son's safety. When the police responded, Ron walked out the front door, raised his arms straight in the air and said to the police, "I will (expletive) kill you."

After spraying Ron with pepper spray and handcuffing him, the officers called the county mental health facility to see if there was room for Ron. There was no space. They called the psychiatric hospital in the neighboring county, no space. They called a facility two counties over, no space. With no other option they charged Ron with assault and took him to jail.

Inadequate Community Services

Many factors contribute to the decision of a law enforcement officer to arrest a mental health client: the nature of the complaint, the circumstances surrounding their behavior, the possibility of an involuntary hold under Penal Code section 5150, and the officer's awareness of mental illnesses and their symptoms.

Serious crimes result in an arrest. Even minor criminal activity may lead to a client being taken to jail. [162] Law enforcement personnel may be reluctant to bring an offender to a psychiatric facility where custody and security are limited, or where they must wait for hours before the person is admitted. Officers also have the options of releasing clients into the custody of a responsible adult, making a referral or doing nothing.

While eligibility rules limit who is served by mental health programs, the criminal justice system refuses no one. Officers who want to remove clients from public settings often weigh the appropriateness of the mental health system and its long waiting times and shortage of bed space, against jails that guarantee at least minimal custody and control. Further, the criminal justice system does not question the officer's judgement in arrest, while the mental health community may challenge his interpretation of symptoms as mental illness.[163]

When community mental health services are not available, arrest may be the only viable option for an officer attempting to ensure public safety and defuse a situation. But preventive mental health services can eliminate the need for initial contact with law enforcement. Researchers have found that adequate mental health treatment can prevent crime.[164]

Lack of Community Treatment Criminalizes Mental Illness

It has become apparent to me that our jails and prisons have become the provider of last resort for the mentally ill. Prior to committing a crime, or putting themselves or others at risk, the mentally ill and their families, and their health providers, are virtually ignored until they are in a serious crisis.

Our system is working backwards for those who are severely mentally ill. Before they can get treatment, they need to get better. Before they get the treatment that they need to get better, they have to get worse and often they must go to jail first to receive any mental health services. We wait until the mentally ill end up in jail, the most inappropriate of settings and only then where it costs the most do we provide comprehensive, medically necessary treatment.

The ultimate irony is after spending all that money to stabilize the mentally ill in jail, we let them out into the public mental health system, which is underfunded and understaffed.

– Assemblymember Helen Thomson
Public Hearing, February 16, 1999
Senate Select Committee on Developmental Disabilities and Mental Health and
Assembly Select Committee on Mental Health

H. Richard Lamb, professor of psychiatry and director of the Division of Mental Health Policy and Law at the University of Southern California, argues that inadequate services lead to a "revolving-door" syndrome that inappropriately relies on expensive jails and hospitals. "The lack of adequate community psychiatric resources, including acute and long-stay hospital beds, subjects mentally ill persons to inappropriate arrest and incarceration."[165]

Alternative Sentencing & Diversion Programs

Some communities have taken it upon themselves to find a better way. Several counties have adopted policies that link law enforcement with mental health staff. The Los Angeles County Mental Evaluation Team (MET) pairs an officer and a mental health professional to respond to police calls involving clients. Forming the MET team has enabled the county to direct more clients into treatment rather than incarceration.[166]

Not all clients are diverted however. When a client is arrested and jailed, mental health assessments are conducted to determine if the individual requires specialized treatment or custody arrangements, such as segregated housing. These assessments also help prosecutors decide whether to bring charges. But once a criminal charge is filed, judges have limited ability to divert clients out of the criminal justice system. State policy does not provide mental health clients with diversion opportunities similar to those afforded developmentally disabled individuals. The penal code allows the court to divert developmentally disabled individuals into services offered through regional centers. [167]

California has invested in two mental health diversion programs – AB 34 and the Mentally Ill Offender Crime Reduction (MIOCR) grant program:

AB 34 – Integrated Services to Homeless Adults. In fiscal year 1999-2000, AB 34 provided $10 million to determine if comprehensive services can keep severely mentally ill adults from being homeless or going to jail. Programs in three counties – Los Angeles, Stanislaus and Sacramento – were able to reduce the number of days that clients spent in jail, homeless and hospitalized. Five months following implementation, the program has shown success.

> *The Department found that the effect of the intensive, integrated outreach and community-based support was to enable the target population to reduce symptoms that impaired their ability to live independently, work, maintain community supports, care for their children, remain healthy, and avoid crime.*[168]

AB 34 targets clients who are likely to end up in high-cost treatment settings, such as hospitals and jails. Through aggressive outreach and comprehensive care, AB 34 has demonstrated that mental health services can keep clients from entering or returning to the criminal justice system.

Mentally Ill Offender Crime Reduction Grants. The MIOCR program was developed to assist county efforts to reduce crime and offenses committed by people with serious mental illnesses.[169] The Legislature provided over $100 million to the Board of Corrections (BOC) to support local programs that will reduce crime, jail overcrowding and criminal justice costs by improving prevention, intervention and incarceration services to clients who become involved with the criminal justice system.[170] The BOC has awarded a total of $50.6 million to 15 counties. Allocation plans for the remaining $50 million are underway.

MIOCR Grantees

Initial Grantees

Humboldt County	$2,268,986
Kern County	$3,098,768
Orange	$5,034,317
Sacramento	$4,719,320
San Bernardino	$2,477,557
Santa Barbara	$3,548,398
Santa Cruz	$1,765,012

1999-2000 Grantees

Los Angeles	$5,000,000
Placer	$2,139,862
Riverside	$3,016,673
San Diego	$5,000,000
San Francisco	$5,000,000
San Mateo	$2,137,584
Sonoma	$3,704,473
Stanislaus	$1,713,490

Source: California Board of Corrections.

MIOCR funds have been used to establish mental health courts, improve services for mentally ill offenders reintegrating into the community after release from jail, improve jail assessment and treatment services, provide diversion opportunities for repeat offenders or a combination of jail, court and community activities. MIOCR programs involve police responses. Clients receive services after an initial qualifying offense or a subsequent police contact.

There is general agreement that clients who have committed minor crimes – trespassing and disorderly conduct – could be diverted into community services.[171] And a majority of crimes committed by mental health clients fit into this category.[172] Research on well-established diversion programs found that psychiatric emergency teams have been able to divert almost all clients they encountered into mental health services, including those with a history of substance abuse and violence.[173] And appropriate training for law enforcement officers has improved their ability to work with clients in ways that avoid violent confrontations and encourage productive relationships.[174]

The Value of Diversion Programs

Diversion programs can generally be divided into four categories:[175]

1. ***Pre-Booking.*** Provide community-based services as alternatives to arrest.
2. ***Post-Booking.*** Encourage client involvement in community mental health programs with court agreement.
3. ***Post-Arraignment.*** Negotiate treatment plans with multiple actors, including the client and representatives of community mental health, jail, court, probation/parole and pre-trial service providers.
4. ***Mixed.*** Include combinations of pre-booking, post-booking and post-arraignment diversion options.

Key components of successful diversion programs include: Case management; training to work with mental health clients; aggressive identification of appropriate cases – within the first 24 to 48 hours of detention – and competent data systems to track clients through criminal justice and mental health systems. [176]

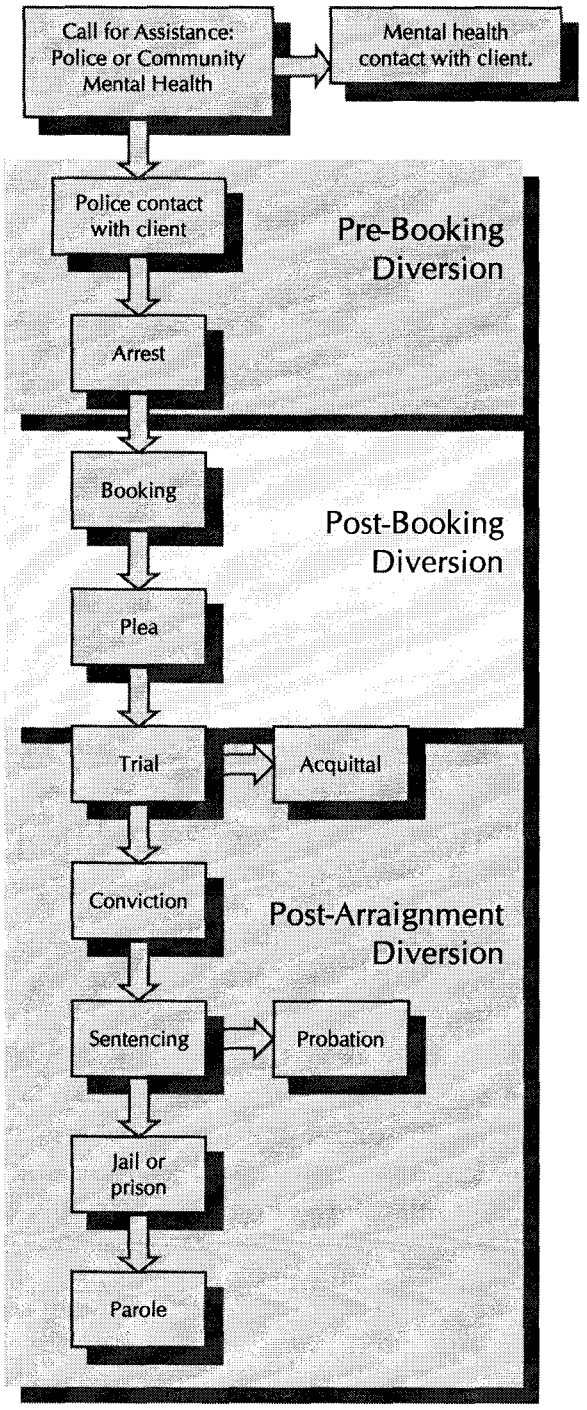
Diversion programs have broad support and are considered the most promising avenue for reducing client involvement with law enforcement. Yet there has been insufficient research on diversion programs to determine when and how they work best.[177] Some argue that diversion is unnecessary when clients are receiving adequate services or when mental health professionals are able to respond to client needs.

Sacramento County uses a pre-diversion approach. Organizations such as Volunteers of America respond to clients in situations when police might otherwise be called. Business owners and citizens can call VOA instead of police to refer clients into community programs or move them away from public settings to defuse situations. A VOA response to a non-criminal situation is significantly cheaper than a law enforcement response. Similarly, Birmingham, Alabama uses community service officers, who are civilian police employees, to respond to these situations.[178]

Public safety organizations are critical of programs that offer an alternative to a law enforcement response to a client in crisis. They contend that only law enforcement is equipped to respond to a public safety incident. Yet law enforcement contacts with mental health clients do not routinely lead to arrest. Of 15,000 responses by the Los Angeles County Mental Evaluation Team, just 437 resulted in an arrest.[179]

Investing in Prevention, Diversion and Incarceration

The challenge for California is to serve mental health clients in a way that ensures public safety, provides appropriate treatment services and is efficient and effective. The graphic below displays the criminal justice process and the opportunities for prevention and intervention.



Prevention

AB 34/AB 2034: the Integrated Services to Homeless Adults Program provides services to clients who are homeless, at risk of homelessness, or at risk of incarceration. The program provides intensive outreach and tailored services to improve the ability of clients to live independently, work, maintain community supports, care for their children, remain healthy and avoid crime.

Intervention

The 15 counties participating in the Mentally Ill Offender Crime Reduction grant program have developed multiple approaches to reducing crime, jail crowding and criminal justice costs associated with mentally ill offenders.

Pre-Booking: The MIOCR program does not fund pre-booking diversion programs. Funds are limited to post-booking and post-arraignment approaches.

Post-Booking: The Santa Barbara County MIOCR program brings together a judge, district attorney, probation staff, psychologist, housing and employment specialists and other court and mental health staff to prepare individualized responses to mentally ill offenders. Release from jail is contingent on developing a treatment plan with the agreement of the court.

Post-Arraignment: The San Bernardino County MIOCR program serves clients after they have served time for an initial qualifying offense. A range of services are available to clients when they commit a subsequent qualifying offense. Reportedly, the Sacramento County program requires clients to have a history of at least two arrests before qualifying for MIOCR services.

Mixed: The majority of the MIOCR programs provide a range of services to targeted clients.

The availability of 24-hour crisis services and prevention programs such as those provided under AB 34 could reduce law enforcement costs and crime. A mental health response to clients in crisis can result in significant cost savings. A mental health professional can work to maintain the client in their own living situation, resolve the immediate need and work toward recovery at the outset of a problem. In contrast, post-police diversions require an initial police response, often an initial period of incarceration, the involvement of the court and the valuable time of other law enforcement personnel.

National researchers working with the Federal Substance Abuse and Mental Health Services Administration are investigating the trade-off between pre-plea and post-plea interventions. Early evidence suggests that pre-plea interventions have greater cost-savings potential because they involve less time in jail and avoid expensive court costs. Post-plea interventions have greater potential for success because the court has greater ability to negotiate client participation in treatment.[180]

Building a Continuum of Mental Health Responses

California needs to better understand why so many mental health clients end up in the criminal justice system. Clearly, some clients commit crimes and should be incarcerated. Equally important, limited criminal justice resources should not be siphoned away to help mental health clients who would have been better served by other community services. The State needs to ensure that no client ends up in jail solely because they did not receive appropriate care. A detailed analysis of arrest and jail trends could help policy-makers fashion an appropriate and cost-effective range of responses for each California community.

Policy-makers need to better understand the conditions that result in clients entering the criminal justice system and the options available to keep them from drawing criminal justice resources away from serious offenders. The Legislature and the Governor need to understand the range of strategies available to the state to improve the availability of mental health services and target programs to clients likely to end up in jail. Diversion and prevention programs such as the MIOCR grant and AB 34/AB 2034 programs are an appropriate start, but more information is needed to determine if these programs offer the most cost-effective responses to the criminalization of mental illness.

Doing the Research: Who Ends Up In Jail?

Researchers in Missouri and Maryland have looked at the rate of client involvement in the criminal justice system. Even basic questions have allowed researchers to explore treatment effectiveness, recidivism, access to services and the nature of client involvement with the criminal justice system.

In California, state and local governments maintain detailed databases on the mental health needs of clients and their history of involvement with the criminal justice system.

The Department of Mental Health and local behavioral health programs maintain data on 380,000 active mental health clients. Similarly, the Department of Justice and local law enforcement agencies maintain detailed records of individuals involved with the criminal justice system - from arrest and incarceration through release.

Bringing together the two separate data systems could allow state and local officials to empirically determine the profile of clients most likely to become involved with the criminal justice system and in what capacity. Reviewing the treatment histories of clients in the jail and prison systems could further inform policies on treatment approaches, integrating services and linking jail/prison mental health and community mental health.

Research proposals involving mental health and criminal justice data should:

- Protect the confidentiality of clients.
- Involve client and family members in determining research goals and protocols.
- Identify the types of crimes clients are involved in and determine factors contributing to their involvement with the criminal justice system.
- Emphasize policy development.
- Lead to improvements in community mental health programs and correctional mental health programs.
- Determine whether mentally ill offenders have adequate access to community mental health services.

The State has dedicated over $160 million dollars to reduce recidivism, jail overcrowding and criminal justice costs through the MIOCR and Integrated Services to Homeless Adults (AB 34/AB2034) programs. Local agencies have provided rich anecdotal data to support the need for these interventions. Focused analysis of existing data could improve the ability of the Legislature and the Administration to target services where they are most effective.

