CALIFORNIA STATE UNIVERSITY, NORTHRIDGE

The Impact of California Mental Health Policy

A graduate project in partial fulfillment of the requirements
For the degree of Master of Public Administration,
Health Administration

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August 2020

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Abstract

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Mental illness is a crisis in the nation resulting in homelessness, joblessness, and imprisonment. The lack of resources and services continues to be a problem that prevents individuals affected from living healthy and fulfilled lives. Although there have been numerous federal and state mandates, including the Patient Protection Affordable Care Act (ACA) expansion, the issue remains. In California, the Mental Health Parity Act of 1999 and the Mental Health Services Act passed in 2004 have made some progress in addressing the needs of adults with serious mental illness and children with serious emotional disturbances, but the efforts have not been sufficient.

This study aimed to examine mental health policy in California and the effects of not adequately addressing the problem. Historical mental health policy in the United States was addressed for contextual purposes.

The findings of the review revealed that there have been various mental health policies implemented in California. However, none has been sufficient to address the needs of

individuals living with serious mental illness, thus resulting in homelessness and incarceration. The study provides the foundation for greater knowledge of mental health policy in California and a basis for evaluating the effects of the state's inadequate policy, specifically homelessness and incarceration.

Keywords: mental illness, inadequate policy, homelessness, incarceration

Introduction

Mental health is increasingly becoming a significant problem in the United States. In any one year, almost 48 million adults experience mental illness, and over 11 million endure serious mental illness (National Alliance on Mental Illness, 2019). Annually, an estimated 1.5 million individuals have schizophrenia, 7 million endure bipolar disorder, and nearly 18 million suffer from severe depression (National Alliance on Mental Illness, 2019). Those affected face diminished capacity to adequately perform essential life functions (Goldman & Grob, 2006). Almost 8 million children between the ages of 6-17 experienced no less than one mental health disorder in 2016 (Whitney & Peterson, 2019).

In California, mental illnesses are prevalent ailments plaguing residents. (California Health Care Foundation, 2018). Almost 17 percent of adults are affected by mental illness, and 4 percent suffer from a serious mental illness (California Budget Center, 2020). Nearly 8 percent of children experience serious emotional disturbance, defined as "a categorization for children 17 and under who currently have, or at any time during the past year have had, a mental, behavioral, or emotional disorder resulting in functional impairment that substantially limits functioning in family, school, or community activities" (California Health Care Foundation, 2018). Serious mental illness occurs more often among the more impoverished Californians. (California Budget Center, 2020). Countless individuals affected become homeless or are imprisoned (California Budget Center, 2020).

Despite the series of mental health laws to ensure individuals living with serious mental illness receive proper care, including President Truman's National Mental Health Act of 1946, President Kennedy's Community Mental Health Act of 1963, President Carter's Mental Health Systems Act of 1980, the Mental Health Parity Act of 1996, and the 2008 Mental Health Parity

and Addiction Equity Act by Senators Paul Wellstone and Pete Domenici, services remain inadequate (Gold, 2015). Although numerous acts and policies have been implemented in California, the lack of sufficient care still exists. So why is mental health policy not good enough to provide adequate mental health services? An immediate need exists "for radical change in the paradigm and practices of mental health care" (Lake & Turner, 2017).

Statement of Purpose

The purpose of this study is to examine mental health policy in California and highlight the effects of not having policy that is able to fulfill the needs of individuals living with serious mental illness. While there are multiple effects resulting from the inadequacies, this study will focus on homelessness and incarceration and will be guided by the following research questions:

Research questions

1. What mental health policies are in place in California to address serious mental illness?
2. What are the effects of not implementing adequate mental health policy in California?

This study includes historical references of mental health policy in the United States. For purposes of this review, "behavioral health" is used to indicate a combination of "serious mental illness" and "substance use disorders."

Background

Prior to 1945, the United States mental health public policy was centered around the opinion that the appropriate setting for individuals affected by serious mental illness was in state psychiatric hospitals (Grob, 2016). This belief was based on the public's increasing knowledge of how individuals were inhumanely treated in prisons, almshouses, and family homes (Grob, 2016).

As the care and treatment of individuals with mental illness remained a point of focus, federal mental health policy was addressed at the grassroots level with the enactment of various laws. The National Mental Health Act of 1946 was one such law implemented to provide funding to states and made mental health a federal priority (Grob, 1995). The Community Mental Health Act followed and ensured federal financial support for mental health centers in the community in place of state mental hospitals (Murphy & Rigg, 2014). The most recent federal law is the Mental Health Parity and Addiction Equity Act. The goal of this Act is to bring equity between medical health and mental health and substance use disorder, together known as behavioral health (Harwood, Azocar, Thalmayer, Xu, Ong, Tseng, Wells, Friedman, & Ettner, 2017).

In California, mental health has also been addressed with the passing of numerous policies. The Short Doyle Act required counties to render services through county-operated and contract providers (Department of Health Care Services, 2013). The Lanterman-Petris Short Act, which stated that an arbitrator must give authorization before a patient could be hospitalized, intended to produce a more standardized method and significantly reduce the number of hospitalizations. (Moore, 2018). The Mental Health Services Act, or MHSA, was the latest

policy to be implemented. This Act was established to ensure funding for the maintenance of county mental health programs throughout the state (Mental Health California, 2020).

Literature Review

Early Beliefs, Treatment, and Stigma

For many years, mental illness, or madness as it was called, was considered to be due to demonic possession, a curse by God, or another mystical force (Schwartz, 2014). It was not seen as an illness, and attempts were made to get rid of the problem in the most dreadful ways (Schwartz, 2014).

Some of the gruesome treatments include 1) trepanation - the boring of holes in the skull, 2) hydrotherapy/waterboarding - the act of pouring water over a clothed face to simulate drowning, 3) chemically induced seizures - the administering of drugs to stimulate the circulatory and respiratory system to cause an abrupt uninhibited electrical disruption in the brain, and 4) lobotomy - the insertion of a long thin device into the eye's orbit to the frontal lobe (Schwartz, 2014).

In ancient Western Asia, exorcisms, spells, and prayer were some of the rituals used to force the evil spirits from the hosts (Foerschner, 2010). In Ancient Egypt, mental illness was treated by having those affected attend concerts, dances, and other recreational activities (Foerschner, 2010).

Beginning around 460 BC, the view that mental illness had a supernatural origin began to give way to more scientific beliefs, such as the cause derived from "natural occurrences in the body," abnormality of the brain in particular (Burton, 2012). In the 19th century, the desire to find cures was the driving force of mental hospitals in the United States (Burton, 2012).

The stigma linked to mental illness has been embedded in societies globally for centuries (Foerschner, 2010). Historically, because of the humiliation associated with mental illness, many people kept their affected loved ones in hiding or even abandoned them, leaving them to

care for themselves on the streets (Foerschner, 2010). Members of families have held biases about their relatives, insisting they were weak, lazy, had character flaws, or just not trying hard enough to overcome the illness (Noonan, 2017).

Stigma is still a significant problem facing individuals who live with serious mental illness (Rössler, 2016). It can diminish a person's self-worth, cause discord with family members, and hinder the ability to fit in socially (Treatment Advocacy Center, 2016a). The potential to maintain housing and employment is also decreased (Treatment Advocacy Center, 2016a). A study conducted by McGinty and associates in 2016 determined that stigma has increased over the last 50 years and continues to increase (Treatment Advocacy Center, 2016a).

