Navigating the Currents:

A Guide to California's Public Mental Health System

California Association of Local Mental Health Boards and Commissions

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Introduction

Knowledge is a process of piling up facts; wisdom lies in their simplification.

— Martin H. Fischer

Over the past decade, California has emerged as a leader in developing innovative ways to fund and deliver public mental health services. From the passage of Proposition 63, the Mental Health Services Act, to unique cooperative efforts among mental health and correctional systems, California has pioneered model programs for success.

Although the public mental health system serves approximately 460,000[1] Californians, mental health stakeholders continue to identify challenges and opportunities to improve the ability of clients, families and professionals to access the services they need. The development of this publication, **Navigating the Currents: A Guide to California's Public Mental Health System**, was a collaborative project led by the California Association of Local Mental Health Boards and Commissions, and Eli Lilly and Company. The concept for the publication grew from the need to compile information on a variety of topics critical to understanding California's mental health system into a single resource.

The Guide provides insight into the organization and complicated structure of our state's mental health system and chronicles its complex history. This comprehensive overview of California's mental health system is divided into five sections:

- **Section I** covers a brief history of California's mental health care system and details the dramatic transformation that has taken place through policy implementation over the last 20 years.
- **Section II** explains the structure of mental health services, the roles and responsibilities of state and local governing bodies, and the allocation of funding.
- **Section III** dives deeper into the system of care at the county level, explaining the structure of county government and the interaction among county supervisors; mental health commissioners; and local organizations, agencies and programs.
- **Section IV** assesses the status of mental health care in California as of 2007 and the current mental health issues facing consumers, providers, legislators, and stakeholders related to treatment access, public attitudes, funding and insurance.
- **Section V** provides the full language of the policies that have reshaped California's mental health system and additional references for background purposes.

Navigating the Currents: A Guide to California's Public Mental Health System was developed to create a deeper understanding of California's mental health system among county supervisors, legislators, board members, commissioners, and other elected officials as well as mental health professionals, advocates, family members, clients and the media. The publication also addresses three important mental health care issues:

(1) What constitutes the goal of California's public mental health system, and what does the system seek to accomplish?

(2) Which organizations and agencies at the state, county and local levels have been tasked with accomplishing that goal, and what are their respective roles and responsibilities?

(3) Which government and community entities have been charged with ensuring that progress is made toward the goal, and what strategies are available for assessing progress and supporting system improvement?

This Guide will have served its purpose if its contents can help policymakers, individuals and organizations involved with California's public mental health system continue to break new ground in providing effective mental health care to all Californians in need.

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SECTION I: Historical Background

"Sociologists contend that the basic humanity of a society can be measured by how it treats its vulnerable populations. People who suffer from mental illness are one such vulnerable group. The early history of American policy toward people with mental illness was at best neglect, and at worst, punitive and cruel. Only in recent decades has progressive policy been evident. Current California policy does provide a basis for optimism for improved attitudes and improved services for people with mental illnesses, though not necessarily improved funding."[2]

The evolution of health care services for Californians with mental illness is a complex story of issues and challenges, involving both public attitudes and public resources. Over time, increased awareness and a better understanding of mental illness; a greater willingness to improve the situation; and cooperation among policymakers, providers and citizens, have resulted in many changes in the delivery of services for children and adults with mental illness in California.

CHAPTER 1. MURKY WATERS: 1850–1960[3, 4, 5, 6, 7, 8, 9]

State Mental Hospitals

The state's mental health system has certainly progressed since the days where mentally ill criminal offenders could be detained indefinitely by law or when the chronically addicted led appalling lives in jails or workhouses. As early as the 1850s, California began to build large public mental health institutions called "asylums" that were designed to care for individuals with mental illness more humanely. Other states were also separating mental health treatment from other public health care at this time. The typical state asylum was built on public land in rural areas, far away from any towns. Food for the institution's residents, referred to as "inmates," was grown on the land surrounding the facility. The idea was to provide a secure haven for individuals with mental illness, protect them from the harsh reality of community life, and keep them out of sight.

Thus, in the 19th century, municipalities in California shifted most of the costs and problems of caring for people with mental illness to state institutions. Patients whose wealthy families could afford better care were housed in secluded private facilities. But for many years, most care for behavioral health disorders would take place in large state facilities. In fact, virtually no community public mental health was provided except for individuals who were jailed before being institutionalized, until the 1960s. By the 1950s, all five existing state mental hospitals were overcrowded, with one doctor for every 300 patients. Options considered to relieve the overcrowding situation included deportation, parole, probation, and even sterilization.

Access to mental health treatment also depended on one's economic status. Private health insurance, which had been created primarily to address the high costs of hospitalization, did not cover behavioral health disorders. Patients who could not pay out of pocket for services were forced to rely on public sector programs. Those of means could obtain private medical treatment, and most psychiatrists treated self-pay patients. The few employer-paid benefit packages available at the time did not include coverage for mental illness. Behavioral health benefits did not become widespread in employers' group health plans until the post-World War II era of the 1950s, as veterans returned to work and labor unions sought to include general health and behavioral health benefits along with pay increases.

Thus, under the traditional state system, most individuals requiring public mental health services were treated for lengthy periods in state hospitals at taxpayer expense. Those diagnosed with a mental illness were historically "locked away" and might be subjected to electric shock therapy or frontal lobotomies. Later, they may have been forced to accept heavy medication. Most had limited contact with the general population and little hope for recovery.

Deinstitutionalization

This model changed significantly after World War II, when public discussions about community-based care emerged, focusing in large part on the questionable effectiveness of institutionalization. In addition, the positive outcomes of psychiatric treatment during the war years prompted a post-war surge in the interest in psychiatry.

During the 1950s, more effective treatments also began to be available, allowing better management of chronic mental illness. However, the medications available at this time often caused severe side effects,

and lack of effective treatment and community support services hampered the ability of most people with mental illness to function productively in society. But, the continued development of more advanced treatments stimulated hope in the potential for successfully treating mental illness as well as the substance abuse (i.e., street drugs) that often co-occurred.

The combination of more readily available medications, the high cost of institutional care, and a genuine concern for humane treatment of patients on the part of mental health professionals and public officials led to what has become known as the "Third Revolution" in mental health care. The community mental health movement, or deinstitutionalization, became the predominant mental health public policy in America. As a profound symbol of this movement, in 1953 shackles from mental institutions across the country were melted down and used to cast a "Bell of Hope," which became the organizational symbol for the National Mental Health Association.

During this period, the California Conference of Local Mental Health Directors, the precursor to the California Mental Health Directors' Association, formed a partnership among the State of California, its counties and some cities to improve the delivery of mental health services. Comprised of local mental health officers and physicians, the group had been active in early symposia on mental health in California in the mid-to-late-1940s, including a conference convened by Governor Earl Warren in 1949. Conference members wanted to ensure that local leaders in the field would help shape state mental health policy and make California's mental health system the leading program in the country.

Indeed, California became a national model for mental health legislation with passage of the Short-Doyle Act in 1957. This measure sought to improve mental health care by:

- "Deinstitutionalizing" mental health care by providing treatment for people with mental disabilities in the community rather than in state hospitals.
- Creating a funding structure for the development of a community-based system of mental health services.
- Directing most services to be provided through the counties under a voluntary, decentralized delivery system.

To assist in funding this new system of community-based care and encourage counties to participate, the state initially covered 50 percent of the costs for those counties that chose to establish a mental health system. Federal participation in this program was not initiated until 1971, when the Short-Doyle/Medi-Cal pilot project enabled counties to obtain a 50 percent federal match for Medi-Cal-eligible services to eligible individuals. In 1958, approximately 37,000 individuals with mental illness resided in California's state hospitals, a number that would decline to less than 1,800 over the next two decades as state facilities were closed and California, along with other states, began the slow process of moving its institutionalized populations back into the community.

It is important to note that the minority population of California in 1950 was less than 10 percent (Hobbs & Stoops, 2002). At that time, minority communities' need for mental health services received little attention in California and the nation as a whole. There were exceptions, however. In Texas, for example, E. Gartly Jaco (1959) observed that during 1951-1952 "Spanish-Americans" had similar admission rates as "Anglo-Americans" in public mental health facilities but were significantly underrepresented in private mental health facilities.

CHAPTER 2. TAKING BEARINGS: 1960–1990[10, 11, 12, 13, 14, 15, 16, 17, 18]

Community Mental Health Care

The community-based approach to mental health care was affirmed by President John F. Kennedy in his "Special Message to the Congress on Mental Illness and Mental Retardation" in February 1963, in which the President called for a new mental health program based on comprehensive community care. Kennedy outlined this as a new model that would bring mental health care to the mainstream of American medicine, improve mental health services, and make diagnosis and treatment readily accessible to all. Kennedy supported increasing mental health insurance coverage and redirecting state resources from state mental institutions to community mental health centers. The President also championed the belief that most mental illness could either be cured or ameliorated so that long hospitalization was unnecessary, thus reducing the plight of thousands of long-term patients in mental hospitals and the associated heavy financial burden.

The California Legislature set the precedent for modern mental health care in the United States by passing the Lanterman-Petris-Short (LPS) Act of 1968. This legislation, considered revolutionary in its time, established standards and legal procedures for the involuntary hospitalization of individuals. The statute eliminated lengthy, open-ended commitments, set forth the conditions under which individuals could be involuntarily hospitalized, and afforded them

with certain due process rights. A person could only be involuntarily detained and treated if there was probable cause to believe that because of a mental disorder, the individual was a danger to themselves, a danger to others, or gravely disabled (i.e., he or she could not provide for basic needs such as food, clothing or shelter).

The intent of the LPS Act was to end inappropriate, indefinite and involuntary commitment of individuals with mental illness and provide them with prompt evaluation and treatment. The Act:

FAQ: Imposing A Legal Hold

Under California's Welfare and Institutions Code, Section 5150, a legal hold may be imposed on a person who is believed to be in need of involuntary psychiatric treatment for up to 72 hours if there was probable cause to believe that because of a mental disorder, the individual was a danger to himself, a danger to others, or gravely disabled (i.e., he or she could not provide for basic needs such as food, clothing or shelter). When a person is initially detained involuntarily, the maximum period of this hold is 72 hours. It gives the professional person in charge of the hospital an opportunity to assess the individual face-to-face in order to determine the appropriateness of involuntarily detaining him or her.

The hospital does not have to hold the person for the complete 72 hours if they do not feel the person requires further evaluation or treatment. By the end of 72 hours, one of the following things must happen:

- The person may be released.
- The person may sign into the hospital as a voluntary patient.
- The person may be placed on a 14-day involuntary hold.

"Frequently Asked Questions, California Involuntary Mental Health Holds," California State Department of Mental Health, External Affairs, April 30, 2007.

- Guaranteed and protected public safety while safeguarding individual rights through judicial review.
- Created provisions and criteria for holds and established conservatorship programs with individualized treatment, supervision and placement services for gravely disabled individuals.
- Basically ended all hospital commitments by the judiciary system, except in the case of criminal sentencing, but did not impede the right of voluntary commitments.
- Expanded the evaluative power of psychiatrists.

The California Conference of Local Mental Health Directors, which in 1963 had played a key role in adjusting the formula for state- and county-shared funding of mental health services from a 50 percent state/50 percent local share to a 75 percent/25 percent split, also successfully advocated that the state/local ratio change to a 90 percent/10 percent ratio, which was accomplished in the LPS legislation.

Proponents of deinstitutionalization had hoped that individuals with mental illness would be able to live in their own communities with family and friends with support from local services and access to short-term hospitalization when necessary. But although patients were "deinstitutionalized," they often went back to communities where anticipated treatment services frequently did not materialize. Many formerly institutionalized clients were placed in small, inexpensive board and care homes, where they commonly received few services other than medication dispensing. The community mental health programs of the late 1960s and 1970s largely emerged as middle class outpatient programs, with some experimental prevention programs.

By the late 1970s, problems resulting from "deinstitutionalization" were becoming evident. Deinstitutionalization was not succeeding because financial support did not follow patients into the community. The Short-Doyle Act was the funding mechanism intended to build the community mental health system by moving state funds to community programs. However, Governor Ronald Reagan vetoed such provisions in 1972 and 1973, so the state failed to distribute the savings achieved through the closures of state hospitals to the community mental health system.

State allocations to counties to support community mental health were also severely diminished due to inflation throughout the 1970s and 1980s. Inadequate funding, coupled with inflation and an increasing number of patients with more serious problems left less than half of the level of funding needed to provide basic care for those who needed it. This resulted in increased homelessness and incarceration of individuals with mental illness, until eventually, county jails would become the largest de facto mental institution in California and the United States overall.

Not only was there growing concern about the failure of the mental health system to address the need of the general California population, there was particular concern about the mental health system's lack of responsiveness to communities of color. For example, Marvin Karno, a psychiatrist, observed that in an outpatient clinic during the late 1950s and early 1960s African-Americans and Mexican-Americans were treated differently than European-Americans. African-Americans and Mexican-Americans received less psychotherapy than Euro-Americans, and when they did receive such services it was of shorter duration (Karno, 1966). During the 1970s and 1980s, these basic findings were replicated in many locales across the country, not only among African-Americans and Mexican-Americans, but also among Asian-Americans and Native Americans (e.g., Sue, 1977). Explanations for the low service use ranged from cultural values and beliefs of communities of color to characteristics of the mental health services (e.g., limited number of staff from the respective minority communities, Wu and Windel, 1980). Recommendations were made to place services within minority communities, to have staff and board members representative of the communities of color, and to train personnel regarding the sociocultural context of the target communities. Oftentimes strong grassroots efforts were required to develop culturally responsive services during this time period, as was the case in the development of El Centro, a community mental health training and treatment center in Los Angeles. During the 1970s and 1980s, these represented novel and relatively independent initiatives that would later inform the *development of standards, guidelines and accountability measures to ensure cultural and linguistic competence throughout California's mental health system.*

"EL CENTRO Community Mental Health Center": From a Grassroots Movement to Culturally Specific Mental Health Services for Latinos[19]

One example of grassroots efforts leading to the development of culture-specific services is the case of El Centro Community Mental Health Center (see Aranda, 2001). In 1969 a group of Los Angeles-based social workers met with the deans of UCLA and USC's Schools of Social Work and raised their concerns about the lack of Latino students and faculty. A consensus was reached that a training center could help address these issues. Soon thereafter, this group of social workers, now members of the recently established professional organization, Trabajadores Sociales de la Raza, started the East Los Angeles Mental Health and Training Center. Eventually funds were obtained from the National Institute of Mental Health to support the training endeavors which were largely community based. By the mid-1970s, the center obtained county funds to provide direct services as a day treatment center. El Centro's biggest transition occurred in 1977 when they received federal funds as a comprehensive community mental health center. The success of El Centro is due to many factors. Unlike many mental health services at the time, it was centrally located in a large Spanish-speaking community and it was staffed with bilingual and bicultural personnel to address the community's needs. Also, the staff was willing to experiment with different approaches, both within the community and within their clinical setting, to provide culturally appropriate services. In addition, El Centro provided professional opportunities for young Latino mental heath professionals, many of whom are leaders in the local mental health field today. Although El Centro was forced to close its doors due to management problems, it began as a model program and its early years reflect the spirit of impassioned Latino mental health professionals dedicated to integrating the rich cultural resources of their clients in providing mental health care.

The Mental Health Consumer Movement[20]

The following was excerpted from "Reaching Across: Mental Health Clients Helping Each Other," Prepared by Sally Zinman, Howie the Harp and Su Budd, 1987.

> *"In 1970 a new movement began: a civil movement. Former mental patients collectively began to realize that what they had experienced in mental hospitals was unjust and oppressive. Involuntary commitment and forced treatment became basic issues of human rights. These former patients began organizing groups to fight for their rights, to stop the abuse and the oppression in psychiatric institutions, and to end the discrimination against and the stigma attached to former and current psychiatric inmates.*
>
> *First in Oregon and then in New York, California, Massachusetts, Kansas, Pennsylvania, Florida, and in other states, a movement grew.*
>
> *At the same time that these mental health clients were struggling against the psychiatric system, they recognized that people did have emotional and other life problems and that they needed some place to go to for help and support (but without the coerciveness and oppressiveness of traditional mental health programs).*

Groups of psychiatric survivors, in the United States and in Canada, formed client-run alternatives to help meet their needs. While some were weekly support groups and others were centers and houses, most were also involved in advocacy. All these alternative groups were (and still are) meeting the needs of clients who were not met by the mental health system.

For many years most groups had little or no funding but, although they were relatively small, they produced impressive results. People in these groups had their needs met in very real ways and their lives were improved. For almost a decade, client-run groups helped hundreds of people, but remained virtually unrecognized by "the system." Finally, in the last few years, the effectiveness of self-help, client-run programs became recognized and several groups around the county received major funding grants. Now, these and other self-help alternatives are expanding, developing programs, and hiring clients who before, could only work as volunteers.

Now that client-run alternatives are beginning to be accepted, they are forming in most states. Through conferences and teleconferences, state and national networks are developing. Individuals and groups who were previously isolated are now being connected, are now sharing information, and are now developing a unified voice.

The Los Angeles Child Guidance Clinic

Since its inception in 1924 as the first child guidance clinic west of the Rockies, the Los Angeles Child Guidance Clinic has built a rich history of leadership and innovation in the field of pediatric mental health. The clinic, which serves Central and South Los Angeles, is the oldest, continuously operating agency of its kind in the West. From its beginning, the Clinic has been at the leading edge of innovative mental health programming: starting in the 1940s when it adopted a multidisciplinary team approach to treatment to best understand the complexities of children's needs and develop individualized treatment plans that result in improved emotional and behavioral outcomes. This approach infused the professional perspectives and work of psychologists and social workers, and added child psychiatrists to the team shortly thereafter. This model of service delivery then evolved to also include a parent and family component that has resulted in the culturally sensitive, family centered, consumer-driven approach that exists today.

The Clinic enhances the mental health and well-being of children and youth ages 0-25 years, and their caregivers through:

- Family centered, culturally sensitive programs.
- Specialized educational services for seriously emotionally disturbed children and youth.
- Advocacy to secure needed services.

Philosophy of the Children's System of Care

The Children's System of Care (CSOC) for seriously emotionally disturbed children, adolescents and families represents a major shift from the previous method of providing special education, child welfare, health, and juvenile justice services in isolation from other education and human services. Children and youth with serious emotional disturbances, like other youth in high-risk situations, have special needs at home, in school and in community settings. In the past, child service providers often defined the needs of these clients differently, resulting in agency conflicts and fragmentation of services. Increased placement in group homes, state hospitals or the juvenile justice system and escalating costs often meant poor outcomes for children and families.

The basic goals of the CSOC model are to redirect funds and resources from institutional levels of care to local programs; keep children "safe, at home, in school, and out of trouble"; and improve child and family functioning. When the initial Ventura County pilot project began in 1984, a collaboratively organized service system was a new concept. Today, CSOC represents an accepted strategy to address the complex needs of children and families living with serious mental illness. It is the model for Proposition 63 children's services, and in fact, the only type of children's services that can be funded under the Mental Health Services Act.

New Responses — 1980s[21, 22, 23, 24, 25, 26, 27]

By the mid-1980s, California's counties began to respond, phasing out traditional outpatient programs and developing new programs aimed at outreach, stabilization and rehabilitation. But while the counties were working to expand much needed programs at the local level, the state continued to reduce available funding. From 1982 to 1987, no cost-of-living increases or caseload adjustments were made for community mental health, and in 1988 state funds were reduced again.

Additionally, unlike the provision of services to individuals with developmental disabilities, the mental health system had never been conceived as an entitlement. This essential difference in attitude, which built rationing of services into the framework of mental health service delivery, made it difficult for these programs to compete for State General Fund (SGF) monies during a time of economic recession and diminishing state revenues. Beginning in 1989, the state began to reduce its General Fund commitment to mental health services, and an additional 15 percent was removed from base funding for community mental health.

Despite the inadequate funding of services, mental health policy did witness advances during the 1980s. **Assembly Bill (AB) 3632, the Special Education Pupils Program**, introduced by Assembly Member Willie Brown (D-San Francisco) and enacted by the State Legislature in 1984, laid out a new framework under which schools would educate, mental health departments would treat, and social services would oversee the placement of children with severe mental illnesses. Funding to implement the new requirements was approximately $3 million statewide.

The Village

"The Village was originally designed with a "For Heaven's Sake, Find Something that Works," attitude. Over the years we have proven that individualized, recovery-focused services delivered with a "whatever it takes" approach can lead us to what all of us want – success. We measure success by that same thing you, the public and most importantly, our clients care about – getting a life."

— Paul Barry, Associate Director, The Village. Excerpted from testimony delivered to the California State Senate Budget Subcommittee #3 in March 2007

The Village Integrated Services Agency in Long Beach, California, is a recovery-based model serving adults and young adults recovering from mental illness. A program of the Mental Health Association of Greater Los Angeles, the Village tailors services to people with mental illness, its "members," and provides services and support to help people recognize their strengths and "power to live, learn, work and be involved" in the community.

One of the three original ISA projects funded by AB 3777 to demonstrate a community-oriented approach to mental health services delivery, in 1990 The Village began serving 120 clients who represented a cross section of the target population in terms of ethnicity, age and gender. The program's integrated services were later expanded to include the homeless, jail populations, and youth.

By incorporating many types of mental health care, including rehabilitation, treatment, self-help and family/community involvement, along with an emphasis on choice, equality between staff and members and encouragement of continued growth, The Village continuously enables the hope and empowerment individuals need for self responsibility and to obtain a meaningful role in life.

In 2006, the Village documented a 63 percent reduction in hospitalization days, an 86 percent reduction in incarceration days, a 71 percent reduction in homeless days, and a 302 percent increase in the number of days employed (greater than or equal to 20 hours per week).

The Village has been acknowledged as a model mental health program "of exemplary practice eligible for federal funding for implementation in local communities." The Village has also emerged as a major training program, offering innovative approaches that have been valuable in affecting widespread system change. In 2003, after visiting The Village, the President's New Freedom Commission on Mental Health cited the program as a model for creating comprehensive state mental health plans to coordinate services. The Village has played a major role in the promotion, passage and implementation of Proposition 63, the Mental Health Services Act.

Prior to 1984, all special education services for children were provided by local school districts. But a special education lawsuit revealed that the state's treatment of seriously emotionally disturbed children in school did not meet the federal government's requirement that schools serve all children. AB 3632 transferred responsibility for providing mental health services to special education students from the school districts to county mental health departments. This program was intended to: (1) build on the counties' existing responsibilities and expertise in providing mental health treatment; and (2) facilitate collaboration between the schools and the public mental health system in serving students.

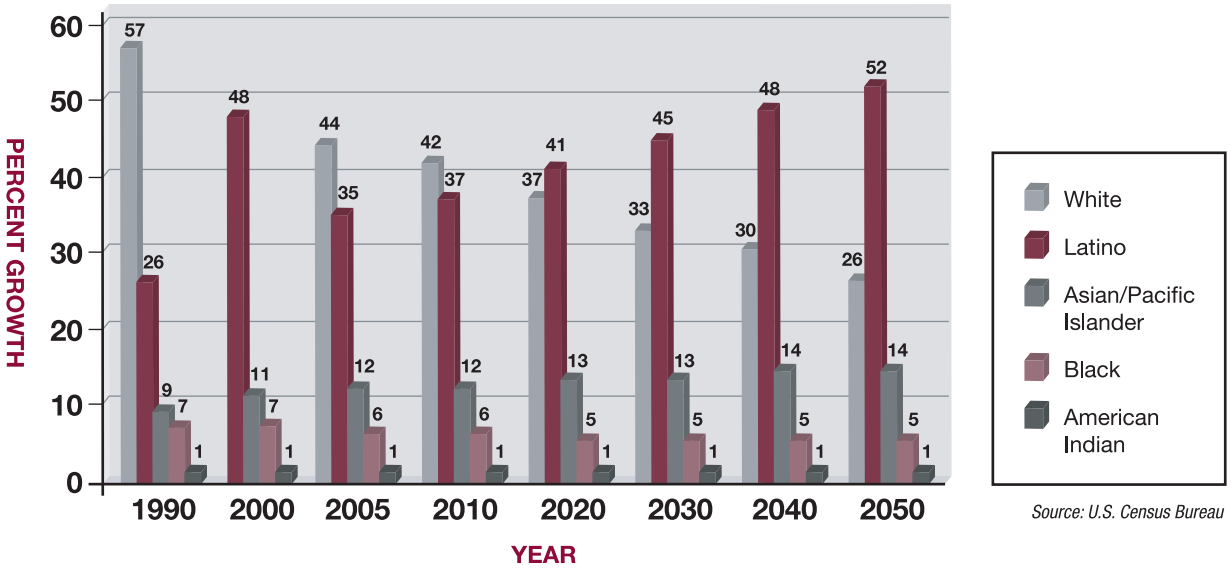
While state law now requires the counties to provide these services, the programs provided under AB 3632 also allow California's public education system to fulfill its federal obligation to students with special needs. The federal Individuals with Disabilities Education Act (IDEA) mandates free, appropriate public education for all children with disabilities to prepare them to live and work in the community. This federal entitlement program guarantees mental health treatment for children and adolescents less than 22 years of age who have an emotional disturbance and are in need of mental health services to benefit from the public education mandated by the Act, regardless of their parent's income level. Counties are reimbursed for their costs in providing these services through a variety of sources currently, including some federal IDEA funds, some state General Fund and mandate reimbursement claims.

In 1987, **AB 377**, sponsored by Assembly member Cathie Wright (R-Canoga Park, Chatsworth, Northridge, Oxnard, Simi Valley, Thousand Oaks), expanded the Children's System of Care pilot program developed in the early 1980s in Ventura County, which was created to test the effectiveness of coordinated, closely monitored community- and home-based services for severely emotionally disturbed children.

Another milestone was reached in 1988, when the passage of the Wright, McCorquodale, Bronzan Act (AB 3777), established reforms regarding services to adults with serious mental illness. The Act instituted the "systems of care" service delivery model consisting of consumer- and family focused services, personal service plans, coordinated care, intensive case management assistance, and measurable and accountable delivery of services. The legislation established three integrated service agency (ISA) demonstration pilot projects in Ventura, Los Angeles and Stanislaus counties – to demonstrate how a community-based, integrated care system could help adults with serious mental illness. Although independent evaluations as well as reviews conducted by the California Department of Mental Health (DMH) showed that the integrated approach behind these projects was cost effective and highly successful, funding was not provided for similar programs in other counties. Ultimately this became the model utilized for providing services under AB 34 and AB 2034, which subsequently became the model for Proposition 63.

CHAPTER 3. WAVES OF CHANGE: 1990–2000[28, 29, 30, 31, 32]

Population Comparison/Projections: California



Source: U.S. Census Bureau

According to a report issued in 1990 by the California Mental Health Directors Association (CMHDA), support for California's mental health system was reduced by $320 million between 1975 and 1990 because of unfunded client population growth and increases in the cost of providing services. The passage of Proposition 13 (property tax reform which resulted in cuts in local property tax revenue for counties) in 1978 further eroded the counties' ability to provide needed funds. The California Coalition on Mental Health (CCMH), an advocacy group comprised of 32 organizations representing mental health professionals, citizen advocates, mental health clients, and families, agreed that more and more Californians with serious mental illness were not receiving assistance due to a lack of funding, which in turn was resulting in increased homelessness and incarceration of these individuals.

The California Mental Health Planning Council (CMHPC), a state and federally mandated advocacy agency charged with oversight and accountability for public mental health issues, also reported at this time that California's mental health system was not only inadequate financially, but also suffered from a lack of clear governance structure. While the state controlled the funding and the counties were responsible for providing services and operating programs, neither side was fully accountable.

California's Master Mental Health Plan[33, 34]

California had gone from being a national leader in community mental health development in the 1960s to a situation characterized by funding instability and programs in turmoil. By 1990, the cumulative impact of annual funding cuts throughout the past decade resulted in a significant underfunding of services. In 1991 policymakers faced a projected $14.3 billion state budget shortfall that meant drastic cuts to mental health services. Many community mental health officials found their programs overwhelmed with demand, unable to meet client needs, and near collapse. Mental health advocates, fearing that the massive program cuts would be irreparable, begin discussions on system reforms. The crisis required that significant policy and fiscal decisions regarding the future of community mental health programs be made quickly. Ultimately this became the impetus for a realignment of funds for mental health services provided by counties.

Various constituent groups came to the State Legislature with proposals, and the stage was set for substantive change to mental health policy. Subsequent new legislation introduced by Assembly Member Sam Farr mandated a planning process to guide the future of California's mental health system. **AB 904** directed the CMHPC to create a master plan for reform.

- The legislation was based on federal law PL 99-660, which required the development of state plans for services to individuals with serious mental illnesses and provided federal funding to achieve that goal.
- The intent of AB 904 was to ensure that all major constituencies — representatives of the family and client movements; professional organizations; county mental health directors; patients' rights groups; and legal, medical and social model advocates — were included in the planning process for a final product that would reflect consensus.

The AB 904 planning process was remarkable in that it succeeded in bringing together disparate stakeholder groups which had spent years arguing over philosophical issues and resource allocation. The family and client movements,

Fundamental Concepts of the Master Plan

- Client- and family driven mental health system of individualized, comprehensive care.
- Focus on wellness that includes the concepts of recovery and resilience.
- Culturally competent programs and services that eliminate racial and ethnic mental health disparities.
- Community collaboration in which various stakeholders share information and resources to accomplish a shared vision.
- Full range of integrated services and multi-agency programs to meet individual and family needs.
- Expanded services to children and adults in underserved populations.
- Commitment to outcome monitoring and system accountability.
- Transformation of the public mental health system through enhanced funding and delivery capacity.

for example, had come to the table angry and frustrated over what they saw as unfair treatment by the system and discrimination by society in general. But stakeholders rose to the occasion and sought common ground, realizing that the most important goal was to improve and stabilize California's faltering mental health system.