Research on mental health and criminal justice data could more clearly answer the following questions:

- What is the prevalence of crime among active mental health clients in community mental health systems? How does client involvement with the criminal justice system compare with the general population's overall involvement with the criminal justice system?
- What types of crimes are clients likely to commit? Are clients arrested for crimes of survival as many advocates assert? Do patterns of arrest and release suggest that law enforcement officials make "mercy bookings" because community mental health services are unavailable? Are AB 34/AB 2034 and MIOCR programs available to the clients most in need of and able to benefit from interventions?
- Which counties face the highest rate of client involvement with the criminal justice system and for what types of behavior? Do those counties receive AB 34/AB 2034 and MIOCR funds?
- Do clients with a history of involvement with the criminal justice system have access to community mental health resources equal to that of other clients?

Sources: Pandiani, John A. et al. 1999. "Using Incarceration Rates to Measure Mental Health Program Performance." Journal of Behavioral Health Services & Research. 25(3):300-311. Personal Communication. July 8, 2000. On file.

Recommendation 5: The State needs to decriminalize mental illness by ensuring that no one ends up in the criminal justice system solely because of inadequate mental health care. The Governor and the Legislature should improve and expand mental health crisis interventions. Specifically, the Department of Mental Health, the Attorney General and the Board of Corrections should:

Immediate Steps

- The Department of Mental Health should query the Department of Justice database to determine how and where clients come into contact with the criminal justice system.
- The Legislative Analyst 's Office should review criminal justice diversion and intervention programs and determine if the State is making the best use of existing investments.
- Legislation should be drafted for introduction in January to expand facility funding available through the Board of Corrections and permit counties to seek funds from the Board to build 24-hour assistance centers or jails.

❑ ***Use data to improve services.*** The State should analyze criminal justice and mental health data to identify priorities, develop promising programs and inform policy decisions that will reduce the number of mental health clients who end up in the criminal justice system.

❑ ***Identify needs.*** The State should document the need in each county for services that would prevent people from ending up in the criminal justice system, such as 24-hour crisis programs, supportive and affordable housing, substance abuse treatment and other services.

❑ ***Evaluate intervention programs.*** The State should determine whether the Mentally Ill Offender Crime Reduction Grant and Integrated Services to Homeless Adults programs represent the greatest opportunities to reduce client involvement in the criminal justice system.

Coordinating Mental Health and Criminal Justice Services

Finding 6: Local and State agencies have failed to integrate and coordinate mental health and criminal justice services – and as a result people with mental health needs leaving jails and prisons do not receive adequate services and are too often rearrested.

California's prisons and jails hold an estimated 30,000 mental health clients. The majority are incarcerated for non-violent crimes of survival. California spends between $1.2 billion and $1.8 billion each year to process, treat and hold these individuals.[181] When they are released, they are left alone to negotiate California's network of community mental health systems. Mental health programs and community parole and probation programs do not work together to reintegrate clients into their communities.

Community mental health and criminal justice agencies seldom work together. They compete for funding, have disparate mandates and lack a culture and history of shared values. Despite estimates that 40 percent of public mental health clients will be arrested at some point in their lives, these two public agencies do not routinely collaborate.[182] State prisons and prison parole services also compete with county programs for resources. Limited funding forces county mental health programs to ration care to the general population. They are reluctant, if not truly unable, to provide services to mental health clients on parole and under the supervision of the State.

As stated in Finding 5, California must do a better job of preventing mental health clients from entering the criminal justice system solely because of inadequate mental health care. Other mental health clients will end up in jail or prison because of criminal behavior unassociated with their illness. Still others develop mental illnesses while incarcerated. Almost all of these clients will leave jail or prison and return to their communities. To improve the chances that they will successfully reintegrate back into their communities, State and community criminal justice programs and State and community mental health programs must collaborate to provide quality services.

Entering and Exiting the Criminal Justice System

While in the custody of state and local criminal justice agencies, clients receive a variety of mental health services. Law enforcement agencies assess inmate treatment needs through an intake process. Mental

health services are generally provided on an outpatient basis, with the inmate living in the general population. In some cases, services are provided on an "inpatient" basis, with the client in a special custody unit providing more structured oversight and care.

Discharge planning has long been a concern among advocates, who argue that clients leaving correctional institutions need assistance transitioning back into their communities. Homelessness and a lack of adequate treatment and support services often led to the incarceration in the first place. Releasing a client back into a community without adequate support often results in their returning to custody.

When a client is preparing to leave jail, it is common for an outreach worker to visit and explain what community resources are available upon release. Outreach workers offer meal and hotel vouchers and can help reestablish public assistance or access to community programs.

In Sacramento County, clients are released from jail and directed to the outreach trailer – which is two miles away, across a train yard and through open fields. Sacramento County has one of the more coordinated community mental health systems in California, yet many clients fail to show up for services and cycle back into custody. County law enforcement and mental health providers have been unable to improve the link between the two programs.

Failed Communications

Community mental health programs and local criminal justice systems often operate at cross-purposes and often without mutual trust.[183] For instance, non-emergency community mental health programs do not generally operate after business hours. Yet county jails routinely release mentally ill offenders between the hours of 9 p.m. and 2 a.m. with limited or no release planning.

The Need for Improved Communication

CDC operates five parole regions. In one of those regions, 1,650 parolees were required to attend outpatient mental health services, but just 505 (31 percent) showed up following release from prison.

Parole staff report that when clients are released from parole, the best staff can do is "cross their fingers" that clients make follow-up appointments with community mental health programs. Parole staff generally have no connection with community mental health programs and therefore are unable to track whether clients receive care through community programs.

Sacramento County asked the CDC for a list of prisoners to be paroled into the county between June 2000 and December 2000. All but two inmates had contact with county mental health prior to entering prison. Despite the value of sharing data, the CDC does not routinely share this information with local mental health programs.

Clients and providers point out that treatment plans in jail often differ from community treatment plans. Many clients require weeks to become accustomed to specific psychotropic medications and inconsistent treatment plans can reduce the overall effectiveness of treatment efforts.

A similar gap exists between state prison and parole mental health programs and community mental health services. Mental health clients on parole from State prison are often prevented from accessing community mental health services. County mental health departments, strapped for funds, contend that the State should serve parolees. Parole outpatient staff argue that they are unable to assist mentally ill parolees with services such as housing, independent living skills, vocational rehabilitation and other services often provided by community programs.

Client advocates argue that poor coordination and barriers between community mental health and state parole agencies conspire to return clients to prison. They charge that parole officers are trained to ensure clients "follow the rules." They are not trained to help them become established back into the community.

At the same time, community mental health agencies are reluctant or unable to provide them with needed services.[184] One high-profile example of this problem involved a sex offender taking a medication that was not available through county mental health services. When his supply of medication ran out, his parole officer returned him to prison because without medication he was likely to re-offend.

Custody-based vs. Community-based Treatment

Prison	
Custody	$21,243
Treatment	$7,346
Total	$28,589
Jail	
Custody	$19,700
Treatment	$7,100
Total	$26,800
Parole	
Supervision	$2,182
Treatment	$3,600
Total	$5,782
Community	
Total, including housing:	$1,500 – $35,000

The average custody costs in the equations above do not reflect additional expense associated with severely mentally ill inmates who require special supervision. Figures also do not include law enforcement and court costs.

The Benefits of Collaboration

It costs the State about $120,000 each year to house a mental health client in a state hospital. Community care ranges from $1,500 to $35,000 per year.[185]

The average annual cost of custody in prison is $21,243.[186] Prison-based psychiatric services for seriously mentally ill inmates cost the State an additional $7,346.[187] Parole services cost the State $2,182 per person, with parole-based mental health care adding up to about half what it costs to provide those services in prison.[188]

Figures for California's jails are similar. Custody costs average $19,700 per year.[189] The Los Angeles County jail provides acute mental health care to 2,300 inmates at an average annual cost of $7,100 each.[190] These figures suggest it is more cost-effective to treat clients in the community than in custody.

Most people who enter the criminal justice system eventually return to their communities. About 40 percent of California's prison population is released each year. Overall, 90 percent of prisoners are eventually released, with the majority getting out in less than two years.[191] County jails generally hold inmates for less than a year. Those that are not sent to other correctional institutions are released. Most are released in a matter of months.

Improving Communication between Service Providers

In some communities, service providers working with mentally ill offenders are coming together to discuss shared goals and challenges. Staff from county mental health, jail psychiatric services, parole, parole outpatient clinics and law enforcement are discussing ways to improve their ability to maintain public safety and improve services to shared clients.

These individuals recognize that community rehabilitation is not necessarily a shared goal across their organizations. Yet successful client reintegration into community life requires improvements in how treatment is delivered, the types of support services available and how the disparate public entities view their roles and responsibilities.

Unfortunately, staff receive little institutional support for their efforts. There is a reluctance to discuss organizational failings and limited opportunities for promoting change among their agencies.

Research on the general prison population shows that less than 5 percent of inmates participate in reentry programs designed to improve their reintegration into society. Once released, the average parolee receives just two 15-minute sessions of face-to-face contacts with a parole agent each month. About 20 percent of parolees fail to maintain contact with their parole agent. Parole violators constitute 71 percent of all admissions to state prisons, presenting an important opportunity to intervene.[192]

Despite the large revocation rate for parole supervision, the State has not adequately considered the ability of support services – including housing and supportive employment – to prevent parolees from returning to custody. Appropriate mental health care creates stability, improves client functioning and can prevent criminal behavior. Finding 5 described the opportunities to analyze existing data to better understand trends and identify opportunities.

Promising Approaches

Pilot programs have begun to demonstrate the potential for coordinated efforts to reduce client involvement in the criminal justice system. The AB 34/AB 2034 Integrated Services to Homeless Adults, the Forensic Conditional Release Program (CONREP) and diversion programs demonstrate that coordination can improve client services and reduce

recidivism and criminal justice costs. Clients spent 74 percent less time in jail under AB 34 programs, re-offense rates are reduced under CONREP and diversion programs can reduce the number of clients who return to custody.[193]

Several states, including California, the federal government and local communities have developed strategies to link and coordinate services for mental health clients leaving correctional institutions. The National GAINS Center in New York, the Texas Council on Offenders with Mental Impairments, a data link project in Maryland, and California's AB 34/AB 2034 and MIOCR grant programs reflect efforts to improve services and outcomes for mentally ill offenders and reduce recidivism.

The National GAINS Center. The National GAINS Center for People with Co-occurring Disorders in the Criminal Justice System disseminates information on effective mental health and substance abuse services for people with co-occurring disorders who come in contact with the justice system. The Center is a partnership of the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, Center for Mental Health Services, National Institute of Corrections, Office of Justice Programs, and the Office of Juvenile Justice and Delinquency Prevention. It brings together researchers, policy-makers, practitioners, consumers, and family members to gather the best available information on the coordination of mental health and substance abuse services in criminal justice settings. It provides technical assistance to improve programs that serve individuals in courts, jails, prisons, probation and parole.

Linking Mental Health and Criminal Justice Data

Maricopa County in Arizona has a data link between county mental health and criminal justice. Data sharing allows law enforcement to determine the appropriateness of referring clients into community services. The program diverts clients who commit crimes of survival. Without a data match, law enforcement officials face a more difficult time determining which offenders are eligible for treatment and diversion.

Data matching between mental health and law enforcement is controversial. Client advocates fear that law enforcement agencies will use history of mental illness in making arrest decisions. They argue that medical history information is confidential and has no bearing on a client's legal status. Yet the trend nationally is to use mental health data to improve decision-making by police officers.

Mental health advocates champion the use of criminal justice and mental health data to demonstrate the inadequacies of local mental health systems. Data sharing and analysis can improve the ability of local mental health systems to tailor services to needs and keep clients out of jails and prisons.

Source: National GAINS Center, 1999. "Using Management Information Systems to Locate People with Serious Mental Illnesses and Co-Occurring Substance Use Disorders in the Criminal Justice System for Diversion." On File. (gains@prainc.com)

The Texas Council on Offenders with Mental Impairments. The council provides a formal structure for criminal justice, health and human service, and other agencies to communicate and coordinate on policy, legislative, and programmatic issues affecting offenders with special needs. The council's target population includes offenders with serious mental illnesses, mental retardation, terminal or serious medical conditions, physical disabilities and those who are elderly.

The council has been instrumental in improving service coordination and reducing state costs. It has developed a special needs parole program that provides early parole review for offenders who could be diverted from incarceration into more cost-effective treatment alternatives. In some cases, parole diversions allow the state to receive federal reimbursements for treatment services through Medi-Cal, Medicare or Social Security. The council reports that for every dollar spent on these alternatives it draws down an equal dollar from federal or other sources.

The council also has developed policies that have streamlined mental health assessments across local and state criminal justice programs, improved communication among agencies and improved coordination among programs. The council's efforts have reduced arrest and re-arrest rates for special needs offenders by 33 percent and they have lowered the cost of parole aftercare.[194]

Maryland's Community Criminal Justice Treatment Program. Maryland has improved the coordination of services and communication between mental health and criminal justice programs by creating a multi-agency collaborative that provides treatment and support services to mentally ill offenders. The state has programs in 18 of Maryland's 24 local jurisdictions. Local programs are lead by a task force of state and local leaders. Services include crisis intervention, screening, counseling, discharge and community service planning. The program provides transitional case management, long-term housing support and substance abuse treatment. The goal of the program is to reduce criminal justice costs and disruptions, reduce the need for hospitalizations and improve the ability of clients to transition out of the criminal justice system.[195]

Opportunities for California

The Texas Council on Offenders with Mental Impairments provides an example of state and community leaders collaborating to improve services and reduce costs. The National GAINS Center represents a national investment in research, technical assistance and information dissemination to improve community responses to mentally ill offenders.

California leads the nation in prison and jail populations and has the largest number of mental health clients in the country. The State should explore the potential of these models and develop strategies to realize similar goals: improving program quality and efficiency and improving research, education and technical assistance. Most importantly, California needs a strategy to break down the barriers between the criminal justice system and the mental health system in every California community.

Recommendation 6: The State should establish a California Council on Offenders with Special Needs to investigate and promote cost-effective approaches to meeting the long-term needs of mentally ill offenders. The council, comprised of state and local officials, should:

- ***Identify treatment strategies.*** The council should propose policies for improving the cost-effectiveness of services for offenders with special needs within jails and prisons, including service coordination and data sharing among community mental health and criminal justice programs.
- ***Promote coordination.*** The council should document the need to coordinate mental health services and improve the ability of clients to transition successfully between corrections-based and community-based treatment programs.
- ***Provide technical assistance.*** The council should develop a technical assistance and resource center to document best practices and provide information and training to improve the efficiency and effectiveness of state and local programs serving mentally ill offenders.
- ***Develop incentives.*** The council should identify incentives that will motivate State and local agencies to coordinate mental health and criminal justice services.

Immediate Steps

- By Executive Order, the Governor should establish the California Council on Offenders with Special Needs.
- The Legislature should call for an independent evaluation of contracts between the California Department of Corrections and local mental health agencies to provide care to parolees.
- The Legislature should direct the CDC to expand to all counties contracts proven to successfully provide quality mental health care to parolees.
- The Legislative Analyst's Office should analyze the State's response to incentive programs offered by the federal Social Security Administration and promote the use of incentive payments to fund pre-authorization efforts that speed up benefits to clients leaving jail or prison.