Historical Development of Federal Mental Health Policies

Throughout the 1840s, Dorothea Dix, an early pioneer for mental health reform, advocated for improved living standards of people with mental illness after observing the unsafe and deplorable circumstances of many patients (Parry, 2006). During the 1800s, mental illnesses were not considered to be treatable but were deemed to be a sign of insanity, deserving imprisonment in the most dreadful conditions (Parry, 2006). Dix intended to erase these views. She visited countless U.S. prisons and almshouses, noting the abuses received by those affected by mental illness and informing state lawmakers (Parry, 2006). Her tireless effort produced over 30 mental health hospitals in many states and assisted in altering the perceptions about mental illness (Parry, 2006).

Dix was undoubtedly motivated by her own experiences with severe mental illness (Whiteman, 2017). Diagnosed with depression, she visited England, desperately seeking a cure for her own illness during the mid-1830s (Whiteman, 2017). While in Europe, she joined social activists, Elizabeth Fry and Samuel Tuke, who were known for advocating for the rights of

prisoners and those experiencing mental illness (Whiteman, 2017). After coming home and observing the agony of imprisoned women while serving as a Sunday School teacher, she began on her journey to assist in the improvement of mental health care (Whiteman, 2017).

The viewpoints that considered institutionalization as the proper policy option started to diminish in the early stages of World War II (Grob, 2016). Over the next twenty years, the validity of mental hospitals was weakened by people dedicated to developing a new policy model - "the care and treatment of persons with severe mental disorders should take place in the community" (Grob, 2016).

The growing opinion that altered the mental health policy was based on several factors. In the 1800s, individuals hospitalized were mainly acute and remained in the facility for no more than one year (Grob, 1987). Older adults were seldom institutionalized. One key factor was that the makeup of those institutionalized began to change after 1890 (Grob, 1987). From 1890 to 1940, there was a significant increase in chronic patients in need of long-term care and a decrease in those requiring care for acute illness (Grob, 1987).

Another factor that contributed to the change in views was the observation of psychiatrists serving in the armed force in World War II (Brand, 1965). More than one million men were disallowed from serving in the military due to them expressing or exhibiting mental or neurological disorders (Brand, 1965). Servicemen were witnessed experiencing mental breakdowns after brief, prolonged, and perceived dangerous encounters in combat in those who had no prior history of mental disturbances. (Grob, 1987).

After treatments which included minimizing the dangers of "combat exhaustion" by limiting combat time, developing troupe unity, maximizing rest cycles, psychotherapy, and narcosynthesis, psychiatrists determined that successes were accomplished when in the

community setting of the aid station versus in a place away from the support network (Grob, 1987). They ultimately concluded that treatment in the civilian world must also be rendered in a setting with people who can support the individual instead of a lonely institution (Grob, 1987).

By 1946, veterans with psychiatric disorders represented 60 percent of all individuals hospitalized under the Veteran's Administration, costing more than $40,000 for each patient. (Brand, 1965).

The policy of deinstitutionalizing state hospitals which shifted individuals affected by severe mental illness from the hospitals into the communities was driven by the opinion that care received in the community would be more compassionate, curative, and cost-efficient than would be received in a hospital (Yohanna, 2013).

In 1946, the National Mental Health Act was signed by President Harry S. Truman in response to the increasing demand to fortify outpatient and community clinics and make grants available to states to establish new outpatient facilities or maintain existing facilities (Grob, 1995). The Act funded the National Institute of Mental Health, officially created in 1949, to alter the perception and treatment of mental illnesses (National Institute of Mental Health, 2017).

President Kennedy and Mental Illness

On February 5, 1963, President John F. Kennedy introduced a new program on "Mental Illness and Mental Retardation" (Torrey, 2013). The government would finance Community Mental Health Centers (CMHCs), and these facilities would replace state mental hospitals (Murphy & Rigg, 2014). That same year, the Community Mental Health Act was signed into law by President Kennedy (Murphy & Rigg, 2014).

President Kennedy's motivation to bring mental illness into the forefront was partly due to his own family's experience. His younger sister, Rosemary, born in 1918, exhibited learning

disabilities and developmental delays at a very young age stemming from a lack of oxygen during delivery (Lenz, 2017). Due to the high level of stigma at that time, her parents employed instructors to teach her at home, but she was eventually sent to boarding school to avoid being placed in an institution (Lenz, 2017).

When President Kennedy's father, Joseph Kennedy, was named United States Ambassador to the United Kingdom in 1938, Rosemary accompanied the family to England, where she flourished, being taught by nuns in Catholic school (Gordon, 2015). However, the Kennedy's were sent back to the states in 1940, and the special attention and guidance she received ended (Gordon, 2015). Rosemary relapsed upon returning home, and she began to become violent and attacked those around her (Gordon, 2015).

Seeking a solution for his daughter's behavior, Joseph authorized for Rosemary to have a lobotomy, a risky procedure developed in 1935 to cure mental illness by placing a device in the eye socket into the brain, performed on his daughter at the age of twenty-three (Lenz, 2015). As a result of the procedure, Rosemary, now institutionalized, never walked or talked again, and it would be twenty years before she saw her family (Lenz, 2015). The experience prompted her sister Eunice to become an advocate for mental illness, thus encouraging her brother, President Kennedy, to address the issue through legislation (Gordon, 2015).

Mental Health Issues Remain

Despite the optimism about changes anticipated to result from the Community Mental Health Act, problems persisted (Teich, 2016). Policymakers were not well informed about what changes would look like (Teich, 2016). Many patients who were released had no families to go to and had to provide for themselves in residential facilities with almost no supervision and treatment limited to psychotropic drugs (Teich, 2016).

With no clear strategy as to how to address all the issues that resulted from the closing of the hospitals, including the lack of funding and a practical financial support plan, what policymakers thought would be a solution, ended with more dilemmas. (Teich, 2016).

From 1963 to 1980, the federal government used $2.7 billion to fund 789 CMHCs, and the number of people housed in state mental health hospitals decreased from 506,604 to 132,164. The excess beds ultimately were eliminated (Torrey, 2013). However, according to federal studies, under 10 percent of patients discharged from state hospitals received CMHCs services (Torrey, 2013).

In 1980, President Jimmy Carter established a Presidential Commission on Mental Health that led to the Mental Health Systems Act of 1980 (Mechanic, 2007). This Act intended to provide grants to CMHCs and increase programs for those affected by serious mental illness (Mechanic, 2007).

In 1981, President Ronald Reagan rescinded the Act, and the Omnibus Budget Reconciliation Act became law, severely cutting federal mental health spending and redirected funding from CMHCs to "block grants" to the states (Mechanic, 2007). The federal government had a greatly reduced role in mental health, and the states were given a substantial amount of flexibility in the use of the funds (Mechanic, 2007).

With a 30 percent decrease in federal dollars and the states having the discretion to use the grants on various other programs, the lack of both institutional and community care left countless individuals living with severe mental illness homeless, incarcerated, or victimized (Guerra, 2017). The negative impact on the lives of those affected still exists today.

In 1996, Congress passed the Mental Health Parity Act (MHPA), which barred "large employer-sponsored group health plans from imposing higher annual or lifetime dollar limits on

mental health benefits than those applicable to medical or surgical benefits" (Goodell, 2014). The MHPA was relevant to plans that already provided the benefits (Goodell, 2014).