The resulting consensus document, the **California Mental Health Master Plan**, provided a clear and shared vision for mental health constituents in California and became the blueprint for the state's mental health services program into the year 2000.

The Plan was updated in 2003 and many of the fundamental concepts outlined are now reflected in the Mental Health Services Act.

Realignment[35, 36, 37, 38, 39, 40, 41]

In the 1990s, mental health reform, program and funding realignment, client and family involvement, and strong leadership at both the state and county level would re-establish California's prominence as a national leader in public mental health. But in 1991, California again faced a serious budget crisis with a $14.3 billion deficit. To keep the collective vision of the *California Mental Health Master Plan* on the horizon, state policymakers had to navigate through the prospect of potentially devastating budget cuts. So, the State Legislature sought to make major structural and programmatic changes as a part of a budget solution.

Much of the vision articulated in the Master Plan was enacted into law as the Bronzan-McCorquodale Act of 1991, also called "realignment." This legislation represented a major shift of authority from the state to the counties for mental health programs. Realignment was intended to: (1) provide a more stable funding source for community based services; (2) establish local county advisory boards to advise local mental health directors; (3) make services more client-centered and family focused; (4) develop performance measures and outcome data; and (5) redefine the state's role and responsibility in providing services and program oversight and evaluation.

Realignment made counties specifically responsible for a target population of children with serious emotional disturbances and adults with severe mental illnesses.

Realignment literally realigned, or transferred, financial responsibility for most of California's mental health and public health programs (and some of its health and social service programs) from the state to local governments and adjusted cost-sharing ratios. Under the new structure:

- Certain programs were realigned from the state to the counties, including all community-based mental health services, state hospital services for civil commitments, and Institutions for Mental Disease (IMDs), which provided long-term nursing facility care.
- Counties were provided with a dedicated, new revenue source to pay for these changes.
- Community mental health funding was removed from the State General Fund (SGF) and annual budget process.
- State oversight responsibility would increasingly focus on outcomes and performance-based measures rather than programming.

Realignment financed mental health services and health and social services through two dedicated funding streams: (1) a half cent increase in the state sales tax; and (2) the state vehicle license fee (VLF), an annual fee on the ownership of registered vehicles in California based on the estimated current value of the vehicle, which is collected by the state on behalf of the counties. In 1992, realignment funding for mental health totaled about $700 million.

The statute defined appropriate uses for these funds and established definitions for priority target populations to help focus how resources would be spent. Specifically, counties were only required to provide services to individuals with severe mental illness or serious emotional disturbances to the extent that resources were available. This clause (to the extent that resources were available) was inserted to ensure that neither an entitlement nor a mandate were created, and to eliminate any expectation of serving anyone who didn't have a severe mental illness or serious emotional disturbance. Thus, there was no entitlement or mandate to serve anyone.

Revenues from the new taxes were deposited into a state Local Revenue Fund and dedicated to funding the realigned programs. Each county would receive deposits into three separate program accounts for mental health, social services and health using a basic formula that determines the amount to each county and each account, which was included in the legislation.

Realignment represented a partnership between the state and county governments regarding the provision of mental health services. The fundamental tenet of the new system was to provide the counties with more discretion in spending state funds. Realignment provided county mental health program managers with many opportunities, including:

- A stable funding source for programs, which has made long-term investment in mental health infrastructure financially practical.
- Greater decision-making power, discretion, control, and long-term planning potential.
- Increased fiscal flexibility to design and purchase services based on client needs.
- The ability to streamline bureaucracy and reduce overhead costs.
- Financial incentives to properly manage mental health resources.
- Removal of traditional "spend it or lose it" requirements, a change that allows the "rollover" funds from one year to the next and multiyear funding of projects.

According to the California Mental Health Planning Council (CMHPC), the realignment of mental health services in California is generally viewed as a moderate success, albeit not a total solution. Among its accomplishments, realignment has:

- Provided some fiscal stability, although sales tax revenues fluctuate with the economy.
- Precluded additional SGF reductions to mental health services that would likely have occurred during the early to mid-1990s.
- Improved service delivery by implementing a client centered system of care approach.

Local County Advisory Boards

In the California Mental Health Master Plan the California Mental Health Planning Council outlined recommendations for system accountability and oversight. In this section, the role of mental health boards and commissions is featured:

"ROLE OF MENTAL HEALTH BOARDS AND COMMISSIONS [MHBCs] IN SYSTEM OVERSIGHT AND ACCOUNTABILITY

MHBCs have an important role to play in system oversight and accountability. Section 5604.2 of the Welfare and Institutions Code authorizes MHBCs to engage in various oversight activities, such as evaluating the community's mental health needs, services, and facilities; advising the governing body and the local mental health director about the local mental health program; and submitting an annual report to the governing body on the needs and performance of the county's mental health system. In addition, Section 5604 states that the board membership should reflect the ethnic diversity of the client population in the county.

MHBCs are essential partners of the CMHPC in the process of using performance indicator data for system oversight. Particularly relevant is Section 5604.2 (a)(7), which requires that the mental health board review and comment on the county's performance indicator data and communicate its findings to the CMHPC. Because understanding the local context is so central to understanding the performance of a county mental health program, MHBCs have a very important role to play in the process of using performance indicator data to evaluate local programs.

8.7. Recommendation:
The CMHPC should provide performance indicator data to MHBCs along with material to assist them in understanding and interpreting the data.

8.8. Recommendation:
The CMHPC should also provide a consistent statewide format that MHBCs should use to report their findings to the CMHPC.

8.9. Recommendation:
The CMHPC should use the reports from the MHBCs along with its own analysis of the results to prepare reports."

- Eliminated categorical program requirements and funding, which has enabled counties to design more innovative programs.
- Increased services to target populations of adults and children with the most serious mental illnesses.
- Established performance outcome measures and the use of consumer-tested instruments with proven reliability.
- Reduced the utilization of state hospitals and moved more care to communities.

Other assessments of realignment point to the relationships and trust developed through the consensus process of the Master Plan and the community infrastructure that was forged among various constituent groups. In describing the development of California's publicly funded mental health system; Sandra Naylor Goodwin of the California Institute for Mental Health (CiMH) and Rusty Selix of the California Council of Community Mental Health Agencies (CCCMHA) cite a number of significant outcomes from realignment in "Development of California's Publicly Funded Mental Health System, 2004." These included: (1) a coherent statutory mission statement based on a common vision and philosophy of services; (2) a systems of care treatment approach with a minimum array of services; (3) increased participation in decision-making by consumers and advocates; and (4) responsibility for integrated, long-term planning and program design at the local level. These accomplishments laid the groundwork for future reforms under the 1993 Medi-Cal Managed Mental Health Plan.

Changes in Medi-Cal Programs[43, 44, 45, 46, 47, 48]

California participates in the federal Medicaid program (called Medi-Cal), the heart of the state's public health system. This national entitlement provides medically necessary care for indigent families, dependent children, and disabled children and adults. Originally, mental health treatment accounted for only a small portion of the program. The available mental health services (which were limited to treatment provided by psychiatrists, psychologists, hospitals, and nursing facilities) were reimbursed through the Fee-For-Service Medi-Cal system (FFS/MC).

As mentioned, the Short-Doyle county mental health programs did not receive federal funding until the early 1970s, when it became apparent that these programs were treating many Medi-Cal beneficiaries. Short-Doyle/Medi-Cal (SD/MC) began as a pilot project in 1971, when counties agreed to take on responsibility for managing mental health services mandated by the federal government for states to provide. Under SD/MC, federal funds were made available to match county funding for a broader range of mental health services for Medi-Cal-eligible individuals than those provided by the original Medi-Cal program.

In 1993, a **Medicaid State Plan Amendment** added more benefits for SD/MC under the federal Rehabilitation Option. The amendment:

- Allowed services that reduced institutionalization and helped people with mental disabilities live in the community.
- Broadened the range of service providers and expanded the locations where services could be delivered both by county providers and through contracts with private clinicians.
- Added services; such as, inpatient hospital, psychiatric health facility, adult residential treatment, crisis residential treatment, crisis stabilization, intensive day treatment, day rehabilitation, linkage and brokerage, mental health services, medication support, and crisis intervention.

However, the loosely managed SD/MC program lacked the coordination, systems of care and cost-effective strategies of the overall county mental health program. In the mid-1990s, state officials determined that more efficient use of Medi-Cal funds could be achieved by consolidating SD/MC with county mental health systems of care. California was allowed to create county-operated, specialty managed mental health care plans with waivers from the Medicaid freedom-of-choice requirements under the Social Security Act. Mental health consolidation charged the counties with providing mental health services granted under Medi-Cal, expanding their traditional responsibility to provide services for the indigent. This significant change enabled counties to greatly increase their claims for federal Medicaid funds.

The two Medi-Cal mental health systems, the original FFS/MC and the SD/MC, first operated as separate programs. In order to enable counties to provide more integrated and coordinated care, the state developed a plan to merge the two Medi-Cal funding streams for mental health services. This would help shift from a heavily hospital-based system to a community-based system. Research had shown that a single integrated system of care was critical to successfully treat persistent mental illness, and that the needs of individuals with mental illness were not always adequately met in an all-inclusive managed health care system. This led the state to "carve out" specialty mental health services from other Medi-Cal managed care services.

Implementation of **Medi-Cal Mental Health Managed Care** included consolidation of Medi-Cal psychiatric inpatient hospital services under "Phase I" beginning in January 1995, followed by consolidation of Medi-Cal specialty mental health services under "Phase II" from November 1997 through June 1998. Together, these two implementation phases consolidated the two existing Medi-Cal mental health programs, Short-Doyle and Fee-For-Service, into one service delivery system. Under the new system:

- Psychiatric inpatient hospital services and outpatient specialty mental health services such as clinic outpatient providers, psychiatrists, psychologists, and some nursing services became the responsibility of a single entity in each county called a Mental Health Plan (MHP).
- All Medi-Cal recipients would obtain services through MHPs.
- The state Department of Mental Health (DMH) would have monitoring and oversight responsibility of MHPs to ensure quality of care and compliance with federal and state requirements.

Policy development for all phases of the implementation included an ongoing public planning process in which the DMH and other state agencies, the California Mental Health Directors Association (CMHDA), the California Mental Health Planning Council (CMHPC), providers, advocates, individuals receiving services, family members, and other interested parties participated. Consolidation not only shifted public mental health services to county mental health plans and allowed counties to claim federal funding, but the process also resulted in a noteworthy transition from an inpatient-focused treatment system in the private sector to an outpatient system that included rehabilitation and recovery.

Mental Health Plans and cultural competence

"Each [mental health] plan shall provide for the culturally competent and age-appropriate services, to the extent feasible. The plan shall assess the cultural competence needs of the program. The plan shall include a process to accommodate the significant needs with reasonable timelines. The department shall provide demographic data and technical assistance. Performance outcome measures shall include a reliable method of measuring and reporting the extent to which services are culturally competent and age appropriate."

California Welfare and Institutions Codes (WIC) 14684(h)

Early and Periodic Screening Diagnosis and Treatment[49, 50, 51, 52, 53]

The next milestone in funding for individuals with mental illness centered on children's mental health services. In 1995, the Mental Health Advocacy Services filed a lawsuit against the state for ignoring the **Early and Periodic Screening Diagnosis and Treatment (EPSDT)** program. This federal Medicaid provision required mental health diagnostic and treatment services for all Medi-Cal-enrolled children. As a result of the legal settlement, the California Department of Health Services (DHS) expanded Medi-Cal services to Medi-Cal beneficiaries less than 21 years of age who needed specialty mental health services, whether or not such services were covered under the Medicaid State Plan. Technically, the counties were responsible for providing services but they had insufficient funding and therefore no ability to provide these services.

- California agreed to provide counties with matching State General Fund (SGF) for their expenditures for these expanded specialty mental health services.
- DHS developed an interagency agreement with DMH through which county mental health plans would be reimbursed the entire nonfederal cost share for all EPSDT-eligible services in excess of each county's expenditures for such services during Fiscal Year 1994-95.
- In Fiscal Year 2002-2003 then-Governor Gray Davis administratively imposed an additional 10 percent share of cost on county mental health plans (over and above the baseline funds they already provided) for any growth in cost of EPSDT services.

Advances in Medications[54, 55]

For decades, a general lack of understanding, fear of draconian treatments and medications, and the public and private stigma associated with mental illness kept many people from seeking help. Beginning in the 1970s, advanced technology allowed scientific studies of the brain and behavior, and although researchers were beginning to understand the chemical imbalances that caused mental illness, there was still widespread skepticism about the biological nature of these disorders.

The 1980s were known as the "decade of the brain," because of the further research that led to the development of medicines that could effectively treat depression usually without the serious side effects of previously available medicines. Although not without side effects, the effectiveness of the newer medications in relieving symptoms brought about a revolution in mental health care. For the first time, people could receive treatment for mental illness in a more socially

acceptable way. Additionally, the success of these medicines proved that the conditions were biologically based since many people responded to medical treatment, and side effects while still present, were less serious for most. This completely changed the relationship between psychiatrists and families, building a new-found trust and partnership in treatment.

Access Coalition for Mental Health[56]

In the late 1990s the U.S. Food and Drug Administration approved several breakthrough medications shown to provide improved management of schizophrenia with fewer side effects. Despite the undisputed scientific evidence, California's Medi-Cal program opted not to add the medications to its formulary, noting the medications were "too expensive." The Mental Health Association in California spearheaded an effort to mobilize key stakeholders from the public and private sector for the Access Coalition for Mental Health. Consumer advocates, psychiatrists, public health officials and mental health advocacy organizations teamed up to inform elected officials about the access challenge of thousands of Medi-Cal recipients and the resulting cost to California. The Mental Health Association and Access Coalition utilized research data from a University of Southern California study that found the financial benefits resulting from the new medicines would more than offset their costs by improving consumer compliance and reducing side effects. This meant the state would save money it spent on hospitalizations and incarcerations often resulting from older, less effective medications. The Coalition conducted media outreach featuring compelling consumer stories that powerfully showed how the new medications could change lives and save state resources. The Access Coalition's unprecedented partnership among stakeholders and its efforts to generate widespread publicity around mental health issues created new opportunities to reduce stigma, increase awareness and establish the mental health community as a force to be reckoned with in the policy arena.

In the early 1990s a new psychopharmacological treatment for schizophrenia was approved by the U.S. Food and Drug Administration. Although not without side effects, these medications were considered an advancement for many people with schizophrenia who were not as responsive to the previous ones. This contributed to the premise that recovery was possible. By 1996, a new class of medications began to make a difference for many individuals with mental illness by reducing symptoms, improving cognition and minimizing the debilitating effect of severe mental illness.

Access to the new medications presented these individuals with the opportunity to enhance their ability to live and work in their communities. These new medicines were designed to correct the imbalance of chemicals in the brain, and they showed that many people with severe mental illness could be treated on an outpatient basis, relying less on hospitalization, and that many of them could regain control of their lives and function in society, especially when community-based wraparound services were provided in tandem with medication.

However, the advent of new and improved treatments raised policy and budgetary issues. One controversial strategy, Medi-Cal's "fail first" policy, required mental health consumers to try and fail to positively respond to the older, less expensive drugs – twice – before the newer medicines could be authorized. Because the older medications often caused severely debilitating side effects, there were few who wanted to take them. Consequently, individuals would sometimes fail on the older drugs, stop taking them, and end up hospitalized for mental health crises. This was resulting in thousands of dollars in additional hospitalizations, far outweighing the cost of the newer medicines. A comprehensive public affairs campaign led by mental health stakeholders in the Access Coalition for Mental Health publicized this penny-wise and pound-foolish practice and spearheaded efforts to change state policy to improve access to the newer medications to ultimately enhance outcomes and reduce state spending.

Surgeon General's Report of 1999[57, 58]

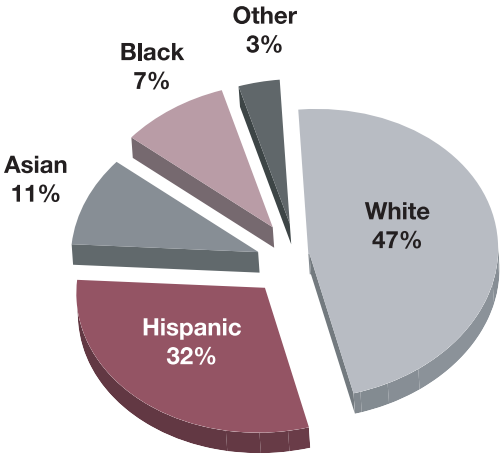
The *Report of the Surgeon General on Mental Health*, published in 1999, was a collaboration between two federal agencies: the Substance Abuse and Mental Health Services Administration (SAMHSA), which provides national leadership and funding to improve the availability, accessibility and quality of mental health services; and National Institutes of Health (NIH), which supports and conducts research on mental illness and mental health through its National Institute of Mental Health (NIMH).

The Surgeon General's report supported existing estimates that 28 percent to 30 percent of the U.S. adult population had either a mental or addictive disorder during a given year. The statistics revealed that 19 percent to 21 percent had a mental disorder alone; 3 percent had both mental and addictive disorders; and 6 percent had only addictive disorders (of which 85 percent were alcohol-related).

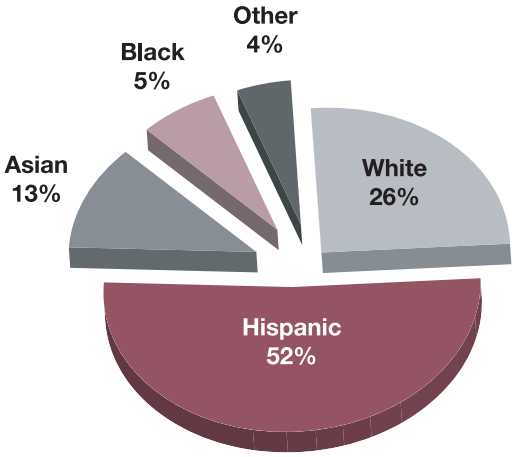
State Ethnic Composition

According to new projections by the California Department of finance, the state's population will soar to nearly 60 million people by 2050 and Hispanics will constitute the majority by 2042.

2000 State Ethnic Composition



2050 State Ethnic Composition



Source: California Department of Finance, July 2007

The report recognized the "inextricably intertwined relationship between … mental health and … physical health and well-being." While noting the extraordinary progress in improvement to public health through medical science and treatment services, the Surgeon General acknowledged the stigma, shame and sense of hopelessness still attached to mental illness and disorders such as schizophrenia, depression and bipolar disorder, and Alzheimer's disease that affected nearly one in five Americans at the time. For the country to reduce the burden of mental illness, improve access to care, and acquire knowledge about the brain, mind and behavior so urgently needed, this stigma could no longer be tolerated.

The Surgeon General's report sought to dispel common myths about mental illness, provide accurate knowledge, and create more informed consumers. Organizations and individuals were encouraged to use the information in their own efforts to combat what the report called "the insidious effects of stigma." According to the report, the majority of Americans in need of mental health services were not seeking treatment. However, the reluctance of individuals with mental illness to obtain care was understandable, given the many barriers standing in their way. There were grave disparities in the availability of and access to mental health services due to racial and cultural diversity, age, gender, and financial status-significant, but not insurmountable barriers the Surgeon General urged be taken down.

Above all, the information contained in the Surgeon General's report was intended to be translated into action and to help Americans *seek help for mental illness*. The report listed the following "calls to action" as the necessary first steps toward overcoming the gaps in mental health services and to removing barriers that kept people from obtaining mental health treatment.

- Improve public awareness of effective treatment.
- Ensure the supply of mental health services and providers.
- Ensure delivery of state-of-the-art treatments.
- Tailor treatment to age, gender, race, and culture.
- Facilitate entry into treatment.
- Reduce financial barriers to treatment.

California's advances in promoting cultural competence

1990 California Mental Health Directors Association creates Ethnic Services Committee

1991 Mental health legislation (AB 1288, AB 1491) mandates cultural competence

1993 First cultural competence summit

1997 California Department of Mental Health establishes cultural competence plan requirements

1998 California Department of Mental Health creates Office of Multicultural Services

Excerpted from "Proceedings from the California Mental Health Directors Association Conference, 2002."

Diverse Needs Require Diverse Responses[59, 60]

As California's diversity expanded so did the need to provide appropriate mental health services for people of color. Because culture plays an essential role in how individuals define mental health and respond to services, it was quickly becoming apparent that mental health programs need to adapt to truly serve local communities and their citizens. Many multicultural communities encounter significant barriers to services and as a result find that "mainstream" mental health services do not meet their needs.

At the national level, policymakers, researchers, and service providers were attending more and more to issues of culture. Terry Cross and his colleagues developed a model of cultural competence, oftentimes referred to as the Georgetown model, which has guided many organizations to improve services for communities of color.[61] They refer to *cultural and linguistic competence as a set of behaviors, attitudes and policies that come together in a system to enable effective work across cultures. "Culture" refers to a pattern of human behavior that include the language, thoughts, communications, actions, customs, beliefs,*

Multicultural programs become a priority in California

Throughout the 1990s, state and local mental health administrators were increasingly focused on cultural competence, and the need to improve efforts to provide appropriate mental health services in ethnic communities. The Georgetown model guided some of these efforts.

During this time the California Mental Health Directors Association created its Ethnic Services Committee, which "… works to ensure that mental health services meet the increasing mental health needs of diverse ethnic populations. The Committee also actively addresses the conditions that contribute to and are indicators of a great need for relevant, high quality mental health services."

The Committee's goals are as follows:

- Promote the development of appropriate mental health services that will meet the needs of clients of different ethnic, gender, religious, and cultural backgrounds by addressing mental health issues impacting county programs.
- Participate in planning and policy formulation to ensure that diverse cultural minorities receive access, and adequate and appropriate services.
- Be available to consult with local planning boards, advisory groups, and task forces to help ensure that services to global minorities and cultures are enhanced.
- Review and critique materials generated at the state and local levels, including but not limited to proposed legislation, state plans, policies, and other documents.
- Embed cultural and ethnic competence into system reform opportunities, managed care, recovery model performance outcomes, and State Quality improvement Committee.
- Assure appropriate training in cultural competency is being provided at the county, state and federal levels.

http://www.cmhda.org/committees/com_esm.html

In 1998 the State Department of Mental health created the Office of Multicultural Services to provide "…leadership direction to the Department of Mental Health (DMH) in promoting culturally competent mental health services within California's Public Mental Health System. The Chief of the Office of Multicultural Services serves as a member of the executive staff in developing policies and procedures to ensure that cultural and linguistic competence guidelines are incorporated within all facets of the Department of Mental Health. Mental health care providers and managers must understand the importance of language and culture in delivering appropriate mental health care. Culturally and linguistically sensitive mental health services improve outcomes and are cost-effective. The Office of Multicultural Services is charged with a leadership role in the development of the Cultural Competency Plan, ensuring culturally appropriate treatment intervention, services, and assessment in each of California's diverse counties. These elements are fundamental to the successful implementation and delivery of managed mental health services. Each county Mental Health Plan (MHP) is responsible for providing an annual Cultural Competency Plan to DMH that enumerates the planned strategies for providing cultural and linguistically competent care.

http://www.dmh.ca.gov

values, and institutions of racial, ethnic, religious or social groups. "Competence" implies having the capacity to function effectively as an individual and an organization within the framework of cultural beliefs, behaviors and needs presented by consumers and their communities. In addition, they describe a culturally competent system as one that "acknowledges and incorporates – at all levels – the importance of culture, the assessment of cross cultural relations, vigilance toward the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally unique needs."

Cross and colleagues also developed a conceptual model that describes where a given mental health system falls along a continuum of cultural competence, ranging from "Cultural Destructiveness," described as outright discrimination and even genocide, to "Cultural Proficiency," described as a position of holding culture in high esteem. Cultural Proficiency is defined as five essential elements that must function at every level of a system. They include:

1. *Valuing diversity – Seeing and respecting diversity's worth.*
2. *Cultural self-assessment – Understanding the existing culture to better interface with other cultures.*
3. *Dynamics of difference – Recognizing the perspectives of the cultures to integrate appropriate interventions.*
4. *Institutionalizing cultural knowledge – Reaching out to community partners to gain a deeper understanding of cultural perspectives and beliefs and building services based on the community partners' perspectives.*
5. *Adaptation to diversity – Creating a better fit between the needs of the minority groups and the services available.*

California's advances in promoting cultural competence

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Mentally Ill Offender Crime Reduction Grant Program[62]

In 1998 the Mental Health Association in California (MHAC) spearheaded an unprecedented effort to learn "what works" in reducing recidivism among mentally ill offenders. The need for such an initiative had become crystal clear. The MHAC partnered with the California State Sheriffs' Association (CSSA) after commissioning a study with the Pacific Research Institute that showed that mental health spending in corrections equaled increased state spending for the entire public health system.

The MHAC sponsored and CSSA supported legislation that created the Mentally Ill Offender Crime Reduction (MIOCR) grant program (Chapter 501, Statutes of 1998) which was designed to create relationships between county mental health departments, sheriffs, the courts and additional stakeholders that didn't previously collaborate to provide services to mentally ill offenders. The State Legislature ultimately invested about $75 million in this program over two years, which supported the implementation and evaluation of 30 projects addressing service needs identified by counties. Most projects involved a combination of in-custody services (e.g., discharge planning) and intensive community-based mental health treatment and support services (i.e., Integrated Services Agencies), including assistance in securing disability entitlements, housing, vocational training, and employment; counseling; life skills training; substance abuse education; medication management and support; and crisis intervention.

The statewide evaluation of this initiative indicated that the enhanced services provided by the MIOCR projects had a significant and positive impact on recidivism. For example, individuals participating in these projects, when compared to individuals receiving treatment as usual, were booked into jail less often and when they did re-offend, they committed less serious offenses. The MIOCR projects also made a statistically significant, positive difference on homelessness, economic self-sufficiency and other "quality of life" outcomes.

The MIOCR demonstration grant program came to an end in June 2004. However, in July 2006, as a result of efforts by the CSSA, the State Legislature re-established the MIOCR program and expanded it to include juvenile offenders with mental illness (Chapter 48, Statutes of 2006). Following a competitive Request for Proposal process and an evaluation of 75 proposals by 12 subject-matter experts, the Corrections Standards Authority awarded available funds (nearly $45 million) to 22 projects targeting adult mentally ill offenders and 22 projects targeting juvenile offenders with mental illness. All of these projects are anchored in practices that have proved effective in helping persons with mental illness function productively and independently within the community.

After being in and out of jail for most of his adult life, D. joined Butte County's Forest Project, an effort that combined a mental health court with intensive treatment and case management offered by a multidisciplinary team. Diagnosed with schizophrenia, the 37-year-old D. also had a 20-year addiction to methamphetamine, which presented a real challenge to the Forest Team.

While in this project, D. went through a rehabilitation program, started counseling and never once relapsed into drug use. When he "graduated" from the program, Judge Stephen Benson presented D. with a special plaque during a ceremony in the courtroom. D.'s mother and 16-year-old daughter, whom he had not seen since she was an infant, were beaming proudly in the audience. "It was the best program," said D. "I got a head start on life again."

Adult Systems of Care/Integrated Services for Homeless Adults[63, 64, 65]

With the passage of **AB 34** *(Steinberg – D-Sacramento)* in 1999, $10 million in state funds were allocated by the Department of Mental Health (DMH) for a three-county pilot program directed at serving homeless individuals, parolees and probationers with serious mental illness. County mental health agencies in Sacramento, Stanislaus and Los Angeles used the funding to expand and improve their existing homeless programs. Continued eligibility for state funding depended on demonstrated, positive client results and system outcomes within the first year in all three counties.

A report to the Legislature compiled in May 2000 clearly showed that the programs were not only cost-effective, but successful in procuring needed services for homeless individuals. Participants in the program experienced:

- A 65.6 percent drop in the number of hospital days
- An 81.5 percent drop in the number of days spent in jail
- A 79.1 percent drop in the number of days spent homeless
- An increased level of employment

When the bill was initially proposed, many in the advocacy and criminal justice communities anticipated that only a fraction of homeless individuals with mental illness approached would accept services because that had been their experience in the past. However, the success of AB 34 was so profound because programs included housing and other supports necessary to enable people to get off the streets. This totally changed the response rate, and the number of people who were willing to engage jumped to 90 percent, and most stayed in treatment. The collaboration with law enforcement to implement programs, along with the focus on wraparound services that included housing, led to a complete shift in the service delivery model and created the impetus for an expansion through **AB 2034** in 2000.

When then-Assembly Member Steinberg (Steinberg was termed out of the Assembly in 2004 and was later elected to the State Senate in 2006) introduced **AB 2034** as an expansion program, it was recognized as a valuable program and funding was expanded to $55 million for an additional 35 counties despite significant state budget shortfalls that year. AB 2034 programs provide outreach and comprehensive services to adults and older adults with severe mental illness who are homeless or at risk for becoming homeless. The program is now funded through the State General Fund (SGF) with oversight by the DMH. Flexible funding allows counties to provide whatever services are necessary to help homeless individuals secure needed resources.