Creating Accountability: Monitoring the Mental Health System

Finding 7: California will never be able to ensure that all Californians have access to mental health care without clear and continuous accountability for outcomes.

Reforming California's mental health policy begins with establishing clear public expectations and responsibility for providing quality mental health care. Transforming the system to meet those expectations requires a strong accountability component that will allow clients, policy-makers, taxpayers and citizens to understand when and where progress is made and change is necessary.

The Department of Mental Health is developing an outcome and performance reporting system as required under realignment. The reporting system is intended to provide the information needed to assess the quality of mental health services in each county. The department must complete its reporting system as required by law. But the department's goal should not be to build a reporting system, but rather to create true accountability.

Particularly for mental health, community leaders, state policy-makers and the public at large need to understand the importance of the services and the value they bring to individuals and communities. In this context, accountability motivates continuous improvement and guides public investments. Accountability is essential to make the previous recommendations meaningful.

- ***Expectations***. Public policy is driven by public expectations. To raise the public's expectations for mental health services, these programs must be able to reliably and clearly communicate their goals, their performance and their potential.

- ***Statewide Leadership***. The department is emerging as the statewide leader needed to help communities improve services and help the state develop more effective policies for funding and managing social service programs. These roles are bolstered by the availability of sound data that can be used to evaluate existing services and their alternatives.

- ***Comprehensive Services***. Mental health, like most other social service programs, is burdened by a reliance on multiple state and local agencies to provide all of the assistance that clients need to succeed.

An effective system of accountability that identifies the weak links and the under-performing partners is essential to developing a system that provides clients with comprehensive, tailored and potentially integrated services.

- ***Resources***. Mental health and related programs have been plagued by a lack of resources. But policy-makers and the public will not dedicate additional resources without confidence the money will be well spent and improve client and system outcomes.

- ***Criminal Justice***. Low expectations, limited services and inadequate resources have resulted in higher criminal justice expenditures and in many cases the inappropriate incarceration of clients. An effective accountability system would document the costs and consequences of this failure and guide solutions that would better serve clients and allow criminal justice resources to be used in ways that better protect the public.

Concern alone for the welfare of mental health clients is inadequate to motivate change. Clients, taxpayers and the public must understand how policy and funding decisions move the State closer to realizing expectations. Without clear and constant accountability, mental health will continue to reflect an inadequate and forsaken component of California's social service programs.

Mental Health Oversight

When the Legislature enacted realignment, it included a requirement that local mental health programs collect and report outcome measures to the State.[196] Client advocates were concerned that without reporting, counties would not adequately fund or administer programs. Reporting requirements were intended to ensure the State was aware of the condition of local mental health programs and able to intervene if necessary.

The State's oversight authority also is established in federal law governing Medi-Cal. The California Code of Regulations, California's waiver from the Health Care Financing Authority and the requirements built into specific programs require the department to ensure that local mental health programs operate in ways that are public, include grievance procedures and meet access and quality standards.

The department's oversight activities have evolved since realignment to include a number of specific efforts. For instance, the department employs a human rights specialist to assist clients concerned with the quality of mental health treatment. Moving into managed care, the

department created an "Ombudsman Office" to solve problems and investigate complaints. Additional oversight efforts include on-site reviews, contract management and monitoring, licensing and certification reviews, financial oversight, and a quality improvement process that features a collection of stakeholder committees.

The department's oversight philosophy emphasizes self-monitoring, rapid attention to problems and clear public accountability. The department's white paper on accountability states:[197]

> *It is of paramount importance that the oversight system and the information it produces is accessible not only to the mental health community but to the general public whose tax moneys support the public mental health system.*

In addition to focused oversight activities, such as compliance reviews, the department is developing a program to monitor and evaluate local mental health services through a performance outcome information system.

Much of the department's present oversight efforts are resource intensive and therefore limited in their ability to motivate change in a timely fashion. For example, department staff visits SAMHSA-funded projects once every three years. Those visits are complemented with "desk reviews" of reports submitted by local agencies. But desk reviews and a visit every 36 months offer limited opportunities to respond to emerging needs or reform ineffective programs.

In contrast, the department's statewide data system offers the promise of providing accurate and timely information to the public, mental health officials and policy-makers on the status of mental health programs.

California's Performance Outcome Data System

The Department of Mental Health envisions a data system that includes information on all mental health clients who receive services for more than 60 days each year. Approximately 25,000 children and 185,000 adults fit this criterion. Each client will receive a unique identifier allowing the department to track demographic, service utilization, cost and outcome data.[198]

The data are intended for statewide oversight of local programs and to provide program administrators feedback on the quality of services. The department's effort is driven in part by the larger trend in social services to adopt data-based analytic tools. The Department of Social Services, the Board of Corrections and other state departments are working to

develop similar data-driven evaluation tools. Departments within the Health and Human Services Agency are discussing how to link data collection and analyses across programs.

California is not alone in moving toward outcome measures for mental health.[199] Managed care has pushed public and private health systems to develop measures of clinical practice, outcomes and cost-effectiveness.[200] Yet despite significant effort, no unequivocal agreement or standard exists for measuring the effects of mental health services. There is no clear measure for evaluating the impact of treatment.[201]

Challenges to Measuring Mental Health Outcomes

Despite nine years of effort, the department does not have a working outcome reporting system. Limited progress has caused some to question the department's commitment to the process. Critics contend that limited progress reflects the department's interest in mollifying the fears of local mental health agencies that their programs will be viewed poorly when subjected to outcome measures. In contrast, supporters argue the enormity of the task undertaken by the department and two pilot surveys to pre-test outcome measures are evidence of true commitment to building an accountability system.

Developing Outcome Measurement Systems

Anne Morris, Ph.D., of the Center for Mental Health Service Research, University of California, has summarized five general principles from recent literature guiding outcome measurement systems.

Principle #1: Success depends upon a shared sense of urgency about the need for change. Although there may be an urgency about accountability and the need to implement outcome assessments at the state level, this may not be fully shared by administrators and staff on the "front lines" of mental health care.

Principle #2: There must be a clear vision at the top defining the need for change and the goals of the new system. This vision must be widely communicated throughout the organization. There must be a consensus about the "worthiness" of those goals.

Principle #3: There must be "buy-in" from front-line managers and direct care staff. Without the "buy-in" of managers and staff, implementation efforts are doomed to failure.

Principle #4: Information should flow in both directions. Managers and staff in mental health organizations should receive feedback about consumer outcomes and program performance on an ongoing basis. This information should be user-friendly and guide decisions about programs and the allocation of scarce resources.

Principle #5: Implementation of new technology/change efforts should be tied directly to the organization's mission and goals, and should be anchored in the culture and climate of the organization. Implementation must be clearly linked to the goals of quality improvement in services to consumers.

It is likely that both claims have merit. The department must build a reporting system that local mental health agencies will respect and that will provide meaningful information. One challenge is developing the ability to accurately measure the impact of treatment. A second challenge will be mustering the political will to set standards that may not completely reflect the value of diverse treatment systems.

Other states have collected mental health performance data. One lesson learned is that departments must understand that they will struggle with data that does not reflect the value of their work. Research suggests the first few years of data are often suspect and should not be tied to funding or administrative decisions. The measurement and reporting process, however, matures with experience. Providers and departments must accept that measurement tools will evolve over time and generally do not provide quality information at the outset.[202]

Measuring Outcomes

Several states have developed strategies for tracking client and system outcomes. The federal government is currently supporting a project to coordinate efforts to develop common indicators. The Mental Health Statistics Improvement Program (MHSIP) Policy Group is working with officials in 16 states to collect information that can help administrators, policy-makers and others understand who's providing the best services at the best price, who needs services, what the best treatments are for different kinds of problems, and even who has the friendliest staff.

Source: Mental Health Statistics Improvement Program. (www.mhsip.org)

Collecting Performance Data is Not Enough

Identifying and collecting performance data is a first step in building an accountability system. But accountability requires the information to be accessible, understandable and meaningful for funding and policy decisions. Policy-makers need guidance on when, where and how additional funding can best improve outcomes. Administrators need feedback on the success of their programs, and information to guide refinements. And the public needs the information to recognize their investment in mental health services is well spent.

Community mental health programs are rarely asked to document how they have changed the lives of the people they serve. A well-designed accountability system can provide consumers and the public with compelling information on how mental health programs change lives.

Recommendation 7: Improvement, public understanding and support for mental health programs depend on an accurate assessment of California's progress toward its goals. As the State's mental health leader, the Department of Mental Health must continuously inform the public, program administrators and policy-makers on the performance of the system, whether quality and access are improving and how they could be enhanced. Specifically, the department should:

Immediate Steps

- The department should publicly report aggregated information for each county on the types of Californians who are being served and the unmet need.
- The department should commit to develop and publicize benchmarks that outline annual goals for expanding access to mental health care.
- The Legislature should direct the Department of Mental Health to complete the statewide performance reporting system.
- The department should provide quarterly reports to the Legislature and the public on its progress in developing the reporting system.
- The department should begin putting data on-line for easy public access.
- The department should publicize the conditions under which it will intervene to ensure mental health services are available in every community.

❑ ***Inform decision-makers.*** The department should provide information that can help the general public, policy-makers and program administrators understand the availability, quality and cost-effectiveness of mental health services.

❑ ***Provide benchmarks.*** The department should provide information that compares performance with expectations. It should reveal variations across programs, counties and over time.

❑ ***Reveal barriers.*** The department should provide data to permit administrators and researchers to identify barriers to program improvement and alert policy-makers when and where policy changes are necessary.

❑ ***Encourage broad access.*** All data and information on mental health programs should be readily accessible to the public, the press, researchers and others whose analyses could lead to better public understanding, program management and policy making.

❑ ***Provide standards.*** Performance data should be structured to indicate to state and local administrators and policy-makers when mental health services are so inadequate that intervention is warranted.

Conclusion

Throughout California, mental health clients have difficulty accessing care. The available services often fail to address core needs such as housing, making it difficult for clients to recover or stabilize. There are no standards or goals for mental health services. And there is no pressure for county mental health agencies or the Department of Mental Health to improve programs. As a result, the quality of mental health care is variable – but generally poor – and does not improve.

Members of the advisory committee and hearing witnesses argued for minimum standards to guide county mental health programs. They called for an ongoing commitment on the part of policy-makers and the public to invest in and improve mental health care. But it is difficult to know what gaps in care need to be filled and how best to fill them. Experts do not agree on the number of people in need of mental health services. No one knows the full extent of the costs associated with ignoring mental health needs. And the public and policy-makers have no shared understanding or obligation to serve mental health clients.

Historically, mental health policy has lurched along from one controversy to the next. Each policy shift reflects an emerging concept, but not a commitment to address mental health needs. Thirty years ago the public demanded an end to state-run institutions where clients were warehoused under intolerable conditions. Despite promises of financial support, mental health funding did not follow clients into their communities. Ten years ago, the State enacted realignment and shifted responsibility for providing direct services to the counties. But limited funding has not allowed the counties to provide adequate services. As a result, California rations care.

Taken together, the Commission's seven findings and recommendations articulate the need to establish broad public expectations for mental health policy and an obligation for providing mental health services. The Department of Mental Health and state funding need to be aligned to the goals of helping communities provide comprehensive mental health care. Finally, the State must end its reliance on the criminal justice system to serve as a surrogate for community-based mental health services.

Appendices

- ✓ *Public Hearing Witnesses*
- ✓ *Adult Mental Health Advisory Committee*
- ✓ *Medical Necessity for Specialty Mental Health Services that are the Responsibility of Mental Health Plans*
- ✓ *Distribution of Mental Health, AB 34 and MIOCR Funding*
- ✓ *Glossary of Terms*
- ✓ *Mental Health Information Sources and Organizations*

Appendix A

Little Hoover Commission Public Hearing Witnesses

Witnesses Appearing at Little Hoover Commission Mental Health Hearing on September 23, 1999

Karen Hart, Vice President, United Advocates for Children of California

Sally Zinman, Executive Director, California Network of Mental Health Clients

Randall Hagar, Legislative Advocate, National Alliance for the Mentally Ill – California

Robert Schladale, Assistant Secretary, Health and Human Services Agency

Stephen W. Mayberg, Director, California Department of Mental Health

Robert Presley, Secretary, Youth and Adult Correctional Agency

Larry Poaster, Director, Stanislaus County Mental Health Department

Catherine C. Camp, Director, California Mental Health Directors Association

Saul Goldfarb, Chief Executive Officer, Gateways Hospital and Mental Health Center, Los Angeles

Roy Alexander, Executive Administrator for Operations, Victor Treatment Centers, Chico

Al Rowlett, Assistant Director, Turning Point Community Programs, Sacramento

Witnesses Appearing at Little Hoover Commission Mental Health Hearing on October 28, 1999

Collie F. Brown, Assistant Director, National GAINS Center, Delmar, New York

Harold E. Shabo, Supervising Judge, Mental Health Division, Los Angeles Superior Court

Jim Thomas, Sheriff, Santa Barbara County

Taylor Moorehead, Commander, Twin Towers Correctional Facility, Los Angeles

Verne Speirs, Chief Probation Officer, Sacramento County

Donald Specter, Director, Prison Law Office, San Quentin

John J. Vacca, Head Deputy, Mental Health Branch, Los Angeles County Public Defender's Office

C. A. "Cal" Terhune, Director, California Department of Corrections

Jon DeMorales, Executive Director, Atascadero State Hospital

Gregorio "Greg" S. Zermeño, Director, California Youth Authority

Witnesses Appearing at Little Hoover Commission Mental Health Hearing on January 27, 2000

Sandra Naylor Goodwin, Executive Director, California Institute for Mental Health

Gary Pettigrew, Deputy Director, Department of Mental Health

Mark Ragins, Medical Director, The Village Integrated Services Agency

Steve Fields, Executive Director, Progress Foundation

Tim Brown, Executive Director, Loaves and Fishes, Inc.

Dave Hosseini, Executive Director, Consumers Self-Help Center and Office of Patients' Rights

Appendix B

Little Hoover Commission Adult Mental Health Advisory Committee

The following people served on the Adult Mental Health Advisory Committee. Under the Little Hoover Commission's process, advisory committee members provide expertise and information but do not vote or comment on the final product. The list below reflects the titles and positions of committee members at the time of the advisory committee meetings in 1999 and 2000.

Howard S. Adelman, Co-director
Center for Mental Health in Schools
Department of Psychology, UCLA

Sylvia Aguirre-Aguilar, Executive Director
El Hogar Mental Health & Community
Service Center, Inc.