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) expanded benefits under the MHPA to cover treatment for substance use (Friedman, Thalmayer, Azocar, Xu, Harwood, Ong, Johnson, & Ettner, 2018). Included in the Act is parity for "deductibles, copayments, number of visits and days of coverage" (Harwood et al 2017).

In March 2010, President Barack Obama signed into law the Patient Protection Affordable Care Act (ACA) (eHealth, 2020). Commencing in 2014, it was mandatory for every "small group and individual market plans" to cover mental health and substance use treatment at levels comparable with medical health and surgical services (Beronio, K., Glied, S., & Frank, R., 2014). The ACA expanded the MHPAEA and was intended to lower the number of people lacking health insurance and enhance "access to mental health services" (Beronio et al., 2014). Medicaid managed-care plans were included two years later (National Council for Behavioral Health, n.d).

The parity law that sought to make behavioral health equal to medical health and surgical coverage has helped to reduce the most noticeable differences, including yearly restrictions on treatment appointments (Gold, 2015). Imbalanced copayments and separate mental health deductibles are also less common (Gold, 2015). However, insurance companies still evade the mandated parity for behavioral health requirements by applying more limiting "medical necessity" criteria with insurers determining a patient's need for treatment and how often that treatment can be administered (Gold, 2015).

Most states have enacted laws requiring mental health parity, but they are not all the same (Sturm & Pacula, 1999). States are required to implement the federal parity law but can assume

even stronger laws (Sturm & Pacula,1999). But in fact, states are relaxed about enforcing these parity laws. (Ollove, 2015). Although years have passed since the enactment of the federal law, the government has yet to develop standards for implementing the requirement (Ollove, 2015). Regrettably, the promise of the parity law has still not been fulfilled (Gold, 2015).

Mental Illness in California

Roughly 1 in 6 adults in California have mental health issues, and approximately 1 in 25 suffers from a serious mental illness that inhibits the ability to perform day-to-day functions (California Budget Center, 2020). Among children, 1 in 13 suffer from a mental illness that impedes daily activities (California Budget Center, 2020). Approximately 67 percent of adults and children receive no treatment (California Health Care Foundation, 2018).

The incidence of adults with serious mental illness in California is 6.6 percent for Native Americans, 5.6 percent for Blacks, 5.5 percent for multiracial groups, 4.8 percent for Latinxs, 4 percent for Whites, 2.4 percent for Pacific Islanders, and 1.6 percent for Asians (California Budget Center, 2020). In children, the rate of serious emotional disturbance is 8 percent for both Blacks and Latinxs, 7.8 percent for Native Americans and Pacific Islanders, and 6.9 percent for multiple races, Asians, and Whites (California Budget Center, 2020).

The rate of serious mental illness is higher among women at 4.8 percent, while men are 3.6 percent (California Health Care Foundation, 2018). By age group, the occurrence among both males and females varies. For individuals aged 18-20, the rate is 2 percent, 21-24 is 4.3 percent, 25-34 is 5.8 percent, 35-44 is 6.3 percent, 45-54 is 5.1 percent, 55-64 is 2.9 percent, and 65 and over is 1.5 percent (California Health Care Foundation, 2018). The state average across all age groups is 4.2 percent (California Health Care Foundation, 2018).

Serious mental illness is highest among Californians who are impoverished, affecting nearly "1 in 10 adults below 100% of the federal poverty level" (California Health Care Foundation, 2018). For adults with income 100% or less of the poverty level, the rate is 9 percent, 100%-199% is 6.3 percent, 200%-299% is 3.6 percent, and 300% and above is 1.9 percent (California Health Care Foundation, 2018).

The rate of individuals in California who experience mental illness, along with substance use disorder, is high. Approximately 33 percent of those who endure serious mental illness and receive county services also have a "co-occurring substance use disorder" (California Health Care Foundation, 2018).

Historical Development of Mental Health Policy in California

California's history of handling mental illness follows that of the nation, abandoning care and treatment in institutions to more community-based programs (Legislative Analyst's Office, 2000).

Before 1957, the State of California was charged with the hospitalization and care of individuals living with mental illness and the developmentally disabled in a system of 14 statewide hospitals (Legislative Analyst's Office, 2000). As intakes in the hospitals increased, communities realized the necessity for outpatient facilities for those not requiring "24-hour hospitalization" (Legislative Analyst's Office, 2000). In 1957, the State Legislature passed the Short-Doyle Act to provide economic aid for cities and counties to create "locally" managed community mental health programs (California Health Care Foundation, 2013).

In 1968, the Lanterman-Petris Short Act (LPS) modified the mandate by making it a requirement that before an involuntary hospitalization can occur, a judicial hearing is made available to a person (California Health Care Foundation, 2013). The Act intended to

discontinue "the inappropriate and indefinite commitment of mentally disordered persons; to provide prompt evaluation; to guarantee and protect public safety; to safeguard individual rights through judicial review; to provide individualized treatment, supervision, and placement services; to encourage the full use of all existing agencies, professional personnel, and public funds to prevent duplication of services and unnecessary expenditures, and to protect mentally disordered persons from criminal acts" (California Hospital Association, 2012).

The Bronzan-Mojonnier Act of 1985 enacted "provisions" to identify the lack of services that result in the "criminalization" of those affected by mental illness and the "provision of community support" and occupational services for the "homeless and mentally disabled and children who are seriously emotionally disturbed" (California Health Care Foundation, 2013). This led to the Wright-McCorquodale-Bronzan Mental Health Act of 1988, which introduced methods to examine the efficiency of the systems of care of individuals with severe mental illness and the Bronzan-Wright-McCorquodale Realignment Act of 1991, which shifted financial accountability of mental health care from the state to counties (California Health Care Foundation, 2013).

The California Mental Health Parity Act passed in 1999 and required that the coverage and degree of care for "serious mental illness in adults and serious emotional disturbances in children" be equal to that of other health conditions or illnesses (Rosenbach, Lake, Williams, & Buck, 2009). The law only applies to plans that are state-regulated and excludes "self-funded plans," and such federal programs as Medicare, Medi-Cal, and Veterans Administration (Disability Rights California, n.d.). Severe mental illnesses, according to California law, are "schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia,

and bulimia nervosa" (Department of Managed Health Care, 2020). The terms of service include maximum lifetime benefits, co-payments, and deductibles (Lilienstein, 2011). The state law requires state-regulated plans to cover "outpatient services, inpatient hospital services, partial hospitalization services, and prescription drugs if included in the plan" (Disability Rights California, n.d).

One of the major prospects of addressing mental illness in recent times in California is the Mental Health Services Act (MHSA), which passed in November 2004 as Proposition 63 and became effective as of January 1, 2005 (Mental Health California, 2020). The Act places a one percent tax on individual income above $1 million (Department of Health Care Services, 2020), and the money generated would be used to allocate "funding, personnel, and resources to support county mental health programs" (Mental Health California, 2020). The California Department of Mental Health monitors the Act (Department of Health Care Services, 2020). Each of the counties, along with their contracted agencies, provides direct services to consumers (Mental Health California, 2020).

The MHSA was implemented to address the problem that resulted over three decades ago when California reduced services in state hospitals without providing sufficient financial support for community mental health services (Mental Health Services Oversight and Accountability Commission, 2020). Consequently, a myriad of individuals affected became homeless (Mental Health Services Oversight and Accountability Commission, 2020). Changing the system and enriching the lives of those enduring mental illness is the declared goal (Mental Health Services Oversight and Accountability Commission, 2020).