In 2003, an estimated 50,000 Californians with severe mental illness were homeless. Many of these individuals had no access to needed mental health

Nontraditional Partners Unite

When Assembly member Darrell Steinberg introduced AB 34 in 1999 it not only laid the foundation for a revolutionary reconstruction of California's mental health system but it also created a common goal for traditionally divergent interests. An estimated 50,000 individuals with mental illness were living on the streets, and about 15 percent of incarcerated prisoners were mentally ill.

Because so many had financial, professional and personal interests in addressing California's mental health crisis, AB 34 received widespread bipartisan support from lawmakers and the mental health community, as well as veterans, the business community and law enforcement.

This collaborative effort created a political will that was unprecedented, resulting in the passage of AB 34 and approval of funding for the three pilot programs that were to create the impetus for significant and sweeping systematic transformation.

Criminal Justice and the Mentally Ill

Although jail was the worst possible setting for providing mental health care, arrest and detention often meant the only access to care for individuals who were homeless and mentally ill. AB 34 provided the vehicle for state government to finally address the long-ignored problems of incarcerated, homeless mentally ill clients who were getting stuck in a "revolving door" between jail and the streets. Mental health and criminal justice experts likened this scenario to the expensive approach of treating sick people only when they arrived at the hospital emergency room.

AB 34, which marked a significant effort to serve homeless individuals with mental illness:

- Directed an initial $10 million to provide grants to counties to expand community mental health and outreach programs to patients ready to transition from institutional care.
- Helped prevent the homeless mentally ill from committing crimes by providing them treatment before they were arrested and imprisoned.
- Demonstrated that millions of dollars being spent by the state and local governments in corrections costs could be saved.
- Received widespread bipartisan support from lawmakers and the mental health community as well as law enforcement.

or other community services and were ending up in the criminal justice system for minor crimes, most of which could likely have been prevented with appropriate mental health services. This population also experienced frequent, high-cost inpatient hospitalizations because their mental health needs were only being addressed when they reached crisis levels.

State funding under AB 2034 provided for a comprehensive range of services, including assessment of the individual's needs; establishing identification and legal assistance needs; and providing shelter/housing, food, clothing, showers, medical, psychiatric and dental care, alcohol/drug treatment, and social rehabilitation. Both policymakers and stakeholders recognized the therapeutic value of having a stable place to live and basic health care needs met, and how important these factors are to seeking employment.

This legislation was the first to focus on homeless people with serious mental illness, mandate immediate housing, provide flexibility of funding, and collect and report "real-time" client and system outcomes. The programs under AB 2034 have reduced recidivism in psychiatric hospitalizations, incarcerations, emergency department visits, and homeless days. This success has provided the impetus to continue funding for this program and the target population.

Little Hoover Commission Report

In 2000, the Little Hoover Commission, an independent state oversight agency, issued a report called *Being There: Making a Commitment to Mental Health*. The Commission, which had been created in 1962 to investigate state government operations and make recommendations to "promote efficiency, economy and improved service," determined that California had failed to deliver on its earlier promise to serve people with mental illness through community programs. In fact, the report stated that "California's mental health policy lacks something fundamental: a clear commitment to provide mental health services to people who need assistance." The Commission's report:

- Noted that California was spending billions of dollars dealing with the consequences of not treating mental illness (e.g., jail space, court costs).
- Called for additional mental health reform based on both a "moral imperative" and "fiscal imperative."
- Focused on the need to help the thousands of Californians whose mental illness had robbed them of self-esteem, productivity and hope.
- Appealed to Californians to build upon previously enacted reforms and the dedication of policymakers and stakeholders to provide higher quality, compassionate mental health care.

Surgeon General's Report on Mental Health: Culture, Race and Ethnicity[66]

In response to a concern that the Surgeon General's Report on Mental Health (see Page 16) did not adequately address the mental health of communities of color, U.S. Surgeon General Dr. David Satcher undertook a second report, one that focused on the United States' four main ethnic and racial minority groups: African-Americans, American Indians/Alaska Natives, Asian-Americans/Pacific Islanders, and Hispanic-Americans. Four main points were raised by the Surgeon General:

- Mental illnesses were real, disabling conditions affecting all populations, regardless of race or ethnicity.
- Ethnic and racial minorities were receiving less services and poorer quality of care than the general population.
- As a result of receiving less and poorer quality of care, ethnic and racial minorities have more unmet mental health needs than the general population.
- The sociocultural context must be taken into account to ensure that all Americans, especially minorities, received mental health care tailored to their needs.

"The cultures from which people hail affect all aspects of mental health and illness, including the types of stresses they confront, whether they seek help, what types of help they seek, what symptoms and concerns they bring to clinical attention, and what types of coping styles and social supports they possess. Likewise, the cultures of clinicians and service systems influence the nature of mental health services," the report pointed out. State and local governments, who had primary oversight responsibility for public mental health spending, must therefore ensure equal access to high-quality mental health services for racial and ethnic minorities to create real mental health care parity.

Strategies to Build Competence and Measure Outcomes

In 2002 the California Mental Health Directors Association, California Department of Mental Health, and the California Council of Community Mental Health Agencies convened a conference, "Many Voices, One Direction: Building a Common Agenda for Cultural Competence in Mental Health," to facilitate an exchange of ideas among the many stakeholders involved in administering and receiving local mental health services.[67] "Collectively, they addressed the task of identifying the steps needed to move cultural competence from concept to operation and from isolated practice to an embedded systemwide standard of practice." The group also continued to develop strategies to build competence and measure outcomes.

The attendees heard from four of the science editors of the Surgeon General's Report on Culture, Race and Ethnicity who recommended the following:

- Counties must continue to strengthen their efforts to promote cultural competence.
- Effective engagement of clients and communities are core components of culturally competent systems and organizations.
- Collaboration among system stakeholders is essential.
- Efforts of researchers and practitioners must become more collaborative.
- Addressing stigma must be given high priority.
- The role of Ethnic Services Managers [liaisons in county organizations] must be strengthened.

Additionally, attendees organized into work groups and recommended the following:

- Embed cultural competence into mental health systems and programs.
- Ensure client and community engagement and participation.
- Assess clinical tools and organization.
- Create a diverse staff that reflects the diversity of the population served.
- Incorporate cultural competence into all training programs.

The conference created the impetus for dialogue and action. Even prior to release of the community report, the California Institute for Mental Health secured funding from The California Endowment for a project to address several of the recommendations outlined.

Laura's Law (AB 1421)[68]

AB 1421, also called **Laura's Law**, was sponsored by Assembly Member Helen Thomson and became effective on January 1, 2003. The statute allowed court-ordered community-based outpatient commitment of mental health clients under certain circumstances by friends, relatives, police, or mental health care professionals.

The impetus for the measure was the tragedy of Laura Wilcox, a 19-year old college student who was working at a Nevada City public mental health clinic during a winter break from college when she was shot to death by Scott Harlan Thorpe, a client of the county mental health department. However, the motivation for the law was the belief among many that the extreme standards of the Lanterman-Petris-Short Act did not satisfy the concerns of families with loved ones whose illnesses actually caused them to resist treatment, although their condition may not have risen to the level to require forced treatment. Throughout the country there as a move to create involuntary outpatient care because many individuals didn't need inpatient care per se, but families felt that their loved ones needed involuntary intervention to become stable.

While AB 1421 received wide bipartisan support in the State Legislature, it was only after significant compromises were made because of the extreme division within the mental health community. Generally, psychiatrists and families of individuals with mental illness supported the measure and consumer organizations, counties and outpatient provider organizations opposed it. Psychologists and social workers also opposed the measure.

Enforcement of the law was voluntary for the counties, and because AB 1421 did not include state funds for implementation (estimated at more than $300 million for the state), counties could decide whether or not to underwrite the costs. Counties wanting to implement the law could not use funds already set aside for outpatient treatment, and in fact they are required to ensure no reduction in voluntary services. This created a major obstacle to implementation. As of 2004, Los Angeles County was the only county to implement Laura's Law, and only on a limited basis as a jail diversion program.

If counties choose to adopt outpatient commitment, AB 1421 ensures that medications are administered only to patients determined to be severely disabled, who have been referred by family members, law enforcement or another agency and provided with community treatment, housing and medication monitoring. According to the law, an individual who is over 18 and suffers from a mental illness may be placed in assisted outpatient treatment if, after a hearing, a court finds that the following criteria have been met:

- It is unlikely that the person can survive safely in the community without supervision, based on a clinical determination.
- The person has a history of noncompliance with treatment that has either: (1) been a significant factor in the person being hospitalized, imprisoned or jailed at least twice within the last 36 months; or (2) resulted in one or more actual, attempted or threat of serious violent behavior toward himself or others within the last 48 months.
- The person has been given an opportunity to voluntarily participate in a treatment plan, but has not participated in treatment.
- The person is substantially deteriorating.

Supporters of Laura's Law maintained that some people with mental illness, especially the most severely disabled, could not recognize their own symptoms and posed an unacceptable threat to their communities. Critics of AB 1421 asserted that coerced treatment could interfere with recovery, destroy trust between clients and providers, and violate human and civil rights. The California Network of Mental Health Clients (CNMHC) opposed the legislation as a regressive plan to force drug treatment on patients and more easily place them into psychiatric hospitals against their will. CNMHC acted as a plaintiff in a lawsuit against Los Angeles County regarding AB 1421. When the suit was settled in 2005, the county proceeded with its implementation.

President's New Freedom Commission — 2003[69]

President George W. Bush announced his New Freedom Initiative on February 1, 2001. The Commission's report identified three obstacles preventing Americans with mental illnesses from getting the quality care they deserved:

- Stigma surrounding mental illnesses.
- Unfair treatment limitations and financial requirements placed on mental health benefits by private health insurers.
- Fragmented mental health service delivery systems.

In April 2002, the President's New Freedom Commission on Mental Health received a mandate to: (1) study the U.S. mental health system, including both private and public sector providers; (2) identify innovative mental health treatments, services and technologies that had demonstrated success and could be widely duplicated in a variety of settings; and (3) make solid policy recommendations that could be immediately implemented at the local, state and federal levels to improve systems and ensure that adults with serious mental illness and children with serious emotional disturbances could live, work and participate fully in their communities. Twenty-two members served as commissioners, including Stephen W. Mayberg, Ph.D., Director of the California Department of Mental Health.

The President's Commission was the first comprehensive study of the nation's mental health service delivery system in nearly 25 years. The Commission's evaluation included visits to innovative model programs across the country; testimony from stakeholders, including consumers of mental health care, families, advocates, public and private providers, administrators, and mental health researchers; feedback, comments and suggestions from nearly 2,500 people from all 50 states; and consultations with nationally recognized experts in many areas of mental health policy. The 1999 Report of the Surgeon General on Mental Health provided the scientific basis for much of the Commission's work.

In the Commission's final report, submitted to the president in May 2003, the Commissioners found that mental illnesses were shockingly common; they impacted almost every American family and touched every community, school and workplace. Mental illness affected people from all backgrounds and could occur at any stage of life, from childhood to old age. And mental illness presented serious health challenges that were not being met because the country's mental health delivery system was "fragmented and in disarray ... lead[ing] to unnecessary and costly disability, homelessness, school failure, and incarceration." Other report conclusions included the following:

- In any given year, about 5 percent to 7 percent of adults have a serious mental illness, and about 5 percent to 9 percent of children had a serious emotional disturbance, indicating that millions of adults and children were disabled by mental illnesses every year.
- Many barriers were impeding care for the mentally ill, including fragmentation and gaps in care for children and adults with serious mental illnesses, high unemployment for people with serious mental illnesses, inadequate care for older adults with mental illnesses, and lack of national priority for mental health and suicide prevention.
- State-of-the-art treatments, based on decades of research, were not being transferred from research to community settings. Access to quality care was poor, resulting in wasted resources and lack of support.
- The country's mental health system was not focused on the single most important goal of the people it served – the hope of recovery.

To improve access to quality care and services, the Commission recommended a fundamental transformation of how mental health care was delivered in America. The goal of this transformed system was, in a word, recovery. The new system would

Olmstead v. L.C.

The L.C. and E.W. v. Olmstead case was brought in 1995 by the Atlanta Legal Aid Society on behalf of Lois Curtis and Elaine Wilson, two state psychiatric hospital patients. Hospital treatment professionals had recommended community program placement for the women, but none was available. The state of Georgia asked the state Supreme Court to decide if the federal Americans with Disabilities Act (ADA) "compell[ed] the state to provide treatment and habilitation for mentally disabled persons in a community placement, when appropriate treatment and habilitation [could] be provided to them in a State mental institution." The U.S. Department of Justice (DOJ) had interpreted this to mean that community placement of institutional residents was required when recommended by state treatment professionals. The 11th Circuit Court upheld the women's right to community treatment and the DOJ's analysis.

Twenty-two states, including California, originally filed a brief asking the U.S. Supreme Court to review the case. On June 22, 1999, the Supreme Court affirmed the lower court ruling that unjustified segregation in institutions was discriminatory because it "perpetuated unwarranted assumptions that people with disabilities [were] incapable or unworthy of participating in community life" and also because confinement in an institution severely impeded daily life activities (family and social relationships, work, school, etc.). The court ruled that patients who could receive treatment in a community setting should be given the opportunity to make that transition. The Olmstead decision encouraged states to implement strategies to comply with the ADA mandate that services be provided "in the most integrated setting appropriate to the needs" of people with mental disabilities. California was already committed to the polices required by the Olmstead Act, and while the State was required to develop a plan based on the decision, there were no major mental health policy changes as a direct result.

ensure community living for everyone and service delivery that would give every American easy, continuous access to the most current treatments and best support services. In this transformed mental health system:

- Americans would understand that mental health was essential to overall health.
- Mental health care would be driven by consumers and families.
- Disparities in mental health services would be eliminated.
- Early mental health screening, assessment and referral to services must be common practice.
- Excellent mental health care would be delivered and research accelerated.
- Technology would be used to help people access mental health care and information.

The Commissioners mentioned several California programs as models, specifically highlighting AB 34 programs throughout the state. While the report findings were solid and the recommendations valid, very little resulted from the report in terms of improving services for individuals with mental illness.

The Case for Cultural Competence[73, 74, 75]

According to the California Institute for Mental Health (CiMH), culturally competent mental health services are essential to providing all Californians with access to quality mental health care.

- California's cultural and linguistic diversity continues to increase rapidly due to immigration and population growth. More than 50 percent of the state's population is made up of individuals of color.
- Culture plays an essential role in how clients and families view mental illness and respond to mental health services. Treatment must take into account the complex interrelationships among client culture, gender, age, sexual orientation, race, ethnicity, and language.
- Substantial disparities in access to and the effectiveness of mental health services exist for racial and ethnic populations.
- Individual and institutional racism continue to exist in today's society, greatly impacting the provision of mental health services.
- California's cultural and linguistic diversity is substantially underrepresented in the state's mental health work force, especially in rural areas.
- Increasing evidence confirms that culturally competent practices result in better mental health outcomes.

California's Mental Health Master Plan[70, 71, 72]

The **California Mental Health Master Plan**, published in March 2003 by the California Mental Health Planning Council, was an update to the plan developed in the 1990s. This plan confirmed the responsibility of the state's public mental health system to provide services for adults with serious mental illnesses and children with serious emotional disturbances who were eligible for publicly funded mental health programs. The Master Plan espoused the fundamental tenet of the President's Commission report: When the public mental health system did not provide such services to children and youth, adults, and older adults in need, these individuals experienced needless human suffering and lost the opportunity to achieve their full potential.

The intent of the Master Plan was to do for California what the President's Commission and the Surgeon General's reports had done for the nation – offer a vision for the public mental health system in which Californians of all ages, ethnicities and cultures with serious mental illness or serious emotional disturbance would receive high-quality, culturally competent, effective services. The Master Plan set forth a fundamental set of values to guide the development and implementation of the state's mental health system. The goal would be to enable all individuals "to access services from a seamless system of care," and the services, support and rehabilitation they received would enable them "to lead happy, productive and fulfilling lives." Priorities included:

- A "client-directed approach to services in which all services for children and their families and for adults and older adults should be guided by an individual's goals, strengths, needs, concerns, motivation, and disabilities."
- Treatment plans that focused on "wellness, recovery and resilience."
- Commitment to cultural competence, including culturally and linguistically appropriate services for mental health clients of all ethnic, racial, cultural, and linguistic backgrounds.
- Programs to address the unmet need for mental health services among children and youth with serious emotional disturbances and adults and older adults with serious mental illnesses in California.
- Improvements in access to mental health care for indigent individuals and increased funding for organizations that had previously turned away thousands of indigent clients because of insufficient fiscal resources.

- Greater provision of services that reflected advancements in the understanding of mental illness over the last two decades, including medications; psychosocial rehabilitation; innovative wraparound programs; and strengths-based, family focused treatment planning.

The Master Plan pointed out that California had to "confront the challenge of improving the capacity and effectiveness of its [public mental health] system in a time of unparalleled fiscal crisis. However, framers of the Master Plan encouraged mental heath stakeholders not to lose hope in the face of anticipated, "unprecedented spending reductions in state programs," but instead to "embrace the vision … provided by the California Mental Health Master Plan and … plan how to implement this vision when sufficient fiscal resources … [became] available."

Recognizing the Barriers[76]

The following were identified by attendees at the California Mental Health Directors 2002 conference, "Many Voices, One Direction: Building a Common Agenda for Cultural Competence in Mental Health," as "Issues in serving" African-American, Latino, Asian and Pacific Islander, and American-Indian clients.

- *Mental health issues are complicated with overlapping social and physical health problems.*
- *There is a significant heterogeneity among ethnic populations (i.e., Latinos from varying cultures).*
- *Language barriers are significant.*
- *Cultural and ethnic differences exist in approaching mental health services (i.e., issues of face, shame and stigma).*
- *Sovereignty must be recognized (i.e., federally recognized Indian tribes) in collaborative efforts to provide services.*

Mental Health Services Act (Proposition 63)[77, 78, 79, 80, 81, 82, 83]

On November 2, 2004, the voters of California enacted Proposition 63, now known as the Mental Health Services Act or MHSA. The Act was designed to fully fund California's children's system of care program and adult and older adult system of care program (AB 34). As an Assembly Member, Senator Darrell Steinberg provided much of the vision and leadership necessary to pass the measure.

The legislation imposes a 1 percent surtax on personal incomes over $1 million to expand mental health services. The MHSA provided the first opportunity in many years for expanded funding to support California's public mental health programs.

The MHSA has been hailed as a complete transformation to a new system. Some believe the MHSA will provide enough funding to eventually enable the state to serve all Californians who face disabling mental illness, including the defined target populations of only children with serious emotional disturbances and adults with severe mental illnesses. The legislation envisions a new approach to keep mental illness from becoming so severe by addressing a broad continuum of prevention, early intervention and service needs as well as the necessary infrastructure, technology and training elements to effectively support the system. The MHSA's main purpose is to promote recovery for individuals with serious mental illness by:

- Defining serious mental illness as a condition deserving priority attention.
- Reducing long-term, adverse impact from untreated serious mental illness.
- Expanding successful, innovative service programs.
- Providing funding to adequately meet system needs.
- Ensuring that funds are expended in a cost-effective manner.
- Providing services consistent with best practices.

Under the old "fail first system," under which people with mental illness had to hit rock bottom and hospitalizations, incarcerations, out-of-home placements, and other unsuccessful treatments were customary, an estimated 50 percent of those who needed services received any and many more didn't get all the services they needed. The MHSA was designed to move California's mental health system from "fail first" to "help first." The Act seeks to end delays in obtaining services must be ended, since when people have access to programs earlier in the onset of a mental illness, disabilities can be reduced. The vision of the MHSA encapsulates this approach:

- Reduce stigma and discrimination of mental illness.
- Expand access to unserved and underserved populations to successful service programs.
- Focus on effective services and cost-effective expenditures, including prevention and early intervention.
- Ensure accountability.

According to the Act, no funds may be provided from the state to the counties unless such spending complies with a plan developed in accordance with numerous requirements, including the provision for significant local stakeholder input and involvement.

- Local plans must be approved by the State Department of Mental Health, after review and comment by the MHSA Oversight and Accountability Commission.
- Each plan is a three-year arrangement that must be updated annually, and each update must also be submitted for state review.
- MSHA funds must be used to expand, not replace, existing services.

Efforts to build this model system have been directed by the Department of Mental Health (DMH), led by Dr. Stephen Mayberg, who has stated, "Proposition 63 presents a once-in-a-lifetime opportunity to transform our mental health system to one that is based on principles of recovery and programs that work and involvement of all of our stakeholders, especially consumers and family members. California can lead the way by developing a system that keeps individuals in their communities with treatment and supports from a variety of sources, rather than in institutions or on the street. A satisfying quality of life in the community is possible with integration, proven programs, accountability, and, most of all, better and earlier access."

The strategy behind the MHSA incorporates four elements:

(1) Focusing on system transformation rather than just expansion so that there will only be one system of care that focuses on "Help First" rather than "Fail First" by having prevention and early intervention and taking approaches to serve everyone under the Children's and Adult Systems of Care model.

(2) Using the specifics of the President's Commission Report and the California Mental Health Master Plan to supplement the vision of the initiative.

(3) Employing an inclusive stakeholder process for design, including participation of clients and family members.

(4) Determining measures of accountability (outcomes/indicators) prior to local plan development.

According to the Act's proponents, the MHSA will expand access to mental health care to those who have been unserved and underserved due to a lack of funding.

- Comprehensive community mental health services to adults with severe mental illness, including transition age youth 18-25, in accordance with the standards of the Adults System of Care will increase the Californians who can be served.
- Comprehensive community mental health services to children and adolescents with serious emotional disturbances will be provided in accordance with Children's System of Care standards for those youths who do not qualify for services under one of the existing entitlement programs such as Medi-Cal (mostly funded through EPSDT), foster care (which creates Medi-Cal eligibility), and Special Education (mental health services funded through the AB 3632 program). This will significantly increase the number of such children who are served.
- Prevention and early intervention programs will offer help early in the onset of a potentially severe mental illness to prevent these conditions from becoming disabling and life-threatening. Currently the leading cause of disability, mental illness affects 35 percent of people who receive Social Security benefits due to disability. Suicide, nearly always caused by mental illness, is the third leading cause of death among teenagers. MHSA monies can fund successful programs like "Teen Screen," which recognize and prevent suicide. New programs that connect primary care and mental health services will help recognize and treat mental illness in primary care settings.

MHSA and Wraparound Services for Children, Youth and Families[84]

The MHSA includes a specific requirement that all California counties develop a Wraparound Program for children and their families unless certain conditions exist. As of August 2006, 31 of California's 58 counties opted to participate in the program. Wraparound had been established in 1997 under **Senate Bill 163** (Solis), which allowed counties to develop the Wraparound Model with state and county Aid to Families With Dependent Children - Foster Care (AFDC-FC) funds that had previously been used to place children and youth in high-end group homes.

Under Wraparound, these monies would fund development of expanded family based services to provide an alternative to group home care – to return children in group homes to their own homes and communities or help children at imminent risk of being placed in a group living situation remain at home. In January 2001, **AB 2706** (Cardoza),

extended the Wraparound legislation to children placed in lower-level group homes or at risk of such placement. Wraparound may also be applied to placements under AB 3632 (although funding for services differs for these children). Wraparound services are required by law to be family centered, culturally relevant, and community-based. Children must be placed in the least restrictive environment, and counties must track and evaluate outcomes and reinvest cost savings into child welfare programs.

The Wraparound process embraces the philosophy of eliminating barriers to services and strengthening and supporting families. Wraparound reduces the risk of out-of-home placement and recidivism by bringing individuals, agencies and the community together on decision-making teams whose responsibility is to meet the needs of each child and his or her family through a strength-based intervention plan. The goal is to provide intensive, individualized services and support to families that facilitate the ability of children to live and grow up in safe, stable, permanent family environments.

Medicare Part D[85]

In 2003, Congress passed and the President signed into law the Medicare Prescription Drug, Improvement and Modernization Act of 2003, often referred to as MMA. MMA established a privatized prescription drug program called Medicare Part D. Prior to the implementation of Medicare Part D, individuals who were dually eligible (eligible for both Medicaid and Medicare) received their prescriptions through Medicaid, operated in California through Medi-Cal.

On January 1, 2006, the Medicare Part D program went into effect and significantly changed the way beneficiaries receiving Medi-Cal and Medicare received their prescriptions. These beneficiaries no longer would receive their medications through Medi-Cal, but rather through privatized prescription drug plans which contract with the federal Centers for Medicare and Medicaid Services (CMS).

When Medicare Part D went into effect the CMS-approved 48 plans to operate in the state of California. However, only 11 of the Prescription Drug Plans (PDPs) contracted with CMS to provide basic coverage to dual eligible beneficiaries. The CMS then randomly assigned dual eligible beneficiaries who had traditional fee-for-service health coverage into these basic plans through "auto enrollment."

Each of these privatized plans has its own drug formulary, which differs from plan to plan. As a result, some or many medications that mental health consumers were taking may or may not have been covered in the plans, and the auto enrollment process did not cross-reference specific medications with Medicare Part D plans to ensure that plans actually covered the medicines enrollees were currently taking. However, dually eligible beneficiaries were permitted to change plans as often as once a month if desired.

Realizing the enormous impact the new Part D program would have upon consumers and their family members, county mental health plans educated staff, consumers and family members about the changes the new program would bring. Some counties were able to use data provided by state and federal agencies to cross reference client records with plan coverages and in some cases, they were able to counsel consumers to change plans for improved access to the medicines they needed.

Mental health consumers, family members and county mental health plans faced a number of changes as implementation of Medicare Part D began:

- **Formulary coverage –** Many plans didn't cover the medicines prescribed for beneficiaries, or they required a high co-pay.
- **Data –** Extensive delays in the exchange of data resulted in confusion, coverage denials and high co-pays.
- **Quantity limits –** Some plans placed unreasonable quantity limits, such as covering only 30 pills for one month when a consumer needed to take the medicine twice each day (for a total of 60 pills needed).
- **Prior Authorizations –** Plans requested a huge number of prior authorizations, with each plan having different requirements and different forms, often for different medications.

SECTION II: California's Mental Health System

CHAPTER 5. STATE ROLES AND RESPONSIBILITIES[86]

*"**The Mission of California's Mental Health System** shall be to enable persons experiencing severe and disabling mental illness and children with serious emotional disturbances to access services and programs that assist them, in a manner tailored to each individual, to better control their illness, to achieve their personal goals, and to develop skills and supports leading to their living the most constructive and satisfying lives possible in the least restrictive available settings."*

— Welfare & Institutions Code 5600.1

California Department of Mental Health

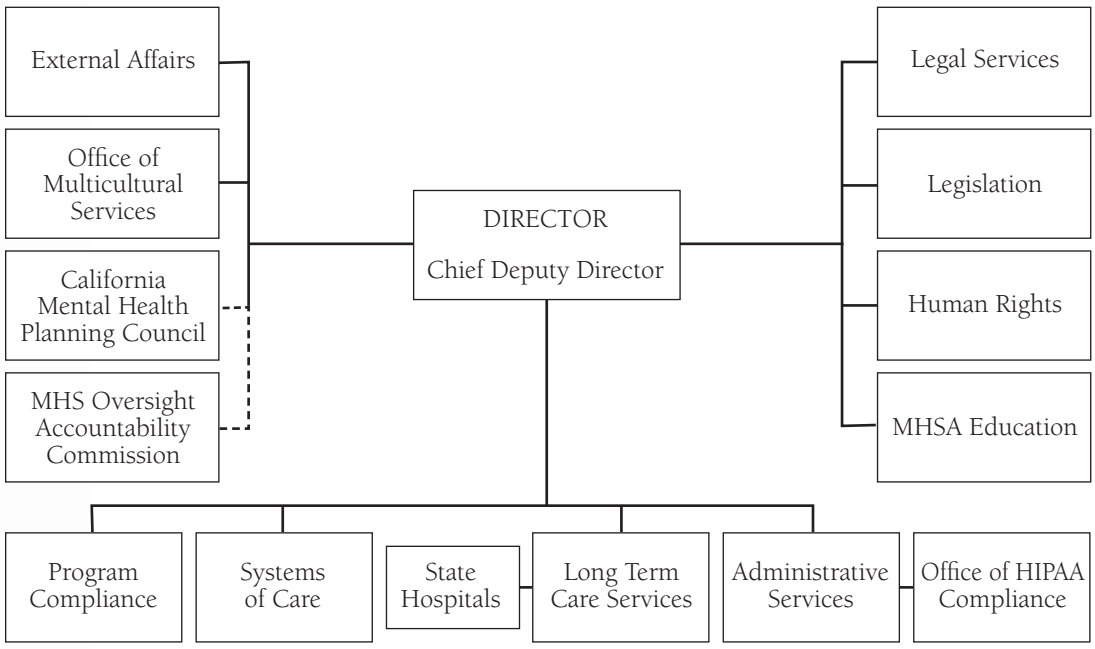
The California Department of Mental Health (DMH) is the state department which has oversight of the state's public mental health system. As a department of the California Health and Human Services Agency, DMH represents the Administrative Branch of government. DMH employs a combined 10,000 at its state headquarters in Sacramento and the five state mental hospitals it oversees. DMH's responsibilities include:

- Leadership for local county mental health departments.
- Evaluation and monitoring of public mental health programs.
- Administration of federal funds for mental health programs and services.
- Treatment of the severely mentally ill at the five state mental hospitals and Acute Psychiatric Programs.
- Development of regulations and oversight of county plans through implementation of the Mental Health Services Act (Proposition 63).