Cassandra Auerbach
Citizens' Commission on Human Rights

Conni Barker
Director of Government Relations
California Psychiatric Association

Gale Bataille, Director
Mental Health Services
Solano County Health and Social Services
Department

Ken Berrick, CEO/President
Seneca Center

Steve Birdlebough, Legislative Advocate
Friends Committee on Legislation of
California

Melissa Bittner
Citizens' Commission on Human Rights
Sacramento

Ann M. Blackwood, Senior Consultant
Assembly Health Committee

Isabel Bravo
California Alliance for the Mentally Ill
Placer County

Tim Brown, Executive Director
Loaves & Fishes

John Brunges
California Mental Health Planning Council

John Buck, Executive Director
Turning Point Community Programs

Catherine Camp, Executive Director
California Mental Health Directors
Association

Diana E. Clayton, President
California Association of Local Mental
Health Boards & Commissions

Frank Cuny, President
California Citizens for Health Freedom

Betty Dahlquist, Executive Director
California Association of Social
Rehabilitation Agencies

Mike Danneker, Executive Director
West Side Regional Center

F. Jerome Doyle, President/CEO
Eastfield Ming Quong
Children and Family Services

Nuin Dunlap
American Friends Service Committee
Oakland

Geraldine Esposito, Executive Director
California Society for Clinical Social Work

Marianne Estes, Staff Services Manager II
Program Accountability
California Department of Alcohol & Drug
Programs

Lara Flynn, Legislative Advocate
Family Service Council of California

Kate Fogle, Executive Director
California Child, Youth and Family Coalition

Lana Fraser, Assistant Deputy Director
California Department of Rehabilitation

Joyce Fukui, Deputy Director
California Department of Aging

Michael Garabedian
Attorney at Law

Barbara A. Gard, Executive Director
California Psychiatric Association

Lenny Goldberg, Legislative Advocate
Family Service Council of California

Gary Grice, Program Coordinator
Sacramento County Mental Health Division

Randall Hagar
National Alliance for the Mentally Ill California & California Treatment Advocacy Coalition

Michael Haley, Executive Director
California Psychological Association

Karen Hart
United Advocates for Children of California

Pam Hawkins, Family Coordinator
Sacramento County Division of Mental Health

Rebecca Hawkins, Youth Advocate
Sacramento County Division of Mental Health

Maxine Hayden
Interested Individual

Kathleen Henry, Executive Director
Sacramento County Mental Health Treatment Center

Stacie Hiramoto
Government Relations Director
National Association of Social Workers – California Chapter

David Hosseini, Executive Director
Consumers Self-Help Center

Susanne Hughes, Acting Chief
Department of Health Services
Medi-Cal Managed Care Division

Valeri Kennedy, Legislative Advocate
Protection & Advocacy, Inc.

Kenneth M. Larsen, Legislative Advocate
Friends Committee on Legislation of California

Steve Leoni
Mental Health Planning Council

Kimberly Lewis
California Association of Mental Health Patients Rights Advocates

Marletta Logan-Curry
California Association of Local Mental Health Boards and Commissions

Bob Macaluso, Director
Government Relations
Crestwood Behavioral Health

Maria Mar, Director
Rehabilitation Support Team
Community Support Network

Janice K. Marques, President
Association for the Treatment of Sexual Abusers

Felicia McCarty
Support Coalition International

Brett McFadden
Director of Government Affairs
California Association of School Psychologists

Elin Modjeska, President
California Division-American Association for Marriage and Family Therapy

Lou Mone
Downtown Mental Health Clinic and California Coalition for Ethical Mental Health Care

Joseph F. Murphy, Senior Assemblyman
California Senior Legislature

Sandra Naylor Goodwin, Executive Director
California Institute for Mental Health

Marcus Nieto*
California Research Bureau

Joyce Ott-Havenner
California Network of Mental Health Clients

Margaret Peña
California State Association of Counties

Gary M. Pettigrew, Deputy Director
Systems of Care Division
Department of Mental Health

Darlene Prettyman
Director, Government Affairs
Anne Sippi Clinic Riverside Ranch
Mental Health Planning Council

Vickie Reis-Allen, First Vice President
California Association of Local Mental
Health Boards and Commissions

Mary Riemersma, Executive Director
California Association of Marriage & Family
Therapists

Abram Rosenblatt, Director of Research
Child Services Research Group
University of California, San Francisco

Patricia Ryan, Vice President
Behavioral Health
California Healthcare Association

John J. Ryan, Director
Riverside County Mental Health

Robert Schladale, Assistant Secretary
Health and Welfare Agency

Rusty Selix, Executive Director
California Council of Community Mental
Health Agencies/California Coalition for
Mental Health

Daphne Shaw, Chair
California Mental Health Planning Council

Charles W. Skoien, Consultant
Community Residential Care Association of
California

Charles Sosebee, Coordinator
California Clients for LPS Reform

Steven Szalay, Executive Director
California State Association of Counties

Zoey Todd Poulton
Sacramento County Division of Mental
Health

Richard Van Horn, President & CEO
Mental Health Association in Los Angeles
County

Diane Wakelin, Deputy Chief Operations
Officer/Clinical Director
Sunny Hills Children's Garden
Family & Children's Services

Edward P. Walker, Director
Marin County Dvision of Mental Health
Services

Sharron Watts
Dementia Program Specialist
State Funded Services Branch
Department of Aging

Irene Williams, Director
Agewell

Gayle Wilson, Director
Center for Youth Policy and Advocacy

Pete Zajac
California Youth Authority

Sally Zinman, Executive Director
California Network of Mental Health Clients

*The Commission would like to acknowledge Marcus Nieto of the California Research Bureau for his assistance to the Commission on issues related to the criminal justice system.

Appendix C

Medical Necessity for Specialty Mental Health Services that are the Responsibility of Mental Health Plans

Must have *all* A, B *and* C:

A. *Diagnoses:* Must have one of the following DSM IV diagnoses, which will be the focus of the intervention being provided:

Included Diagnoses:

- Pervasive Developmental Disorders, except Autistic Disorder which is excluded
- Attention Deficit and Disruptive Behavior Disorders
- Feeding & Eating Disorders of Infancy or Early Childhood
- Elimination Disorders
- Other Disorders of Infancy, Childhood, or Adolescence
- Schizophrenia & Other Psychotic Disorders
- Mood Disorders
- Anxiety Disorders
- Somatoform Disorders
- Factitious Disorders
- Dissociative Disorders
- Paraphilias
- Gender Identity Disorders
- Eating Disorders
- Adjustment Disorders
- Impulse-Control Disorders Not Elsewhere Classified
- Personality Disorders, excluding Antisocial Personality Disorder
- Medication-Induced Movement Disorders

Excluded Diagnoses:

- Mental Retardation
- Learning Disorders
- Motor Skills Disorder
- Communication Disorders
- Autistic Disorder
- Tic Disorders
- Delirium, Dementia, and Amnestic and Other Cognitive Disorders
- Mental Disorders Due to a General Medical Condition
- Substance-Related Disorders
- Sexual Dysfunctions
- Sleep Disorders
- Antisocial Personality Disorder
- Other Conditions That May Be a Focus of Clinical Attention, except Medication Induced Movement Disorders which are included

A beneficiary may receive services for an included diagnosis when an excluded diagnosis is also present

B. *Impairment Criteria*

Must have *one* of the following as a result of the mental disorder(s) identified in the diagnostic ("A") criteria; Must have *one*, 1, 2, *or* 3:

1. A significant impairment in an important area of life functioning, *or*
2. A probability of significant deterioration in an important area of life functioning, *or*
3. Children also qualify if there is a probability the child will not progress developmentally as individually appropriate. Children covered under EPSDT qualify if they have a mental disorder which can be corrected or ameliorated (current DHS/EPSDT regulations also apply)

C. *Intervention Related Criteria*

Must have *all*, 1, 2, *and* 3 below:

1. The focus of proposed intervention is to address the condition identified in impairment criteria "B" above, *and*
2. It is expected the beneficiary will benefit from the proposed intervention by significantly diminishing the impairment, or preventing significant deterioration in an important area of life functioning, and/or for children it is probable the child will progress developmentally as individually appropriate (or if covered by EPSDT can be corrected or ameliorated), *and*
3. The condition would not be responsive to physical healthcare based treatment.

Appendix D

Distribution of Mental Health, AB 34 and MIOCR Funding Across California Counties, 1997–98 (unless otherwise noted)

County	Realignment	Short–Doyle Medi–Cal	Comm. Svcs. Other Trmt.	Adult SOC	Dual Diagnosis	PATH Grants	Children's M. H. Svcs.	EPSDT
Alameda	44,858,886	26,154,475	–	–	–	74,701	1,000,000	7,073,089
Alpine	177,750	–	–	–	–	–	–	–
Amador	672,799	168,121	–	–	–	2,526	–	1,271
Butte	5,731,551	3,810,060	–	–	–	12,376	400,000	2,858,051
Calaveras	787,011	244,108	–	–	–	–	40,000	118,358
Colusa	637,633	147,119	–	–	–	–	–	17,899
Contra Costa	22,418,626	11,818,555	20,505	–	250,000	39,982	654,000	3,792,308
Del Norte	857,793	665,465	–	–	–	2,848	184,000	430,401
El Dorado	2,800,892	1,334,874	20,505	–	–	10,000	79,000	333,007
Fresno	23,475,532	6,865,911	20,505	–	–	45,278	–	1,440,710
Glenn	809,617	353,974	–	–	–	3,486	50,000	84,031
Humboldt	4,445,559	2,653,271	–	–	–	10,000	468,000	2,114,960
Imperial	3,918,926	1,904,581	–	–	–	10,000	100,000	306,483
Inyo	895,433	115,289	–	–	–	2,217	77,000	–
Kern	16,505,115	9,249,297	20,505	–	–	31,013	1,400,000	8,461,271
Kings	3,068,558	1,001,044	–	–	–	10,000	163,333	245,575
Lake	1,726,043	514,157	–	–	–	7,162	54,000	154,509
Lassen	849,678	273,644	–	–	–	3,003	116,667	145,980
Los Angeles	266,206,290	69,832,334	61,515	1,883,430	–	577,271	2,132,893	27,262,476
Madera	2,666,276	984,371	–	–	–	10,000	248,461	617,608
Marin	9,553,895	2,065,403	–	–	–	10,000	40,000	317,960
Mariposa	481,450	100,714	–	–	–	1,359	89,833	36,424
Mendocino	2,974,797	1,299,739	–	–	–	10,000	183,750	402,105
Merced	6,229,733	2,884,383	–	–	250,000	11,565	–	50,070
Modoc	474,644	179,504	–	–	–	–	100,000	92,848
Mono	369,341	10,815	–	–	–	–	–	20,196
Monterey	8,386,674	3,811,187	–	–	–	16,882	–	927,470
Napa	4,888,474	1,809,687	–	–	–	9,743	–	377,117
Nevada	1,975,810	697,917	–	–	–	–	175,000	231,903
Orange	51,908,426	7,969,700	20,505	–	–	80,856	–	4,788,605
Placer	3,906,880	2,112,041	20,505	–	–	10,000	284,000	254,859
Plumas	638,105	245,813	–	–	–	2,498	–	48,832
Riverside	27,798,597	11,729,348	20,505	–	–	41,261	2,523,560	1,444,418
Sacramento	32,903,018	9,131,044	416,000	–	–	64,150	1,400,000	13,300,897
San Benito	894,565	279,862	–	–	–	–	–	38,607
San Bernardino	38,191,226	14,128,877	20,505	–	–	52,198	115,000	1,908,278
San Diego	65,457,037	16,402,637	20,505	–	250,000	111,291	800,000	2,791,825
San Francisco	50,301,046	26,318,642	–	–	–	75,882	583,333	3,189,383
San Joaquin	16,308,064	5,534,344	–	–	–	30,299	263,615	2,586,207
San Luis Obispo	4,535,328	2,360,873	–	–	–	10,000	450,000	811,339
San Mateo	23,054,594	9,831,968	–	–	–	24,668	621,306	1,656,498
Santa Barbara	8,734,172	7,309,451	–	–	–	15,526	–	3,810,535
Santa Clara	42,419,973	23,477,362	2,700,000	–	–	62,364	1,121,171	2,357,962
Santa Cruz	5,278,616	6,338,330	–	–	250,000	11,214	722,694	1,439,784
Shasta	4,782,869	2,182,885	–	–	–	10,000	250,000	413,904
Sierra	246,353	–	–	–	–	–	–	–
Siskiyou	1,277,286	1,022,422	–	–	–	–	142,571	501,413
Solano	9,621,909	4,419,371	–	–	–	15,676	505,212	1,574,207
Sonoma	10,011,487	5,813,263	20,505	–	–	16,405	–	2,081,112
Stanislaus	10,706,321	7,181,072	20,505	1,888,570	–	22,576	–	2,365,782
Sutter–Yuba	4,120,690	1,884,698	–	–	–	10,000	50,000	845,360
Tehama	1,826,328	867,905	–	–	–	6,073	594,000	118,474
Trinity	502,335	276,949	–	–	–	–	50,000	48,369
Tulare	10,595,228	4,744,229	–	–	–	22,206	–	1,248,537
Tuolumne	1,158,853	471,215	–	–	–	4,574	199,033	296,576
Ventura	13,592,484	9,837,162	20,505	4,000,000	–	25,271	1,333,440	–
Yolo	4,541,975	1,795,239	–	–	–	10,000	250,000	919,820
Total	**884,158,551**	**334,616,701**	**3,423,575**	**7,772,000**	**1,000,000**	**1,646,400**	**20,014,872**	**108,755,663**

Continued

Distribution of Mental Health, AB 34 and MIOCR Funding Across California Counties, 1997–98 (unless otherwise noted)