Mental Health Services Act Programs

The MHSA focuses on an extensive range of "prevention, early intervention, and service needs as well as providing funding for infrastructure, technology, and training for the community mental health system" (Mental Health California, 2020). The five required components specified by the MHSA are "Community Services and Supports (CSS), Capital Facilities and Technological Needs (CFTN), Workforce, Education, and Training (WET), Prevention and Early Intervention (PEI), and Innovation (INN)" (Mental Health California, 2020). Table 1 gives an explanation and overview of each component.

Table 1: MHSA Components

The Five Components of MHSA	
Community Services and Supports (CSS)	"Focused on community collaboration, cultural competence, client and family driven services and systems, wellness focus, which includes concepts of recovery and resilience, integrated service experiences for clients and families, as well as serving the unserved and underserved; housing is also a large part of the CSS component"
Prevention and Early Intervention (PEI)	"The goal is to help counties implement services that promote wellness, foster health, and prevent the suffering that can result from untreated mental illness"
Innovation (INN)	"The goal is to increase access to underserved groups, increase the quality of services, promote interagency collaboration and increase access to services"
Capital Facilities and Technological Needs (CFTN)	"Works toward the creation of a facility that is used for the delivery of MHSA services to mental health clients and their families or for administrative offices; funds may also be used to support an increase in peer-support and consumer-run facilities, development of community based settings, and the development of a technological infrastructure for the mental health system

	to facilitate the highest quality and cost-effective services and supports for clients and their family members"
Workforce, Education, and Training	"The goal is to develop a diverse workforce; clients and families/caregivers are given training to help others by providing skills to promote wellness and other positive mental health outcomes, they are able to work collaboratively to deliver client-and family-driven services, provide outreach to unserved and underserved populations, as well as services that are linguistically and culturally competent and relevant, and include the viewpoints and expertise of clients and their families/caregivers"

*Source: Mental Health Services Oversight and Accountability Commission, 2020

Sixteen years following the implementation of the MHSA, there is still no statewide plan to effectively spend the funds on services with assessable results (Steinberg & Wiener, 2018). The state lacks a system of oversight that guarantees that all county providers are utilizing identical benchmarks and evaluating outcomes for commonality (Steinberg & Wiener, 2018). Each county continues to operate in its own distinct modes, which has resulted in services not being distributed equitably across the state (Steinberg & Wiener, 2018).

Effects of Inadequate Mental Health Policy in California

Individuals enduring mental health disorders are negatively impacted and suffer in varying ways resulting from the inefficiencies of the system. Severe mental illness is a major cause of homelessness in the nation (Martin, 2015). Roughly 33 percent of homeless individuals live with severe mental illness that goes untreated (Martin, 2015). Mental illness is the "third largest cause of homelessness for single adults" (Mental Illness Policy, 2019).

In California, approximately 151,278 adults were reported to be homeless (California Budget Center, 2020). Nearly 25 percent of those individuals live with a serious mental illness

(California Budget Center, 2020). A 2019 survey revealed that 67 percent of California's homeless were affected by either a mental health or substance use disorder (Smith & Oreskes, 2019). However, homelessness experts disagree and believe that 100 percent of the people who live on the streets suffer mental illness, substance use disorder, or both (Shellenberger, 2019). John Snook of the Treatment Advocacy Center, who counsels states across the nation on mental health and homelessness policy, says that other states have done a much better job than California at addressing the issue despite expending much less money (Shellenberger, 2019).

Treatment for the homeless with serious mental illness is an issue that must be addressed. Among other factors, lack of access and even refusal can play a part in the person not receiving services (Wiener, 2018). A California mother, Diane Shintock, saw her son decline in the streets for years suffering from schizophrenia (Wiener, 2018). He often refused housing or was removed from places he lived for his terrible behavior (Wiener, 2018). Shintock requested that he be placed under conservatorship (Wiener, 2018), which gives the responsibility to manage the complete mental health treatment of an adult who has serious mental illness to another adult (National Alliance on Mental Illness Los Angeles, 2020). Her son's personal freedom would be taken away because his illness rendered him unable to provide food, clothing, and shelter, termed "gravely disabled" (Wiener, 2018). However, county representatives informed her that he could not be conserved under state law because it was his choice to dwell on the street, and he did not meet the standard for "gravely disabled" (Wiener, 2018). The government's role in protecting individuals affected by serious mental illness who refuse treatment and how it should balance the right to personal freedom with the need for care is a major question. (Wiener, 2018).

Racial/ethnic disparities are very present in the reality of homelessness and serious mental illness (Cimini, 2019). African Americans, or Blacks, are disproportionately homeless in

California (Cimini, 2019). While Blacks account for 6.5 percent of California's population, they represent almost 40 percent of the homeless in the state (Cimini, 2019). In a 2012 study completed by the African American Health Institute of San Bernardino County, respondents, which included the homeless, consistently indicated significant levels of shame and embarrassment about mental health issues that prevented them from seeking professional help (Substance Abuse and Mental Health Services Administration, 2019). Additionally, respondents throughout the state revealed that their local Mental Health Departments routinely failed them in providing care (Substance Abuse and Mental Health Services Administration, 2019). Los Angeles' Skid Row dwellers were significant to the study (Substance Abuse and Mental Health Services Administration, 2019). Based on the results, suggestions that would assist the Black population living with mental health issues included providing mentoring services and alternative options to medication, better ways to inform people about local mental health resources, and building a cultural facility (Substance Abuse and Mental Health Services Administration, 2019).

Individuals with psychotic disorders have an increased chance of becoming chronically homeless (Treatment Advocacy Center, 2018). This would be relevant to the nearly 3 million veterans in the nation who were active in Afghanistan and Iraq between 2001 and 2014 (Treatment Advocacy Center, 2018). It is estimated that approximately 43,200 of these troops have an untreated serious mental illness, which often results in homelessness, substance use disorders, incarceration, acts of violence, and early death (Treatment Advocacy Center, 2018). More than 9 percent of the homeless in the country are reported to be veterans (United States Interagency Council on Homelessness, 2018). Of the total 21 million veterans in the United States, almost 2 million veterans reside in California (Legislative Analyst's Office, 2017).

Veterans in the state were more likely to receive mental health or substance use treatment than individuals who did not serve in the military (Tran, Grant & Aydin, 2016). However, more than 76 percent of veterans who needed treatment were given insufficient care or none at all (Tran, Grant & Aydin, 2016). Approximately 11,000 veterans in California experience homelessness on any one night, representing nearly 8 percent of the state's homeless population (Levin & Botts, 2019).

Governor Newsom called for the improvement of mental health care to assist California's massive homeless population in his "State of the State" speech in February 2020. (Wiener, 2020). The Governor brought focus to the need to treat chronically homeless individuals who endure serious mental illness and substance use disorders (Wiener, 2020). When discussing involuntary treatment laws, Newsom expressed that some individuals are not capable of accepting help for treatment to leave the streets. He further stated, "Policy is an empty promise without creating more placements" (Wiener, 2020).