Mission

The California Department of Mental Health, entrusted with leadership of the California mental health system, ensures through partnerships the availability and accessibility of effective, efficient, culturally competent services. This is accomplished by advocacy, education, innovation, outreach, understanding, oversight, monitoring, quality improvement, and the provision of direct services.

Department of Mental Health Organization Chart



Highlights of Major DMH Programs

The following overview of Department of Mental Health programs was summarized from the Department's Web site at http://www.dmh.cahwnet.gov/. *(Informing you of the existence of these Web sites is not a representation or warranty of the accuracy of the material they may contain. Any medication claim regarding efficacy, safety, or of a comparative nature of multiple products, is simply information in their materials, which may change from time to time, and is not part of this publication. The authors of this program do not have content control over these Web sites.)*

1. **Program Compliance –** Oversees the licensing and certification of facilities such as psychiatric health facilities (PHF) and Mental Health Rehabilitation Centers. The department also administers the Pre-Admission Screening and Resident Review (PASRR) program for appropriate placement of individuals in nursing facilities. DMH administers federal funding for local departments in support of mental health services and conducts program and provider reviews and financial and management audits of state and federal funds for compliance with various laws, regulations and policies.

2. **Systems of Care –** Develops, evaluates, monitors and supports an array of coordinated services, that deliver care to California's adults and older adults who are severely mentally ill, and children who are seriously emotionally disturbed. Systems of Care provides planning, research, development, and evaluation efforts for all public mental health programs as follows:

   a. **Evaluations, Statistics and Support –** Caregiver Resource Centers; Disaster Assistance to Counties; Performance Outcomes & Quality Indicators; Statistics and Data Analysis; Traumatic Brain Injury

   b. **Program Policy and County Operations –**

      i. **Adult and Older Adult Policy –** California AIDS Project; Supported Employment; Dual Diagnosis; Integrated Services (AB 34 and AB 2034); Olmstead, New Freedom Commission; Projects for Assistance in Transition from Homelessness; Substance Abuse and Mental Health Services Administration (SAMHSA); Supportive Housing Initiative

      ii. **Children and Family Program Policy, County Operations, Early Mental Health Initiative –** Mental Health Services for Children in Special Education (AB 3632); Infant-Preschool Family Mental Health Initiative; Children's System of Care Initiative

      iii. **County Operations –** Assists and supports county community mental health programs in meeting programmatic goals to provide high quality public mental health care.

      iv. **Early Mental Health Initiative –** Provides funding for school-based early intervention and prevention services to kindergarten through third grade students who have mild to moderate school adjustment issues and would benefit from additional support.

   c. **Medi-Cal Mental Health Policy (MCMHP) –** Specialty mental health care provided by counties in a managed care model of service delivery

   d. **Ombudsman Services for Medi-Cal Beneficiaries –** Provides information and assistance to Medi-Cal Mental Health Plan beneficiaries

   e. **State Quality Improvement Council –** Identifies and monitors system performance indicators to improve quality of care within the Medi-Cal mental health managed care program

   f. **Long-Term Care Services –** Oversees operations at California's state hospitals, two psychiatric programs and four units:

      i. **Forensic Services –** Supervises the California Forensic Conditional Release Program (CONREP – community outpatient program for mentally ill offenders) and performs evaluations of prison inmates who meet statutory criteria as mentally disordered offenders.

      ii. **Hospital Operations –** Provides administrative and operational oversight for California's state hospitals.

      iii. **Program Policy and Fiscal Support –** Provides direction on licensing, certification and accreditation; contracts and interagency agreements relating to state hospital services and hospital fiscal operations.

      iv. **Sex Offender Commitment Program –** Reviews, assesses and evaluates inmates referred after pre-screening as potential Sexually Violent Predators.

   g. **Administration –** Strategic planning, policies, budget, labor relations, personnel, health and safety, accounting, support services and rate and allocation setting and reimbursements for the DMH.

3. **Administrative Services –** The department licenses facilities and certifies programs that provide care to individuals with major mental disorders. DMH licenses psychiatric health facilities and mental health rehabilitation centers and certifies the mental health programs of community residential treatment systems and special treatment programs in skilled nursing facilities.

4. **Mental Health Services Act –** The passage of Proposition 63, now known as the Mental Health Services Act or MHSA, in November 2004, provided the first opportunity in many years for DMH to provide increased funding, personnel and other resources to support county mental health programs and monitor progress toward statewide goals for children, youth, adults, older adults, and families. The Act addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements to effectively support the system.

DMH Services and Programs

Information about each of these programs can be found at www.dmh.cahwnet.gov/Services_and_Programs/default. *(Informing you of the existence of these Web sites is not a representation or warranty of the accuracy of the material they may contain. Any medication claim regarding efficacy, safety, or of a comparative nature of multiple products, is simply information in their materials, which may change from time to time, and is not part of this publication. The authors of this program do not have content control over these Web sites.)*

- Adult and Older Adult Program Policy (AOAPP)
- California AIDS Project
- California Mental Health Cooperative Programs Employment with Support
- Caregiver Resource Centers (CRCs)
- Children and Family Program Policy (CFPP)
- Children's System of Care (CSOC) Initiative
- Conditional Release Program (CONREP)
- County Operations
- Disaster Assistance to Counties
- Dual Diagnosis (Co-Occurring Disorders)
- Early Mental Health Initiative (EMHI)
- Evaluation, Statistics, and Support (ESS)
- Federal Grants
- Forensic Services
- Infant-Preschool Family Mental Health Initiative (IPFMI)
- Integrated Services for Homeless Adults with Serious Mental Illness (AB 34 & AB 2034)
- Mental Health Services Act (MHSA)
- Medi-Cal Mental Health Policy (MCMHP)
- Mental Health Services for Children in Special Education (AB 3632 Program)
- Older Adult Systems of Care Demonstration Projects
- Olmstead, New Freedom Initiative
- Ombudsman Services for Medi-Cal Beneficiaries
- Performance Outcomes and Quality Improvement (POQI)
- Preadmission Screening and Resident Review (PASRR)

State Hospitals

The California Department of Mental Health (DMH) currently operates five state hospitals with a combined average daily census of 878 individuals. Two facilities are located in Southern California (Metropolitan State Hospital in Los Angeles County and Patton State Hospital in San Bernardino County), one facility near the Central Coast (Atascadero State Hospital) and one in Northern California (Napa State Hospital). A fifth facility, Coalinga State Hospital in the Central Valley, opened its doors in September 2005.

Each of California's state hospitals is staffed by professionally trained clinicians and administrative support team who provide full-time inpatient care to the most serious mentally ill and those incapable of living in the community. These referrals come from county mental health departments, the courts, the Department of Corrections and Rehabilitation and the California Youth Authority. In recent years, the population of the state mental hospitals has shifted to a majority (approximately 90 percent) of forensic patients, and DMH has met this challenge by prioritizing and balancing state-of-the-art treatment and public safety.

DMH also operates two psychiatric programs located at correctional facilities under contract with the California Department of Corrections and Rehabilitation (CDCR). Salinas Valley Psychiatric Program (SVPP) is located at Salinas Valley State Prison and the Vacaville Psychiatric Program (VPP) is located at the Correctional Medical Facility at Vacaville.

- Program Compliance/System of Care Advisory Team (formerly Staff Work Advisory Team)
- Project for Assistance in Transition from Homelessness (PATH)
- Sex Offender Commitment Program (SOCP)
- State Quality Improvement Council (QIC)
- Statistics & Data Analysis (SDA)
- Substance Abuse and Mental Health Services Act (SAMHSA)
- Supportive Housing Initiative Act (SHIA)
- Traumatic Brain Injury (TBI)

Department of Mental Health – Additional Responsibilities

The California Mental Health Planning Council

California's Department of Mental Health has had an independent, statewide advisory board providing public input for mental health policy development and planning since the 1960s. The current entity, the California Mental Health Planning Council (CMHPC), was established in 1993 by state and federal statute in response to the realignment of mental health program responsibility and funding back to the counties. Specifically, the Welfare and Institutions Code (WIC) Section 5772(b) authorizes the CMHPC to review and assess all components of the mental health system and issues affecting adults and older adults with serious mental illness and children with serious emotional disturbances.

CMHPC is a multicultural consumer, family, provider, and advocacy organization that:

- Provides oversight to the DMH regarding accessibility, availability and accountability of the state public mental health system.
- Reviews, assesses and makes recommendations to the DMH, the administration, the Legislature, and local mental health boards and commissions (MHB/Cs) on priority issues.
- Supports and promotes accessible, timely, appropriate, and effective services that are culturally competent, age- and gender-appropriate, strengths-based, and recovery-oriented.
- Educates the public and the mental health constituency about current needs for public mental health services and ways to better meet those needs.

The CMHPC also participates in statewide planning development and provides MHB/Cs with technical assistance.

CMHPC Vision Statement

The CMHPC envisions a public mental health system that offers excellent, effective, and affordable consumer and family driven mental health services that are timely, accessible, and appropriate for all of California's diverse populations.

Mental Health Services Oversight and Accountability Commission

The Mental Health Services Act (MHSA) called for the establishment of the Mental Health Services Oversight and Accountability Commission (MHSOAC) under Section 5845(a) of the Welfare and Institutions Code. The MHSOAC was charged with oversight responsibility for the portions of the new law covering the Adults and Older Adults Systems of Care Act, Human Resources, Innovative Programs, Prevention and Early Intervention Programs, and Children's Mental Health Services Act.

The Commission consists of 16 voting members as follows:

- The attorney general or his or her designee.
- The superintendent of public instruction or his or her designee.
- The chairperson of the Senate Health and Human Services Committee or another member of the Senate selected by the president pro tempore of the Senate.
- The chairperson of the Assembly Health Committee or another member of the Assembly selected by the speaker of the Assembly.
- Two individuals with a severe mental illness; a family member of an adult or senior with a severe mental illness; a family member of a child who has or has had a severe mental illness; a physician specializing in alcohol and drug

Major Sources of Public Mental Health Funding Prior to the MHSA[94]

The following chart was developed by the Senate Committee on Budget and Fiscal Review in 2000

	Realignment	Medi-Cal	CalWORKS	EPSDT	Children's System of Care	Healthy Families
Purpose	Provides mental health services to target population, *to the extent resources are available.*	Provides medically necessary psychiatric inpatient hospital, rehabilitative services and case management.	Reduces mental health barriers to employment.	Early Periodic Screening, Diagnosis, and Treatment (EPSDT) provides medically necessary specialty mental health services, such as behavior management modeling, medication monitoring, family therapy, and crisis intervention.	Provides mental health services to children who are seriously emotionally disturbed.	Provides supplemental mental health services to children who are seriously emotionally disturbed.
Eligibility	Services based on sliding fee.	Enrolled in Medi-Cal.	Temporary Assistance for Needy Families (TANF) recipient.	Enrolled in Medi-Cal.	Enrolled by county.	Enrolled in Healthy Families Program and referred to that county.
Age Limits	None.	None.	16 (if not through school) through 59 years;voluntary after 59.	Under age 21 years.	Under age 21 years.	Birth to 19 years.
Severity of Disability	Focuses mainly on people with serious and/or persistent mental illness or serious emotional disturbance.	Requires a diagnosis of severe impairment in life functioning and not responsive to physical health care based on treatment. Includes episodic users as well as people with serious disabilities.	Based on whether mental health is barrier to employment rather than severity of mental illness. Expect broad range of disability.	Requires determination of being "medically necessary" to correct or ameliorate a mental health condition. Includes episodic users as well as people with serious disabilities.	Serious emotional disturbance.	Serious emotional disturbance.
Type of Funding	County Realignment funds – Mental Health Subaccount – which consists of state sales tax and vehicle licensing fee.	Depending upon the service being provided, either Realignment funds or state General Fund monies are used to draw a federal match.	For Medi-Cal eligible services, State General Fund monies from an annual allocation amount are used to draw a federal match.	Realignment funds are used up to a baseline amount established for each county and then State General Fund monies are used beyond the baseline. These funds are used to draw a federal match.	State General Fund.	Realignment funds are used to draw a federal match.
Federal Funds	None.	About 50% match.	About 50% match.	About 50% match.	None.	About 65% match.

treatment; a mental health professional; a county sheriff; a superintendent of a school district; a representative of a labor organization; a representative of an employer with less than 500 employees and a representative of an employer with more than 500 employees; and a representative of a health care services plan or insurer, all appointed by the governor. In making appointments, the governor will look for individuals who have had personal or family experience with mental illness.

The Office of Multicultural Services

Established in December 1997, the Office of Multicultural Services (OMS) provides leadership direction to the Department of Mental Health (DMH) in promoting culturally competent mental health services within California's public mental health system. The chief of the OMS serves as a member of the executive staff in developing policies and procedures to ensure that cultural and linguistic competence guidelines are incorporated within all DMH programs and services. The OMS is charged with ensuring that:

- Cultural and linguistical sensitivity remains fundamental to the successful implementation and delivery of cost-effective, managed mental health services.

- Mental health care providers and managers understand the importance of language and culture to delivering appropriate mental health care and securing improved outcomes.

The OMS also has a leadership role in ensuring culturally appropriate treatment intervention, services and assessment in all of California's diverse counties. Each county mental health plan (MHP) is responsible for providing an annual cultural competency plan to DMH that outlines the county's intended strategies for providing cultural and linguistically competent care.

CHAPTER 6. FUNDING AND BUDGET ALLOCATION[87, 88, 89, 90, 91, 92, 93]

Funding for the public mental health system is somewhat complex. It consists of a blending of funding sources, including state General Fund, County Realignment funds, county match funds, federal Medicaid funds (Title XIX), federal Substance Abuse and Mental Health Services Administration block grant funds, federal State Children's Health Insurance Program (SCHIP) (Title XXI) funds, Temporary Assistance for Needy Families (TANF) and CalWorks funds, and even some Proposition 98 General Fund monies. Beginning in 2005, the Mental Health Services Act also began to generate funds for the state's mental health system.

Mental Health Services Act

Proposition 63, the Mental Health Services Act (MHSA), imposes a 1 percent income tax on the personal income of Californians in excess of $1 million. Statewide, the Act was projected to generate approximately $254 million in fiscal year 2004-05, $690 million in 2005-06 and increasing amounts thereafter from the new tax. Thus far, the actual revenues from the tax have substantially exceeded the earlier estimates by about 40 percent. Much of the funding will be provided to county mental health programs to fund programs consistent with their local plans.

To provide an orderly implementation of each of these complex elements, the MHSA is being put into operation in phases. An extensive stakeholder process of advisory committees and workgroups has been developed to help improve the state's implementation of the MHSA. More than 100,000 people have participated in the planning process. Estimated expenditures under MHSA for Fiscal Year 2006-07 are $494.4 million. Improvement in client outcomes remains a fundamental expectation throughout the implementation process.

Components of the MHSA

The intention of the MHSA is to provide a better program of mental health services in California by addressing six components, which were designed to work in tandem and eventually lead to a transformed, culturally competent mental health system for California.

- **Community Planning** provides an inclusive local process involving clients, families, caregivers, and local agencies to identify community issues related to mental illness and resulting from a lack of programs and services. The process will assess capacity to provide services, define populations to be served, outline strategies for delivering services, and develop work plans and funding requests. Funding for this component comes out of Community Services and Supports allocations.

- **Community Services and Supports (CSS)** make up the programs, services and strategies being identified by each county through the stakeholder process outlined above, with a focus on improving access and outcomes within the systems of care. Seventy percent of MHSA funding is dedicated to this component, which are the children's and adult systems of care.
- **Capital Facilities and Technological Needs** addresses the capital infrastructure needed to implement the CSS and Prevention and Early Intervention programs, including funding to improve or replace existing technology systems.
- **Education and Training** funding will provide work force development programs to remedy the shortage of qualified professionals needed to provide services for people with mental illness. Funding for this component comes out of CSS allocations.
- **Prevention and Early Intervention** programs will strive to prevent mental illness from becoming severe and disabling through more timely, enhanced services for individuals who are currently in unserved or underserved populations. A minimum of 20 percent of MHSA funding is dedicated to this component.
- **Innovation** funds will be used to develop and implement promising practices designed to improve service quality and outcomes, promote interagency collaboration, and increase access to services for underserved groups. Five percent of MHSA funding is dedicated to this component.

Community Services and Supports

Community Services and Supports (CSS) refers to "System of Care Services" as required by the MHSA in WIC Sections 5813.5 and 5878.1-3. The change in terminology will differentiate MHSA Community Services and Supports from existing and previously existing System of Care programs funded at the federal, state and local levels.

The MHSA requires that "each county mental health program shall prepare and submit a three-year plan which shall be updated at least annually and approved by the Department of Mental Health (DMH) after review and comment by the Oversight and Accountability Commission." The MHSA further requires that "the department shall establish requirements for the content of the plans." Annual updates of this plan will be required pursuant to MHSA requirements. Community Services and Supports was the first MHSA component to be implemented, under a defined set of requirements.

- Mental health programs that receive MHSA funds must be voluntary in nature (i.e., people can choose the services and supports they want and need).
- All individuals who meet the qualifications for receiving services can obtain those services, even if they are in jail or juvenile hall, if they are under permanent or temporary conservatorship, or if they are temporarily considered to be dangerous to themselves or others.
- Mental health services and supports provided in a jail or juvenile hall setting must be for the purpose of helping the individual to get out of this setting and to live and receive any additionally needed treatment in the community.

All county plans under the CSS program must include the following five concepts: (1) community collaboration that includes all stakeholders (e.g., agencies, organizations, individuals); (2) cultural competence; (3) client/family driven services that allow those who receive services a voice in decisions concerning programs and policies that affect them; (4) a focus on wellness; and (5) integrated service experiences in which people get all of the kinds of services they need at the same time and in a coordinated manner.

State and County Roles

The Department of Mental Health (DMH) is a "designated partner" in the implementation of the MHSA. In the agency's *Vision Statement and Guiding Principles for the DMH Implementation of the Mental Health Services Act*," DMH made the commitment to "dedicate its resources and energies to work with stakeholders to create a state-of-the-art, culturally competent system that promotes recovery/wellness" for individuals with mental illness and their families. The department further pledged to look beyond "business as usual" and help build a system that provides easier access, more effective services, less out-of-home and institutional care, and reduced stigma toward those with severe mental illness or emotional disorders. The state's role is that of providing leadership, technical assistance, contract monitoring, advocacy, and quality assurance with regard to outcomes within the DMH.

Through the passage of Proposition 63, the DMH was provided the first opportunity to provide increased funding, personnel and other resources to support county mental health programs and monitor progress toward statewide goals for children, transition age youth, adults, older adults, and families through the imposition of a 1percent income tax on personal income in excess of $1 million.

California's counties are another critical sector of involved stakeholders. They have been charged with developing mental health programs that reflect and respect cultural diversity and are based on the "recovery model," or the premise that people with mental illness can indeed get better and live happier, more productive lives. In other words, individuals with serious mental disabilities and children with mental or emotional problems are capable of "wellness" and "resilience," which means they can be helped, can obtain help, can grow to be healthy, and can learn to manage their problems successfully.

Three Types of Funding. Counties could request three different kinds of funding to make changes and expand their mental health services and supports:

- **Full-Service Partnership Funds.** This money will provide all of the mental health services and supports an individual wants and needs to reach his or her goals.
- **General System Development Funds.** This money will improve mental health services and supports for people who receive mental health services.
- **Outreach and Engagement Funds.** This money will help counties reach out to people who may need services, but who are not getting them.

County Funding Requests

The purpose of Community Program Planning is to provide a structure and process counties can use, in partnership with their stakeholders, in determining how best to utilize funds that will become available for the MHSA Community Services and Supports component. Draft plan requirements for Community Services and Supports were developed and made available for stakeholder review and comment, through an extensive and expensive stakeholder process that took many counties up to one year to complete. Counties were asked to submit a Funding Request to the DMH in order to receive MHSA funding to develop their local Community Program Planning Process by March 15, 2005. DMH has committed to working in partnership with counties and stakeholders to ensure a broad, effective community planning process in every county and will continue to provide technical assistance to monitor the planning processes.

Additionally, framers of the MHSA hoped the law would change the public mental health system in a number of important ways:

- Greater participation from people with mental illness and their families.
- More mental health services organized and run by people who have or have had mental illness and their families.
- More culturally appropriate programs and services.
- More variety in the types of mental health programs and services offered.

Funding

California now has three funding streams for mental health services: the dedicated sales tax from Realignment (see Section I in this report for a discussion of Realignment funding); Medi-Cal (which includes federal, state and local dollars); and Proposition 63, "the millionaires' tax," which imposed a 1 percent surtax on personal incomes over $1 million to fully fund California's children's system of care program and the state's adult and older adult system of care program through the MHSA. Proposition 63 broadened the array of mental health services that could be provided, without the constraints of Medicaid.

To date, tax revenues for the MHSA are exceeding expectations, although experts caution that people should be careful not to assume this trend will continue on an ongoing basis due the historical fluctuations in California's economy. The MHSA had a predicted 7 percent growth rate in revenue each year, and current estimates project the state's MHSA revenue will average $800 million over the next few years to exceed $1 billion by year 2008/2009 (more than a 26 percent increase in funding for public mental health services). The following numbers compare the original estimates for the MHSA with the state's forecasted estimates for May 2007:

Year	MHSA Estimate	May 2007 Estimate
2005/06	$683 million	$902 million
2006/07	$690 million	$1.6 billion
2007/08	$800 million	$1.8 billion

Proposition 63 included language specifically stating that this funding is to be used solely to increase mental health funding and not to be used to replace or "supplant" existing state or county funds. While there have been proposals in several counties, to date none of the counties has violated this requirement. Until the 2007-2008 year, the same was true for the state. However, in the 2007-08 year, Governor Arnold Schwarzenegger "blue penciled" (or used his line item veto authority) to eliminate $55 million in funding for the so called AB 2034 program for services to homeless adults, thereby shifting to the counties the financial responsibility for the 4,700 people that program had been serving.

This action of the Governor appears to violate the maintenance of effort provision within the statute established by Proposition 63, and mental health advocates have filed a lawsuit seeking to have this action overturned.

However, this language does not protect against a downturn in Realignment revenues which has happened over the last several years resulting in forced cuts in services totaling several hundred million dollars. The losses in realignment funds are due to volatility in sales tax revenues as well as special provisions in the Realignment funding formulas that give certain county social service programs priority over mental health for its share of those revenues when the case loads grow in those programs faster than sales tax revenues increase.

These service reductions caused by realignment revenue shortfall is comparable to the initial new MHSA funding for services so that at present few counties can show an overall improvement in the levels of services from the passage of the Mental Health Services Act. This should change over time as the Proposition 63 revenues are projected to grow at a healthy rate and realignment revenues should eventually stabilize. However, for the next few years county mental health budgets will still be reflecting cuts in some programs in spite of the new funding from Proposition 63 and it may be several years before significant improvements can be seen.

CHAPTER 7. KEY STAKEHOLDERS

The following summaries of statewide advocacy organizations were excerpted from each respective Web site. *(Informing you of the existence of these Web sites is not a representation or warranty of the accuracy of the material they may contain. Any medication claim regarding efficacy, safety, or of a comparative nature of multiple products, is simply information in their materials, which may change from time to time, and is not part of this publication. The authors of this program do not have content control over these Web sites.)*

California Alliance of Child and Family Services

Web site: www.cacfs.org/

The California Alliance of Child and Family Services is a statewide association of more than 160 private nonprofit child and family serving agencies representing providers of services to children in foster care. The Alliance provides legislative and regulatory advocacy on behalf of its member agencies regarding a wide range of key policy issues. The members of the Alliance are a diverse group of organizations reflecting the racial, ethnic, and cultural diversity of the people of California.

California Association of Local Mental Health Boards and Commissions (CALMHB/C)

The purpose of the Association is to assist local mental health boards and commissions in carrying out their mandated functions; to advocate at the state level as a united voice for local mental health boards and commissions' concerns, and to promote improvement of the quality, quantity and cultural competency of mental health services deliverable to the people of California.

California Association of Social Rehabilitation Agencies (CASRA)

Web site: www.casra.org

CASRA represents providers of adult community care, both in residential and community settings. CASRA is dedicated to improving services and social conditions for people with psychiatric disabilities by promoting their recovery, rehabilitation and rights. CASRA's purposes are:

- To promote and support the development of community-based systems of services which provide choices for consumers and which are based upon the promise of growth and recovery.
- To encourage the development and implementation of community-based mental health programs that are consistent with the philosophy and practice of social rehabilitation.
- To provide leadership and consultation to enhance the development of effective community services which promote self-help and rehabilitation.

- To address legislative and regulatory issues which affect the provision of mental health services.
- To facilitate a network for the sharing of ideas, experiences and expertise among association members.
- To offer educational and training opportunities which address and evaluate the effective use of the social rehabilitation approach to meet human needs.

California Coalition for Mental Health (CCMH)

The California Coalition for Mental Health (CCMH) is made up of 32 organizations with a membership of 115,000 mental health professionals, citizen advocates, clients, and their family members across the state. As an advocacy alliance, CCMH's common goal is to "restore California to a position of leadership as an initiator of state-of-the-art treatment and rehabilitation of people who have mental illness."

CCMH is currently monitoring the implementation of the Mental Health Services Act (MHSA), acting as a forum to ensure that the vision behind the MHSA is being implemented at the local level. The group also offers trainings and other information regarding the MHSA. CCMH also works to protect core funding streams (PSDT, Medi-Cal, SSI, Section 8 and Housing funding), mental health parity and appropriate use of MHSA funds. The organization has several additional roles, which include:

- Serving as an informational forum for member organizations on regulatory or legislative initiatives and as a watchdog to regulations or legislation that threatens community-based mental health services or their funding, including federal government actions.
- Working to reduce stigma and educate policymakers and the public about a recovery vision of mental health care and mental illness.
- Promoting model programs and policies, including human resource development for mental health professionals.
- Protecting against the criminalization of individuals with mental illness.

California Council of Community Mental Health Agencies (CCCMHA)

Web site: www.cccmha.org

The California Council of Community Mental Health Agencies represents 65 community mental health providers of all types of community mental health care. CCCMHA is dedicated to the proposition that the people of California deserve a rational, comprehensive; community based mental health system that is adequately funded to serve all of those in need of services. The CCCMHA mission statement reads:

"The California Council of Community Mental Health Agencies (CCCMHA) promotes comprehensive, responsive, and integrated service systems by enhancing the ability of nonprofit member agencies to provide mental health services that empower the people we serve to lead full and productive lives." They achieve this purpose through:

- Shaping and leading public policy.
- Advocating for needed legislation and funding.
- Creating a forum for the exchange of information and expertise.
- Working with all relevant stakeholders.

The California Institute for Mental Health (CiMH)

Web site: www.cimh.org

The California Institute for Mental Health (CiMH) was established in 1993 with a declared mission to "promote excellence in mental health services through training, technical assistance, research and policy development." It was the specific intent of the local mental health directors who founded CiMH that the organization work collaboratively with all mental health system stakeholders. The commitment to that collaboration led the board to expand membership to consumers, family members and other interested individuals representing the public interest.

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CiMH values include the belief that clients, families, providers, and policymakers must work in partnership to ensure that services enhance each individual's integrity and dignity. Healthy communities are measured by the extent to which individuals with psychiatric disabilities can lead meaningful and productive lives free of stigma and discrimination. The California mental health system must be culturally and linguistically competent in order to be effective, and all people, regardless of resources, must have access to necessary mental health services.

The primary goals of CiMH are to:

- Maintain, develop and strengthen constituent partnerships to eliminate stigma and discrimination and promote integrity, dignity and community involvement in mental health and wellness.
- Support continuous development of a mental health system that sustains effective practices for people who are diverse in age, race, culture, ethnicity, language, gender, and sexual orientation.
- Promote an accountable mental health system that utilizes effective outreach, engagement, treatment, support, and retention practices.
- Support ongoing training and recruitment of culturally competent human resources who are dedicated to improving quality in the workplace.
- Identify priority areas for and provide training, technical assistance, research, and policy analysis to impact and improve the local mental health systems.

The CiMH training mission is "to provide collaborative and progressive/leading-edge training for publicly funded mental health systems." The organization collaborates with local systems of care (providers and mental health boards and commissions), the California Department of Mental Health (DMH), the California Mental Health Planning Council, and stakeholders groups to define and provide training for mental health constituent groups.

- Staff training categories include clinical skills; translating research into practice; system awareness and policy direction; incorporating change into daily practice, attitude and behavior; and incorporating technology into practice.
- The training needs of mental health boards and commissions include orientation, basic roles and duties, system awareness and policy direction, and advocacy skills.

Center for Multicultural Development (CMD)

Web site: www.cimh.org/services/multicultural.aspx

The Center for Multicultural Development (CMD) was established with the support of California's county mental health directors. The CMD is designed to promote the cultural competence of publicly funded behavioral health systems and ensure the integration of cultural competence into policy development, research, training, technical assistance, and other activities and products of CiMH. Programs, trainings and materials are being developed to help provide culturally appropriate services that meet the needs of diverse populations. An advisory committee comprised of consumers and professionals with expertise in developing culturally competent mental health services serves the CMD.

California Women's Mental Health Policy Council (CWMHPC)

Web site: www.cimh.org/services/special-projects/womens-mental-health.aspx

The California Women's Mental Health Policy Council is a statewide nonpartisan membership organization, with a mission to ensure effective, gender-specific culturally appropriate mental health services for women and girls. A project of CiMH, The Policy Council achieves its mission through training, research, and advocacy.