County	Early M. H. Initiative	Mental Health Managed Care	SEPAssess Trmnt.Cas.Mgmt.	97–98 Base SAMHSAUnallocated	96–97Rollover SAMHSA	CSOC	County MOE
Alameda	347,352	4,819,310	383,940	378,270	–	–	3,086,507
Alpine	–	7,606	12,883	–	–	–	–
Amador	55,972	64,299	12,883	12,563	–	–	–
Butte	174,876	1,395,989	79,063	140,761	–	–	271,345
Calaveras	32,666	152,844	24,029	85,203	2,748	–	7,189
Colusa	–	62,052	12,883	50,124	19,208	–	8,040
Contra Costa	544,642	1,678,653	477,362	1,421,004	–	–	1,080,774
Del Norte	–	112,177	12,883	86,257	–	–	12,481
El Dorado	73,381	350,496	20,919	56,427	81,344	–	16,510
Fresno	303,641	5,179,765	386,963	620,786	19,994	–	955,639
Glenn	–	155,999	12,883	88,206	–	–	10,144
Humboldt	126,712	398,052	46,674	211,338	8,703	183,692	43,803
Imperial	263,989	647,341	62,851	222,868	–	–	18,731
Inyo	–	66,213	12,883	158,289	4,000	–	23,857
Kern	99,061	4,556,279	215,804	629,737	–	–	744,867
Kings	39,285	352,061	39,550	70,953	15,870	–	34,551
Lake	115,929	567,583	17,078	136,090	–	–	40,358
Lassen	–	193,715	12,883	61,546	–	–	–
Los Angeles	3,285,412	46,132,205	2,778,722	10,330,198	460,612	1,012,034	16,467,826
Madera	154,425	607,125	31,144	114,169	–	–	8,429
Marin	66,261	1,126,810	151,052	146,092	10,000	–	529,485
Mariposa	37,990	72,450	12,883	87,928	–	–	3,318
Mendocino	51,286	519,726	38,987	18,372	–	–	28,840
Merced	47,924	1,076,690	83,545	275,040	152,478	351,535	266,911
Modoc	10,238	59,568	12,883	–	–	–	–
Mono	–	26,765	12,883	–	–	–	7,149
Monterey	313,498	803,567	138,195	303,844	–	740,475	532,678
Napa	111,584	507,617	81,685	102,386	–	–	126,315
Nevada	–	213,770	27,537	33,934	–	–	30,893
Orange	580,472	10,040,021	699,001	1,043,752	–	–	3,436,264
Placer	125,847	311,081	92,966	146,111	–	444,188	231,960
Plumas	–	100,394	15,054	191,291	7,671	–	7,672
Riverside	510,899	6,879,433	496,344	1,691,795	–	–	1,513,199
Sacramento	440,578	8,648,805	339,791	915,196	46,230	–	1,761,153
San Benito	16,791	104,383	31,710	18,152	–	–	29,539
San Bernardino	884,142	9,470,432	721,668	1,850,813	7,840	–	1,842,753
San Diego	2,045,793	9,982,226	813,276	1,406,965	90,706	–	3,173,290
San Francisco	287,625	2,804,717	387,233	1,267,103	89,507	–	2,748,050
San Joaquin	485,278	3,487,252	260,686	529,768	125,765	–	1,063,736
San Luis Obispo	161,719	277,414	96,368	63,094	–	254,061	335,430
San Mateo	17,370	1,813,554	568,934	507,581	–	–	1,477,507
Santa Barbara	80,333	116,703	154,961	129,876	–	–	644,045
Santa Clara	778,544	3,816,164	959,599	350,860	–	–	1,551,653
Santa Cruz	75,379	1,455,237	284,054	71,261	–	–	328,689
Shasta	68,193	627,384	60,015	111,485	–	–	266,778
Sierra	–	16,082	13,841	48,318	–	–	–
Siskiyou	20,190	228,807	18,594	71,946	20,364	–	7,402
Solano	68,062	–	119,582	68,492	–	–	749,016
Sonoma	172,920	638,684	212,920	157,353	28,347	–	560,252
Stanislaus	349,920	1,873,737	208,244	335,189	195,039	1,001,530	647,182
Sutter–Yuba	61,672	1,453,654	66,312	192,314	11,123	–	22,803
Tehama	18,953	277,026	17,858	137,148	–	–	25,947
Trinity	–	106,357	12,883	81,884	27,102	–	5,924
Tulare	267,358	2,451,149	121,178	442,510	–	–	334,122
Tuolumne	21,166	202,471	14,017	24,623	–	–	20,042
Ventura	302,870	1,187,826	236,184	128,006	40,549	–	1,027,131
Yolo	19,507	553,895	96,797	176,135	–	–	377,365
Total	**14,117,705**	**140,831,615**	**12,334,000**	**28,001,406**	**1,465,200**	**3,987,515**	**48,545,544**

Continued

Distribution of Mental Health, AB 34 and MIOCR Funding Across California Counties, 1997–98 (unless otherwise noted)

County	County Overmatch	Medicare	Other Grants	Fees & Insurance	Other Revenue	Local Mandate SED Children	Total County Funds
Alameda	9,901,507	3,226,196	–	661,084	17,380,609	2,512,446	121,858,372
Alpine	–	–	–	–	–	–	198,239
Amador	–	–	12,473	34,951	5,977	28,947	1,072,782
Butte	–	282,514	411,729	153,038	2,975,303	–	18,696,656
Calaveras	–	5,775	–	9,834	–	–	1,509,765
Colusa	–	–	–	4,568	–	–	959,526
Contra Costa	5,372,991	5,122,931	–	837,312	3,414,255	1,149,988	60,093,888
Del Norte	164,502	5,322	–	45,555	52,061	–	2,631,745
El Dorado	–	–	95,482	177,178	2,330	304,095	5,756,440
Fresno	–	86,579	102,737	243,281	797,918	304,862	40,850,101
Glenn	–	–	–	20,045	313,571	–	1,901,956
Humboldt	–	717,389	272,718	451,361	799,225	–	12,951,457
Imperial	–	264,130	87,432	77,805	175,635	–	8,060,772
Inyo	–	2,534	–	3,644	77,930	–	1,439,289
Kern	–	1,422,130	–	348,101	866,630	239,214	44,789,024
Kings	52,318	46,256	80,953	102,026	199,186	–	5,521,519
Lake	–	–	–	37,742	33,583	–	3,404,234
Lassen	–	–	–	44,590	47,708	–	1,749,414
Los Angeles	–	3,911,770	–	3,242,997	27,863,345	9,196,681	492,638,011
Madera	–	44,308	114,169	40,579	147,976	–	5,789,040
Marin	–	147,444	637,487	1,816,298	1,839,045	203,136	18,660,368
Mariposa	3,900	3,297	51,486	27,161	50,666	–	1,060,859
Mendocino	–	121,305	–	91,565	248,730	–	5,989,202
Merced	–	52,580	90,000	96,481	344,767	–	12,263,702
Modoc	–	–	–	34,295	19,389	–	983,369
Mono	–	–	–	21,875	–	–	469,024
Monterey	–	72,387	80,151	46,379	202,763	392,161	16,768,311
Napa	–	46,708	822,992	99,978	338,884	255,208	9,578,378
Nevada	–	36,310	–	20,647	128,495	–	3,572,216
Orange	10,585,561	689,270	–	1,592,036	5,440,815	10,585,561	109,460,845
Placer	–	19,492	–	95,052	504,698	207,201	8,766,881
Plumas	–	–	–	68,035	4,754	–	1,330,119
Riverside	831,832	911,413	575,682	1,070,622	17,371,008	3,995,957	79,405,873
Sacramento	–	50,164	–	707,008	146,683	1,679,500	71,950,217
San Benito	–	–	–	77,072	25,934	–	1,516,615
San Bernardino	–	1,113,016	608,724	997,467	2,911,208	1,103,266	75,927,413
San Diego	–	492,919	28,732	2,461,836	1,437,316	232,447	107,998,801
San Francisco	12,676,896	2,865,852	1,122,175	701,756	20,070,904	4,808,675	130,298,779
San Joaquin	–	411,068	37,203	688,466	2,962,889	87,133	34,861,773
San Luis Obispo	902,500	729,250	–	417,325	883,855	88,617	12,377,173
San Mateo	–	2,756,549	253,495	1,203,488	5,316,801	2,429,787	51,534,100
Santa Barbara	200,545	1,014,831	3,087,305	188,768	3,057,998	228,372	28,773,421
Santa Clara	21,976,234	3,893,556	176,096	952,162	4,808,289	1,748,407	113,150,396
Santa Cruz	2,582,037	297,170	381,004	901,636	661,141	331,062	21,409,308
Shasta	–	839,381	–	188,698	246,192	–	10,047,784
Sierra	–	–	–	3,828	15,677	–	344,099
Siskiyou	–	74,141	–	97,237	52,333	–	3,534,706
Solano	131,478	119,982	593,169	74,739	2,177,534	327,123	20,565,552
Sonoma	–	222,299	1,583,439	170,793	8,025,594	1,018,837	30,734,210
Stanislaus	–	1,274,530	71,142	2,720,410	3,170,581	956,618	34,988,948
Sutter–Yuba	–	29,091	288,310	105,987	110,555	–	9,252,569
Tehama	45,974	38,253	–	74,386	307,691	–	4,356,016
Trinity	–	–	–	9,997	35,973	–	1,157,773
Tulare	–	133,025	126,458	95,675	57,849	46,832	20,686,356
Tuolumne	–	88,806	184,452	53,092	84,559	–	2,823,479
Ventura	4,475,034	2,311,724	139,037	858,566	361,229	1,529,313	41,406,331
Yolo	–	41,390	109,506	274,255	262,813	128,236	9,556,933
Total	**69,903,309**	**36,035,037**	**12,225,738**	**25,640,762**	**138,838,854**	**46,119,682**	**1,939,434,129**

Continued

Distribution of Mental Health, AB 34 and MIOCR Funding Across California Counties, 1997-98 (unless otherwise noted)

In addition to providing the funding outlined above, the State also provides the following funds.

MIOCR (1998 & 1999)

Humboldt	$2,268,986	San Diego	$5,000,000
Kern	$3,098,768	San Francisco	$5,000,000
Los Angeles	$5,000,000	San Mateo	$2,137,584
Orange	$5,034,317	Santa Barbara	$3,548,398
Placer	$2,139,862	Santa Cruz	$1,765,012
Riverside	$3,016,673	Sonoma	$3,704,473
Sacramento	$4,719,320	Stanislaus	$1,713,490
San Bernardino	$2,477,557		

AB 34 (1990-2000)

Los Angeles	$4,800,000
Sacramento	$2,800,000
Stanislaus	$1,900,000

Caregiver Resource Centers:

•CSUC Research Foundation:	$309,775	Serving: Butte, Glenn, Lassen, Modoc, Plumas, Shasta, Siskiyou, Tehama and Trinity
•Del Oro Caregiver Resource Center:	$428,004	Serving: Alpine, Amador, Calaveras, Colusa, El Dorado, Nevada, Placer, Sacramento, San Joaquin, Sierra, Sutter, Yolo and Yuba
•Family Caregiver Alliance:	$786,230	Serving: Alameda, Contra Costa, Marin, San Francisco, San Mateo and Santa Clara
•Health Projects Center:	$310,775	Serving: Monterey, San Benito and Santa Cruz
•Inland Caregiver Resource Center:	$437,014	Serving: Inyo, Mono, Riverside and San Bernardino
•North Coast Opportunities:	$459,475	Serving: Del Norte, Humboldt, Lake, Mendocino, Napa, Solano and Sonoma
•Rehabilitation Institute of Santa Barbara:	$384,435	Serving: San Luis Obispo, Santa Barbara, Ventura
•Southern Regional Resource Center:	$416,829	Serving: Imperial and San Diego
•St. Jude Medical Center:	$328,699	Serving: Orange
•USC, Andrus Older Adult Center:	$498,790	Serving: Los Angeles
•Valley Caregiver Resource Center:	$315,375	Serving: Fresno, Kern, Kings, Madera, Mariposa, Merced, Stanislaus, Tulare and Tuolumne
•Family Caregiver Alliance:	$571,594	Statewide Resources Consultant

AIDS Contracts

Mental Health/Health Departments	
Los Angeles	$376,000
San Diego	$85,000
San Francisco	$264,000
San Joaquin	$34,286
San Mateo	$60,000
Santa Barbara	$25,000
Santa Clara County	$75,000

Private Nonprofit Agencies	
Aid Service Foundation of Orange County	$85,714
Center for Social Services (San Diego)	$65,114
Hemophilia Council of California (Sacramento)	$300,000
Inland AIDS Project (San Bernardino)	$34,286
Minority AIDS Project (Los Angeles)	$34,000
Pacific Center For Human Growth (Alameda)	$27,312

TRAUMATIC BRAIN INJURY CONTRACTS

Central Coast Center for Independent Living (Santa Cruz)	$193,388
The Betty Clooney Foundation (Los Angeles)	$223,741
Mercy Healthcare (Sacramento)	$125,000
St. Jude Medical Center (Orange)	$124,821

Source: Department of Mental Health.

Appendix E

Glossary of Terms

5150. California Health and Welfare Code, Section 5150 outlines the circumstances in which a person can be detained against their will for mental health treatment. Those circumstances are when a person is a danger to self or others, or gravely disabled, meaning unable to provide for their own clothing, food or shelter.

Biological factors. Factors that contribute to mental illness that are biological in origin, such as genetics, chemical imbalances or the structure of the brain.

Civilly committed clients. Refers to clients who have been committed to an institution under the Lanterman-Petris-Short Act.

Co-occurring disorders. Refers to two or more disorders occurring simultaneously. Generally refers to mental health and substance use disorders but can refer to mental health, physical health, developmental or other disorders.

Dual diagnosis. Refers to mental health clients who have been diagnosed with a mental illness and a substance use disorder.

Fixed risks. Factor that can contribute to mental illness that cannot be altered, such as genetic factors, gender or age.

Insurance Parity. Federal and state laws that establish the extent to which insurance providers can impose limits on access to mental health care that are more restrictive than limits imposed on access to physical health care. Legislation to align access to mental and physical health care under insurance programs is referred to as parity legislation.

Integrated services. Generally refers to providing an array of services through a single agency or entity. Often requires discretionary or blended funding to cover the cost of multiple services.

Lanterman-Petris-Short Act (LPS). California Welfare and Institutions Code, Section 5100 – 5550 is known as the Lanterman-Petris-Short Act. It establishes provisions for providing community-based care to mental health clients. The LPS Act includes provisions for providing involuntary treatment.

Outpatient involuntary treatment. The LPS Act limits the conditions under which mental health clients can be involuntarily treated. In practice, involuntary treatment is only provided on an inpatient basis where service providers can compel clients to participate in treatment, by force if necessary. Several states, including New York, have adopted legislation that allows the use of outpatient treatment that is involuntary. In general, outpatient involuntary treatment refers to mandating participation in outpatient treatment with the threat of forced inpatient treatment.

Protective factors. Factors that can reduce the likelihood that a person will experience a mental illness or will reduce the severity or reoccurrence of symptoms. Stable and safe housing and social support networks are examples of potential protective factors.

Psychological factors. Psychological attributes that can contribute to the likelihood that a person will experience a mental illness, such as how person responds to stress.

Rehabilitation option/Rehabilitation model. Federal law, under the Medicaid Rehabilitation option, allows mental health providers to bill Medi-Cal for an array of services that contribute to a client's rehabilitation. The Rehabilitation model contrasts with the Clinic Model that is more restrictive in the services that are covered.

Self-help. Refers to a movement within the mental health field in which clients develop and provide mental health services to other clients to promote recovery.

Social factors. Refers to learned behaviors and other social attributes that contribute to the likelihood that a person will develop a mental illness.

Supportive housing. Supportive housing is an approach to providing services and housing in a single location. It recognizes that some people who are homeless are poorly equipped to navigate the social service system. The concept of supportive housing is based on the premise that providing an array of services very near people's homes can improve outcomes. (Source: Corporation for Supportive Housing. Nd. Why Supportive Housing. New York, NY: Corporation for Supporting Housing. www.csh.org)

Systems of Care. An approach to providing services that links multiple agencies, provides care in the community as opposed to institutional care and offers a continuum of services. Systems of Care often involves measuring the costs and outcomes of services. (Source: Abram Rosenblatt, Center for Mental Health Service Research, University of California. 2000. On file.)

Wrap-around services. An approach to providing services that are individualized and unconditional. Wrap-around services are usually possible only with flexible funding that allows service providers to develop individual treatment plans that address an array of needs. (Source: Abram Rosenblatt, Center for Mental Health Service Research, University of California. 2000. On file.)

Appendix F

Mental Health Information Sources and Organizations

The following organizations can provide useful information, data and resources on mental health services and policies. This is a partial list.