Individuals with mental health issues are also over-represented in the criminal justice system (Baillargeon, Penn, Knight, Harzke, Baillargeon, Becker, 2010). It is reported that 64 percent of individuals in jail, 50 percent in state prison, and 45 percent in federal prison express mental health concerns (American Psychiatric Association, 2014). Roughly 20 percent of the jail population and 15 percent of prison inmates have a serious mental illness (Treatment Advocacy Center, 2016b). Serious mental illness in the nation's corrections system has become so common that jails and prisons are commonly known as "the new asylums" (Treatment Advocacy Center, 2016b). Many people experiencing treatable mental illnesses are incarcerated in the nation's prisons and jails instead of being placed in inpatient psychiatric facilities (American Psychiatric Association, 2014).

Nearly one-third of inmates in California have a recognized serious mental illness (Wiener, 2019a). Senator Jim Beall of San Jose expressed, "We're going to end up with an incarceration system that's mainly dealing with people that have serious mental health problems; it's our own fault, in a way, for not having a good mental health system" (Wiener, 2019a). California's criminal justice system reveals its mental health crisis. After many years of failure to establish and finance policies that successfully assist individuals with serious mental illness, the jails and prisons are now believed to be the state's default mental institutions (Wiener, 2019a). Over the last five years, California has noted a climb in the number of individuals determined to be "incompetent to stand trial" following arrest and ordered to be placed in a state hospital for treatment (Wiener, 2019a). Judges refer defendants when doctors conclude that they cannot work with their attorneys or comprehend legal proceedings (Wiener, 2019a). Defendants are returned to stand trial once stabilized (Wiener, 2019a). However, it could take months or years before individuals are sent to the hospital, leaving them to linger in county jails (Wiener, 2019a). In 2014, there were approximately 343 inmates awaiting placement, and by 2018, the number had increased to 819 (Wiener, 2019a).

Los Angeles County incarcerates more individuals than anywhere in the nation, and the jails are California's largest mental health treatment facilities with almost 5000 individuals in the mental health units on any given day (Appel, Stephens, Shadravan, Key, & Ochoa (2020). The county's jail system has evolved into the largest treatment facility in the nation (Baker, 2020). Individuals who live with serious mental illness are warehoused into the system with no adequate staff, services, or support (Baker, 2020). At the county's Twin Towers jail, there is a lack of counselors, and ten psychiatrist positions have remained vacant for two years (Baker, 2020). In prior years, the more acute patients would meet with psychiatrists every other week, but due to

the lack of staff, they are only seen once each month by a doctor (Baker, 2020). Additionally, since the facility was not designed for treatment, it lacks the space necessary to provide care appropriately. (Baker, 2020). An added concern is the disparate number of black individuals housed in this system (Appel et al., 2020). Blacks make up 41 percent of individuals receiving mental health services in LA County jails, although they represent 30 percent of the jail population (Appel et al., 2020).

According to health policy experts, mental illness in California jails has risen considerably over the last 11 years (Hice, 2020). California Health Policy Strategies (CHPS), a Sacramento-based consulting group, explained that there had been a 42 percent increase in mental health cases reported and an 80 percent increase in inmate medication prescribed since 2010 based on a recent study conducted (Hice, 2020). The percentage of people incarcerated in the state's jails with an active mental health case was 19 percent in 2009 and 31 percent in 2019 (Goldberg, 2020). In 2009, 80,000 individuals were in jail, with 15,500 having an active mental health case (Goldberg, 2020). However, in 2019, 72,000 individuals were jailed, and 22,000 had an active mental health case (Goldberg, 2020). The statistics demonstrate that the number of people incarcerated between 2009 and 2019 decreased, whereas the number of those incarcerated with an active mental health case increased (Goldberg, 2020). David Panush, the president of CHPS, stated that the data reveals a problem that has been discussed for a long time (Hice, 2020). He declared that an alarming number of people who experience mental illness are incarcerated and called for new strategies to address it (Hice, 2020).

Methodology

This study is a qualitative literature review of archival data. The peer-reviewed journal articles published between 1965 and 2020 were identified through the bibliographic databases ProQuest Central, JSTOR, EBSCO, PubMed Central, American Medical Association, American Psychiatric Publishing Journals, Science Direct Journals, JAMA, Sage Journals, Gale, Ovid Kluwer Journal, and NCBI. Non-peer reviewed government sites were the Department of Health Care Services, Department of Managed Care, Disability Rights California, Legislative Analyst's Office, Mental Health Services Oversight and Accountability Commission, National Institute of Mental Health, Substance Abuse and Mental Health Services Administration, and United States Interagency Council on Homelessness.

Other non-peer reviewed sites were the American Psychiatric Association, California Budget Center, California Health Care Foundation, California Hospital Association, eHealth, Mental Illness Policy, Psychology Today, Associated Press, Inquiries Journal, Kaiser Health News, US News, DL Law Group, LA Times, American Journal of Managed Care, National Alliance on Mental Illness, National Council for Behavioral Health, Sacramento Bee, New York Times, Marie Claire, Pennsylvania State University, The Permanente Journal, Medical News Today, CalMatters, Mental Health California, ABC10 News, Salon, Forbes, Treatment Advocacy Center, National Public Radio, Capitol Weekly, Health Affairs, and State of Reform.

At the beginning of the search, 28 sources were used to conduct the study. By the end of the review, 202 sources were obtained. Many of these sources consisted of articles relating to the various effects of inadequate mental health policy other than homelessness and incarceration, which excluded them from the study. Also excluded were articles with older dates when more

recent sources could be obtained. After the inclusion/exclusion criteria were applied, 75 sources remained.

Findings and Analysis

After conducting literature review, various California mental health policies were identified that address serious mental illness. It was found that these policies were insufficient and resulted in negative impacts, specifically homelessness and incarceration, in the state for those affected.

Homelessness Persists

The study confirmed that homelessness among individuals experiencing serious mental illness results from ineffective policy. One survey concluded that nearly 70 percent of homeless people in California live with mental health or substance use disorder (Smith & Oreskes, 2019). However, some homeless experts say that 100 percent is more accurate (Shellenberger, 2019). Sources do agree that a key factor of homelessness in the state is the lack of sufficient mental health care. As a result of failed laws and limited access to services, individuals have been left without the assistance they need. The disproportionate rate at which Blacks are affected compared to other racial and ethnic groups reveals an even deeper issue rooted in the deficiencies of existent legislation. The same is true for the state's veterans with mental illness who dwell on California's streets. The governor has expressed the need to improve mental health care to address homelessness among those requiring treatment (Wiener, 2020). One controversial proposal has been to broaden services that MHSA can fund (Wiener, 2020).

Jails and Prisons Are Treatment Facilities

The study also confirmed that individuals affected by serious mental illness are incarcerated at alarming rates due to insufficient policy. The research found that almost 33 percent of inmates in California have a serious mental illness, and the jails and prisons are used as mental institutions (Wiener, 2019a). The study revealed the neglect of the vast number of

individuals unable to go to trial due to their illness and ordered to a state hospital but suffer in jails for extended periods during the waiting process (Wiener, 2019a). Since there is no policy to appropriately address this issue, the cases continue to increase (Wiener, 2019a). Jails and prisons should not be substitutes for treatment facilities. These individuals have a greater chance of being placed in solitary confinement, which could exacerbate their illness and make it more difficult for them to be removed from isolation (Hice, 2020). Policymakers have acknowledged that the problem is due to a weak mental health system in the state (Wiener, 2019b). However, there is no foreseeable resolution.

Parity is Still Non-existent

Although there have been several parity laws to address the inequity of coverage between behavioral health and physical health, the gap still exists. While the Affordable Care Act and the associated parity requirements of benefits resulted in significant progress in enhancing behavioral health care coverage, the law's potential to increase complete access to these services has yet to be reached (Maxwell, Bourgoin & Lindenfeld, 2020).