The WMHPC has five initiative areas:

- Building collaborations for women's mental health advocacy.
- Transition Age Young Women Initiative.
- Mental health, substance abuse and domestic violence cross-training.
- Closing the disparities gap.
- Girls and juvenile justice.

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California Mental Health Advocates for Children and Youth (CMHACY)

Web site: www.cmhacy.org

CMHACY is a diverse association of citizens dedicated to advancing children's mental heath services in California. CMHACY is the only statewide voice for children's mental health in California. CMHACY is a strong champion for children in the legislative and public policy areas. They are frequently identified in legislation as an organization with which policymakers should consult, and are increasingly included on task forces and work groups. Through public testimony, newsletters, position papers and an annual statewide conference, we strive to educate and influence decision-makers affecting vulnerable children. CMHACY is committed to a comprehensive mental health system that:

- Promotes prevention and early intervention.
- Provides child-centered, family focused services within a culturally relevant context.
- Emphasizes community-based co-location of services with other agencies (e.g., schools).
- Serves children in the environment least restrictive to the child's needs.
- Includes a full continuum of care, with residential services within family proximity.
- Requires interagency collaboration and cooperation.
- Advocates for statewide policy and standards for services (allowing for local flexibility and accountability).
- Assures a public/private partnership at all levels.
- Is cost effective, fully funded, and accountable.
- And assures entitlement of service to seriously emotionally disturbed children and youth.

The CMHACY's diverse membership networks with key decision-makers in legislative, administrative and judicial branches of government. They connect parent groups with state and national advocates, mental health administrators with public policymakers, and service providers with exemplary program innovators.

California Mental Health Directors Association (CMHDA)

Web site: www.cmhda.org

The California Mental Health Directors Association (CMHDA) provides leadership, advocacy, expertise, and support to California's county and city mental health programs (and their system partners) and assists them in serving individuals with serious mental illness and serious emotional disturbance. CMHDA's goal is to help build a public mental health system that ensures the accessibility of quality, cost-effective mental health care which is consumer and family driven, resiliency-based and culturally competent.

CMHDA's philosophical foundation rests on a set of basic values:

- Healthy families require healthy communities; healthy communities are built through the partnership and collaboration of the public and system stakeholders.
- Community collaboration assures that a safety net is in place and no one falls through the cracks of the system of care.
- Consumers, families/caregivers, and advocates are central to the design, operation and governance of the public system.
- Services will be high-quality, evidence- and best practices-based, and organized to assist consumers to achieve satisfactory outcomes, including goals addressing physical health, housing, education, employment and other activities.
- Providers will treat mental illness clients and their families with dignity, respect and choice, regardless of the setting in which services are provided or the legal status of the consumer.
- Programs and policies must foster public understanding and awareness of mental illness, the damage caused by stigma and discrimination, and the public benefit of quality care.

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CMHDA identifies mental health policy issues and collaborates with other state associations and state agencies, including the Department of Mental Health (DMH). The organization provides assistance, information and training to the public mental health agencies that are its members and supports mental health directors in their work on behalf of multiple constituencies: citizens, elected officials, mental health boards and commissions, consumers, families, advocates, payors, the California Mental Health Planning Council, other service system partners, and the county staff and/or community-based organizations that provide services.

CMHDA works to enhance the resources available to people with mental illnesses, in systems of care that meet the organization's values. The group supports delivery of quality mental health services through adoption and promotion of best practices and benchmarking of quality measures. CMHDA provides information and technical assistance and also collaborates with the California Institute for Mental Health (CiMH) in developing best practices, new delivery models, research, analysis, and public policy/program operation development options.

The Story of the Bell

"Cast from shackles which bound them, this bell shall ring out hope for the mentally ill and victory over mental illness." (Inscription on NMHA Bell)

During the early days of mental health treatment, asylums often restrained individuals with mental illness by binding iron chains and shackles around their ankles and wrists. Better understanding of mental illness eventually ended this cruel practice. In the early 1950s, the National Mental Health Association (NMHA) asked asylums across the country for their discarded chains and shackles. In 1953, the NMHA melted down these inhumane bindings at the McShane Bell Foundry in Baltimore, Maryland, and had them recast into a sign of hope: the Mental Health Bell.

Today, the 300-pound bell serves as the NMHA symbol, a powerful reminder that the invisible chains of misunderstanding and discrimination continue to bind people with mental illnesses. Over the years, the bell has been rung to mark progress in the fight for victory over mental illness, and it continues to ring out hope for efforts to improve mental health care.

California Mental Health Planning Council (CMHPC)

Web site: www.dmh.ca.gov/mental_health_planning_council/default.asp

The California Mental Health Planning Council is mandated by federal and state statute to advocate for children with serious emotional disturbances and adults and older adults with serious mental illness, to provide oversight and accountability for the public mental health system, and to advise the Administration and the Legislature on priority issues and participate in statewide planning.

California Network of Mental Health Clients (CNMHC)

Web site: www.californiaclients.org

"In this long struggle to achieve true human dignity and personal empowerment for mental health clients … a new statewide organization composed of individuals whose lives had been dramatically affected by histories of psychiatric diagnoses and treatment comes together in conference to form and build the California Network of Mental Health Clients. This was the first mental health client run state organization in the country."

Their goals are: (1) To empower clients of the mental health system through self-help groups and networking statewide, (2) To confront discriminating attitudes about mental health clients in the public, the media, the mental health system, and within mental health clients themselves, (3) To provide a strong voice of, by and for mental health clients; to be heard on all issues concerning clients and public policies affecting them in the government, the media, and the community, (4) To promote and instill the rights of clients in and out of treatment situations, with special attention to the right to freedom of choice, and (5) To provide every possible reasonable accommodation to enable person with a psychiatric disability to work; and provide a range of employment opportunities from subsidized pre-vocational training to on-the-job skills development through to employment comparable to non-disabled individuals in similar positions.

- Ensuring access to effective medications and services that reduce the burden of living with mental illness.
- Ending the criminalization of individuals with mental illness.

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Mental Health Association in California (MHAC)

Web site: www.mhac.org

The Mental Health Association in California brings together 18 local chapters of the oldest national mental health consumer organization, the National Mental Health Association. The mission of the Mental Health Association is to provide advocacy, education, information and other assistance necessary to ensure that all people who require mental health services are able to receive the mental health and other services that they need, and are not denied any other benefits, services, rights, or opportunities based on their need for mental health services. The Mental Health Associations have a mission that transcends that of being a provider, recipient or a family member of recipients of services. As the so-called 'glue' that holds the California Coalition for Mental Health together, the Mental Health Association of California must not only have a strong presence in Sacramento, but also must have a strong presence in every community in California.

Access Campaign for Mental Health Care

Web site: www.mhac.org/advocacy/access_background.cfm

The Access Campaign for Mental Health Care is a project of the Mental Health Association in California which works to educate state and local opinion leaders and lawmakers on the importance and cost-effectiveness of mental health care. The Campaign accomplishes these goals through advocacy, education and outreach.

A network of local and state mental health advocacy organizations, the Access Campaign was established in 1995. The Campaign is coordinated by the Mental Health Association in California.

The goals of the Campaign are to eliminate the barriers that keep Californians from accessing the care they need when they need it. The Access Campaign seeks to eliminate barriers to access through:

- Increasing mental health literacy and increasing the understanding of mental illness.
- Reducing the barriers to access imposed by both public and private payers.
- Reducing discriminatory practices within the education system, the workplace, and communities.

Alliance for Better Medicine (ABM)

Web site: http://www.mhac.org/advocacy/alliance_medicine.cfm

Also coordinated by the Mental Health Association in California, the Alliance for Better Medicine is a coalition of:

- Health Advocacy Organizations
- Ethnic Organizations
- Physicians
- Patients

The mission is to educate policymakers and the public to achieve the best and most cost-effective outcomes in health care utilizing the best available science and information developed in consultation with researchers, practitioners and recipients of care, that considers the differences in responses to specific medications or procedures - based upon factors such as age, sex, race, ethnicity and co-occurring disorders.

National Alliance on Mental Illness – California (NAMI-CA)

Web site: www.namicalifornia.org

NAMI California is a grassroots organization of families and individuals whose lives have been affected by serious mental illness. The organization advocates to improve the quality of life and eliminate discrimination and stigma for all its constituents. NAMI California provides leadership in advocacy, legislation, policy development, and education, speaking with the voice of 76 local affiliates and 16,500 people to the California Legislature and Governor, state and county administrators, local mental health directors, health care professionals, and law enforcement and judicial authorities about mental illness issues. The group is dedicated to strengthening local grass roots mental health organizations by providing updated information and support. NAMI California:

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- Educates clients, families and the public about the scientific evidence that shows serious mental illnesses are neurobiological brain disorders.
- Advocates for more research to discover causes of mental illness and new, effective treatments.
- Works to provide a strong, integrated system that offers a continuum of care for the persistent, long-term needs of individuals with mental illness.
- Strives to increase awareness of the needs of people with mental illness.

United Advocates for Children and Families (UACF)

Web site: www.uacf4hope.org

The United Advocates for Children and Families (UACF) is a nonprofit advocacy organization that works on behalf of children and youth with serious emotional disturbances and their families. UACF is a family organization, which means that the majority of the organization's board and staff are parents of youth who have received services for mental health. UACF provides training and technical assistance to family run organizations, local family partnership programs, county departments, school districts, child welfare agencies, juvenile justice programs, and private mental health agencies. UACF helps those it serves to develop a strong vision that articulates the hopes and dreams of a broad range of family members as well as the leadership necessary to accomplish their personal visions for improved outcomes.
UACF operates with the following core principles:

- Individualized technical assistance tailored to the goals, strengths and needs of each program.
- Focus on multiculturalism and the needs of the entire family.
- Promotion of interagency collaboration and peer-to-peer learning environments.
- Commitment to routine evaluation of outcomes.

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SECTION III: Local/County Mental Health Systems

CHAPTER 8. COUNTY GOVERNANCE[95]

County Structure, Duties and Responsibilities

The basic provisions for the government of California counties are contained in the California Constitution and the California Government Code. A county is the largest political subdivision of the state having corporate powers. It is vested by the legislature with the powers necessary to provide for the health and welfare of the people within its borders. The specific organizational structure of a county in California will vary from county to county.

County as Distinguished from a City

There is a fundamental distinction between a county and a city. Counties lack broad powers of self-government that California cities have (e.g., cities have broad revenue generating authority and counties do not). In addition, legislative control over counties is more complete than it is over cities. Unless restricted by a specific provision of the State Constitution, the legislature may delegate to the counties any of the functions which belong to the state itself. The state may also take back to itself and resume the functions which it has delegated to counties.

Types of Counties

The California Constitution recognizes two types of counties: general law counties and charter counties. General law counties adhere to state law as to the number and duties of county elected officials. Charter counties, on the other hand, have a limited degree of "home rule" authority that may provide for the following:

- The election, compensation, terms, removal, and salary of the governing board.
- The election or appointment (except the sheriff, district attorney, and assessor who must be elected).
- The compensation, terms, and removal of all county officers.
- The powers and duties of all officers.
- The consolidation and segregation of county offices.

A charter does not give county officials extra authority over local regulations, revenue-raising abilities, budgetary decisions, or intergovernmental relations.

A county may adopt, amend, or repeal a charter with majority vote approval. A new charter or the amendment or repeal of an existing charter may be proposed by the Board of Supervisors, a charter commission, or an initiative petition. The provisions of a charter are the law of the state and have the force and effect of legislative enactments. There are currently 45 general law counties and 13 charter counties. They are as follows:

General Law Counties: Alpine, Amador, Calaveras, Colusa, Contra Costa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Kern, Kings, Lake, Lassen, Madera, Marin, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Napa, Nevada, Plumas, Riverside, San Benito, San Joaquin, San Luis Obispo, Santa Barbara, Santa Cruz, Shasta, Sierra, Siskiyou, Solano, Sonoma, Stanislaus, Sutter, Trinity, Tulare, Tuolumne, Ventura, Yolo, Yuba.

Charter Counties: Alameda, Butte, El Dorado, Fresno, Los Angeles, Orange, Placer, Sacramento, San Bernardino, San Diego, San Francisco, San Mateo, Santa Clara, Tehama.

County Powers

The California Constitution authorizes a county to make and enforce local ordinances that do not conflict with general laws. A county also has the power to sue and be sued, purchase and hold land, manage or dispose of its properties, and levy and collect taxes authorized by law. Many additional powers have been granted to counties by the legislature. The powers of a county can only be exercised

by the Board of Supervisors or through officers acting under the authority of the Board or authority conferred by law. In addition, the Board must follow the procedural requirements in the statutes or its actions will not be valid. For example, if the legislature has provided a method by which a county may abandon a road, that method must be followed. Also, where state law requires land use zoning by an ordinance, this statutorily prescribed method is binding on the county. On the other hand, where the law does not specifically prescribe a method for accomplishing a task, the county may adopt any reasonably suitable means.

The Board of Supervisors

Unlike the separation of powers that characterizes the federal and state governments, the Board of Supervisors is both the legislative and the executive authority of the county. It also has quasi-judicial authorities.

Board Structure

Government Code Section 25000 requires each county to have a Board of Supervisors consisting of five members. The section applies to general law counties and to charter counties, except where the charter provides otherwise (e.g., San Francisco City and County has 11 members and one mayor). A board member must be a registered voter of, and reside in, the district from which the member is elected. A county charter can provide a local method for filling vacancies on the Board of Supervisors. In the absence of such a provision, the Governor appoints a successor.

A majority of the members of the Board constitutes a quorum for conducting business. A majority of all the members must concur on any act of the Board. A Board may enact rules governing how abstentions are counted. Some extraordinary actions, like passing emergency ordinances, require four votes.

California State Association of Counties

The California State Association of Counties (CSAC) was established in 1991, but the organization grew from a long history of meetings by county supervisors who came together to discuss state and federal legislation since the 1850s. Until 1991 the organization was called the County Supervisors Association of California. CSAC's primary purpose is to represent county government before the California Legislature, administrative agencies and federal government. The group places a strong emphasis on educating the public about the value and need for county programs and services.

Many common issues exist despite the diversity of California's 58 counties. CSAC's long-term objective is to significantly improve the fiscal health of all counties so that they can adequately meet the demand for vital public programs and services.

The following overview of county structure and responsibility was excerpted from the California State Association of Counties Web site, www.csac.counties.org. *(Informing you of the existence of these Web sites is not a representation or warranty of the accuracy of the material they may contain. Any medication claim regarding efficacy, safety, or of a comparative nature of multiple products, is simply information in their materials, which may change from time to time, and is not part of this publication. The authors of this program do not have content*

An official act of the Board of Supervisors can only be performed in a regularly or specially convened meeting. The individual members have no power to act for the county merely because they are members of the Board of Supervisors. Meetings of the Board of Supervisors are subject to the restrictions of the Ralph M. Brown Act (Government Code Section 54950 et. seq.). With limited exceptions, the Brown Act requires that all Board of Supervisors meetings be open and public. The county clerk, whose duty it is to record all proceedings of the Board of Supervisors, is the ex officio clerk of the Board, unless the Board appoints its own separate clerk. The Board must keep a record of its decisions and the proceedings of all regular and special meetings.

Board of Supervisor Powers

The Board of Supervisors exercises its power and authority by undertaking the following roles: executive, legislative, and quasi-judicial.

Executive Role

The Board performs its executive role when it sets priorities for the county. The Board oversees most county departments and programs and annually approves their budgets; supervises the official conduct of county officers and employees; controls all county property; and appropriates and spends money on programs that meet county residents' needs.

Supervision of County Officials — The Board of Supervisors may supervise the official conduct of county officers and require them faithfully to discharge their duties, but the Board cannot add to those duties or relieve the officers from these obligations. The Board may not direct or control the day-to-day operations of a county department, or otherwise limit the exercise of discretion vested by law in a particular officer.

The supervision of elected officers by the Board of Supervisors is somewhat more limited. The district attorney, as public prosecutor, is a state or quasi-state officer and is under the direct supervision of the attorney general. Consequently, the Board of Supervisors does not have supervisory authority over the district attorney's prosecutorial duties. On the other hand, the Board has general supervisory authority over the district attorney to the extent that the district attorney functions as a county officer.

The Board of Supervisors may supervise the sheriff to the extent that the sheriff acts as a county officer, and may investigate the officer's performance of county duties. However, in enforcing state law, the sheriff is acting as a peace officer of the state and is under the direct supervision of the attorney general. In addition to being an officer of the county, the sheriff is also an officer of the courts. While acting in that capacity, the sheriff is not under the supervision of the Board, and the Board may not investigate the sheriff in connection with such duties. The assessor is also under state control in many respects, but not to the same degree as are the district attorney and sheriff.

The Board of Supervisors has a unique relationship with the courts. The Board shares funding responsibility for the courts with the state and cannot fully control their budget or operations. As a court of record (i.e., maintain records of proceedings), the court has all powers (i.e., inherent powers as defined in the law) reasonably required to enable it to perform its judicial functions efficiently, to protect its dignity, independence, and integrity, and to make its lawful actions effective. But inherent powers have limits. The court may not exercise its powers in such a manner as to thwart, nullify, or frustrate legitimate legislative bodies. To this end, there are some conditions on the court's ability to order the Board of Supervisors to provide funding.

County Litigation — The Board of Supervisors also has the power to direct and control the conduct of litigation in which the county or any public entity which the Board governs is a party, and by a two-thirds vote, it may employ outside attorneys to assist the county counsel in conducting such litigation. The decision to hire special counsel is up to the supervisors.

Relationship of the Board of Supervisors to the Civil Grand Jury — The Civil Grand Jury, when working in concert with the Board of Supervisors and the county executive, can prove to be a valuable tool to audit county programs and provide constructive recommendations for the improved operation of local government.

The Civil Grand Jury in California serves two basic purposes: "(1) To weigh the allegations of misconduct against public officials and determine whether to present formal accusations requesting their removal from office; and (2) To act as the public's watchdog by investigating and reporting upon the affairs of local government. Of these functions, the watchdog role is by far the one most often played by the modern grand jury in California." (McClatchy Newspapers v. Superior Court (1988) 44 Cal.3d 1162, 1170.)

Statutory authority of the grand jury:

- To investigate all branches of county, city and special district governments to ensure they are being run in an efficient and honest manner, in the best interest of citizens it serves. Reports may be issued anytime during the year.
- To investigate and report on the operational and financial aspects of all offices within its jurisdiction, including an audit. This authorization extends to any incorporated city or joint powers agency. The grand jury may also report on county officials' records and accounts as ex officio officers of any district.
- To investigate, at its option, any case of an inmate in the county jail on a criminal charge and not indicted. To investigate the condition and management of detention facilities within its jurisdiction.
- To investigate the willful or corrupt misconduct of public officers within its jurisdiction.
- To investigate all sales and transfers of land and matters of land ownership.
- To address the need for salary increases or decreases for county elected officials.

Responsibility of the Board of Supervisors: No later than 90 days after the report is submitted, the Board of Supervisors must comment to the presiding judge of the Superior Court on the findings and recommendations. An elected official or agency head with responsibility pertaining to an area addressed in the report shall respond in writing to the presiding judge, with a copy sent to the Board of Supervisors within 60 days.

Joint Powers Agreement/Joint Powers Agency-Authority — A Board of Supervisors may also establish a joint powers agreement and/or joint powers agency with another public agency. A joint powers agreement (JPA) is created where two

or more local governments enter into a cooperative agreement to provide any service which either of them could provide on their own. A joint powers agreement involves mutually agreeing to specific conditions and terms which may limit each agency's ability to act independently, but it does not alter the basic structure of each agency's decision-making processes. These JPAs are fairly common; a sheriff's department may provide police services to a city, or a county and a city may form a JPA to jointly run an emergency dispatching center. A joint powers agency takes the concept of agreement and cooperation to a new level. Under California Government Code Section 6500, counties, cities, special districts, and other public agencies are allowed to enter into agreements which create new and distinct authorities. The new authorities have a separate operating board of directors which has the powers inherent in all of the participating agencies. The powers of the authority can be general or specific, the term of the authority must be established, and other administrative decisions must be made (e.g., how the board meets and conducts its business). For example, two parties may agree to create a joint transit authority, where both parties contribute the necessary resources and the capital assets. Personnel may become employees of the new authority, and with a new operating board, policies may be independently set to create transportation services for both jurisdictions.

Legislative Role

As the legislative body of the county, the Board of Supervisors may act by resolution, by board order, or by ordinance. A resolution of a Board is ordinarily not equivalent to an ordinance; it is usually a declaration about future purposes or proceedings of the Board or a policy statement by the Board. Resolutions are often used when specific findings are made by the Board of Supervisors. A Board order is usually a directive from the Board of Supervisors to its subordinate county officers.

An ordinance is a local law adopted with all the legal formality of a statute. The California Constitution allows a county or city to make and enforce within its limits all local, police, sanitary, and other ordinances and regulations that do not conflict with the state's own general laws. Most legislative acts, including using the police power, are adopted by ordinance. There are, however, numerous exceptions and specific state laws sometimes indicate whether the action requires an ordinance or resolution.

California Government Code Section 25120 et seq. specifies the form, content, and adoption process for county ordinances. For example, there are urgency ordinances (i.e., those required for the immediate preservation of the public peace, health, or safety) and ordinances which are statutorily required to have a noticed public hearing in order to be adopted (e.g., land use zoning or new fees).

County Revenue Authority

Boards of Supervisors can raise local revenue by imposing or increasing a tax, an assessment, or a fee. Each of these local revenue sources has its own constitutional and statutory authority and unique laws governing its use. A county can only impose those taxes, assessments, and fees which the legislature or the constitution allow the county to impose and which are approved by either a simple or two-thirds majority of local voters per Propositions 13 and 62.

There are important differences between taxes, assessments, and fees. A tax is an involuntary charge against an individual or landowner which pays for public services regardless of the taxpayer's benefit. An assessment is an involuntary charge on land which pays for public improvements or services which directly benefits the taxpayer. All revenue generated by an assessment must be used for the improvements or services specified. A fee is a voluntary charge on an individual which cannot exceed the reasonable cost of providing the service.

Other Duties — Intergovernmental Relations

A county supervisor may serve in other capacities on various boards, commissions, or special districts. State statute authorizes, and in some cases mandates, that various services or functions be carried out by entities other than the Board of Supervisors. These entities, in addition to including locally elected officials, seek public participation and technical expertise:

- Councils of Government (COG)
- Local Agency Formation Commissions (LAFCO)
- Special Districts
- Air Quality Management Districts (AQMD)
- Airport Land Use Commissions (ALUC)
- Joint Powers Authorities (JPA)

The roles and functions of these entities primarily relate to planning for future development and the associated service needs (e.g., water, sewer) and impacts (e.g., air quality, airport safety). Board members serving on one of these entities may find themselves making decisions on a variety of issues from regional planning to establishing spheres of influence for new cities or special districts within the county.

County Health Departments

Health Services

In California, counties have been providing health care services for almost 150 years. With the exception of local health departments operated by the cities of Berkeley, Long Beach, and Pasadena, counties provide a wide variety of health services to all residents of the county, regardless of whether they reside in the unincorporated area or within city limits. In other words, the county health department is also the cities' health department. A County Organized Health System (agency or department) is usually administered by an administrative director who is appointed by either the county administrative officer (CAO) and/or the board of supervisors and is responsible to them for all health-related issues. The board also appoints a public health officer (physician) who serves as the chief medical officer for the county on public health issues. The type of organizational structure and programs offered can vary from county to county, as this is one of the most complex and diverse areas of county government and one which affects every county resident. County health departments are responsible for the following health services, as they relate to mental health:

Indigent Medical Care — Provides medical care to indigent persons (those without financial resources of any kind), including Medically Indigent Adults, in a variety of ways including operating a county hospital and/or primary care clinics, or using a wide variety of contracts with providers of care to fulfill their responsibilities.

Medically Indigent Adults (MIA) — Counties are separated into two categories in fulfilling state-mandated medical and dental services to eligible persons. Those counties with a population over 300,000 in 1980 are referred to as Medically Indigent Services Program (MISP) counties and are required to administer their medical program. Those counties with a population under 300,000 in 1980 have an option of either contracting with the state to administer their MIA program as a County Medical Services Program (CMSP) or administering it themselves (MISP county).

Mental Health — Provides a wide range of mental health services to the public either directly or by contract with providers (to the extent that resources are available). Services typically include acute inpatient care, evaluation of individuals under Welfare and Institutions Code Section 5150 persons (to determine whether they are a danger to themselves, others, or are gravely disabled), State Mental Hospital placements, community long-term care nursing (in institutes for mental disease or IMDs), local crisis services, day treatment, outpatient care, and operation of a conditional release programs for Penal Code offenders in some counties through contracts with the State.

Under Welfare & Institutions Code Sections 5650-5667 mental health departments must give the State Department of Mental Health assurances regarding the following issues in accordance with state law through the development of an annual Performance Contract. Counties must exhibit compliance in:

- The "Maintenance of Effort" requirements, which requires the county to match funds deposited into the mental health account from the Sales Tax Account of the Local Revenue fund.
- Providing mental health services required by state statute.
- Providing for evaluation and treatment to individuals who are a danger to self or others, or are gravely disabled.
- Following requirements necessary for Medi-Cal reimbursement for mental health services under the Medi-Cal mental health managed care program.
- Assuring citizen and professional involvement with planning processes.
- Adhering to applicable laws, regulations and state policies relating to patients' rights.
- Following federal law relating to federally funded mental health programs.
- Providing all data reports and information needed to meet the state's needs.
- Cultural competence of mental health services.
- Using quality assurance techniques to improve mental health services.

Mental Health Directors

"Local mental health services shall be administered by a local director of mental health services to be appointed by the governing body. He shall meet such standards of training and experience as the State Department of Mental Health, by regulation shall require, " according to State Welfare & Institutions Code 5607-5623.5. (See www.leginfo.ca.gov for full text of this code.) *(Informing you of the existence of these Web sites is not a representation or warranty of the accuracy of the material they may contain. Any medication claim regarding efficacy, safety, or of a comparative nature of multiple products, is simply information in their materials, which may change from time to time, and is not part of this publication. The authors of this program do not have content control over these Web sites.)*

The local mental health director has the following powers and duties, summarized from the State Welfare & Institutions Code 5607-5623.5:

- Serves as chief executive officer of the community mental health service.
- Supervises mental health services.
- Recommends (to the governing body) the provision of services, establishment of facilities, contracting for services or facilities, after consultation with the advisory board.
- Submits an annual report to the governing body comprising activities, financial accounting and a forecast of anticipated needs.
- Carries on studies appropriate for the discharge of his or her duties, including the control and prevention of mental disorders.
- Possesses authority to enter into negotiations for contracts or agreements to provide mental health services in the county.

Mental health directors must also meet state and federal reporting requirements through development and maintenance of a data system that measures costs and outcomes. An annual Performance Contract comprising these outcome data must be reported and reviewed by the mental health board, which must then comment on the findings and deliver a report to the California Mental Health Planning Council.

County Boards and Commissions[96]

County boards and commissions (these terms are often used interchangeably) are advisory panels established to encourage citizen involvement and expertise to assist the board of supervisors in serving the community. They are created by state or federal law, county ordinance or by the board of supervisors, depending on the commission. Boards of supervisors rely on these groups to advise them on a wide range of issues affecting their constituencies, and to assure they are responsive to community needs.

Local mental health boards are mandated by state law and play an important role in the delivery of public health to Californians. There is also a unique relationship between the board of supervisors in each county and the local mental health board. Because some counties may be arranged differently, mental health commissioners may report to "governing bodies" other than county supervisors.

Placer, Fresno and San Diego counties don't have freestanding local mental health departments. In these counties, portions of the mental health department related to age-specific services are provided through collaborative agencies. Additionally, there are three mental health boards that don't work for a "board of supervisors": Tri-City, Berkeley City and Yuba-Sutter (which use a Joint Powers Agreement).

Source: CALMHB/C Workbook, Page 124

Establishment of Mental Health Boards/Commissions[97]

Mental health boards were created in 1957 when the State of California passed the Short-Doyle Act that made counties responsible for providing treatment and care for the mentally ill through a community-based and community-operated mental health system. These boards remain the primary vehicle for citizens to have oversight of the administration and provision of county mental health services. Under the Short-Doyle Act, the board of supervisors of every county must establish a community mental health service for the county. Each of these community health services must have a mental health board consisting of no more than 15 members (depending on the population and preference of the county), appointed by the governing body, and one member of the board will be a member of that local governing body. Local

mental health boards may recommend appointees to the county supervisors. The ultimate goal of mental health boards is to ensure the development of improved services, access to services and the best mental health department possible.

Makeup of the Local Mental Health Boards/Commissions

Counties are encouraged to appoint individuals who have experience and knowledge of the mental health system, and the board's makeup should reflect the ethnic diversity of the client population in the county. Members serve for three-year terms.

- The local mental health board must develop bylaws, to be approved by the governing body.
- Local boards are required to have at least half consumers and family members (parents, siblings or adult children of consumers) who are receiving or who have received mental health services on their boards.
- Boards created to function as advocates and spokespersons for consumers, families and the larger community in the design and financing of mental health programs.

Regional Groups of Counties

California's local mental health boards are organized by the California Association of Local Mental Health Boards/Commissions into groups of counties and five regions:

- Bay Area Region
- Southern Region
- Los Angeles Region
- Superior Region
- Central Region

Mental Health Boards and Commissions: Statutory Duties[98]

Mental health boards and commissions serve as advisors with the following purposes:

- Oversee and monitor the local mental health system.
- Advocate for individuals with serious mental illness.
- Advise the local governing body and the mental health director.