Educational Institutions and Research Centers

Center for Mental Health Service Research
University of California
2020 Milvia Street, # 405
Berkeley, CA 94720
http://socrates.berkeley.edu:80/~cmhsr/index.html

Center for Mental Health in Schools
Department of Psychology, UCLA
Box 951563
Los Angeles, CA 90095-1563
http://smhp.psych.ucla.edu/

National GAINS Center.
345 Delaware Avenue, Delmar, NY 12054
http://www.prainc.com/gains/index.html

State and Federal Offices

Assembly Select Committee on Mental Health
State Capitol, Room 4140
P.O. Box 942849
Sacramento, CA 94249-0001
http://www.assembly.ca.gov/acs/newcomframeset.asp?committee=83

California Board of Corrections
600 Bercut Drive
Sacramento, CA 95814
http://www.bdcorr.ca.gov/

California Commission on Aging
1020 9th Street, Room 260
Sacramento, CA 95814
http://www.aging.state.ca.us/internet/ccoa.htm

California Department of Aging
1600 K Street
Sacramento, CA 95814
http://www.aging.state.ca.us/

California Department of Alcohol & Drug Programs
1700 K Street, 4th Floor
Sacramento, CA 95814
http://www.adp.cahwnet.gov/

California Department of Corrections
1515 S Street
Sacramento, CA 95814
http://www.cdc.state.ca.us/

California Department of Health Services
714 P Street
Sacramento, CA 95814
http://www.dhs.cahwnet.gov/

California Department of Managed Health Care
980 Ninth Street, Suite 500
Sacramento, CA 95814
http://www.dmhc.ca.gov/

California Department of Mental Health
1600 9th Street, Room 130
Sacramento, CA 95814
http://www.dmh.ca.gov/

California Department of Rehabilitation
2225 19th Street
Sacramento, CA 95818
http://www.rehab.cahwnet.gov/

California Department of Veterans Affairs
1227 "O" Street
Sacramento, CA 95814
http://www.ns.net/cadva/

California Mental Health Planning Council
1600 9th Street, Room 350
Sacramento, CA 95814
http://www.dmh.ca.gov/mhpc/default.htm

Maryland Community Criminal Justice Program.
Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, MD 21201

Pennsylvania Partnership for Children
Clay R. Yeager, Executive Director
P.O. Box 1167
Harrisburg, PA 17108-1167
http://www.cp.state.pa.us

Senate Select Committee on Developmental Disabilities and Mental Health
State Capitol, Room 3070
Sacramento, CA 95814
http://www.sen.ca.gov/ftp/sen/committee/select/DEVELOP/_home1/PROFILE.HTM

Substance Abuse and Mental Health Services Administration
Room 12-105 Parklawn Building
5600 Fishers Lane
Rockville, MD 20857
http://www.samhsa.gov/

Texas Council on Offenders with Mental Impairments
8610 Shoal Creek Blvd.
Austin, TX 78757
http://www.tdcj.state.tx.us/tcomi/tcomi-home.htm

Non-Profit Agencies and Associations

California Alliance of Child & Family Services
2201 K St.
Sacramento, CA 95816
http://www.cacfs.org

California Association of Local Mental Health Boards & Commissions
20224 Goleta Court
Redding, CA 96002

California Association of Marriage & Family Therapists
7901 Raytheon Road
San Diego, CA 92111-1606
http://www.camft.org

California Association of School Psychologists
1400 K Street, Suite 311
Sacramento, CA 95814
http://www.casponline.org

California Association of Social Rehabilitation Agencies
Post Office Box 388
Martinez, CA 94553
http://www.casra.org

California Child, Youth and Family Coalition
1220 H Street, Suite 103
Sacramento, CA 95814
http://www.ccyfc.org

California Citizens for Health Freedom
8048 Mamie Avenue
Oroville, CA 95966
http://www.citizenshealth.org/

California Coalition for Ethical Mental Health Care
1568 6th Avenue
San Diego, CA 92101
http://www.ccemhc.org/home.html

California Council of Community Mental Health Agencies/California Coalition for Mental Health
1127 11th Street, Suite 830
Sacramento, CA 95814
http://www.cccmha.org

California Division-American Association for Marriage and Family Therapy
57 Longfellow Road
Mill Valley, CA 94941
http://www.aamft.org/

California Healthcare Association
1215 K Street
Sacramento, CA 95814
http://www.calhealth.org

California Institute for Mental Health
2030 J Street
Sacramento, CA 95814
http://www.cimh.org/

California Mental Health Directors Association
2030 J Street
Sacramento, CA 95814
http://www.cmhda.org/

California Network of Mental Health Clients
1722 J Street, Suite 324
Sacramento, CA 95814
http://www.cnmhc.org/

California Psychiatric Association
1400 K Street, Suite 302
Sacramento, CA 95814
http://www.calpsych.org/

California Psychological Association
1022 G Street
Sacramento, CA 95814
http://www.calpsychlink.org/

California Society for Clinical Social Work
720 Howe Avenue, Suite 112
Sacramento, CA 95825
http://www.cswf.org/states/calif/cascsw.html

Citizen's Commission on Human Rights
Post Office Box 1730
Thousand Oaks, CA 91358
http://www.cchr.org

Community Residential Care Association of California
Post Office Box 163270
Sacramento, CA 95816
http://hometown.aol.com/SNCNEWS/index.html

Los Angeles Coalition to End Hunger and Homelessness
548 South Spring Street, Suite 339
Los Angeles, CA 90013
http://www.lacehh.org/

LPS Task Force
203 Argonne B-104
Long Beach, CA 90803

Mental Health Association in Los Angeles County
1336 Wilshire Boulevard, 2nd Floor
Los Angeles, CA 90017-1705
http://www.mhala.org/

Mental Health Client Action Network
1024-A Soquel Avenue
Santa Cruz, CA 95062
http://www.sasquatch.com/~mhcan/index.shtml

National Alliance for the Mentally Ill, California
1111 Howe Avenue, Suite 475
Sacramento, CA 95825
email: namica@pacbell.net
http://www.nami.org/about/namica/

National Association of Social Workers, California Chapter
1016 23rd Street
Sacramento, CA 95816
http://www.naswca.org/

Protection & Advocacy, Inc.
100 Howe Avenue, Suite 185N
Sacramento, CA 95825
http://www.pai-ca.org/

Volunteers of America
530 Bercut Drive
Sacramento, CA 95814
http://www.voa.org

Notes

Notes

1. Nunnally, J. 1981. Popular Conceptions of Mental Health. New York, NY: Holt, Rinehart and Winston. As referenced in Link, Bruce G., Jo C. Phelan, Michaeline Bresnahan, Ann Stueve and Bernice Pescosolido. 1999. "Public Conceptions of Mental Illness: Labels, Causes, Dangerousness, and Social Distance." American Journal of Public Health. 89(9):1328-1333.

2. California Mental Health Planning Council. 2000. Letter to the Assembly Budget Committee on "unmet needs." April 7, 2000. On file

3. Taylor K. Moorehead, Commander, Los Angeles County Sheriff's Department. Twin Towers Correctional Facility. Testimony before the Little Hoover Commission. October 28, 1999. Sacramento, State Capitol Building.

4. McIntosh, John L. nd. "USA State Suicide Data 1997: Rate, Number, and Ranking of Suicide, Each U.S.A. State." Washington, D.C.: American Association of Suicidology. (www.iusb.edu/~jmcintos/USA97StatesTab.htm)

5. U.S. Department of Health and Human Services. 1999. Mental Health Report: A Report of the Surgeon General. Rockville, MD: United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health. Page 6.

6. U.S. Department of Health and Human Services. 1999. (See endnote #5) Page 57.

7. The California Department of Corrections provides mental health services to 18,500 inmates with serious mental illness. C. A. "Cal" Terhune. Director, California Department of Corrections. Testimony before the Little Hoover Commission. October 28, 1999. Sacramento, State Capitol Building. California's jails hold an estimated 11,500 mentally ill individuals. California Board of Corrections. 2000. Improving California's Response to Mentally Ill Offenders: An Analysis of County-Identified Needs – Staff Report. Sacramento, CA: California Board of Corrections.

8. The National Comorbidity Study found that 41.2 percent of those with affective disorders had any alcohol or drug disorder and that 50.9 percent of persons with any mental disorder had any alcohol or drug disorder. The Department of Finance reports that California has 24,882,708 adults (ages 18 or older). National estimates suggest that 21 percent of adults experience some form of diagnosable mental illness, or 5,225,368 California adults. Similarly, 5.4 percent of all adults experience a *serious* mental illness, or 1,343,666 adults in California. Based on the National Comorbidity study, 50.9 percent of the 5,225,368 million adults who experience some form of mental illness also have some form of alcohol or drug disorder, or 2.659 million adults in California. Using the more conservative co-morbidity estimate of 41.2 percent, applied only to adults with serious mental illness, the figure is about 553,590 adults. Sources: Candace Cross-Drew. Department of Mental Health. Personal Communication October 10, 2000. On file. Kessler, Ronald C., Christopher B. Nelson, Katherine A. McGonagle, Mark J. Endlund, Richard G. Frank, Philip J. Leaf. 1996. "The Epidemiology of Co-Occurring Addictive and Mental Disorders: Implications for Prevention and Service Utilization." American Journal of Orthopsychiatry. 66(1):17-31. Department of Finance. 1998. "Race/Ethnic Population with Age and Sex Detail, 1970-2040." Sacramento, CA: Department of Finance. http://www.dof.ca.gov/newdr/california.txt. Department of Alcohol and Drug Programs. 2000. "Drug and Alcohol Treatment Access Report." Sacramento, CA: Department of Alcohol and Drug Programs. On file.

9. California Statewide Supportive Housing Initiative. Welfare and Institutions Code, Section 53250.

10. David Pingatore, Ph.D., Center for Mental Health Service Research. University of California. 2000. "Summary of Best Practice Guidelines." Personal Communication. On file.

11. Jonathan Vernick. Director, Baker Places San Francisco. Personal Communication. July 18, 2000.

12. Pennsylvania Partnership for Safe Children. 2000. Personal Communication.

13. Wolff, Nancy, R. J. Diamond and T. W. Helminiak. 1997. "A New Look at an Old Issue: People with Mental Illness and the Law Enforcement System." Journal of Mental Health Administration. 24:152-165. As referenced in Clark, Robin E., Susan K. Ricketts and Gregory J. McHugo. 1999. "Legal System Involvement and Costs for Persons in Treatment for Severe Mental Illness and Substance Abuse Disorders." Psychiatric Services. 50(5):641-647. Page 642.

14. Substance Abuse and Mental Health Services Administration. 2000. "Jail Diversion Programs Enhance Care." SAMHSA News. 8(2):1-4. City of Memphis. Nd. "Memphis Police Crisis Intervention Team." On file.

15. Clark, Robin E., Susan K. Ricketts and Gregory J. McHugo. 1999. (See Endnote #13) Page 641.

16. Clark, Robin E., Susan K. Ricketts and Gregory J. McHugo. 1999. (See endnote #13)

17. The Legislature has authorized $104 million for the Mentally Ill Offender Crime Reduction Program and $60 million for the Integrated Services to Homeless Adults (AB 34/AB 2034) program.

18. Substance Abuse and Mental Health Services Administration. nd. "Jail Diversion: Knowledge Development and Application Program." Washington, D.C.: Substance Abuse and Mental Health Services Administration.

19. Welfare and Institutions Code. Section 5600.2(J).

20. California Mental Health Planning Council. September 29, 2000. "Draft – Mental Health Master Plan." Page 77. On file.

21. Wayne Clark and Bill McConnell. 2000. Center for Mental Health Service Research. University of California. "Implementation of Outcome Measures." Personal Communication. On File.

22. Wayne Clark and Bill McConnell. 2000. (See Endnote #21).

23. Little Hoover Commission. 1999. Now in Our Hands: Caring for California's Abused and Neglected Children. Sacramento, CA: Little Hoover Commission.

24. Little Hoover Commission. 1998. Beyond Bars: Correctional Reforms to Lower Prison Costs and Reduce Crime. Sacramento, CA: Little Hoover Commission.

25. Little Hoover Commission. 1994. The Juvenile Crime Challenge: Making Prevention a Priority. Sacramento, CA: Little Hoover Commission.

26. Please contact the Commission if you would like copies of the testimony provided to the Commission during these hearings.

27. U.S. Department of Health and Human Services. 1999. (See Endnote #5) Page 39.

28. U.S. Department of Health and Human Services. 1999. (See Endnote #5) Page 52.

29. U.S. Department of Health and Human Services. 1999. (See Endnote #5) Page 57.

30. U.S. Department of Health and Human Services. 1999. (See Endnote #5) Page 55.

31. Catherine Camp. Executive Director. California Mental Health Directors Association. Testimony before the Little Hoover Commission. September 7, 1999. Sacramento, State Capitol Building.

32. U.S. Department of Health and Human Services. 1999. (See Endnote #5) Page 46.

33. Regier, D. A., Narrow, W.E., Rupp, A., and Rae, D. S. (in press). "The Epidemiology of Mental Disorders Treatment Needs: Community Estimates of 'Medical Necessity.' As referenced in U.S. Department of Health and Human Services. 1999. (See Endnote #5) Page 49.

34. National Advisory Mental Health Council. 1993. "Health Care Reform for Americans with Severe Mental Illnesses: Report of the National Advisory Mental Health Council." American Journal of Psychiatry. 15:1447-1465. As referenced in U.S. Department of Health and Human Services. 1999. (See Endnote #5) Page 46.

35. National Advisory Mental Health Council. 1993. (See Endnote #34)

36. U.S. Department of Health and Human Services. 1999. (See Endnote #5) Page 48.

37. Friedman, Robert M., Judith W. Katz-Levey, Ronald W. Manderschied and Diane L. Sondheimer. 1996. "Prevalence of Serious Emotional Disturbance in Children and Adolescents." In R. W. Manderschied and M. A. Sonnenschein. (Eds.) 1996. Mental Health, United States. Rockville, MD: Center for Mental Health Services. Pages 71-88.

38. U.S. Department of Health and Human Services. 1999. (See Endnote #5) Page 48.

39. U.S. Department of Health and Human Services. 1999. (See Endnote #5) Page 48.

40. Legislative Analyst's Office. April 14, 2000. "California's Mental Health System: Selected Data." Presented to Joint Committee on Mental Health Reform. Sacramento, CA: Legislative Analyst's Office. Figure 4c. "Clients Receiving Publicly Funded Community Mental Health Services. Medi-Cal and Non-Medi-Cal Status and Expenditures. All Funds. Selected Years."

41. Gelber, Suzanne and David Rinaldo. 2000. "The State of the State of Behavioral Health in California: Alcohol, Drug, and Mental Health Services and Systems." Berkeley, CA: SGR Health Alliance. Page 151.

42. Rice, D. P. and L. S. Miller. 1996. "The Economic Burden of Schizophrenia: Conceptual and Methodological Issues, and Cost Estimates." In M. Moscarelli, A. Rupp and N. Sartorious. (Eds.) Handbook of Mental Health Economics and Health Policy. Volume 1: Schizophrenia. New York: John Wiley and Sons. Pages 321-324. As referenced in U.S. Department of Health and Human Services. 1999. (See Endnote #5) Page 411.

43. U.S. Population, January 1, 2000: 274,024,000. As reported by the U.S. Census Bureau. "Monthly Estimates of the United States Population: April 1, 1980 to July 1, 1999, with Short-Term Projections to July 1, 2000." (www.census.gov/population/estimates/nation/intfile1-1.txt) California population, January 2000: 34,336,000. As reported by the Department of Finance. "City/County Population Estimates and Annual Percentage Change." (www.dof.ca.gov/HTM/DEMOGRAP/e-1table.html).

44. U.S. Department of Health and Human Services. 1999. (See Endnote #5) Page 288.

45. RachBeisel, Jill, Jack Scott and Lisa Dixon. 1999. "Co-occurring Severe Mental Illness and Substance Use Disorders: A Review of Recent Research." Psychiatric Services. 50(11):1427-1434. Page 1427.