Insurance companies continue to elude the mandated parity requirements by using limiting "medical necessity" criteria (Gold, 2015). Complaints have been filed in California, asserting that insurers are intentionally ignoring mental health claims, thus negatively impacting those affected (Gold, 2015).

Michael Kamins from California is the father of a 20-year old mental health patient who has filed a lawsuit with several other individuals (Gold, 2015). His son had been placed in the hospital on two occasions due to bipolar disorder and saved from suicide (Gold, 2015). Afterward, the insurer stated that the young man had improved, and they would now only pay for

two psychiatrist visits per month as it was now not considered "medically necessary" for the visits twice a week (Gold, 2015).

Disparity in Access to Care

The review found that access to "specialty mental health treatment resources" is more prevalent in communities with higher income levels than low-income areas (Mattina, 2017). These resources include "rehabilitative mental health services, psychiatric inpatient hospital services, targeted case management, psychiatrist services, and psychologist services" (Disability Rights California, 2018). Metropolitan or suburban areas have a considerably higher possibility of having outpatient centers, psychiatry practices, and non-psychiatry practices than rural communities (Mattina, 2017). Mental health clinics operated by specialists are available in almost 18 percent of metropolitan and suburban areas and close to 2 percent in rural areas (Mattina, 2017). Communities with lower incomes are more likely to have outpatient facilities (Mattina, 2017). Specialty mental health care must be accessible to those that need it regardless of the community in which they live.

Oversight and Accountability

There must be enhanced mental health policy management in the state to ensure Californians with serious mental illness receive the care they need. Despite legislation implemented in California throughout the years, there has yet to be a system of oversight and accountability to ensure that the individuals affected receive adequate treatment. Mental illness must be a top priority for state lawmakers, and reform of current policy is imperative. But without the proper system in place to oversee the operations, correcting the problem will be impossible. To develop the appropriate means by which the inadequacies of California's mental

policy can be addressed, county and mental health agencies need more robust state direction and oversight (Wiener, 2020).

Shortage of Mental Health Providers

California's shortage of mental health professionals is becoming an increasing problem (Wiener, 2019b). Individuals living with serious mental illness may have to wait long periods or travel far to obtain the treatment they require (Wiener, 2019b). Psychiatrists in jails and prisons are very scarce, leaving those affected to suffer without timely and appropriate care (Wiener, 2019b). The shortage is expected to worsen if no immediate action is taken to reverse the current trend (Wiener2b).

Policy Implications

This thesis entails opportunities for future research to support policy implementation. It offers the framework for understanding mental health policy in California and a foundation for assessing the effects of inadequate policy in the state, specifically homelessness and incarceration. The study found that these issues not only exist at the state level but at the federal level as well. It has established that California's lack of an adequate plan of action has been detrimental to individuals living with serious mental illness. As legislators continue to express their discontent and stress the urgent need to resolve the problem, this work could be instrumental in developing an appropriate strategy.

The findings present insight into the need to improve mental health policy in California to support people with serious mental illness more effectively. It also serves as a useful source to understand the problem on a broader scale and could be used to influence existing systems in other states in an effort to eliminate homelessness and incarceration, and other effects of inadequate policy throughout the nation.

Future research on the subject would be valuable and could concentrate on why the state's mental health policy has not been sufficient to provide adequate services. The point of focus should be evaluating the lack of effective oversight and accountability. Since there is currently no adequate system to control and manage the effectiveness of existing policy, further studies could be used to determine how to develop and implement such systems.

Conclusion

The purpose of this study was to review policies in California that address serious mental illness. It further intended to assess the effects of not implementing adequate mental health policy and focused specifically on homelessness and incarceration. The study was successful in answering the research questions presented and has resulted in the expansion of knowledge of the subject matter. It concluded that although there has been legislation implemented at the state level, none has been sufficient enough to address the negative impacts. If the issue is not appropriately addressed, homelessness and incarceration among individuals living with serious mental illness will persist, and those affected will be unable to have a safe and productive existence.

References

American Psychiatric Association (2014, October). Incarceration Nation. Retrieved from https://www.apa.org/monitor/2014/10/incarceration. Accessed June 17, 2020

Appel, O., Stephens, D., Shadravan, S.M., Key, J., & Ochoa, K. (2020, April 28). Differential Incarceration By Race-Ethnicity and Mental Health Service Status in The Los Angeles County Jail System. *Psychiatric Services (Washington, D.C.)*, 2020, p. appi.ps.2019004.

Baillargeon, J., Penn, J. V., Knight, K., Harzke, A. J., Baillargeon, G., & Becker, E. A. (2010). Risk of Reincarceration Among Prisoners With Co-occurring Severe Mental illness and Substance Use Disorders. *Administration and Policy in Mental Health and Mental Health Services Research, 37*(4), 367-74. doi:http://dx.doi.org.libproxy.csun.edu/10.1007/s10488-009-0252-9

Baker, L. (2020, February 25). America's Mental Health Crisis Hidden Behind Bars. Retrieved from https://www.npr.org/2020/02/25/805469776/americas-mental-health-crisis-hidden-behind-bars. Accessed July 8, 2020

Beronio, K., Glied, S., & Frank, R. (2014, October). How The Affordable Care Act and Mental Health Parity and Addiction Equity Act Greatly Expand Coverage of Behavioral Health Care. *The Journal of Behavioral Health Services & Research, 41*(4), 410-428. doi:http://dx.doi.org.libproxy.csun.edu/10.1007/s11414-014-9412-0

Brand, J L. (1965). The National Mental Health Act of 1946: A Retrospect. Bulletin of The History of Medicine, vol. 39, no. 3, pp. 231–245.

Burton, N. (2012, June 2). A Brief History of Psychiatry. Retrieved from https://www.psychologytoday.com/us/blog/hide-and-seek/201206/brief-history-psychiatry. Accessed July 1, 2020

California Budget Center (2020). Mental Health in California: Understanding Prevalence, System Connections, Service Delivery, and Funding. Retrieved from https://calbudgetcenter.org/wp-content/uploads/2020/03/CA _Budget_ Center_ Mental_Health_CB2020. Accessed June 16, 2020

California Health Care Foundation, (2013, July). Mental Health Care in California: Painting a Picture. Retrieved from https://www.chcf.org/wp-content/uploads/2017/12/pdf-mentalhealthpaintingpicture. Accessed June 16. 2020

California Health Care Foundation (2018, March 28). For Too Many, Care Not There. Retrieved from https://www.chcf.org/publication/2018-edition-mental-health-ca-for-too-many-care-not-there. Accessed June 16, 2020

California Hospital Association, (2012, September 5). The Lanterman Petris-Short Act - Involuntary Commitment Act of 1967. Retrieved from https://www.calhospital.org / sites /main/files/file-attachments/lps_act_problem_ summary. Accessed June 16, 2020

Cimini, K. (2019, October 5). Black People Disproportionately Homeless in California. Retrieved from https://calmatters.org/california-divide/2019/10/black-people-disproportionalely-homeless-in-california. Accessed July 6, 2020

Department of Health Care Services (2013). Medi-Cal Mental Health Policy: Background. Retrieved from https://dhcs.ca.gov/services/MH/Pages/MH-MedicalMentalHealthPolicy(MCMHP)Background. Accessed June 30, 2020