The statutory duties are outlined in the Welfare & Institutions Code 5604.2 as follows. The italicized items are potential opportunities and/or methods to meet the requirements, as suggested in the CALMHB/C Workbook.

1. Review and evaluate the community's mental health needs, services, facilities and special problems.
    - *Have presentations by various agencies, contractors, community groups and program managers.*
    - *Review facilities and services through site visits.*
    - *Hold public meetings on various topics.*
    - *Establish committees to review issues.*
2. Review any county agreement entered into pursuant to Section 5650.
    - *This refers to the county's annual Performance Contract required to be submitted to the State Director of Mental Health. The mental health board/commission should review their mental health department's "county plan" to assure that the county is in compliance with the required elements.(see www.leginfo.ca.gov for text of this code.)*
    - *Proactively monitor and review the budget process.*
    - *Monitor and review subaccount transfers.*
3. Advise the governing body and the local mental health director as to any aspect of the local mental health program.
    - *Testify at board of supervisors' meetings and workshops.*
    - *Provide written advice.*
    - *Meet with supervisors individually.*
    - *Review and comment on the mental health budget.*

4. Review and approve the procedures used to ensure citizen and professional involvement at all stages in the planning process.
    - *Encourage community input at mental health board meetings.*
    - *Join department committees.*
    - *Conduct public meetings.*
5. Submit an annual report to the governing body on the needs and performance of the county's mental health system.
    - *Provide a summary of the mental health board's membership, attendance and major activities in the past year.*
    - *Address the mental health board's goals for the coming year.*
    - *Provide comments on the planning process and citizen involvement.*
    - *Evaluate the local mental health program (i.e., unmet needs, gaps in services, consumer satisfaction, etc.).*
    - *Make recommendations for system improvements.*
6. Review and make recommendations on applicants for the appointment of a local director of mental health services. The board shall be included in the selection process prior to the vote of the governing body.
7. Review and comment on the county's performance outcome data and communicate its findings to the California Mental Health Planning Council.
    - *Appoint a committee to review the process and criteria, and to work with the mental health staff.*
    - *Seek input from providers and the community.*
    - *Consult with the mental health director at all stages in compiling the report.*
8. Nothing in this part shall be construed to limit the ability of the governing body to transfer additional duties or authority to the mental health board.
    - *The board of supervisors may ask the mental health board to take on additional duties which by law they would be required to perform.*

CHAPTER 9. CALIFORNIA ASSOCIATION OF LOCAL MENTAL HEALTH BOARDS AND COMMISSIONS[99, 100]

In 1991, the Welfare and Institutions Code had mandated that local mental health boards/commissions re-establish their membership with 50 percent consumer and family members. Although they now had a voice and a vested interest, new members did not receive training to assist them in performing their duties.

The California Association of Local Mental Health Boards and Commissions (CALMHB/C) was created in 1993 by Jean Liechty as a 501(c)3 nonprofit organization. The CALMHB/C was established to educate new mental health board members. The CALMHB/C would also provide a safe forum in which to exchange ideas in a constructive, focused way and a vehicle whereby new members could learn how to: (1) perform their mandated oversight duties; (2) conduct complete and thorough reviews of their departments; (3) provide the necessary funding and tools to do their jobs; and (4) confront other challenges facing local mental health boards around the state.

The organization features a board of directors consisting of five executive officers (president, 1st vice president, 2nd vice president, secretary and treasurer.) Board members represent five regions throughout California, with three directors, three alternate directors and a coordinator, all elected at the regional level.

CALMHB/C is structured with a "bottoms-up" system. Each of the 59 local mental health boards is invited to attend regional meetings to discuss issues, keep informed of legislative issues, state issues, and obtain and share information to evaluate the effectiveness of their own local boards.

The organization's primary goal is to become an "informational highway" from the local boards to the regional level and then to

CALMHB/C Mission Statement

The purpose of the Association shall be to assist local mental health boards and commissions carry out their mandated functions; to advocate at the state level as a united voice for local mental health boards and commissions' concerns, and to promote improvement of the quality, quantity and cultural competency of mental health services deliverable to the people of California.

the state level and back down. CALMHB/C helps local boards become effective in performing their duties and roles. This organization provides the only place where board members can learn from other board members, share ideas and find solutions to make them more effective. When local boards are informed of all the issues before them, and board members are empowered to perform their duties effectively, the mental health departments and people they serve will benefit.

CALMHB/C works to ensure that citizen and professional involvement occur in the county's mental health planning process at all stages of development.

Section IV: Assessing Progress: Today and Beyond

"We envision a future when everyone with a mental illness will recover, a future when mental illnesses can be prevented or cured, a future when mental illnesses are detected early, and a future when everyone with a mental illness at any stage of life has access to effective treatment and supports – essentials for living, working, learning, and participating fully in the community."

— From President George W. Bush's New Freedom Commission on Mental Health, 2001

CHAPTER 10. MENTAL HEALTH SERVICES ACT[101, 102, 103, 104, 105, 106, 107]

In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA), which now provides funding for new and expanded mental health services and supports for people with serious mental illness. Enactment of this landmark legislation initiated an expectation of a comprehensive planning process within the mental health system. Passage of the MHSA reflected years of grassroots efforts by the California Council of Community Mental Health Agencies (CCCMHA), led by Rusty Selix; hundreds of other endorsing organizations representing consumers, family members, providers, and county mental health interests; visionary legislators such as Assemblyman Darrell Steinberg (Steinberg served in the California State Assembly when Proposition 63 was passed and was later elected to the State Senate in 2006); nearly 7,000 individual citizens who contributed to the campaign; and a host of professionals in the mental health and legislative fields as well as educators, law enforcement, and older adult and children's advocacy groups.

The MHSA was created to help both adults and older adults who have been diagnosed with or may have serious, persistent mental illness, and children and youth who have been diagnosed with or who may have serious emotional disorders, and their families. The Act was designed to bring about certain outcomes, including: (1) getting people the specific help they need when and where they need it; (2) having fewer adults in jail and young people in juvenile hall who have serious mental health problems; (3) ensuring that people with mental illness have safe and adequate housing and that children with emotional problems can live with their families in safety; and (4) promoting the ability of people with mental illness to experience employment, vocational training, education, social and community activities, and the support of family and friends.

Implementation of the Mental Health Services Act

Above all, the MHSA was intended to transform the public mental health system in California. The Act promised to improve mental health services by moving toward a "Help First" system in which people who need mental health services can obtain the right care at the right time in the right place, rather than a crisis-driven, "Fail First" system, in which treatment is rationed to those whose illness is most severe. Under the old fail first structure, people with mental illnesses often had to hit rock bottom before they could get treatment or services. Hospitalizations, incarcerations, out-of-home placements, special education, and other less-than-successful responses were often the norm. The MHSA was designed to change the current crisis-driven system of episodic treatment to a case-driven, integrated state system of mental health care, and the hope for the Act is that it will generate new money to begin to bring the quality of care up to meet the needs of Californians with mental illness who are without services and in crisis.

To accomplish those goals, the MHSA will focus more proactively on prevention and early intervention to address symptoms sooner and keep mental illnesses from becoming so severe in the first place. California is the first state in the country to utilize this innovative approach. Eventually, the hope is that the MHSA will provide enough funding to enable the system to serve everyone who faces a disabling mental illness. The hope is that no child will age out of the child welfare system and end up on the streets, and that no one will be discharged from psychiatric hospitalization without follow-up care or discharged from jail or the juvenile justice system without being enrolled in an appropriate treatment program. The experts agree that this will not happen overnight, but in a few years, the vision of the MHSA should be an expectation.

MHSA proponents anticipate the end of "business as usual" for the state's mental health system, and implementation of the Act certainly calls for change. California will need a major expansion of

mental health workers – professionals who are culturally competent, skilled at best mental health care practices, and open to using the recovery/wellness model. The basic goal of increasing access to care will require attention to issues of language, color, locations where people are most in need of services, and the stigma still associated with stereotypes and misconceptions. Mental health funding from the MHSA will be used for targeted populations of people who have been untreated or undertreated for mental illness (e.g., the homeless, institutionalized or incarcerated).

And because MHSA funding can only be used for new or expanded programming by the counties, transforming the system will require building new infrastructure and developing innovative solutions. But the MHSA does provide counties with a new way of doing business, since monies allocated for their initial three-year mental health plans and not spent within that time frame can "rollover" and be reinvested into the next three-year plan.

One of the goals of Proposition 63 was to enhance public awareness concerning mental illness and to decrease discrimination against those individuals with mental and emotional problems. Stigma and fear still exist in most communities, despite the fact that more than 20 percent of Californians will experience a mental health problem during their lifetime, and 50 percent of families in California will have a member with a mental illness (Source: Selix, Rusty, Executive Director, Mental Health Association in California, and California Council of Community Mental Health Agencies. Personal Interview.). The MHSA has begun to improve public attitudes by increasing the understanding that mental and emotional disorders are treatable conditions. Supporters of the Act feel confident that the MHSA will not only change public opinion, but alter the way mental illness is treated by developing integrated models of care within a system that: (1) serves all clients in need; and (2) is able to treat them early enough to make a significant difference in recovery and wellness.

Challenges and Achievements

However, there are a number of policy issues within the MHSA which are currently being discussed and are central to understanding the impact – and the promise – of the MHSA. The following issues, which were raised during one-on-one interviews with various key stakeholders, are summarized below:

1. One of the greatest needs is to ensure adequate funding to serve people who need mental health care. While the MHSA will bring an exciting and much-needed infusion of new funds into the public mental health system, it will not fix the current chronic under funding of the system overnight.

Some observers believe that counties will inevitably need to reduce services in their non-MHSA systems, at the same time they are building new services under MHSA. Realignment, which never fully funded mental health needs in California, was intended to increase over time. But that growth has not occurred; in fact, Realignment has not kept up with the costs of providing services, and funding for mental health is actually less than it was in the year 2000, with most of the monies going to social and health services (Source: Ryan, Patricia, Executive Director, California Mental Health Directors Association. Personal Interview.). Because the Realignment formula is weighted in favor of caseload-driven entitlement programs (e.g., In-Home Supportive Services and Foster Care), mental health services have not received any sales tax growth in several years and will not receive any for the foreseeable future. Vehicle License Fee (VLF) growth has only averaged 2.1 percent a year for the past three years. Meanwhile, the costs of services and other demands have steadily risen (Source: California Mental Health Financing 101, PowerPoint Presentation, "The Mental Health Services Act in the Context of Overall County Mental Health Financing Pressures." Sacramento: California Mental Health Directors Association, 2006.). Thus, from the start, revenues from Realignment (VLF and sales tax) fell short of expectations.

In addition, Medi-Cal services managed by counties for the state have not received a cost of living adjustment, which constitutes a cost shift from the state to counties. Realignment funds must be used to pay for these increased costs. Failure of the state to fully reimburse counties for AB 3632 services has forced counties to redirect Realignment funds away from their target population. Each year, services that can be delivered erode under multiple demands on scarce dollars. Realignment funding has not kept pace with growth in population nor the consumer price index since it began. Thus, the system is still serving only about 40 percent of people with serious, disabling mental illness, and many of those served do not get all of the services they need (Source: California Mental Health Financing 101, PowerPoint Presentation, "The Mental Health Services Act in the Context of Overall County Mental Health Financing Pressures." Sacramento: California Mental Health Directors Association, 2006.).

Some leaders in the field have called for the following actions:

- Restore state funding.
- Increase California's share of federal funds.

- Recapture funds being expended less cost effectively in other programs.
- Eliminate the lack of parity between mental and physical health benefits in health insurance plans.
- Reform our correctional system to provide more rehabilitation services, particularly to those with serious mental illness and substance abuse disorders.

Creating parity will mean that those who have insurance will have their needs met with private insurance funds and not be dependent upon taxpayer-supported mental health programs.

2. Developing and managing successful programs for youth ages 16-25 is one area of pressing need, as existing services are scarce and minimally competent. The need to provide integrated services for people with co-occurring disorders is also crucial.

Denial and delays in providing appropriate services also significantly increase the likelihood of complications due to substance abuse. Using MHSA funds to serve this population of seriously mentally ill or disturbed youth will maximize the potential for reversing the current pattern of crisis-driven care. Also, the necessity of providing integrated mental health and alcohol/drug abuse services because of the large number of individuals with co-occurring disorders has been acknowledged, access to these types of services still remains limited. What is needed is a "No Wrong Door" approach to ensure that no one is turned away from services, no matter what the entry point to seeking treatment. The state needs to take a strong leadership role through the DMH in helping counties and public/private entities strengthen collaborative efforts at integrated care.

3. There is a critical need for oversight and accountability for the MHSA.

Implementation of the MHSA has generated new policy questions for both state and local agencies. Some in the mental health community think that the Oversight and Accountability Commission (OAC) must articulate:

- How it will conduct oversight and accountability duties.
- How it will determine whether county prevention plans measure up to standards.
- Exactly what aspects of the Act are subject to oversight activities.

OAC is also responsible for eliminating discrimination and stigma as part of prevention and early intervention efforts. There is no "one size fits all" anti-stigma campaign message, and some observers note that advertising and marketing must be tailored to each audience to combat widespread superstitions, ignorance and fears about mental illness. Since community mental health services are stigmatized as the only Medicaid and public assistance programs that are not caseload-driven, the resultant, ongoing legal and systematic discrimination makes changing public attitudes and behaviors even more challenging.

Other suggested activities for the OAC include the following:

- Obtaining current data to assess the capacity of California's public mental health system, including such information as the capacity of counties to provide services and the quality of those services (i.e., how many people need how many services; how many people are getting what they need; the effectiveness of specific programs; and outcomes for particular individuals).
- Working to ensure the understanding and application of state standards regarding service levels and systems of care, training guidelines, curriculum, and anti-stigma campaigns.
- Taking a leadership role in promoting the collaboration models that are central to implementing the MHSA.

4. The expectations set up by passing the MHSA and the planning process go way beyond the likely possibility of meeting those expectations.

While huge amounts of time have been spent on governance issues, some leaders in the field point out that a similar effort has not always been made in program design and development. They think that the DMH has been slow to develop expertise and technical assistance and has rarely been able to transform its own delivery of services to the extent demanded of county programs. The failure to fund Medi-Cal cost of living increases and potential removal of AB 2034 funds – actions that chip away at the funding sources for mental health programs – will further limit the impact of MHSA funds, and the slow progress of getting money "out the door" will only make additional chipping away more likely. Staff shortages also continue to hinder the ability of counties to fulfill their commitments.

Other experts are concerned that the MHSA does not address the fundamental frailty of the public mental health system, which is its governance and financing structure. As long as California retains a county-based delivery system, the potential for significant change and improvement is limited. County government (and service delivery by extension) is concerned with risk avoidance, minimization or containment. Thus, a basic conflict arises when an entity that is fundamentally risk-avoidant is asked to take on an enterprise which requires risk (i.e., supporting choice and recovery). This fundamental paradox means that a mental health system organized, administered and delivered by the counties may not accomplish its objectives.

Some professionals in the mental health field also point out that while Proposition 63 raised expectations and involved the community, the MHSA funding only creates new programs for a small number of people with mental illness – the unserved – but has no impact on the existing system of care because it does nothing to help most of the underserved or the inadequately served. In other words, the MHSA did not attempt to change the current system of service delivery, and now money is actually being directed into a parallel system.

5. Implementation of the MHSA is a work in progress.

As noted in this report, the DMH will implement the Act incrementally. Some leaders in the mental health field feel that the timetable lacks a strategic rationale for timing the implementation of different components, phasing in certain services, and targeting specific populations. Others think that resources are not going to underserved populations where the need is greatest, and that better assessment of who receives funding and how services are provided is required, especially for the elderly, Latinos and Asian Americans. Some people are dispirited by the pace of implementing the Act and fear that the slow pace may make it difficult to collectively protect the money over the long term. Others have a "time will tell" attitude as to whether the additional parts of the Act yet to be implemented will allow county departments to deliver to the community the programs that will meet the needs which have been articulated.

However, state leaders believe that transformation has happened and is happening. The extent of community input and participation in planning at the county level has been exciting to many observers who felt the process has transformed the way the leadership in many county departments and the community look at mental health.

- More than 100,000 people participated in the MHSA planning process.
- Consumer and family groups have been empowered and strengthened to find their voice.
- In some communities, this voice has gone beyond the mental health department to become an active part of the larger community dialogue.
- At the local level, the MHSA process has reached out to engage consumers, family members and underserved communities in a real way – their participation has influenced policy choices made by the state and the counties.
- In addition, new partnerships have been developed among nontraditional partners such as primary care providers and housing and employment experts.

Most experts point out that California's mental health system has been broken for a long time, and thus the transformation will not be an overnight process. While the impact of the MHSA over time is yet to be known, the promise still remains that eventually more people will be able to participate in the system and receive integrated, "wraparound" services for all of their needs (i.e., whatever it takes to help them – medication, treatment, housing, job assistance). Stephen W. Mayberg, Ph.D., director of the DMH, has said that Californians need to:

- Celebrate successes and share them whenever possible.
- Build on current energy and enthusiasm.
- Recognize that stigma and discrimination diminish through personal stories.
- Never forget the process is about people, not systems.

Navigating the Currents: Voices from the Mental Health Community

Roughly 20 organizational and individual stakeholders were contacted to contribute their thoughts, feelings and vision for California's mental health system as it relates to the Mental Health Services Act. The following are the responses received.

"The planning process [of the MHSA] at the local level was, by and large, exciting and changed the community status of mental health. The recovery model has become the standard expectation and is, in the counties I know about, changing the way in which current services are conceived and – in the best cases – delivered. I am optimistic about the impact of transformation, if we can only jump-start the capacity of educational institutions to provide the training, and trained individuals, needed to move forward. I am a little nervous about funding and feel like distributing the money will help protect the funds. DMH needs to strengthen its own ability to recognize what's going well, support it, and provide targeted assistance to what isn't going well."

— Catherine Camp, Consultant, Health and Human Services

"We are excited by the opportunity to make significant changes to the mental health delivery system in our state. We believe the prevention component holds great promise as a new direction. We expect to see a stronger focus on collaboration between community-based providers and county systems. Greater collaboration coupled with an emphasis on prevention is needed if we are to truly transform California's mental health system. Proposition 63's recognition that mental health must work through primary care is a vital component that will yield results. California's community clinics and health centers are the best kept secret in mental health. Their inclusion in the mental health delivery system is the key to the future."

— Carmela Castellano-Garcia, Esq., President and Chief Executive Officer, California Primary Care Association

"After decades of neglect, California is finally addressing the major health problem of death by suicide. While over 3,300 Californians die each year by suicide, the issue has been largely ignored until suicide reduction was identified as a significant goal of the MHSA. We applaud the investment that is made possible by the MHSA, and we strongly encourage all persons involved with the MHSA OAC to become educated about the serious health issue of suicide. We look forward to having the State of California and every county mental health department develop plans and programs to solve this tragic health problem."

— Mark Chaffee, President, Suicide Prevention Advocacy Network – California

"We believe that the biggest potential for system change will be the hiring of persons in recovery. To the extent that organizations and systems truly appreciate and honor the value of consumers employed at all levels, the culture of services and programs and the system will change. At issue is not just preparing the consumer work force, but equally preparing the existing work force, many of whom would quit before working alongside of consumers. Creating 'safe' workplaces for folks to be 'out' about their disability and developing career pathways for consumers and family members is key. The good news is that we have assessment tools, planning guides, curriculum, and examples of how it can be done."

— Betty Dahlquist, C.P.R.P., Executive Director, California Association of Social Rehabilitation Agencies

"The transformation of mental health service delivery in California needs to be to one that integrates the MHSA model, money and service concepts into the existing, inadequate, failing, crisis-driven system, rather than one that creates a parallel system. In order to do this, we need an infusion of state leadership and established, articulated state standards for quality care. We must also end the discrimination in Realignment funding that allows counties to take money from mental health services and put those funds into caseload-driven health and social services. Our objective should be to serve people with mental illness earlier – to encourage them to utilize mental health benefits as soon as they need them, before they lose their job, their insurance and their homes and have to move into the public mental health system."

— Rose King, Political and Policy Consultant

"We've learned how much passion there is for doing something better for people with mental illness. Our hope is that given the right services, people with mental illness can live life in the community, which in the long run is good for the community because they become employed, tax-paying citizens. If we can keep people out of the mental health system by providing them with services earlier, then this is a good public investment. If our mental health system is adequately funded, with the right set of values and accountability, we can make a substantive difference in the quality of people's lives. We have the opportunity to change how we do business in the mental health system for California, the nation and the world. It's really about outcomes and promises."

— Stephen W. Mayberg, Ph.D., Director, California Department of Mental Health

"When Proposition 63 first passed, I thought there would be the opportunity to provide services for the underserved, which includes the elderly, Latinos and Asian Americans, and I was encouraged. However, little has changed for those communities. We are still unable to serve the uninsured populations with the most need because the system is unable to secure payment. The Latino Behavioral Health Institute will continue to work in two areas, addressing disparities in serving the community and the work force. We need more Latinos within the system who will advocate for services and on policy issues."

— Ambrose Rodriguez, President, Latino Behavioral Health Institute

"The MHSA will not give us the ability to serve every need of every person in California who has a mental health problem, at least not in the foreseeable future. But we will be able to serve more people than ever before. The MHSA is most important as a change agent. Now, prevention and early intervention will be important components of our system for the first time. If we put money into the front end of services, we will not have to spend as much in the more expensive part of the system. MHSA funds are initially going to go to people with the highest need, to keep them from becoming homeless or ending up in jail. Eventually, this should relieve stress on the crisis end of the system and free up money for others in need, thus creating a more efficient system with better outcomes. Now is the difficult time – we are in transition – but great things are happening."

— Patricia Ryan, Executive Director, California Mental Health Directors Association

"We want to completely change the mental health system in California, so we need to take enough time to do it right. We're not there yet. But this is the brightest future there has ever been in the United States regarding mental illness. Proposition 63 has given us the possibility of an appropriate structure and adequate funding. California is the first state to make an adequate investment of funds and put them in a system to give people the care they need – prevention, intervention and models of care that work. And it is access to care that will change the most. No longer will someone with a disabling mental illness end up on the street. And we believe that as the rest of the nation sees the changes in California, this will become the wave of the future for the country. It's incredibly promising."

— Rusty Selix, Co-author of Proposition 63, Executive Director, California Council of Community Mental Health Agencies, Executive Director, Mental Health Association in California

The [Mental Health Services] Act has sparked a movement to make mental health services and education a statewide and national priority. This is imperative to bring mental health treatment on par with the way we treat cancer, diabetes and heart disease. We need to bring this issue out of the shadows so that people who live with mental illness can genuinely say they are "living with mental illness."

— Senator Darrell Steinberg, Author of Proposition 63, the Mental Health Services Act
Senate appointee to the Mental Health Services Oversight and Accountability Commission (chair emeritus)

SECTION V: Bibliography

BIBLIOGRAPHY — Interview Candidates

Camp, Catherine, Consultant, Health and Human Services. Personal Interview.

Castellano-Garcia, Esq., Carmela, President and Chief Executive Officer, California Primary Care Association. Personal Interview.

Chaffee, Mark, Executive Director, Suicide Prevention Advocacy Network – California. Personal Interview.

Dahlquist, Betty, Executive Director, California Association of Rehabilitation Agencies. Personal Interview.

Frost, Lynda, Field Representative, Corrections Standards Authority. Personal Interview.

King, Rose, Policy and Political Consultant, Directions. Personal Interview.

Mayberg, Stephen W., Ph.D., Director, California State Department of Mental Health. Personal Interview.

Rodriguez, Ambrose, President, Latino Behavioral Health Institute. Personal Interview.

Ryan, Patricia, Executive Director, California Mental Health Directors Association. Personal Interview.

Selix, Rusty, Executive Director, Mental Health Association in California, and California Council of Community Mental Health Agencies. Personal Interview.

BIBLIOGRAPHY — Web Sites

(Informing you of the existence of these Web sites is not a representation or warranty of the accuracy of the material they may contain. Any medication claim regarding efficacy, safety, or of a comparative nature of multiple products, is simply information in their materials, which may change from time to time, and is not part of this publication. The authors of this program do not have content control over these Web sites.)

Access Campaign for Mental Health Care - www.mhac.org/advocacy/access_background.cfm

Alameda County Behavioral Health Services – http://bhcs.co.alameda.ca.us

Bazelon Center for Mental Health Law – www.bazelon.org

California Coalition for Ethical Mental Health Care (CCEMH) – www.ccemhc.org

California Coalition for Mental Health (CCMH) – www.mhac.org/advocacy/ccmh.cfm

California Council of Community Mental Health Agencies (CCCMHA) – www.cccmha.org

California Department of Mental Health (DMH) – www.dmh.ca.gov

California Institute for Mental Health (CIMH) – www.cimh.org

California Mental Health Directors Association (CMHDA) – www.cmhda.org

California Mental Health Master Plan, Chapter 8 – http://www.dmh.ca.gov/Mental_Health_Planning_Council/docs/Master%20Plan/Chapt8.pdf

California Senate and Assembly Bills since 1993-1994 session – www.leginfo.ca.gov/

California State Association of Counties (CSAC) – www.csac.counties.org

Los Angeles Child Guidance Clinic – www.lachild.org/about_history.htm

Mental Health Association in California (MHAC) – www.mhac.org

Mental Health Services Act – www.dmh.ca.gov/Prop_63/MHSA/default.asp

Office of the Surgeon General – www.surgeongeneral.gov/library/mentalhealth/home.html

Papers of John F. Kennedy – www.presidency.ucsb.edu/john_f_kennedy.php

President's New Freedom Commission on Mental Health – www.mentalhealthcommission.gov

Ralph M. Brown Act – http://en.wikipedia.org/wiki/Brown_Act

The Village – www.village-isa.org

BIBLIOGRAPHY — Documents

California Mental Health Financing 101, PowerPoint Presentation, "The Mental Health Services Act in the Context of Overall County Mental Health Financing Pressures." Sacramento: California Mental Health Directors Association, 2006.

California Mental Health Master Plan: A Vision for California. Sacramento: California Mental Health Planning Council, 2003.

California's Mental Health System, Underfunded from the Start. Sacramento: California State Senate Committee on Budget and Fiscal Review, 2000.

California Welfare & Institutions Code 5607-5623.5.

Cross, Terry L., Karl W. Dennis, Mareasa R. Isaacs, and Barbara J. Bazron, under the auspices of the National Technical Assistance Center for Children's Mental. *Cultural Competence in Serving Children and Adolescents With Mental Health Problems*. Washington, D.C.: Georgetown University, SAMSHA's National Mental Health Information Center, The Center for Mental Health Services, 1989.

Crowell, Areta, Ph.D., Beth Briscoe, M.S.P.H. and Dean Whitehead, eds. *The Story of Public Mental Health Services in Los Angeles County: The First Forty Years, 1960-2000*. County of Los Angeles: Department of Mental Health, 2000.

Gelber, Suzanne, Ph.D. and David Rinanldo, Ph.D., SGR Health Alliance. *The State of the State of Behavioral Health in California: Alcohol, Drug and Mental Health Services and Systems*. Oakland, California: California HealthCare Foundation, 2000.

Goodwin, Sandra Naylor, Ph.D., MSW. California Institute of Mental Health and Rusty Selix, Executive Director, California Council of Community Mental Health Agencies. *The Development of California's Publicly Funded Mental Health System*, 2004.

History and Funding of California's Public Mental Health System. Sacramento: California Mental Health Directors Association, November 2006.

James, J. Frank, M.D. and Truman C. Schoenberger. *California Conference of Local Mental Health Directors, 1958-1978*. September 1978.

Many Voices, One Direction: Building a Common Agenda for Cultural Competence in Mental Health, A Report to the Community. Sacramento: California Institute for Mental Health and California Mental Health Directors Association, 2002.

Parent, Dale, President, California Association of Local Mental Health Boards/Commissions. Sacramento, 2007.

Partnerships for Quality: California's Statewide Quality Improvement System. Sacramento: California Mental Health Planning Council, 2005.

Report on the Mental Health Governance Study. Sacramento: California Mental Health Planning Council, 1993.

Report to the Legislature on the Effectiveness of Integrated Services for Homeless Adults With Serious Mental Illness. Sacramento: California Department of Mental Health. May 2003.

Selix, Rusty, Executive Director, California Council of Community Mental Health Agencies. *Mental Health Services Act Long Range Plan: A Road Map From Fail First to Help First and Proposition 63 – Standing on the Shoulders of Giants*. Sacramento: California Mental Health Services Oversight and Accountability Commission, 2006.

Selix, Rusty, Executive Director, California Council of Community Mental Health Agencies, and Assemblyman Darrell Steinberg (D-Sacramento). *From Fail-First to Help-First: Proposition 63 Transforms California's Mental Health System*. Sacramento: Mental Health Association in California, 2006.

Workbook on the Roles and Duties of Local Mental Health Boards & Commissions. Sacramento: California Association of Local Mental Health Boards and Commissions (CALMHB/C), 2000.

BIBLIOGRAPHY — Links to Documents and Legislation

(Informing you of the existence of these Web sites is not a representation or warranty of the accuracy of the material they may contain. Any medication claim regarding efficacy, safety, or of a comparative nature of multiple products, is simply information in their materials, which may change from time to time, and is not part of this publication. The authors of this program do not have content control over these Web sites.)