46. National Survey of Homeless Assistance Providers and Clients. 1999. Homelessness: Programs and the People they Serve. Washington, D.C.: Interagency Council on the Homeless.

47. U.S. Department of Health and Human Services. 1999. (See Endnote #5) Page 63.

48. U.S. Department of Health and Human Services. 1999. (See Endnote #5) Page 63.

49. U.S. Department of Health and Human Services. 1999. (See Endnote #5) Page 63.

50. U.S. Department of Health and Human Services. 1999. (See Endnote #5) Page 63.

51. Harding, C., J. S. Strauss, and J. Zubin. 1992. "Chronicity in Schizophrenia: Revisited." British Journal of Psychiatry. 161:27-37. As referenced in U.S. Department of Health and Human Services. 1999. (See Endnote #5) Page 97.

52. Frese, F. J. 1998. "Advocacy, Recovery, and the Challenges of Consumerism for Schizophrenia." Psychiatric Clinics of North America. 21:233-249. As referenced in U.S. Department of Health and Human Services. 1999. (See Endnote #5) Page 97.

53. Fisher, Daniel. nd. "A New Vision of Recovery: People Can Fully Recover from Mental Illness, It is Not a Life-Long Process." Lawrence, MA: National Empowerment Center. On file.

54. U.S. Department of Health and Human Services. 1999. (See Endnote #5) Page 98.

55. California has 59 local mental health authorities. Fifty-six counties operate authorities, two counties, Yuba and Sutter, have a joint mental health authority and two cities, Berkeley and a Tri-City authority in eastern Los Angeles County, operate public mental health services directly. Source: Catherine Camp. September 7, 1999. (See Endnote #31).

56. Medi-Cal Policy Institute. 2000. "Frequently Asked Questions." Oakland, CA: Medi-Cal Policy Institute. www.medi-cal.org/resources/faqs/index.html. On file.

57. Under Medicaid states can receive reimbursement under a "clinic option" or a "rehabilitation option." The clinic option provides federal funds primarily for mental health treatment offered through a clinical setting. In contrast, the rehabilitation option allows reimbursement for services offered in a variety of settings intended to treat a mental disorder as well as services intended to address functional limitations associated with a mental disorder. See California Department of Mental Health. 1994. Medi-Cal Managed Mental Health Care. Sacramento, CA: Department of Mental Health. Attachment M, Page 2.

58. California Department of Mental Health. 1999. "Frequently Asked Questions About Systems of Care, Medicare and Medi-Cal." Sacramento, CA: Department of Mental Health.

59. Scheffler, Richard and Neal Wallace. 1999. "The Impact of the 1991 Program Realignment on California's Public Mental Health System." CPRC Briefing. Berkeley, CA: California Policy Research Center. November 18, 1999.

60. California Department of Mental Health. 1994. (See Endnote #57)

61. California Department of Mental Health. 1999. "Report to the Legislature: Status Update on the Implementation of Mental Health Managed Care." Sacramento, CA: Department of Mental Health.

62. California Department of Mental Health. 2000. "Description of the Department." Sacramento, CA: Department of Mental Health Homepage. (www.dmc.cahwnet.gov/programs.html).

63. Department of Finance. 2000. "Department of Mental Health." Governor's Budget: 2000-01. Sacramento, CA: Department of Finance. Page HHS 109. The Governor's Budget 2000-01 reports 153.7 personnel positions for the "Community Services" division. The Department of Mental Health refers to this unit as the "Systems of Care" division in its organizational chart. The 153.7 figure includes 51 positions dedicated to the department's

"Program Compliance" unit. Source: Department of Mental Health. Personal Communication. September 20, 2000.

64. California Mental Health Planning Council. 1997. Adult Performance Outcome Study: Wave 1 to Wave 3. Sacramento, CA: Mental Health Planning Council.

65. California Mental Health Planning Council. January 2001. (See Endnote #20) Page 77.

66. California Mental Health Planning Council. January 2001. (See Endnote #20).

67. Welfare and Institutions Code, Section 5772(c).

68. Welfare and Institutions Code, Section 5604.2. (See Endnote #19)

69. Department of Finance. 2000. (See Endnote #63).

70. Department of Finance. 1993/94 – 2000-01. "Department of Mental Health. State Hospital Inhospital Population Count." Governor's Budget: 1993-94 through Governor's Budget: 2000-01. Sacramento, CA: Department of Finance.

71. Department of Finance. 1993/94 – 2000-01. (See Endnote #70). Penal Code figures include clients reported in the budgets as "PC" and "Other" clients. "Other" clients as reported in the budget include PC2684/PC2974, Youth Authority, Developmentally Disabled-Forensic, Other PC and SVP clients.

72. Department of Mental Health.

73. Department of Mental Health.

74. Counties are the responsible authority for the delivery of public mental health services. Catherine Camp. September 7, 1999. (See Endnote #31).

75. California Association of Local Mental Health Boards and Commissions. 2000. Letter to the Little Hoover Commission. On File.

76. Department of Mental Health. 1999. California Department of Mental Health. Sacramento, CA: Department of Mental Health. On File.

77. Welfare and Institutions Code, Section 5600.3 as cited in California Mental Health Planning Council. 1995. Effects of Realignment on the Delivery of Mental Health Services. Sacramento, CA: Mental Health Planning Council. Page 81.

78. Department of Mental Health. 1999. (See Endnote #58).

79. Protection and Advocacy, Inc. 1999. "Medi-Cal Mental Health Managed Care: Questions and Answers." Sacramento, CA: PAI, Inc.

80. Mental Health Planning Council. Letter to Senator Chesbro and Assemblymember Thomson. April 25, 2000. On file.

81. Nunnally, J. 1981. (See endnote #1)

82. Nieto, Marcus. 1999. Mentally Ill Offenders in California's Criminal Justice System. Sacramento, CA: California Research Bureau. Norman, Cotton and Associates. 1989. Stirling Report. California Department of Corrections, Western Consortium for Public Health and Scarlett Carp and Associates. Mental Health Services Delivery System. 1993. As referenced by Donald Specter, Director, Prison Law Office, San Quentin, California. Testimony before the Little Hoover Commission, October 28, 1999. Sacramento, State Capitol Building.

83. C. A. "Cal" Terhune. October 28, 1999. (See endnote #7)

84. California Department of Corrections. 2000. "CDC Facts." www.cdc.state.ca.us/factsht.htm.

85. Donald Specter. October 28, 1999. (See Endnote #82).

86. As referenced in Assembly Bill 34, Steinberg, Chapter 6178, Statutes of 1999.

87. Commander Taylor Moorehead. October 28, 1999. (See endnote #3)

88. Izumi, Lance, Mark Schiller, and Steven Hayward. 1996. "Corrections, Criminal Justice and the Mentally Ill: Some Observations About Costs in California." San Francisco: Pacific Research Institute for Public Policy.

89. Leo McFarland. Executive Director, Volunteers of America, Sacramento, CA. Personal Communication. September 12, 2000.

90. The U.S. Surgeon General reports the indirect costs of mental illness at $79 billion for the United States. California's share based on population is $9.875 billion. SGR Healthcare Alliance reports the direct costs of mental illness in California at $9.5 billion. U.S. Department of Health and Human Services. Page 411. Gelber, Suzanne and David Rinaldo. 2000. "The State of the State of Behavioral Health in California: Alcohol, Drug, and Mental Health Services and Systems." Berkeley, CA: SGR Healthcare Alliance. Page 151. On file.

91. U.S. Department of Health and Human Services. 1999. (See Endnote #5) Page 46.

92. Department of Finance. 2000. (See Endnote #63) Page 15.

93. Üstün, T. Bedirhan. 1999. "The Global Burden of Mental Disorders." American Journal of Public Health. 89(9):1315-1318.

94. U.S. Department of Health and Human Services. 1999. (See Endnote #5) Page 411.

95. Appendix D lists the latest available expenditure data for county mental health programs. In fiscal year 1997-98 California counties spent $1.939 billion on public mental health services. These figures reflect State, local, federal and private expenditure on services delivered through the public mental health system. Expenditure data for later fiscal years are not available but have undoubtedly increased. That same year the State spent an additional $451 million on the State hospital system. The 1999-2000 fiscal year budget for the state hospital system exceeds $500 million. The $2.5 billion estimate also does not include the costs of treatment provided through the criminal justice system or other criminal justice and public safety costs.

96. U.S. Department of Health and Human Services. 1999. (See Endnote #5) Page 6.

97. Link, Bruce G., Jo C. Phelan, Michaeline Bresnahan, Ann Stueve and Bernice Pescosolido. 1999. (See Endnote #1)

98. Hanson, K. W. 1998. "Public Opinion and the Mental Health Parity Debate: Lessons from the Survey Literature." Psychiatric Services. 49:1059-1066.

99. U.S. Department of Health and Human Services. 1999. (See Endnote #5) Page 9.

100. Phelan, J., B. Link, A. Stueve and B. Pescosolido. 1997. "Public Conceptions of Mental Illness in 1950 in 1996: Has Sophistication Increased? Has Stigma Declined?" Paper presented at the meeting of the American Sociological Association, Toronto, Ontario. As referenced in U.S. Department of Health and Human Services. 1999. (See Endnote #5) Page 7.

101. Swanson, J. W. 1994. "Mental Disorder, Substance Abuse, and Community Violence: An Epidemiological Approach." In John Monahan and Henry J. Steadman. (eds.) 1996. Violence and Mental Disorder: Developments in Risk Assessment. Chicago, IL: University of Chicago Press. (Pages 101-136.) Chicago, IL: University of Chicago Press. Pescosolido, Bernice A., John Monahan, Bruce G. Link, Ann Stueve and Saeko Kikuzawa. 1999. "The Public's View of the Competence, Dangerousness, and Need for Legal Coercion of Persons with Mental Health Problems." American Journal of Public Health. 89(9):1339-1345.

102. Nunnally, J. 1981. (See endnote #1)

103. U.S. Department of Health and Human Services. 1999. (See Endnote #5) Page 9.

104. U.S. Department of Health and Human Services. 1999. (See Endnote #5) Page 9.

105. Clark Brooks. May 9, 2000. "County's Mental Health Services May Get Boost." Union Tribune. San Diego, CA: Union Tribune.

106. Society for Human Resource Management and the National Foundation for Brain Research. 1999. "Depression in the Workplace Survey." As reported by Guynn, Jessica. 1999. "Job Sites Hurt by Depression." San Ramon Valley Times. Danville, CA: San Ramon Valley Times.

107. Dayton, Bruce. 2000. Maxwell School of Citizenship and Public Affairs. Syracuse University. Personal Communication. July 5, 2000.

108. National Academy of Sciences. 2000. "About the NAS." Washington, D.C.: National Academy of Sciences. On file.

109. In 1993 the California Mental Health Planning Council stated that the "major role of the DMH is to passionately articulate the vision for the mental health system and to facilitate achievement of the mission and goals." California Mental Health Planning Council. 1993. "Report on the Mental Health Governance Study." Sacramento, CA: Mental Health Planning Council. Page 15.

110. Department of Finance. 2000. (See Endnote #63) Page HHS 109.

111. Department of Mental Health. 2000. Personal communication. September 8, 2000.

112. In 1991-92 the department employed a total of 6,956 personnel: 159 in Community Services, 6,655 in State Hospital Services and 151 in Departmental Administration. Source: Department of Finance. 1993. Governor's Budget. 1993-94. Sacramento, CA: Department of Finance. Page HW 47. In 2000-01 the department employs 8,547 personnel: 154 in Community Services, 8,241 in Long Term Care and 152 in Departmental Administration. Source: Department of Finance. 2000. (See Endnote #63) Page HHS 109.

113. California Mental Health Planning Council. 2000. "Statewide Survey on Vacancy Rates in MH Positions." Sacramento, CA: California Mental Health Planning Council.

114. I.D.E.A. Consulting. 1999. "California's Medi-Cal Mental Health Service Delivery System: Assuring Access, Quality, and Cost Effectiveness." On file with the California Department of Mental Health. Sacramento, CA.

115. Protection and Advocacy, Inc. 2000, Letter to the Little Hoover Commission. On file. Protection and Advocacy, Inc. 2000. Managing Mental Health Care: A Report on California's Medi-Cal Mental Health System, 1997-1999. Los Angeles, CA: Protection and Advocacy, Inc.

116. Editorial. July 3, 2000. "Separate and Equal? Some Insurers Treat Mental Health Care as 'Carve-Out.'" Sacramento Bee.

117. Department of Finance. 1993. Governor's Budget: 1993-94. Sacramento, CA: Department of Finance. Page HW 48.

118. California Mental Health Planning Council. 2000. (See Endnote #2)

119. Dr. Mark Ragins, Medical Director. The Village Integrated Services Agency, Long Beach. Testimony before the Little Hoover Commission. January 27, 2000. Sacramento, State Capitol Building. Page 3.

120. Editorial. October 21, 1999. "Homeless in Sacramento: Build Solutions Such as Quinn Cottages, Not More Jails." Sacramento Bee.

121. National Survey of Homeless Assistance Providers and Clients. 1999. (See Endnote #46)

122. California Statewide Supportive Housing Initiative Act. (See Endnote #9)

123. California Statewide Supportive Housing Initiative Act. (See Endnote #9)

124. Hurlburt, Michael S., Richard L. Hough, and Patricia A. Wood. 1996. "Effects of Substance Abuse on Housing Stability of Homeless Mentally Ill Persons in Supportive Housing." Psychiatric Services. 47:731-736. United States General Accounting Office. 2000. "Homelessness: Barriers to Using Mainstream Programs." Washington D.C.: General Accounting Office. GAO/RCED-00-184.

125. Bond, Gary R., Robert E. Drake, Kim T. Mueser and Deborah R. Becker. 1997. "An Update on Supported Employment for People with Severe Mental Illness." Psychiatric Services. 48(3):335-347. Judith A. Cook and Lisa Razzano. 2000. "Vocational Rehabilitation for Persons with Schizophrenia: Recent Research and Implications for Practice." Schizophrenia Bulletin. 26(1):87-103.

126. Cook, Judith A. and Lisa Razzano. 2000. (See Endnote #125)

127. David Pingatore. (See Endnote #10)

128. RachBeisel, Jill, Jack Scott and Lisa Dixon. 1999. (See Endnote #45) Page 1427.

129. U.S. Department of Health and Human Services. 1999. (See Endnote #5) Page 288.

130. United States General Accounting Office. 2000. (See Endnote #124) Page 10.

131. Kaplan, A, B. Sadock and J. Grebb. 1998. Synopsis of Psychiatry. 7th Edition. NP: Williams and Wilkins. Page 299. Koran, L. 1985. "Physical Illness in a Sampling of California Psychiatric Patients." Paper presented at the Academy of Psychosomatic Medicine 32nd Annual Meeting. November. As referenced in California Mental Health Planning Council. 2000. (See Endote #20) Page 45.

132. Koran, Lorrin. M.D. 1991. Medical Evaluation Field Manual. Prepared for the California Department of Mental Health and Local Mental Health Programs Pursuant to Chapter 376, Statutes of 1988. AB 1877. On file.

133. Kopelowicz, Alex, Charles J. Wallace and Roberto Zarate. 1998. "Teaching Psychiatric Inpatients to Re-Enter the Community: A Brief Method of Improving the Continuity of Care." Psychiatric Services. 49(10):1313-1316.