Department of Health Care Services (2020, April 10). Mental Health Services Act. Retrieved from https://www.dhcs.ca.gov/services/MH/Pages/MH_Prop63. Accessed June 18, 2020

Department of Managed Health Care (2020) Mental Health Care. Retrieved from https://www.dmhc.ca.gov/HealthCareinCalifornia/GettheBestCare/

MentalHealthCare. Accessed June 30, 2020

Disability Rights California (n.d.) What is Mental Health Parity? Retrieved from https://sd15.senate.ca.gov/sites/sd15.senate.ca.gov/files/DRA%20%20mental%20health%20parity%20-%20final. Accessed June 13, 2020

Disability Rights California (2018). Specialty Mental Health Services Through a County Mental Health Plan (MHP). Retrieved from https://www.disabilityrightsca.org/publications/specialty-mental-health-services-through-a-county-mental-health-plan-mhp. Accessed July 18, 2020

eHealth (2020, March, 2). History and Timeline of the Affordable Care Act (ACA). Retrieved from https://www.ehealthinsurance.com/resources/affordable-care-act-history-timeline-affordable-care-act-aca. Accessed June 12, 2020

Foerschner, A.M. (2010). The History of Mental Illness: From "Skull Drills" to "Happy Pills." Retrieved from http://www.inquiriesjournal.com/articles/1673/the-history-of-mental-illness-from-skull-drills-to-happy-pills. Accessed on June 30, 2020

Friedman, S.A., Thalmayer, A.G., Azocar, F., Xu, H., Harwood, J.M., Ong, M.K., Johnson, L.L., & Ettner, S.L. (2018). The Mental Health Parity and Addiction Equity Act Evaluation Study: Impact on Mental Health Financial Requirements Among Commercial "Carve-In" Plans. *Health Services Research*, vol. 53, no. 1, pp. 366–388.

Gold, J. (2015). Advocates Say Mental Health Parity Law Is Not Fulfilling Its Promise. Retrieved from https://khn.org/new/advocates-say-mental-health-parity-law-is-not-fulfilling-its-promise. Accessed June 13, 2020

Goldberg, M. (2020, February 24). Report Finds That The Prevalence of Mental Illness in California Jails is Rising. Retrieved from https://stateofreform.com/featured/2020/02/

report-finds-that-the-prevalence-of-mental-illness-in-california-jails-is-rising. Accessed July 9, 2020

Goldman, H.H. & Grob, G.N. (2006). Defining Mental Illness in Mental Health Policy. Health Affairs (Project Hope), vol. 25, no. 3, pp. 737-749

Goodell, S. (2014, April 3). Mental Health Parity. Health Affairs.org, doi 10.1377/hpb20140403.871424

Gordon, M. (2015). Rosemary: The Hidden Kennedy Daughter Retrieved from https://www.nytimes.com/2015/10/11/books/review/rosemary-the-hidden-kennedy-daughter-by-kate-clifford-larson. Accessed on June 29, 2020

Grob, G.N. (1987). The Forging of Mental Health Policy in America: World War II to New Frontier. Journal of the History of Medicine and Allied Sciences, vol. 42, no. 4, pp. 410–446.

Grob, G. (1995). The Paradox of Deinstitutionalization. Society, vol. 32, no. 5, pp. 51-59

Grob, G. (2016). Community Mental Health Policy in America: Lessons Learned, Isr J Psychiatry Relat Sci -vol. 53 -no. 5

Guerra, E. (2017, February 8). Ronald Reagan and the Federal Deinstitutionalization of Mentally Ill Patients. Retrieved from https://sites.psu.edu/psy533wheeler/2017/02/08/u01-ronald-reagan-and-the-federal-deinstitutionalization-of-mentally-ill-patients/comment-page-1/#comments. Accessed June 30, 2020

Harwood, J.M., Azocar, F., Thalmayer, A., Xu, H., Ong, M.K., Tseng, C., Wells, K.B., Friedman, S., & Ettner, S.L. (2017). The Mental Health Parity and Addiction Equity Act Evaluation Study: Impact on Specialty Behavioral Health Care Utilization and Spending Among Carve-In Enrollees. *Medical Care*, vol. 55, no. 2, pp. 164–172.

Hice, J. (2020, February 6). Mental Illness Cases Up in California Jails. Retrieved from https://capitolweekly.net/mental-illness-cases-up-in-california-jails. Accessed July 9, 2020

Lake, J. & Turner, M.S. (2017). Urgent Need for Improved Mental Health Care and a More Collaborative Model of Care. The Permanente Journal, vol. 21, pp. 17-024

Legislative Analyst's Office (2000). Major Milestones: 43 Years of Care and Treatment of Mentally Ill. Retrieved from https://lao.ca.gov/2000/030200_mental _illness/030200_mental_illness

Legislative Analyst's Office (2017, January 17). Understanding the Veterans Services Landscape in California. Retrieved from https://lao.ca.gov/Publications/Report/3525. Accessed on July 7, 2020.

Lenz, L. (2017, March 31). The Secret Lobotomy of Rosemary Kennedy. Retrieved from https://marieclaire.com/celebrity/a26261/secret-lobotomy-rosemary-kennedy. Accessed June 29, 2020

Levin, M. & Botts, J. (2019, December 31). California's Homelessness Crisis - And Possible Solutions - Explained. Retrieved from https://calmatters.org/explainers/californias-homelessness-crisis-explained. Accessed July 7, 2020

Lilienstein, D. (2011, June). California's Mental Health Parity Act: An Under-Discovered Piece of Legislation to Ensure Mental Health Treatment And Coverage. Retrieved from https://www.dllawgroup.com/Articles/Californias-Mental-Health-Parity-Act. Accessed on June 13, 2020

Martin, E.J. (2015). Affordable Housing, Homelessness, and Mental Health: What Health Care Policy Needs To Address. Journal of Health and Human Services Administration, vol. 38, no. 1, pp. 67-89

Mattina, C. (2017, April 6). Low-Income Communities Lacking in Specialty Mental Health Treatment Options. Retrieved from https://www.ajmc.com/newsroom/low-income-communities-lacking-in-specialty-mental-health-treatment-options. Accessed June 15, 2020

Maxwell, J., Bourgoin, A., Lindenfeld, Z. (2020, February 10). Battling The Mental Health Crisis Among The Underserved Through State Medicaid Reforms. Retrieved from https://www/healthaffairs.org/do/10.1377/hblog20200205.346125/full. Accessed June 15, 2020

Mechanic, D. (2007). Mental Health Services Then and Now. *Health Affairs, 26*(6), 1548-50. doi:http://dx.doi.org.libproxy.csun.edu/10.1377/hlthaff.26.6.1548

Mental Health California, (2020). California Mental Health Services Act (MHSA). Retrieved from https://www.mentalhealthca.org/faq-1. Accessed June 13, 2020

Mental Health Services Oversight and Accountability Commission (2020). The Act. Retrieved from http://mhsoac.ca.gov/about-us/prop63mhsa/act. Accessed June 15, 2020

Mental Illness Policy (2019). Homeless Mentally Ill Facts and Figures. Retrieved from https://mentalillnesspolicy.org/consequences/homelessness-mentally-ill. Access June 15, 2020

Moore, Sarah (2018, April 17). A Brief History of Mental Health Care in California. Retrieved from https://www/abc10.com/amp/article/news/local/california/a-brief-history-of-mental-health-care-in-california/103-537434252. Accessed June 15, 2020

Murphy, J.W., & Rigg, K. K. (2014) Clarifying The Philosophy Behind The Community Mental Health Act And Community-Based Interventions. *Journal of* Community Psychology, vol. 42, no. 3, pp. 285–298.