Aranda, M. *The development of the Latino social work profession in Los Angeles. Research on Social Work Practice*, 11. 2001. 254-265.

Being There: Making a Commitment to Mental Health. Little Hoover Commission, 2000.

California Involuntary Mental Health Holds. California State Department of Mental Health, External Affairs, April 30, 2007.

California Mental Health Master Plan: A Vision for California www.dmh.ca.gov/Mental_Health_Planning_Council/Master_Plan.asp

For more information on California Senate and Assembly Bills since 1993-1994 session: www.leginfo.ca.gov/

California Mental Health Master Plan: A Vision for California. Sacramento: California Mental Health Planning Council, 2003.

California State Association of Counties Web site, www.csac.counties.org

California's Mental Health System, Underfunded from the Start. Sacramento: California State Senate Committee on Budget and Fiscal Review, 2000.

Crowell, Areta, Ph.D., Beth Briscoe, M.S.P.H. and Dean Whitehead, eds. *The Story of Public Mental Health Services in Los Angeles County: The First Forty Years, 1960-2000.* County of Los Angeles: Department of Mental Health, 2000.

Frequently Asked Questions, California Involuntary Mental Health Holds. Sacramento: California State Department of Mental Health, External Affairs, April 30, 2007.

Gelber, Suzanne, Ph.D. and David Rinanldo, Ph.D., SGR Health Alliance. *The State of the State of Behavioral Health in California: Alcohol, Drug and Mental Health Services and Systems.* Oakland, California: California HealthCare Foundation, 2000.

Goodwin, Sandra Naylor, Ph.D., MSW. California Institute of Mental Health and Rusty Selix, Executive Director, California Council of Community Mental Health Agencies. *The Development of California's Publicly Funded Mental Health System*, 2004.

History and Funding of California's Public Mental Health System. Sacramento: California Mental Health Directors Association, November 2006.

Hobbs, Frank, and Nicole Stoops. *Demographic trends in the 20th century (Census 2000 Special Report, Series CENSR-4)*. Washington, D.C.: U.S. Government Printing Office, 2002.

Jaco, E. Gartley. *Mental health of the Spanish American in Texas. In M. K. Opler (Ed.), Culture and mental health: Cross cultural studies.* New York: Macmillan, 1959.

James, J. Frank, M.D. and Truman C. Schoenberger. *California Conference of Local Mental Health Directors, 1958-1978*. September 1978.

Karno, Marvin. "The enigma of ethnicity in a psychiatric clinic." *Archives of General Psychiatry*, 14. 1966. 516-520.

Many Voices, One Direction: *Building a Common Agenda for Cultural Competence in Mental Health, A Report to the Community.* Sacramento: California Institute for Mental Health and California Mental Health Directors Association, 2002.

McClatchy Newspapers v. Superior Court 44 Cal.3d 1162, 1170. 1988.

Mental Health Parity in California Survey Summary Report. California Department of Managed Health Care, 2007. http://www.dmhc.ca.gov/library/reports/med_survey/parity/sfor.pdf

Office of Regulations: California Mental Health Laws and Regulations, 2006 Edition. California Department of Mental Health, www.dmh.ca.gov/Laws_and_Regulations/docs/intro_Laws_and_Regulations_2006edition.pdf

Partnerships for Quality: California's Statewide Quality Improvement System. Sacramento: California Mental Health Planning Council, 2005.

Proceedings from the California Mental Health Directors Association Conference. 2002.

Report on the Mental Health Governance Study. Sacramento: California Mental Health Planning Council, 1993.

Report to the Legislature on the Effectiveness of Integrated Services for Homeless Adults With Serious Mental Illness. Sacramento: California Department of Mental Health, May 2003.

Selix, Rusty. *Mental Health Services Act Long Range Plan: A Road Map From Fail First to Help First.* Sacramento: California Mental Health Services Oversight and Accountability Commission, 2006.

Sue, S. "Community mental health services to minority groups: Some optimism, some pessimism." *American Psychologist*, 32. 1977. 616-624.

(Informing you of the existence of these Web sites is not a representation or warranty of the accuracy of the material they may contain. Any medication claim regarding efficacy, safety, or of a comparative nature of multiple products, is simply information in their materials, which may change from time to time, and is not part of this publication. The authors of this program do not have content control over these Web sites.)

Surgeon General's Office, *Report of the Surgeon General on Mental Health*, 1999. www.surgeongeneral.gov/reportspublications.html#public

Wu, I., & Windle, C. "Ethnic specificity in the relationship of minority use and staffing of community mental health centers." *Community Mental Health Journal*, 16. 1980. 156-168.

Zinman, Sally, Howe the Harp and Su Budd. *Reaching Across: Mental Health Clients Helping Each Other.* 1987.

(Informing you of the existence of these Web sites is not a representation or warranty of the accuracy of the material they may contain. Any medication claim regarding efficacy, safety, or of a comparative nature of multiple products, is simply information in their materials, which may change from time to time, and is not part of this publication. The authors of this program do not have content control over these Web sites.)

BIBLIOGRAPHY — RESOURCES (List of Agencies and Organizations)

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Association of Mental Health Patients' Rights Advocates (CAMHPRA)
C/O Monterey County Mental Health
1270 Natividad Road
Salinas, CA 93906-3198
Office: (831) 755-4518
Fax: (831) 424-9808
Internet: http://www.camhpra.org

California Alliance of Child and Family Services (CACFS)
2201 K Street
Sacramento, CA 95816
Office: (916) 449-2273
Fax: (916) 449-2294
Internet: http://www.cacfs.org

California Association of Health Facilities (CAHF)
2201 K Street
Sacramento, CA 95816-4922
Office: (916) 441-6400
Fax: (916) 441-6441
Internet: http://www.cahf.org

California Association of Local Mental Health Boards & Commissions (CALMHB/C)
711 East Longview Avenue
Stockton, CA 95207
Office: (209) 477-9187

California Coalition for Mental Health (CCMH)
1127 11th Street, Suite 925
Sacramento, CA 95814
Office: (916) 557-1166
Fax: (916) 447-2350
Internet: www.mhac.org/advocacy/ccmh.cfm

California Council of Community Mental Health Agencies (CCCMHA)
1127 11th Street, Suite 925
Sacramento, CA 95814
Office: (916) 557-1166
Fax: (916) 447-2350
Internet: www.cccmha.org

California Hospital Association (CHA)
1215 K Street, Suite 800
Sacramento, CA 95814
Office: (916) 443-7401
Fax: (916) 552-7588
Internet: www.calhealth.org

California Medical Association (CMA)
1201 J Street, Suite 200
Sacramento, CA 95814
Office: (916) 444-5532
Fax: (916) 444-5689
Internet: www.cmanet.org

California Mental Health Advocates for Children and Youth (CMHACY)
P.O. Box 2036
Sonoma, CA 95476
Office: (707) 795-4261
Fax: (707) 795-4204
Internet: www.cmhacy.org

California Mental Health Directors Association (CMHDA)
2125 19th Street
Sacramento, CA 95818
Office: (916) 556-3477
Fax: (916) 446-4519
Internet: www.cmhda.org

California Mental Health Planning Council (CMHPC)
1600 9th Street, Room 350
Sacramento, CA 95814
Internet: www.dmh.ca.gov/mhpc

California Network of Mental Health Clients (CNMHC)
2012 19th Street, Suite 1200
Sacramento, CA 95818
Office: (800) 626-7447
Fax: (916) 443-4089
Internet: www.californiaclients.org

California Psychiatric Association (CPA)
1400 K Street, Suite 302
Sacramento, CA 95814
Office: (916) 442-5196
Fax: (916) 442-6515
Internet: www.calpsych.org

California Psychological Association (CPA)
3835 North Freeway Blvd, Suite 240
Sacramento, CA 95834
Office: (916) 286-7979
Fax: (916) 286-7971
Internet: www.cpapsych.org

California State Association of Counties (CSAC)
1100 K Street, Suite 101
Sacramento, CA 95814
Office: (916) 327-7500
Fax: (916) 442-2769
Internet: www.csac.counties.org

Mental Health Association in California (MHAC)
1127 11th Street, Suite 925
Sacramento, CA 95814
Office: (916) 557-1167
Fax: (916) 447-2350
Internet: www.mhac.org

National Alliance for the Mentally Ill (NAMI) California
1010 Hurley Way, Suite 195
Sacramento, CA 95825
Office: (916) 567-0163
Fax: (916) 567-1757
Internet: www.namicalifornia.org

Protection & Advocacy, Inc. (PAI)
100 Howe Avenue, 185-N
Sacramento, CA 95825-9968
Office: (916) 488-9955
Fax: (916) 488-2635
Internet: www.pai-ca.org

United Advocates for Children and Families (UACF)
2035 Hurley Way, Suite 290
Sacramento, CA 95825
Office: (916) 643-1530
Fax: (916) 643-1592
Internet: www.uacf4hope.org

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SECTION VI: APPENDIX

*The **Brown Act**, officially known as the **Ralph M. Brown Act** (California Government Code Sections 54950-54963), was authored by Ralph M. Brown, a Central Valley assemblyman representing Turlock. It was enacted in 1953 by the California State Legislature in an effort to safeguard the public's right to access and participate in government meetings within the State.*

Originally a 686-word statute that has grown substantially over the years, The Brown Act was enacted in response to mounting public concerns over informal, undisclosed meetings held by local elected officials which were not in compliance with requirements for advance public notice; instead, they were skirting laws by holding secret 'workshops' and 'study sessions.' The Brown Act solely applies to California city and county government agencies, boards, and councils, whereas the comparable Bagley-Keane Act mandates open meetings for State government agencies.

Source: Wikipedia; http://en.wikipedia.org/wiki/Brown_Act *(Informing you of the existence of these Web sites is not a representation or warranty of the accuracy of the material they may contain. Any medication claim regarding efficacy, safety, or of a comparative nature of multiple products, is simply information in their materials, which may change from time to time, and is not part of this publication. The authors of this program do not have content control over these Web sites.)*

OPEN MEETING REQUIREMENTS — THE BROWN ACT

"In enacting this chapter, the Legislature finds and declares that the public commissions and boards and councils and other public agencies, in this state ***exist to aid in the conduct of the people's business***. It is the intent of the law that their actions be taken openly and that their deliberations be conducted openly.

The *people of this State* do not yield their sovereignty to the agencies which serve them. The people, in delegating authority, do not give their public servants the right to decide what is good for the people to know and what is not good for them to know. The people *insist on remaining informed* so that they may retain control over the instruments they have created."

— Ralph M. Brown Act, 54950 Policy Declaration

Requirements of the Brown Act

The legislature determined in the Brown Act that "public commissions, boards and agencies exist to aid in the conduct of the people's business. It is the extent of the law that their actions be taken openly and that their deliberations be conducted openly." However, Brown Act law is complex and changes regularly. Board activities must be governed by the "spirit" of the Brown Act. Specific procedures should be determined in consultation with county staff and counsel so that the specific and changing requirements are met. It may be helpful to contact county staff or counsel for clarification of any sections pertaining to the Brown Act as well as updates to the requirements. *Source: CiMH Board Training Manual, Section 9*

The following was excerpted from "Open Meetings for Local Legislative Bodies, The Brown Act," published by the Office of Attorney General Bill Lockyer, 2003. Items noted in [brackets] are found in the CiMH Board Training Manual, Section 9.

Summary of Key Brown Act Provisions

Preamble: 54950 Ch. I

Public commissions, boards, councils and other legislative bodies of local government agencies exist to aid in the conduct of the people's business. The people do not yield their sovereignty to the bodies that serve them. The people insist on remaining informed to retain control over the legislative bodies they have created.

Governing Bodies: 54952(a) Ch. I & II

Includes city councils, boards of supervisors, and district boards. Also covered are other legislative bodies of local government agencies created by state or federal law.

Subsidiary Bodies: 54952(b) Ch. II
Includes boards or commissions of a local government agency as well as standing committees of a legislative body. A standing committee has continuing subject matter jurisdiction or a meeting schedule set by its parent body. Less-than-a-quorum advisory committees, other than standing committees, are exempt.

Private or Nonprofit Entities or Agencies: 54952(c)(1)(A) Ch. II and 54952(c)(1)(B)
Covered only if:

a. A legislative body delegates some of its functions to a private corporation or entity; or

b. If a legislative body provides some funding to a private corporation or entity and appoints one of its members to serve as a voting member of entity's board of directors.

Meeting Defined: 54952.2 Ch. III
Any gathering of a quorum of a legislative body to discuss or transact business under the body's jurisdiction; serial meetings are prohibited.

Exempts: 54952.2(c)(1) Ch. III, 54952.2(c)(2), and 54952.2(c)(5)

(1) Individual contacts between board members and others who do not constitute serial meetings;

(2) Attendance at conferences and other gatherings which are open to public so long as members of legislative bodies do not discuss among themselves business of a specific nature under the body's jurisdiction;

(3) Attendance at social or ceremonial events where no business of the body is discussed.

Locations of Meetings: 54954 Ch. IV
A body must conduct its meetings within the boundaries of its jurisdiction unless it qualifies for a specific exemption.

Teleconference Meetings: 54953 Ch. III
Teleconference meetings may be held under carefully defined conditions. The meeting notice must specifically identify all teleconference locations, and each such location must be fully accessible to members of the public.

Public Rights

Public Testimony: 54954.3 Ch. IV & V
Public may comment on agenda items before or during consideration by legislative body. Time must be set aside for public to comment on any other matters under the body's jurisdiction.

Non-Discriminatory Facilities: 54953.2; 54961 Ch. V
Meetings may not be conducted in a facility that excludes persons on the basis of their race, religion, color, national origin, ancestry, or sex, or that is inaccessible to disabled persons, or where members of the public may not be present without making a payment or purchase.

Copy of Recording: 54953.5 Ch. V
Public may obtain a copy, at cost, of an existing tape recording made by the legislative body of its public sessions, and to listen to or view the body's original tape on a tape recorder or viewing device provided by the agency.

Public Vote: 54953(c) Ch. VI
All votes, except for those cast in permissible closed session, must be cast in public. No secret ballots, whether preliminary or final, are permitted.

Closed Meeting Actions/Documents: 54957.1 Ch. IV, V and VI
At an open session following a closed session, the body must report on final action taken in closed session under specified circumstances. Where final action is taken with respect to contracts, settlement agreements and other specified records, the public may receive copies of such records upon request.

Taping or Recording: 54953.5; 54953.6 Ch. V
Meetings may be broadcast, audio-recorded or video-recorded so long as the activity does not constitute a disruption of the proceeding.

Conditions to Attendance: 54953.3; 54961 Ch. V
Public may not be asked to register or identify themselves or to pay fees in order to attend public meetings.

Public Records: 54957.5 Ch. V
Materials provided to a majority of a body which are not exempt from disclosure under the Public Records Act must be provided, upon request, to members of the public without delay.

Required Notices and Agendas

Regular Meeting: 54954.2 Ch. IV
Agenda containing brief general description (approximately 20 words in length) of each matter to be considered or discussed must be posted at least 72 hours prior to meeting.

Special Meetings: 54956 Ch. IV
Twenty-four hour notice must be provided to members of legislative body and media outlets including brief general description of matters to be considered or discussed.

Emergency Meetings: 54956.5 Ch. IV
One hour notice in case of work stoppage or crippling activity, except in the case of a dire emergency.

Closed Session Agendas: 54954.2; 54954.5; 54957.1 and 54957.7 Ch. IV
All items to be considered in closed session must be described in the notice or agenda for the meeting. A model format for closed-session agendas appears in section 54954.5. Prior to each closed session, the body must orally announce the subject matter of the closed session. If final action is taken in closed session, the body generally must report the action at the conclusion of the closed session.

Agenda Exception: 54954.2(b) Ch. IV
Special procedures permit a body to proceed without an agenda in the case of emergency circumstances, or where a need for immediate action came to the attention of the body after posting of the agenda.

Closed Session Meetings

Personnel Exemption: 54957 Ch. VI
The body may conduct a closed session to consider appointment, employment, evaluation of performance, discipline or dismissal of an employee. With respect to complaints or charges against an employee brought by another person or another employee, the employee must be notified, at least 24 hours in advance, of his or her right to have the hearing conducted in public.

Public Security: 54957 Ch. VI
A body may meet with law enforcement or security personnel concerning the security of public buildings and services.

Pending Litigation: 54956.9 Ch. VI
A body may meet in closed session to receive advice from its legal counsel concerning existing litigation, initiating litigation, or situations involving a significant exposure to litigation. The circumstances which constitute significant exposure to litigation are expressly defined in section 54956.9(b)(3).

Labor Negotiations: 54957.6 Ch. VI
A body may meet in closed session with its negotiator to consider labor negotiations with represented and unrepresented employees. Issues related to budgets and available funds may be considered in closed session, although final decisions concerning salaries of unrepresented employees must be made in public.

Real Property Negotiations: 54956.8 Ch. VI
A body may meet in closed session with its negotiator to consider price and terms of payment in connection with the purchase, sale, exchange or lease of real property.

Remedies and Sanctions

Civil Remedies: 54960; 54960.1 Ch. VII

Individuals or the district attorney may file civil lawsuits for injunctive, mandatory or declaratory relief, or to void action taken in violation of the Act. Attorneys' fees are available to prevailing plaintiffs. 54960.5

Criminal Sanctions: 54959 Ch. VII

The district attorney may seek misdemeanor penalties against a member of a body who attends a meeting where action is taken in violation of the Act, and where the member intended to deprive the public of information which the member knew or has reason to know the public was entitled to receive.

California Involuntary Mental Health Holds
California State Department of Mental Health, External Affairs
April 30, 2007

California law provides for 72-hour involuntary mental health holds. These are often referred to as "5150" holds, in reference to state Welfare and Institutions code section 5150. Under California law, police or designated mental health professionals may initiate the process for an involuntary hold by taking a person to a hospital for 72 hours if there is probable cause to believe that, due to a mental disorder, the individual is either a danger to self, a danger to others, or gravely disabled. The involuntary hold may be extended by a "14-day certification" hearing if the hospital believes the patient requires further evaluation or treatment. A certification review hearing is required, and the patient, or the patient's advocate, has the opportunity to present evidence to the contrary at the hearing.

When did involuntary holds originate in California law?

In 1967, California enacted the Lanterman-Petris-Short (LPS) Act, which establishes clear standards and limitations on holding persons with mental illness involuntarily. Prior to LPS, judges could order involuntary detentions for treatment based on a doctor's statement that the person was mentally ill and needs treatment, but no clear standards existed for who could be held or the maximum duration. Individuals had few due process rights to appeal their hospital stay, and individuals were denied all civil and constitutional rights during their hospital stay.

Who can initiate an involuntary hold?

Under California law, only the following individuals can initiate an involuntary hold:

- Mental health professionals approved by the county after completing training and passing a test;
- Selected members of attending staff at evaluation facilities/hospitals that are designated for involuntary detainment by the county; or
- Peace Officers, including Sheriffs, State Park Rangers, State University Peace Officers.

What criteria must be met in order to place a person on an involuntary hold?

The designated personnel must believe there is probable cause that, because of a mental disorder, the individual is:

- A danger to him or herself;
- A danger to others; or
- Gravely disabled (unable to provide for his/her basic personal needs for food, clothing, or shelter).

If the criteria must be linked to a mental disorder, how can a designated professional be sure that a person is "mentally disordered" if they have no knowledge of the person's mental health history or diagnosis?

To constitute probable cause to take a person to a designated "5150" facility, facts must be known that would lead an ordinary person to believe or entertain a strong suspicion that the person is mentally disordered (and is a danger to him or herself or others, or is gravely disabled). This is not a clinical decision and does not require a diagnosis. The term "mental disorder" in this context is not defined by law, but the initiator of the hold must be able to articulate specific behavioral symptoms of a mental disorder. Once the person has been brought to a designated "5150" facility, a qualified mental health professional must evaluate the person and make a clinical judgment as to whether the criteria are met, including the existence of a mental disorder, for admission and detention for treatment.

Additionally, the designated personnel at the facility must consider all available relevant information provided by the person, service providers, or family members about the historical course of the person's mental disorder if it is thought to have a reasonable bearing on whether the person is a danger to him or herself, others, or is gravely disabled as a result of a mental disorder.

(1) Initial 72 Hours
When a person is initially detained involuntarily, the maximum period of this hold is 72 hours. It gives the professional person in charge of the hospital an opportunity to assess the individual face-to-face in order to determine the appropriateness of involuntarily detaining him or her.

The hospital does not have to hold the person for the complete 72 hours if they do not feel the person requires further evaluation or treatment. By the end of the 72 hours, one of the following things must happen:

- The person may be released;
- The person may sign in to the hospital as a voluntary patient; or
- The person may be placed on a 14-day involuntary hold.

If the professional person directly responsible for the person's treatment believes, as a result of his or her personal observations, that the person no longer requires involuntary evaluation or treatment, then treatment and support services must be offered to the person on a voluntary basis, which the person can accept or decline and leave the facility.

(2) Fourteen-day Certification
If a facility determines the person should be placed on a 14-day involuntary hold for additional treatment, there must be a certification review hearing ("probable-cause hearing"). The hospital must present evidence as to why the patient needs further treatment. The patient, assisted by a patients' rights advocate, can explain why he/she believes there is no need for further hospital stay. A hearing officer, court-appointed commissioner, or referee will decide whether or not there is probable cause to keep the patient in the hospital against his/her will for a maximum of 14 days.

If probable cause to hold the person is not found, he or she may request to remain in the hospital on a voluntary basis. If probable cause is found – and the patient disagrees – he or she has the right to request a Writ of Habeas Corpus and a hearing in the local county Superior Court.

(3) Second 14-day Certification for Suicidal Persons
At the end of the 14-day period, a person may be detained for an additional maximum of 14 days if all of the following apply:

- The person, as a result of a mental disorder, either threatened or attempted to suicide during the 72-hour or 14-day period, or was detained originally for that reason;
- The person continues to present an imminent threat of suicide;
- The facility providing additional treatment is equipped and staffed to provide treatment, is designated by the county, and agrees to admit the person; and
- The person has been advised of, but has not accepted voluntary treatment.

(4) Thirty Days (Note: This is only in counties that choose to implement this option)
At the end of the 14-day period, the person may be certified for an additional maximum of 30 days if either of the following applies:

- The person remains gravely disabled as a result of a mental disorder or impairment by chronic alcoholism; or
- The person remains unwilling or unable to accept voluntary treatment.

If a person is certified for an additional 30 days, a certification review hearing must be held. The professional staff must analyze the person's condition at least every 10 days to determine whether the person continues to meet the criteria daily monitor the person's treatment plan and progress.

At the end of the 30-day period the person must be released, unless the person:

- Agrees to receive further treatment on a voluntary basis;
- Is the subject of a conservatorship petition that has been filed; or
- Is the subject of a petition to detain him or her for an additional 180 days.

(5) 180 Day Post-Certification for Persons Who Are a Demonstrated Danger

At the end of the 14-day period, a person may be detained for up to 180 days of additional treatment if, due to a mental disorder, the person presents a demonstrated danger of substantial physical harm to others, and has:

- Attempted, inflicted, or made a serious threat of harm to another after having been taken into custody for evaluation or treatment;
- Been taken into custody because of having attempted or inflicted harm to another; or
- Made a serious threat of substantial physical harm to another within seven days of being taken into custody.

A person's behavior over the past six years may be considered when determining his or her current mental condition and demonstrated danger. Neither conviction of a crime nor amenability to treatment is a necessary prerequisite to establishing a 180-day post certification. The petition to detain a person for an additional 180 days must be filed during the person's 14-day certification period by the County District Attorney or County Counsel. A court hearing or trial must be held to establish this legal hold.

What happens when a person is involuntarily held on a 5150?

The police officer or mental health professional will transport the individual to a designated psychiatric inpatient facility. During the initial 72 hours, the hospital is required to fully evaluate the person (medical, psychological, educational, social, financial, and legal issues) and provide needed mental health treatment, including therapy and medications.

Is the person arrested? Will there be a criminal or other record?

No, the person is not arrested or charged criminally in relation to the 5150 hold, so the involuntary detention is not entered into a criminal record. The 72-hour hold application becomes part of the person's medical record.

What rights does the person being held have while being involuntarily held?

The person placed in an involuntary hold must be advised of his or her rights in a language or manner he or she can understand, which include the rights to:

- Keep and use personal possessions, including toilet articles and clothing, and access to individual storage space for private use;
- Keep and spend a reasonable sum of his/her own money (a conservator shall be appointed if required);
- See visitors each day and have reasonable access to telephones and letter writing materials;
- Receive unopened mail;
- Refuse convulsive treatment and psychosurgery;
- See a patients' rights advocate;
- Be assisted by an attorney at the certification review hearing;
- Be informed fully of the risks/benefits of the proposed treatment and give his/her informed consent; and
- Refuse medication, unless there is an emergency condition or the patient is found – after a judicial hearing – to lack the capacity to make an informed decision (the patient may appeal this decision to the Superior Court).

Is the hospital required to notify anyone, such as family members, when a person is held involuntarily?

Yes. Upon admission, whether voluntary or involuntary, the facility must make reasonable attempts to notify the person's next of kin, or other individual designated by the person, to inform them of the person's admission (unless the patient requests that this information not be provided).

What privacy laws apply in cases where a person is being held involuntarily?

California law, which complies with Health Insurance Portability and Accountability Act (HIPAA), requires that all information and records obtained in the course of providing services to either voluntary or involuntary recipients of services be confidential (including services provided prior to the implementation of LPS in 1969), with some exceptions such as service referrals, court proceedings, and criminal proceedings.

Is a person that has been held involuntary banned from purchasing firearms?

Yes. The federal Gun Control Act of 1968 and Firearms Owners' Protection Act of 1986 ban certain individuals from purchasing firearms, including individuals who are involuntarily committed to a mental institution. California law similarly prohibits purchase or possession during involuntary detention for treatment.

California law also bars a person from possessing or purchasing firearms for five years if he or she has been evaluated under a 72-hour hold and involuntarily admitted to a facility for treatment. The facility is required to inform the person, prior to discharge, that he or she is banned from possessing a firearm for five years, but that he or she has the right to petition the court for permission to possess a firearm. Information is transmitted to the designated unit of the United States Department of Justice.

Who pays for the services provided to a person who is held involuntarily?

The same entities pay for the hospital services as would pay for any other hospital treatment (e.g., private insurance, Medi-Cal, patient, government funding).

Are there any differences in how involuntary holds are handled among children and adults?

Minors have the same legal rights as adults with respect to involuntary holds, and must also meet the same criteria.

However, the definition of "gravely disabled" is somewhat different for minors (anyone under age 18); a minor is considered "gravely disabled" if, as a result of a mental disorder, he or she is unable to use the elements of life which are essential to health, safety and development, including food, clothing, shelter, even though provided to the minor by others.

Additionally, minors should only be admitted for treatment on an involuntary hold when parental authorization for treatment is not available. However, if the minor meets detention criteria, and if evaluation and treatment are indicated, he or she may be treated against the wishes of the child's parents, guardian, or conservator.

Is there liability for the actions of a person who was involuntarily held after they have been released?

No. If all requirements have been met during the evaluation and release process, personnel (the peace officer/mental health personnel who wrote the involuntary hold order, the person in charge of the facility, the medical director of the facility, the psychiatrist directly responsible for the person's treatment, the psychologist) are not civilly or criminally liable for any action by a person who is released before or at the end of the 72-hour period.

Mental Health Board
Training Documents

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Local Mental Health Board/Commission Roles and Responsibilities

Requirements

Source: California Welfare & Institutions Code 5604 (a)-(g)

I. Each community mental health department shall have a mental health board
   - 10-15 members
   - 3-year terms
   - One member shall be a member of the governing body
   - 50% shall be consumers, parents, siblings, adult children of consumers who are receiving or have received services

II. No member of the board shall be a full-time or part-time employee or contractor of county mental health or DMH

III. Members shall abstain from voting on any issue in which they have a financial interest

IV. Each board must establish bylaws

V. Boards must represent the demographics of the county

VI. Boards must comply with the Brown Act (Open Meeting Act)

Roles: Board of Supervisors

Source: California Welfare & Institutions Code 5602-5604.5

I. The Board of Supervisors shall establish a community mental health service to cover the entire area of the county

II. The Board of Supervisors shall appoint a mental health board consisting of 10-15 members (except counties with a population under 80,000)
   - One member of the mental health board shall be a member of the Board of Supervisors
   - The mental health board should reflect the ethnic diversity of the client population

Roles: Mental Health Directors

Source: California Welfare & Institutions Code 5607-5623.5

I. Local mental health directors shall administer mental health services
   - Training and experience shall meet DMH standards
   - Need not be a resident of the county
   - Position can be full time or part time

II. Powers and duties
   - CEO of community mental health
   - Supervise mental health services
   - Consult with the advisory board to recommend services, facilities, contracting
   - Submit an annual financial and activity report

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Roles: Relationship Between Mental Health Directors and Mental Health Boards

Source: California Welfare & Institutions Code 5604.2 (a); 5604.5; 5608

I. The board should review and make recommendations on applicants for the appointment of a local director
    - The board shall be included in the selection process prior to the Board of Supervisors' vote

II. The board chair should consult with the local mental health director

III. The mental health director should recommend to the BOS after consulting with the mental health board

Mental Health Board/Commission Statutory Duties

Source: California Welfare & Institutions Code 5604.2 (a); 5604.5; 5608

1. The board should review and evaluate the community's mental health needs, services, facilities and problems
2. Review any county agreements entered into pursuant to Section 5650
    - County Performance Contract, cultural competency, the budget, sub account transfers
3. Advise the Board of Supervisors and the local mental health director
    - Written and verbal testimony, individual meetings
4. Review and approve procedures used to ensure citizen and professional involvement at all stages of the planning process
    - Community input at meetings, department committees
5. Submit an annual report to the Board of Supervisors on the needs and performance of the county's mental health system
    - Summarize major activities, membership, attendance, future goals, comment on planning and citizen involvement, evaluate local programs, recommend improvements
6. Review and recommend the appointment of the mental health director – prior to the Board of Supervisors' vote
7. Review and comment on the county's performance outcome data and communicate findings to the California Mental Health Planning Council
    - Work with staff and mental health director
    - Seek input from providers and community
8. Nothing in this part shall be construed to limit the ability of the BOS to transfer additional duties or authority to a mental health board
    - The Board of Supervisors may ask the mental health board to take on additional duties, which by law they would be required to perform
    - Assess the impact of realignment

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Mental Health Board Policy and Procedure Manual

An Overview

Over the years, boards develop policies and procedures to deal with how the bylaws and its broad scope of issues should be handled. These policies and procedures are usually voted on and approved by the full board. Rarely are these policies and procedures kept in one place. The need for a manual and the benefits of a manual become very apparent to new board chairs in dealing with the many issues that arise. Sometimes the chair must rely upon the word of the board secretary or another member to inform him/her as to how these issues were dealt with in the past and what forms were used. Policies and procedures can be easily changed by a simple majority vote of the board. Sometimes the only way for a new chair to know what policies and procedures were established in the past is to review the minutes of many years. It would be more beneficial for the board to have on hand a "Policy and Procedure Manual" that can be added to or changed as the need arises, that also puts the information at the fingertips of a new chair.