134. Anne Morris, Ph.D. Center for Mental Health Service Research, University of California. Personal Communication.

135. Drake, Robert E. and Kim T. Mueser. 2000. "Psychosocial Approaches to Dual Diagnosis." Schizophrenia Bulletin. 26(1):105-118.

136. Bond, G. R., Robert E. Drake, Kim T. Mueser and D. R. Becker. 1997. (See Endnote #125)

137. Koran, Lorrin M.D. 1991. (See Endnote #132)

138. Chandler, Daniel, Joan Meisel, Michelle McGowen, Jim Mintz and Kristin Madison. 1996. "Client Outcomes in Two Model Capitated Integrated Services Agencies." Psychiatric Services. 47:175-180.

139. McFarland, Bentson H. and Gary Blair. 1995. "Delivering Comprehensive Services to Homeless Mentally Ill Offenders." Psychiatric Services. 46:179-181. Morrissey, Joseph, Michael Calloway, Matthew Johnsen and Michael Ullman. 1997. "Service System Performance and Integration: A Baseline Profile of the ACCESS Demonstration Sites. Access to Community Care and Effective Services and Supports." Psychiatric Services. 48:374-380. Young, Nancy and Christine Grella. 1998. "Mental Health and Substance Abuse Treatment Services for Dually Diagnosed Clients: Results of a Statewide Survey of County Administrators." Journal of Behavioral Health Services & Research. 25(1):83-92.

140. Lehman, Anthony F. and Donald M. Steinwachs. 1998. "Patterns of Usual Care for Schizophrenia: Initial Results from the Schizophrenia Patient Outcomes Research Team (PORT) Client Survey." Schizophrenia Bulletin. 24(1):11-32.

141. Jonathan Vernick. July 18, 2000. (See Endnote #11)

142. Steve Fields, Executive Director, Progress Foundation. February 16, 2000. Personal Communication.

143. Lehman, Anthony F. 2000. "Commentary: What Happens to Psychosocial Treatments on the Way to the Clinic." Schizophrenia Bulletin. 26(1):137-139.

144. AB 3777, Statutes of 1988. On File. Mark Ragins. 2000. (See Endnote #119) "History of the Village."

145. Legislative Analyst's Office. 2000. (See Endnote #40)

146. Legislative Analyst's Office. 2000. (See Endnote #40)

147. Legislative Analyst's Office. 2000. (See Endnote #40)

148. California Mental Health Planning Council. 2000. (See Endnote #80)

149. Welfare and Institutions Code, Section 5600.2. (See Endnote #19)

150. David Pingatore. (See Endnote #10)

151. Legislative Analyst's Office. 2000. (See Endnote #40) "Figure 4c. Clients Receiving Publicly Funded Community Mental Health Services. Medi-Cal and Non-Medi-Cal Status and Expenditures. All Funds. Selected Years."

152. Sean McDermitt. Assistant Sheriff, Sonoma County. Testimony before the Senate Select Committee on Developmental Disabilities and Mental Health and the Assembly Select Committee on Mental Health. February 16, 1999. Sacramento, CA: State Capitol Building. Pages 63 - 67

153. Dr. Barry Perrou. Deputy Sheriff, Los Angeles County Sheriff's Department. Testimony before the Senate Select Committee on Developmental Disabilities and Mental Health and Assembly Select Committee on Mental Health. February 16, 1999. Sacramento, CA: State Capitol Building. Page 73.

154. Commander Taylor Moorehead. October 28, 1999. (See endnote #3)

155. Neal Wallace. Center for Mental Health Service Research. Personal Communication.

156. Department of Mental Health. 2000. "Effectiveness of Integrated Services for Homeless Adults with Serious Mental Illness: A Report to the Legislature as Required by Assembly Bill (AB) 34 Steinberg, Chapter 617, Statutes of 1999." Sacramento, CA: Department of Mental Health.

157. Lamb, Richard H. and Linda E. Weinberger. 1998. "Persons with Severe Mental Illness in Jails and Prison: A Review." Psychiatric Services. 49(4):483-501. Conly, Catherine. 1999. "Coordinating Community Services for Mentally Ill Offenders: Maryland's Community Criminal Justice Treatment Program." National Institute of Justice Program Focus. Washington, DC: National Institute for Justice (www.ojp.usdoj.gov/nij).

158. Lamb, Richard H. and Linda E. Weinberger. 1998. (See Endnote #157)

159. Van Tosh, L. (Ed.) 1996. Consumer Managed Care Network Platform for Action. Washington, DC: Consumer Managed Care Network. As referenced in Pandiani, John A., Steven M. Banks and Lucille M. Schacht. 1999. "Using Incarceration Rates to Measure Mental Health Program Performance." The Journal of Behavioral Health Services and Research. 25(3):300-3111. Page 300.

160. Lamb, Richard H. and Linda E. Weinberger. 1998. (See Endnote #157)

161. John Vacca. Head Deputy, Mental Health Branch, Los Angeles County Public Defender's Office. Testimony before the Little Hoover Commission, October 28, 1999. Sacramento, State Capitol Building. Page 3.

162. Lamb, Richard H. and Linda E. Weinberger. 1998. (See Endnote #157)

163. Lamb, Richard H. and Linda E. Weinberger. 1998. (See Endnote #157)

164. Dvoskin, Joel A. and Henry Steadman. 1994. "Using Intensive Case Management to Reduce Violence by Mentally Ill Persons in the Community." Hospital and Community Psychiatry. 45:679-684.

165. Lamb, H. R. and Roderick Shaner. 1993. "Where There are Almost No State Hospital Beds Left." Hospital and Community Psychiatry. 44(10):974-976.

166. Dr. Barry Perrou. 1999. (See Endnote #153) Pages 68-80.

167. John Vacca. 1999. (See Endnote #161) Page 5. Penal Code Section 1001.20 et. seq.

168. Department of Mental Health. 2000. (See Endnote #156) Page 2.

169. SB 1485 (Rosenthal), Chapter 501, Statutes of 1998.

170. California Board of Corrections. 2000. (See Endnote #7)

171. Lamb, Richard H. and Linda E. Weinberger. 1998. (See Endnote #157)

172. Husted, J. R., R.. A. Charter and Barry Perrou. 1995. "California Law Enforcement Agencies and Mentally Ill Offenders." Bulletin of the American Academy of Psychiatry and the Law. 23(3):315-329.

173. Lamb, Richard H. and Linda E. Weinberger. 1998. (See Endnote #157)

174. Substance Abuse and Mental Health Services Administration. (See Endnote #14)

175. Backer, Thomas E., Elizabeth A. Howard, Donald J. Richardson and Carla Jacobs. 1997. Resource Manual for Local Systems Change: Improving Mental Health Services in California's Local Criminal Justice System. Los Angeles, CA: Human Interaction Research Institute. Page 13.

176. Backer, Thomas, Elizabeth Howard, Donald J. Richardson and Carla Jacobs. 1997. (See Endnote #175) Page 13.

177. Steadman, Henry. Joseph Cocozza and Bonita Veysey. 1999. "Comparing Outcomes for Diverted and Nondiverted Jail Detainees with Mental Illness." Law and Human Behavior. 23(6):615-627.

178. Steadman, Henry, Martha Williams Deane, Randy Borum and Joseph Morrisey. 2000. "Comparing Outcomes of Major Models of Police Response to Mental Health Emergencies." Psychiatric Services. 51(5):645-649.

179. Dr. Barry Perrou. (See Endnote #153)

180. Matthew Farley. Health Economist. Research Triangle Institute. Personal communication. July 20, 2000.

181. Izumi, Lance, Mark Schiller, and Steven Hayward. 1996. (See Endnote #88).

182. Torrey, E. Fuller, J. Stieber, J. Ezekiel, S. M. Wolf, J. Sharfstein, J. H. Noble, and L. M. Flynn. 1992. Criminalizing the Seriously Mentally Ill: the Abuse of Jails as Mental Hospitals. Washington, DC: Public Citizen's Health Research Group and National Alliance for the Mentally Ill. As referenced in Backer, Thomas, Elizabeth Howard, Donald J. Richardson and Carla Jacobs. 1997. (See Endnote #175) Page 7.

183. Roskes, Erik and Richard Feldman. 1999. "A Collaborative Community-Based Treatment Program for Offenders with Mental Illness." Psychiatric Services. 50(12):1614-1619.

184. Roskes, Erik and Richard Feldman. 1999. (See Endnote #182). Jemelka, Ron, Eric Trupin and John A. Chiles. 1989. "The Mentally Ill In Prison: A Review." Hospital and Community Psychiatry. 40:481-491. Draine, J., P. Solomon and A. Meyerson. 1994. "Predictors of Reincarceration Among Patients Who Received Psychiatric Services in Jail." Hospital and Community Psychiatry. 45:163-167.

185. $1,500 figure reflects Sacramento County cost for outpatient services through contract service provider. $35,000 reflects high-end cost at an Integrated Services Agency (ISA), based on conversation with Turning Point ISA, Sacramento County.

186. California Department of Corrections. 2000. (See Endnote #84).

187. California Department of Corrections. 1999. Letter from C.A. "Cal" Terhune, Director. Department of Corrections to Assemblymember Thomson. March 15, 1999. Data reflect costs from fiscal year 1997-98.

188. California Department of Corrections. 2000. (See Endnote #83).

189. Little Hoover Commission. 1998. (See Endnote #24) Page 50.

190. Commander Taylor Moorehead. October 28, 1999. (See endnote #3) The Los Angeles County Jail provides acute mental health services to 2,300 inmates with a budget of $16.3 million.

191. Petersilia, Joan. 2000. "Challenges of Prisoner Reentry and Parole in California." CPRC Brief. University of California, Berkeley: California Policy Research Center.

192. Petersilia, Joan. 2000. (See Endnote #191)

193. Department of Mental Health. 1999. (See Endnote #156). Wiederanders, Mark and Noelle Sprinkman. 1999. "Questions and Answers About the Effectiveness of CONREP." Sacramento, CA: Department of Mental Health.

194. Texas Council on Offenders with Mental Impairments. 1998. "Rate of Reduction in Arrests for Special Needs Offender Program." Austin, TX: Texas Council on Offenders with Mental Impairments.

195. Conly, Catherine. Nd. (See Endnote #157)

196. Legislative Analyst's Office. 1992. "The 1991-92 State and Local Program Realignment: Overview and Current Issues." Reprint. In California Institute for Mental Health. Nd. Realignment Fiscal Manual. Sacramento, CA: California Institute for Mental Health.

197. Department of Mental Health. June 18, 1998. White Paper: "State of California. Department of Mental Health. System of Care. Mental Health Medi-Cal Managed Care Oversight." Sacramento, CA: DMH. Page 4.

198. Mental Health Planning Council. 2001. (See Endnote #20).

199. Wayne Clark and Bill McConnell. 2000. (See Endnote #21).

200. Sederer, L.I., Dickey, B. 1996. Outcomes Assessments in Clinical Practice. Philadelphia, PA: Williams and Wilkins. As referenced by Wayne Clark and Bill McConnell. 2000. (See Endnote #21).

201. Wayne Clark and Bill McConnell. 2000. (See Endnote #21).

202. Michael Dow. Professor and Director, Research Division. Department of Community Mental Health. Florida Mental Health Institute. July 6, 2000. Personal Communication.

LITTLE HOOVER COMMISSION MEMBERS

CHAIRMAN RICHARD R. TERZIAN *(R-Los Angeles)* Originally appointed to the Little Hoover Commission by Governor George Deukmejian in May 1986. Reappointed by Governor Pete Wilson in March 1994 and in March 1998. Partner in the law firm of Bannan, Green, Frank & Terzian. Chairman of the Commission since March 1994. Served as Vice Chairman from 1992 to 1994.

VICE CHAIRMAN MICHAEL E. ALPERT *(D-Coronado)* Originally appointed to the Little Hoover Commission by Assembly Speaker Willie L. Brown, Jr. in May 1994. Reappointed by the Senate Rules Committee in August 1997. Retired partner in the law firm of Gibson, Dunn & Crutcher. Former Chief Deputy Commissioner of the California Department of Corporations.

ASSEMBLYMEMBER BILL CAMPBELL *(R-Villa Park)* Appointed to the Little Hoover Commission by Assembly Speaker Antonio Villaraigosa in January 1999. Elected to the 71st State Assembly District in 1996. Vice Chair of the Assembly Appropriations Committee.

CARL COVITZ *(R-Los Angeles)* Appointed to the Little Hoover Commission by Governor Pete Wilson in October 1993. Reappointed in March 1996. Owner and President of Landmark Capital, Inc. Served as Secretary of the Business, Transportation and Housing Agency from 1991 to 1993 and Undersecretary for the U.S. Department of Housing and Urban Development from 1987 to 1989.

DANIEL W. HANCOCK *(D-Milpitas)* Appointed to the Little Hoover Commission by Assembly Speaker Cruz Bustamante in July 1997. President of Shapell Industries of Northern California since 1985.

ASSEMBLYMEMBER SALLY HAVICE *(D-Cerritos)* Appointed to the Little Hoover Commission by Assembly Speaker Antonio Villaraigosa in April 1998. Elected to the 56th State Assembly District in 1996. Chair of the Assembly International Trade & Development Committee.

SENATOR CHARLES S. POOCHIGIAN *(R-Fresno)* Appointed to the Little Hoover Commission by Assembly Speaker Curt Pringle in March 1996. Reappointed by Speaker Antonio Villaraigosa in November 1997, and reappointed by the Senate Rules Committee in February 1999. Elected to the 14th State Senate District in 1998. Vice Chair of the Senate Revenue and Taxation Committee.

H. ERIC SCHOCKMAN *(D-Sherman Oaks)* Appointed to the Little Hoover Commission by Assembly Speaker Antonio Villaraigosa in January 2000. Associate Dean and Associate Professor of Political Science at the University of Southern California. Former administrator and consultant to the California State Assembly and to the City Council of Los Angeles.

SENATOR JOHN VASCONCELLOS *(D-Santa Clara)* Appointed to the Little Hoover Commission by the Senate Rules Committee in February 1997. Elected to the 13th State Senate District in 1996 after serving in the Assembly for 30 years. Chair of the Senate Public Safety Committee, the Senate Education Committee, the Subcommittee on Aging and Long-Term Care, and the Select Committee on Economic Development.

SEAN WALSH *(R-Oakland)* Appointed to the Little Hoover Commission by Governor Pete Wilson in December 1998. Former Deputy Chief of Staff, Communications & Press for Governor Wilson.

STANLEY R. ZAX *(I-Beverly Hills)* Appointed to the Little Hoover Commission by the Senate Rules Committee in March 1994. Reappointed in January 1998. Chairman and President of Zenith Insurance Company.

STANLEY M. ZIMMERMAN *(D-Beverly Hills)* Appointed to the Little Hoover Commission by Governor Gray Davis in January 2000. President of Home Budget Loans in Los Angeles, and involved with Mortgage Mart, Inc., a property management firm.

"Democracy itself is a process of change, and satisfaction and complacency are enemies of good government."

Governor Edmund G. "Pat" Brown,
addressing the inaugural meeting of the Little Hoover Commission,
April 24, 1962, Sacramento, California

The cover art was created by Shirley Cooley, an artist with the Creative Arts Consortium in San Diego, California. It is entitled "Being There," which inspired the title of this report.