National Alliance on Mental Illness (2019, September). Mental Health By the Numbers. Retrieved from https//www.nami.org/mhstats. Accessed on July 10, 2020

National Alliance on Mental Illness, Los Angeles (2020). Guide To LPS Conservatorship. Retrieved from https://namila.org/resources/guide-to-lps-conservatorship. Accessed July 10, 2020

National Council for Behavioral Health (n.d.) Parity. Retrieved from https://www.the nationalcouncil.org/topics/parity. Accessed June 25, 2020

National Institute of Mental Health (2017, February 17). Important Events in NIMH History. Retrieved from https://www.nih.gov/about-nih/what-we-do/nih-almanac/national-institute-mental-health-nimh. Accessed June 11, 2020.

Noonan, S.J. (2017, May 18). Mental Illness Splits Families. Retrieved from https://www.psychologytoday.com/us/blog/view-the-mist/201705/mental-illness-splits-families. Accessed July 1, 2020

Ollove, M. (2015, May 7). Despite Laws, Mental Health Still Getting Short Shrift. *TCA Regional News*. Retrieved from http://libproxy.csun.edu/login?url=https://search-proquest-com.libproxy.csun.edu/docview/1679189228?accountid=7285

Parry, M. S. (2006, April). Dorothea Dix (1802-1887). American Journal of Public Health, *96*(4), 624-5. Retrieved from http://libproxy.csun.edu/login?url= https://search-proquest-com.libproxy.csun.edu/docview/215086715?accountid= 7285

Rosenbach, M.L., Lake, T.K., Williams, S.R., & Buck, J.A. (2009, December). Implementation of Mental Health Parity: Lessons From California. Psychiatric Services, vol. 60, no. 12, pp. 1589–1594.

Rössler, W. (2016, September). The Stigma of Mental Disorders: A Millennia-Long History of Social Exclusion and Prejudices. *EMBO Reports*, vol. 17, no. 9, pp. 1250–1253.

Schwartz, L. (2014, December 17). 8 Horrific "Cures" For Mental Illness Through The Ages. Retrieved from https://www.salon.com/2014/12/17/8_horrific_cures_for_ mental_illness_through_the_ages_partner. Accessed July 1, 2020

Shellenberger, M. (2019, September 12). Why California Keeps Making Homelessness Worse. Retrieved from https:www.forbes.com/sites/michaelshellenberger/2019/09/12/why-california-keeps-making-homelessness-worse. Accessed on July 6, 2020

Smith, D., & Oreskes, B. (2019, October 7). Are Many Homeless People in L.A. Mentally Ill? New Findings Back The Public's Perception. Retrieved from https://www.latimes.com/california/story/2019-10-07/homeless-population-mental-illness-disability?_amp=true. Accessed July 1, 2020

Steinberg, D., & Wiener, S. (2018, August 5). Sacramento Bee: California Has Mental Health Billions. It's Time To Improve How They're Spent. Retrieved from https://sd11.senate.ca.gov/news/ 20180805-sacramento-bee-california-has-mental-health-billions-it's-time-improve-how-they're. Accessed June 15, 2020

Sturm, R., & Pacula, R. L. (1999). State Mental Health Parity Laws: Cause or Consequence of Differences in Use? Health Affairs*, 18*(5), 182-192. Retrieved from http://libproxy.csun.edu/login?url=https://search-proquest-com.libproxy.csun.edu/docview/2075694935?accountid=7285

Substance Abuse and Mental Health Services Administration (2019, July 31). California Study Reveals Mental Health Disparities Among African Americans. Retrieved from https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/study-reveals-mental-health-disparities. Accessed July 10, 2020

Teich, J. (2016). Better Data for Better Mental Health Service: Evidence Based Policies for Improving Care and Treatment of Those with Serious Mental Illness Are Urgently Needed--But Good Evidence is Hard to Find. Issues in Science and Technology, vol. 32, no. 2, pp. 61-67

Torrey, E.F. (2013, February 5). Fifty Years of Failing America's Mentally Ill. *Wall Street Journal* Retrieved from http://libproxy.csun.edu/login?url=https://search-proquest-com.libproxy.csun.edu/docview/1283977637?accountid=7285

Tran, L.D., Grant, D., & Aydin, M. (2016, April). The Mental Health Status of California Veterans. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6913533. Accessed July 7, 2020.

Treatment Advocacy Center (2016a). Stigma and Serious Mental Illness. Retrieved from https://www.treatmentadvocacycenter.org/evidence-and-research/learn-more-about/3631?gclid=EAlalQobChMly5-lrl2t6gIVED2tBh3P3QDjEAAYAiAAEgJ8APD_BwE. Accessed July 1, 2020

Treatment Advocacy Center (2016b, September). Serious Mental Illness Prevalence in Jails and Prisons. Retrieved from https://www.treatment advocacy center.org/evidence-and-research/learn-more-about/3695. Accessed July 7, 2020

Treatment Advocacy Center (2018, July 10). Homelessness Among Veterans With Serious Mental Illness. Retrieved from https://www.treatmentadvocacycenter.org/fixing-the-

system/features-and-news/4018-research-weekly-homelessness-among-veterans-with-serious-mental-illness. Accessed July 7, 2020

United States Interagency Council on Homelessness (2018, June). Homelessness in America: Focused on Veterans. Retrieved from https://www.usich.gov/resources/uploads/asset_library/Homelessness_in_America._Focus_on_Veterans. Accessed July 7, 2020

Whiteman, H. (2017, May 5). Redefining Mental Illness, Medical News Today. Retrieved from https://www.medicalnewstoday.com/articles/amp/317321. Accessed June 15, 2020

Whitney, D.G. & Peterson, M.D. (2019). US National and State-Level Prevalence of Mental Health Disorders and Disparities of Mental Health Care Use in Children. JAMA Pediatr. 2019;173(4):389–391. doi:10.1001/jamapediatrics.2018.5399

Wiener, J. (2018, August 29). Why is It So Hard to Get Mentally Ill Californians Into Treatment? Retrieved from https://calmatters.org/health/2018/08/california-homeless-mental-illness-conservatorship-law. Accessed July 6, 2020

Wiener, J. (2019a, February 4). All Too Often, California's Default Mental Institutions Are Now Jails and Prisons. Retrieved from https://calmatters-newspack-1.newspackstaging.com/projects/California-mental-health-treatment-in-prisons. Accessed July 7, 2020

Wiener, J. (2019b, April 30). Breakdown: California's Mental Health System, Explained. Retrieved from https://calmatters.org/explainers/breakdown-californias-mental-health-system-explained. Accessed July 4, 2020

Wiener, J. (2020, February 19). Inside The Governor's Bid To Fix Homelessness: Changing How California Deals With Mental Illness. Retrieved from https://calmatters.org/health/breakdown-mental-health/2020/02/mentally-ill-homeless-force-treatment-california-newsom-state-of state. Accessed July 7, 2020

Yohanna, D. (2013). Deinstitutionalization of People with Mental Illness: Causes and Consequences. The Virtual Mentor: VM, vol.15, no. 10, pp. 886-891