Potential Contents of a "Policy and Procedure Manual":

1. A summary of roles and duties for board members.
2. A contact information update form that can be provided to the California Mental Health PlanningCouncil, the State Department of Mental Health, the California Mental Health Directors Association and the California Association of Local Mental Health Boards and Commissions.
3. A form for posting meeting notices monthly and identifying the places where they should be posted.
4. A "press release" form announcing meetings (day, time, place and contact person) to the media.
5. The "Requirements of the Brown Act" developed by the California Institute for Mental Health (CiMH).
6. A list of persons, departments or organizations that should receive monthly agendas and other items provided to board members prior to a monthly meeting.
7. A list of media names and contact information should be developed and updated annually for notification of special events of the board.
8. A form letter that might be sent to board members who have missed a specified number of meetings, or who have failed to fulfill a commitment to the board.
9. Procedures developed by committees for completing tasks:
    a. Membership Committee – Procedures for recruiting and interviewing prospective applicants; a form letter notifying applicants whether they will be recommended for the board; a "welcome" letter for new board members.
    b. Budget Committee – Calendar of events and deadlines; checklist for reviewing the budget; guidelines for communicating with the department and the local governing body.
    c. Executive Committee – Roles and responsibilities; format for a board report.
10. A checklist for strategic planning and goal setting.
11. Evaluation forms.
12. An annual calendar and/or checklist.

Source: California Institute for Mental Health CALMHB/C Workbook.

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Work Sheet: Recruitment

The purpose of this discussion is to identify strategies and develop a workplan to recruit mental health commissioners who will maximize the effectiveness of your board/commission.

Please be succinct in your responses but feel free to elaborate when more detail is necessary.

Working Group Outline

For the purposes of this discussion please consider the most important qualities needed to enhance your county's mental health board/commission.

I. Of the following, list the five most important qualities a mental health commissioner should possess.

_____
_____
_____
_____
_____

Other?

_____
_____
_____

a. Knowledge of the county's mental health system
b. Communications skills
c. Professional expertise
d. Personal experience
e. Represents ethnic communities
f. Diplomacy
g. Existing relationships
h. Ability to build relationships
i. Leadership skills
j. Ability to put aside personal agenda
k. Writing skills
l. Available time

II. From among those listed above identify the top three qualities that would most benefit your county's board/commission right now.

1. _____
2. _____
3. _____

III. Briefly list opportunities to identify individuals with these qualities.

- _____
  _____
- _____
  _____
- _____
  _____

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Work Sheet: Recruitment

IV. Define activities or strategies required to identify specific individuals.

- _____
- _____
- _____

V. Briefly outline next steps and make assignments if appropriate.

- _____
- _____
- _____

Additional Notes

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Work Group Report

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Work Sheet: Training

The purpose of this discussion is to identify priorities for training new and/or existing board/commission members, as well as strategies to obtain training that achieves your goals.

Please be succinct in your responses but feel free to elaborate when more detail is necessary.

Working Group Outline

For the purposes of this discussion please consider the most important information and skills needed to maximize the effectiveness of your county's mental health board/commission.

I. Of the following, list the three most important skills board/commission members should possess.

_____
_____
_____
Other?
_____
_____

a. Written communications skills
b. Conflict resolution
c. Leadership
d. Running an effective meeting
e. Verbal communications skills
f. Organization
g. Networking/building relationships
h. Budgeting
i. Teamwork

II. Of the following, list the three most important areas of expertise board/commission members should work to master.

_____
_____
_____
Other?
_____
_____

a. Knowledge of how the county's mental health system functions
b. Knowledge of the county's specific services and programs
c. The county's budget
d. Knowledge of how the state's mental health system functions
e. The state budget
f. Understanding of cultural issues
g. Mental illness (i.e., symptoms, diagnosis and treatment)
h. Understanding of board/commission members' roles/duties/responsibilities/restrictions
i. Mental Health Services Act

III. From among those listed above, identify the top two areas that you would like to address in the next 12 months.

1. _____
_____
2. _____
_____

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Work Sheet: Training

IV. From among those listed above, list the most feasible trainings to obtain.

- _____
- _____
- _____

V. Briefly list opportunities to identify ways to obtain these trainings.

- _____
- _____
- _____

VI. Define activities or strategies required to coordinate these trainings.

- _____
- _____
- _____

VII. Identify ways to ensure you achieve expected outcomes from the trainings.

- _____
- _____
- _____

Work Sheet: Training

VIII. Briefly outline next steps and make assignments if appropriate.

- _____
- _____
- _____

Additional Notes

Work Group Report

Navigating the Currents:
A Guide to California's Public Mental Health System

Work Sheet: Maximizing Board/Commission Effectiveness

The purpose of this discussion is to identify strategies to maximize your board/commission's effectiveness.

Please be succinct in your responses but feel free to elaborate when more detail is necessary.

Working Group Outline

The purpose of this discussion is to identify strategies to maximize your board/commission's effectiveness.

I. Of the following, list the most important activities, skills and/or expertise areas where your board needs to be more effective.

_____ a. Communications
_____ b. Teamwork
_____ c. Understanding of member roles/responsibilities/ requirements/restrictions
_____ d. Knowledge of your county's mental health system
_____ e. Knowledge of your county's services and programs
f. Leadership
Other? g. Budgeting
h. Networking/building relationships
_____ i. Understanding of cultural issues
_____ j. Knowledge about mental illness (i.e., symptoms, diagnosis and treatment)
_____ k. Professional experience
_____ l. Political savvy
_____ m. Understanding of the Mental Health Services Act

II. From those listed above, identify the top three areas you would like to address in the next 12 months.

1. _____
2. _____
3. _____

III. Identify what your board/commission needs to improve to address these issues.

_____ a. Training
_____ b. Recruit new members
_____ c. Commitment
_____ d. Organizational skills
e. Communications
Other? f. Conflict resolution
g. Strategic planning/goal setting
_____ h. Funding

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Work Sheet: Maximizing Board/Commission Effectiveness

IV. From among those listed above, list the most feasible to obtain or complete.

- _____
- _____
- _____

V. Briefly list opportunities to identify ways to obtain or complete these.

- _____
- _____
- _____

VI. Define activities or strategies required to coordinate, obtain or complete these.

- _____
- _____
- _____

VII. Identify specific ways you will measure success.

- _____
- _____
- _____

Work Sheet: Maximizing Board/Commission Effectiveness

VIII. Briefly outline next steps and make assignments if appropriate.

- _____
- _____
- _____

Additional Notes

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Work Group Report

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Strategically Planning for Effective Communications

Strategic Planning Checklist

- ☐ Set one to three goals or priorities. What do you want to accomplish, change, encourage, etc.?
  - *These should be related*
- ☐ Define your audience as narrowly as possible
  - *You may have more than one audience (Fellow board members, county government, the public, advocates, potential partners, consumers, the community, etc.)*
- ☐ Determine the main argument or message that will appeal to that audience
  - *You may need different messages for different audiences*
- ☐ Develop three supporting points for your main message
- ☐ Outline tactics or activities in detail in a way that allows you to deliver your message
  - *Determine the most effective way to reach your target audience(s). (Meetings, presentations, testimony, written reports, media, etc.)*
- ☐ Identify key spokespersons
  - *Depending on audience and medium (board member, advocates, partners, community members, etc.)*
  - *Make sure spokespersons are appropriate for the message and the medium*
- ☐ Prepare key spokespersons
  - *Discuss key messages and how to integrate them into anticipated questions*
  - *Provide schedule, timeline, hearing dates, etc.*
  - *Make sure messages remain consistent*
- ☐ Prepare list of potential contacts
- ☐ Develop "pitch" tailored to appropriate contacts
  - *Determine which supporting points will best deliver your message with the contacts*
- ☐ Be assertive, not aggressive when following up
  - *Know when to pursue and when to back off*
- ☐ Confirm appointments, and meetings
- ☐ Prepare, collect brief collateral materials
  - *Statistics, charts, studies, one-page summary of messages and goals*
- ☐ Conduct speech, meeting, testimony, etc.
- ☐ Follow-up
  - *Thank you note, additional materials, etc.*
- ☐ Continue to develop relationship with contact
  - *Provide periodic updates, information, and opportunities*

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Communication Tips

Develop Your Message

- Examine the goals, objectives and strategy
    - *Identify your audience(s)*
    - *Determine how to achieve the greatest impact*
- Develop 2-3 key discussion points – maximum
    - *Keep it relevant*
    - *Say it simply*
- Communicate consistently
    - *Designate spokespersons*
    - *Multiple spokespersons must coordinate*

Deliver an Effective Message

- Get organized
    - *Gather facts*
    - *Prepare key messages*
    - *Refine your story*
- Stay on point
    - *Stick to key messages*
    - *Make it relevant to your audience*
    - *Understand opinion vs. feeling vs. fact*
- Put a face on it
    - *Make it memorable*
    - *Think in pictures, emotions, illustrations*
- Keep it brief
    - *Grab your audience*
    - *Think in "headlines"*

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Work Sheet: Building Effective Relationships

The purpose of this discussion is to identify strategies to build relationships both internally (within your board/commission) and/or externally (outside of your board/commission) to improve your board/commission's ability to be more effective.

Please be succinct in your responses but feel free to elaborate when more detail is necessary.

Working Group Outline

For the purposes of this discussion please consider areas where your board/commission would like to improve.

I. Of the following, list the most important relationships as they relate to your board/commission. You may also consider areas for improvement based on your board/commission's needs.

_____	a. Fellow board/commission members
_____	b. Mental health director
_____	c. Supervisors
_____	d. Other elected officials
_____	e. Media
_____	f. Corrections officials (i.e., sheriff, police, judges, etc.)
Other?	g. Community/advocacy groups (i.e., NAMI)
_____	h. Business community
_____	i. Faith community
_____	j. Ethnic communities

II. From among those listed above, which does your board/commission need to focus on?

1. _____
2. _____
3. _____

III. Briefly list potential strategies to build effective relationships.

- _____
  _____
- _____
  _____
- _____
  _____

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Work Sheet: Building Effective Relationships

IV. Define specific activities required.

- _____
- _____
- _____

V. Briefly outline next steps and make assignments if appropriate.

- _____
- _____
- _____

Additional Notes

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Work Group Report

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Navigating the Currents:
A Guide to California's Public Mental Health System

Work Sheet: Cultural and Linguistic Competence

The purpose of this discussion is to identify strategies to ensure that your board/commission addresses issues related to cultural and linguistic competency.

Please be succinct in your responses but feel free to elaborate when more detail is necessary.

Working Group Outline

For the purposes of this discussion please consider the cultural and linguistic competence of your board/commission.

I. Of the following, list the issues your board/commission faces.

_____	a. Ethnically diverse county population (i.e., many ethnicities)
_____	b. Board/commission does not represent constituency in terms of cultural diversity
_____	c. Challenges in recruiting diverse applicants
_____	d. Large county/small county
Other?	e. Conflicts among diverse stakeholders
_____	f. Language barriers

II. From among those listed above, which are the most feasible to address?

_____

_____

_____

III. Briefly list potential strategies to address these issues.

_____

_____

_____

IV. Define specific activities required.

- _____
  _____
- _____
  _____
- _____
  _____

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Work Sheet: Cultural and Linguistic Competence

V. Briefly outline next steps and make assignments if appropriate.

- _____
- _____
- _____

Additional Notes

Work Group Report

Navigating the Currents:
A Guide to California's Public Mental Health System

Work Sheet: Conflict Resolution

The purpose of this discussion is to identify strategies to resolve conflicts among board/commission members or with individuals or groups with whom your board/commission must interact.

Please be succinct in your responses but feel free to elaborate when more detail is necessary.

Working Group Outline

For the purposes of this discussion please consider conflicts that must be resolved to improve the effectiveness of your board/commission.

I. Of the following, list potential areas of conflict. You may also consider issues your board/commission is currently facing.

_____ a. Personality conflicts

_____ b. Difference of opinion

_____ c. Personal agendas

_____ d. Unequal workload

Other? e. Quality of work

_____ f. Philosophical differences

II. From among those listed above, which does your board/commission need to focus on?

1. _____
2. _____
3. _____

III. Briefly list potential strategies to address conflicts.

_____

_____

_____

IV. Define specific activities required.

- _____
  _____
- _____
  _____
- _____
  _____

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Work Sheet: Conflict Resolution

V. Briefly outline next steps and make assignments if appropriate.

- _____
- _____
- _____

Additional Notes

Work Group Report

FOOTNOTES

[1] California Mental Health Master Plan: A Vision for California. Sacramento: California Mental Health Planning Council, 2003.

[2] Goodwin, Sandra Naylor, Ph.D., MSW. California Institute of Mental Health and Rusty Selix, Executive Director, California Council of Community Mental Health Agencies. The Development of California's Publicly Funded Mental Health System, 2004.

[3] Mental Health Association in California (MHAC) – www.mhac.org

[4] Crowell, Areta, Ph.D., Beth Briscoe, M.S.P.H. and Dean Whitehead, eds. The Story of Public Mental Health Services in Los Angeles County: The First Forty Years, 1960-2000. County of Los Angeles: Department of Mental Health, 2000.

[5] Goodwin, Ph.D., M.S.W., et al.

[6] History and Funding of California's Public Mental Health System. Sacramento: California Mental Health Directors Association, November 2006.

[7] James, J. Frank, M.D. and Truman C. Schoenberger. California Conference of Local Mental Health Directors, 1958-1978. September 1978.

[8] Hobbs, Frank, and Nicole Stoops. Demographic trends in the 20th century (Census 2000 Special Report, Series CENSR-4). Washington, D.C.: U.S. Government Printing Office, 2002.

[9] Jaco, E. Gartley. Mental health of the Spanish American in Texas. In M. K. Opler (Ed.), Culture and mental health: Cross cultural studies. New York: Macmillan, 1959.

[10] Papers of John F. Kennedy – www.presidency.ucsb.edu/john_f_kennedy.php

[11] California Mental Health Financing 101, PowerPoint Presentation. Sacramento: California Mental Health Directors Association, 2006.

[12] California's Mental Health System, Underfunded from the Start. Sacramento: California State Senate Committee on Budget and Fiscal Review, 2000.

[13] Crowell, et al.

[14] Goodwin, Ph.D., M.S.W., et al.

[15] History and Funding of California's Public Mental Health System. Sacramento: California Mental Health Directors Association, November 2006.

[16] James, et al.

[17] Selix, Rusty, Executive Director, California Council of Community Mental Health Agencies. Mental Health Services Act Long Range Plan: A Road Map From Fail First to Help First and Proposition 63 – Standing on the Shoulders of Giants. Sacramento: California Mental Health Services Oversight and Accountability Commission, 2006.

[18] Karno, Marvin. "The enigma of ethnicity in a psychiatric clinic." Archives of General Psychiatry, 14. 1966. 516-520.

(Informing you of the existence of these Web sites is not a representation or warranty of the accuracy of the material they may contain. Any medication claim regarding efficacy, safety, or of a comparative nature of multiple products, is simply information in their materials, which may change from time to time, and is not part of this publication. The authors of this program do not have content control over these Web sites.)

[19] Aranda, M. The development of the Latino social work profession in Los Angeles. Research on Social Work Practice, 11. 2001. 254-265.

[20] Zinman, Sally, Howe the Harp and Su Budd. Reaching Across: Mental Health Clients Helping Each Other. 1987.

[21] Los Angeles Child Guidance Clinic – www.lachild.org/about_history.htm

[22] For more information on California Senate and Assembly Bills since 1993-1994 session: www.leginfo.ca.gov/

[23] Goodwin, Ph.D., M.S.W., et al.

[24] History and Funding of California's Public Mental Health System. Sacramento: California Mental Health Directors Association, November 2006.

[25] Selix, Rusty, Executive Director, California Council of Community Mental Health Agencies. Mental Health Services Act Long Range Plan: A Road Map From Fail First to Help First and Proposition 63 – Standing on the Shoulders of Giants. Sacramento: California Mental Health Services Oversight and Accountability Commission, 2006.

[26] Goodwin, Ph.D., M.S.W., et al.

[27] History and Funding of California's Public Mental Health System. Sacramento: California Mental Health Directors Association, November 2006.

[28] California Coalition for Mental Health (CCMH) – www.mhac.org/advocacy/ccmh.cfm

[29] California Mental Health Directors Association (CMHDA) – www.cmhda.org

[30] Report on the Mental Health Governance Study. Sacramento: California Mental Health Planning Council, 1993.

[31] Report on the Mental Health Governance Study. Sacramento: California Mental Health Planning Council, 1993.

[32] Hobbs, et al.

[33] California Mental Health Master Plan, Chapter 8 – http://www.dmh.ca.gov/Mental_Health_Planning_Council/docs/Master%20Plan/Chapt8.pdf

[34] California Mental Health Master Plan: A Vision for California. Sacramento: California Mental Health Planning Council, 2003.

[35] California Mental Health Directors Association (CMHDA) – www.cmhda.org

[36] California Mental Health Financing 101, PowerPoint Presentation. Sacramento: California Mental Health Directors Association, 2006.

[37] California's Mental Health System, Underfunded from the Start. Sacramento: California State Senate Committee on Budget and Fiscal Review, 2000.

[38] Goodwin, Ph.D., M.S.W., et al.

[39] History and Funding of California's Public Mental Health System. Sacramento: California Mental Health Directors Association, November 2006.

[40] Report on the Mental Health Governance Study. Sacramento: California Mental Health Planning Council, 1993.

(Informing you of the existence of these Web sites is not a representation or warranty of the accuracy of the material they may contain. Any medication claim regarding efficacy, safety, or of a comparative nature of multiple products, is simply information in their materials, which may change from time to time, and is not part of this publication. The authors of this program do not have content control over these Web sites.)

[41] California Mental Health Master Plan: A Vision for California. Sacramento: California Mental Health Planning Council, 2003.

[42] California Mental Health Master Plan: A Vision for California. Sacramento: California Mental Health Planning Council, 2003.

[43] California Mental Health Financing 101, PowerPoint Presentation, "The Mental Health Services Act in the Context of Overall County Mental Health Financing Pressures." Sacramento: California Mental Health Directors Association, 2006.

[44] California's Mental Health System, Underfunded from the Start. Sacramento: California State Senate Committee on Budget and Fiscal Review, 2000.

[45] Goodwin, Ph.D., M.S.W., et al.

[46] Office of Regulations: California Mental Health Laws and Regulations, 2006 Edition. California Department of Mental Health, www.dmh.ca.gov/Laws_and_Regulations/docs/intro_Laws_and_Regulations_2006edition.pdf

[47] California's Mental Health System, Underfunded from the Start. Sacramento: California State Senate Committee on Budget and Fiscal Review, 2000.

[48] History and Funding of California's Public Mental Health System. Sacramento: California Mental Health Directors Association, November 2006.

[49] California Department of Mental Health (DMH) – www.dmh.ca.gov

[50] California Mental Health Financing 101, PowerPoint Presentation. Sacramento: California Mental Health Directors Association, 2006.

[51] California's Mental Health System, Underfunded from the Start. Sacramento: California State Senate Committee on Budget and Fiscal Review, 2000.

[52] Goodwin, Ph.D., M.S.W., et al.

[53] Report on the Mental Health Governance Study. Sacramento: California Mental Health Planning Council, 1993.

[54] Mental Health Association in California (MHAC) – www.mhac.org

[55] Goodwin, Ph.D., M.S.W., et al.

[56] Access Campaign for Mental Health - www.mhac.org/advocacy/access_background.cfm

[57] Surgeon General's Office, Report of the Surgeon General on Mental Health, 1999. www.surgeongeneral.gov/reportspublications.html#public

[58] Office of the Surgeon General – www.surgeongeneral.gov/library/mentalhealth/home.html

[59] Many Voices, One Direction: Building a Common Agenda for Cultural Competence in Mental Health, A Report to the Community. Sacramento: California Institute for Mental Health and California Mental Health Directors Association, 2002.

[60] Many Voices, One Direction: Building a Common Agenda for Cultural Competence in Mental Health, A Report to the Community. Sacramento: California Institute for Mental Health and California Mental Health Directors Association, 2002.

(Informing you of the existence of these Web sites is not a representation or warranty of the accuracy of the material they may contain. Any medication claim regarding efficacy, safety, or of a comparative nature of multiple products, is simply information in their materials, which may change from time to time, and is not part of this publication. The authors of this program do not have content control over these Web sites.)

[61] Cross, Terry L., Karl W. Dennis, Mareasa R. Isaacs, and Barbara J. Bazron, under the auspices of the National Technical Assistance Center for Children's Mental. Cultural Competence in Serving Children and Adolescents With Mental Health Problems. Washington, D.C.: Georgetown University, SAMSHA's National Mental Health Information Center, The Center for Mental Health Services, 1989.

[62] Frost, Lynda, Field Representative, Corrections Standards Authority. Personal Interview.

[63] Mental Health Association in California (MHAC) – www.mhac.org

[64] Report to the Legislature on the Effectiveness of Integrated Services for Homeless Adults With Serious Mental Illness. Sacramento: California Department of Mental Health, May 2003.

[65] Selix, Rusty, Executive Director, California Council of Community Mental Health Agencies. Mental Health Services Act Long Range Plan: A Road Map From Fail First to Help First and Proposition 63 – Standing on the Shoulders of Giants. Sacramento: California Mental Health Services Oversight and Accountability Commission, 2006.

[66] Office of the Surgeon General – www.surgeongeneral.gov/library/mentalhealth/home.html

[67] Many Voices, One Direction: Building a Common Agenda for Cultural Competence in Mental Health, A Report to the Community. Sacramento: California Institute for Mental Health and California Mental Health Directors Association, 2002.

[68] California Senate and Assembly Bills since 1993-1994 session – www.leginfo.ca.gov/

[69] President's New Freedom Commission on Mental Health – www.mentalhealthcommission.gov

[70] California Mental Health Master Plan, Chapter 8 – www.dmh.ca.gov/Mental_Health_Planning_Council/docs/Master%20Plan/Chapt8.pdf

[71] California Mental Health Master Plan: A Vision for California. Sacramento: California Mental Health Planning Council, 2003.

[72] California Mental Health Master Plan: A Vision for California. www.dmh.ca.gov/Mental_Health_Planning_Council/Master_Plan.asp

[73] California Institute for Mental Health (CIMH) – www.cimh.org

[74] Goodwin, Ph.D., M.S.W., et al.

[75] Many Voices, One Direction: Building a Common Agenda for Cultural Competence in Mental Health, A Report to the Community. Sacramento: California Institute for Mental Health and California Mental Health Directors Association, 2002.

[76] Many Voices, One Direction: Building a Common Agenda for Cultural Competence in Mental Health, A Report to the Community. Sacramento: California Institute for Mental Health and California Mental Health Directors Association, 2002.

[77] California Department of Mental Health (DMH) – www.dmh.ca.gov

[78] California Institute for Mental Health (CIMH) – www.cimh.org

[79] Report to the Legislature on the Effectiveness of Integrated Services for Homeless Adults With Serious Mental Illness. Sacramento: California Department of Mental Health, May 2003.

(Informing you of the existence of these Web sites is not a representation or warranty of the accuracy of the material they may contain. Any medication claim regarding efficacy, safety, or of a comparative nature of multiple products, is simply information in their materials, which may change from time to time, and is not part of this publication. The authors of this program do not have content control over these Web sites.)

[80] Mental Health Association in California (MHAC) – www.mhac.org

[81] Selix, Rusty, Executive Director, California Council of Community Mental Health Agencies. Mental Health Services Act Long Range Plan: A Road Map From Fail First to Help First and Proposition 63 – Standing on the Shoulders of Giants. Sacramento: California Mental Health Services Oversight and Accountability Commission, 2006.

[82] Selix, Rusty, Executive Director, California Council of Community Mental Health Agencies, and Assemblyman Darrell Steinberg (D-Sacramento). From Fail-First to Help-First: Proposition 63 Transforms California's Mental Health System. Sacramento: Mental Health Association in California, 2006.

[83] Report to the Legislature on the Effectiveness of Integrated Services for Homeless Adults With Serious Mental Illness. Sacramento: California Department of Mental Health. May 2003.

[84] California Department of Mental Health (DMH) – www.dmh.ca.gov

[85] California Department of Mental Health (DMH) – www.dmh.ca.gov

[86] California Department of Mental Health (DMH) – www.dmh.ca.gov

[87] California Department of Mental Health (DMH) – www.dmh.ca.gov

[88] California Mental Health Financing 101, PowerPoint Presentation. Sacramento: California Mental Health Directors Association, 2006.

[89] California's Mental Health System, Underfunded from the Start. Sacramento: California State Senate Committee on Budget and Fiscal Review, 2000.

[90] Goodwin, Ph.D., M.S.W., et al.

[91] Report on the Mental Health Governance Study. Sacramento: California Mental Health Planning Council, 1993.

[92] Selix, Rusty, Executive Director, California Council of Community Mental Health Agencies. Mental Health Services Act Long Range Plan: A Road Map From Fail First to Help First and Proposition 63 – Standing on the Shoulders of Giants. Sacramento: California Mental Health Services Oversight and Accountability Commission, 2006.

[93] Selix, Rusty, Executive Director, California Council of Community Mental Health Agencies, and Assemblyman Darrell Steinberg (D-Sacramento). From Fail-First to Help-First: Proposition 63 Transforms California's Mental Health System. Sacramento: Mental Health Association in California, 2006.

[94] California's Mental Health System, Underfunded from the Start. Sacramento: California State Senate Committee on Budget and Fiscal Review, 2000.

[95] California State Association of Counties (CSAC) – www.csac.counties.org

[96] Workbook on the Roles and Duties of Local Mental Health Boards & Commissions. Sacramento: California Association of Local Mental Health Boards and Commissions (CALMHB/C), 2000.

[97] Workbook on the Roles and Duties of Local Mental Health Boards & Commissions. Sacramento: California Association of Local Mental Health Boards and Commissions (CALMHB/C), 2000.

[98] California Welfare & Institutions Code 5607-5623.5.

(Informing you of the existence of these Web sites is not a representation or warranty of the accuracy of the material they may contain. Any medication claim regarding efficacy, safety, or of a comparative nature of multiple products, is simply information in their materials, which may change from time to time, and is not part of this publication. The authors of this program do not have content control over these Web sites.)

[99] Workbook on the Roles and Duties of Local Mental Health Boards & Commissions. Sacramento: California Association of Local Mental Health Boards and Commissions (CALMHB/C), 2000.

[100] Parent, Dale, President California Association of Local Mental Health Boards/Commissions. Sacramento. 2007.

[101] California Institute for Mental Health (CIMH) – www.cimh.org

[102] Mental Health Association in California (MHAC) – www.mhac.org

[103] Mental Health Services Act – www.dmh.ca.gov/Prop_63/MHSA/default.asp

[104] Papers of John F. Kennedy – www.presidency.ucsb.edu/john_f_kennedy.php

[105] President's New Freedom Commission on Mental Health – www.mentalhealthcommission.gov

[106] Report to the Legislature on the Effectiveness of Integrated Services for Homeless Adults With Serious Mental Illness. Sacramento: California Department of Mental Health, May 2003.

[107] California's Mental Health System, Underfunded from the Start. Sacramento: California State Senate Committee on Budget and Fiscal Review, 2000.

[108] California Welfare & Institutions Code, 5328

[109] California Welfare & Institutions Code, 8100 and 8103

[110] California Welfare & Institutions Code, 5585.25

[111] California Welfare & Institutions Code, 5154

(Informing you of the existence of these Web sites is not a representation or warranty of the accuracy of the material they may contain. Any medication claim regarding efficacy, safety, or of a comparative nature of multiple products, is simply information in their materials, which may change from time to time, and is not part of this publication. The authors of this program do not have content control over these Web sites.)

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