PERCEPTIONS AND IMPLICATIONS OF PROPOSITION 63

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Division of Criminal Justice
Abstract

PERCEPTIONS AND IMPLICATIONS OF PROPOSITION 63

by

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Introduction

The purpose of this study is to understand how advocates perceive their job in relation to meeting and fighting for the standards of the Mental Health Services Act that was enacted in 2004 with the passage of Proposition 63. The research questions for this study look at how people negotiate with both counties and legislators in the implementation of Proposition 63, how they negotiate with the State of California, and how they view their role in relation to the bigger issue of mental health.

Historical Context

This chapter gives in-depth background to the history of mental health in the United States, exploring both the history of legislation and advocacy movements that were imperative in future endeavors by mental health advocates. The chapter begins in the early 19th century and concludes to present day issues that relate to Proposition 63.

Analysis

The data were collected from two primary ways, interviews and observation at a six person lobbying firm. The qualitative data analysis was adopted from grounded theory.
In effect, the data showed that the staff views themselves as an informational organization which allows them to be a voice for others.

Discussion

This chapter covers discussion around current criminal justice and health care topics and concludes with what can be done in the future to support mental health. The main concerns for the future is that mental health needs to be equal to that of other health care conditions, and second that the federal government has to do its part in reducing stigma. These conversations are important to further the message for a stronger community driven, bottom up, mental health care system.

_______________________, Committee Chair
Dimitri Bogazianos, Ph.D.

_______________________
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Chapter 1

INTRODUCTION

Mental health in California has faced many challenges in the legislative process. Often on the low end of the totem pole, mental health services always seem to be on the funding chopping block over the last 20 years. It was not until 2001 when advocates sought out the initiative process to seek the funds they had been so desperately trying to get for years, in an attempt to fight the broken promise of the Reagan administration. As a progressive leader and innovator, California’s use of the initiative process has been controversial since its implementation in 1911 when it was added as an amendment to the State Constitution. Both progressive and controversial, California is a leader and innovator when it comes to the using initiative process. As Scheffler & Adams (2005) write in an article for Health Affairs, the initiative allows voters to bypass the legislative branch and place measures on the ballot themselves, so long as they have enough signature support.

Bambauer (2005) maintains that Proposition 63, also known as the Mental Health Services Act (MHSA), taxes one percent on those who make over one million dollars a year, of which, one percent goes directly to expanding services to adults and children who suffer from mental illness. This initiative, voted on by the people of California, was the mental health community’s dream come true. Their advocacy paid off as they finally saw people taking mental health seriously as a community issue.
Proposition 63 passed with an overwhelming majority, thanks to support from a variety of proponents such as the California Teachers Association, California Council of Community Mental Health Agencies, Service Employees International Union, and Morongo Band of Mission Indians, to name a few (Scheffler & Adams, 2005). What also aided in the victory was that, although Governor Arnold Schwarzenegger was against the initiative, he did not fund a media campaign against it. Rather, he spent his time fighting other initiatives. In 2004, the mental health community won their battle with 6,183,119 (53.8 percent) in favor to 5,330,052 (46.2 percent) opposed (Scheffler & Adams, 2005).

Since mental health became a social problem years ago, funding for communities to serve the mentally ill has been a roller coaster depending on the political movements of the time. Historically, mental health policy has progressed through many stages, one of which included the moral treatment model. In order to understand the changes, it is important to go back to the early stages of mental health advocacy. During the first stage, when the moral treatment model was used, communities did not see the mentally ill as a population who deserved human rights (McCarthy, 2009). Communities disregarded the mentally ill population without any care or concern. Here in America, we have see a long history of reform attempts and failures. As Morrissey & Goldman (1986) explain, the history of mental health initiatives, which started with the dim asylums of the early 1800s, can be viewed as having a pattern of being short lived, gaining strong momentum in the beginning and failing to withstand over the years.

Each reform introduced a different mission, from focusing on moral treatment, mental hygiene and the psychopathic hospital to the community mental health movement
(Morrissey & Goldman, 1986). The first major reform focused on improving the quality of life for the mentally ill, which revolved around the belief centered on the idea that human lives could be improved by manipulating their social and psychological environment (Morrissey & Goldman, 1986). This movement went away from a theological approach and adopted a medical and psychiatric approach. As Jones (1972) explains, defining mental illness proved difficult. There was no clear definition and there was no distinct form of treatment as there is today. The majority of those who were considered insane was treated as though they were fully responsible for their actions and had no protection from the law (Jones, 1972). A main component of theology in regards to mental illness was that many saw every possible difference between themselves and the lunatic (Jones, 1972). Moral condemnation of the mentally ill was a main attitude for both eighteenth century rationalist theology and the inarticulate beliefs of the laboring classes (Jones, 1972). Regardless if the insane person was rich or poor he or she was most certainly to be confined, neglected, and intimidated, if not treated with open cruelty (Jones, 1972).

The second cycle shifted towards the psychopathic hospital due to criticism that the asylums were deteriorating and the general stagnation of the profession (Morrissey & Goldman, 1986). This reform revived the notion that with proper treatment and early intervention, acute cases of mental illness could be handled (Morrissey & Goldman, 1986). However, this social reform movement also failed, as, once again, the chronic cases of mental illness were not addressed.
In an edition of the American Psychologist, Humphrey & Rappaport (1993) wrote that, in the 1960s, when the progressive force was strong, the community took a stance on mental health thanks to the liberal movement and political party that was in place. The last reform of the 1960s took a community health approach. Carrying on the idea that with early intervention and treatment, mental illness could be stabilized, this new approach took people out of far away hospitals and treated them with psychotropic medications and in aftercare clinics and acute psychiatric inpatient units (Morrissey & Goldman, 1986). This period saw both the additions of psychotropic medications, and federal reform. The National Mental Health Act was created in addition to the Joint Commission on Mental Illness and Health to analyze the needs and resources of the mentally ill in the United States (Morrissey & Goldman, 1986).

What all reforms had in common was a generic approach that only addressed acute or mild--not chronic-- forms of a mental disorder (Morrissey & Goldman, 1986). All had an environmental approach and attempted a new innovative way that had not been seen before (Morrissey & Goldman, 1986). Faced with a rapidly growing population, each reform movement failed in the face of unexpected obstacles that were not accounted for when the movement first attempted take off. Each time the public found it difficult to fund such a growing need and when expectations were not met, the reforms failed (Morrissey & Goldman, 1986). Each time a reform failed a new one would quickly follow. Unfortunately, the failures of the previous reform were not addressed and the cycle of failing mental health practices continued (Morrissey & Goldman, 1986).
In the decades that followed, continuous expansion of mental health services attempted to carry out the goals of the 1960s. Enacted in 1980, The Mental Health Act was put into place after a long fight to increase and expand mental health services. However, this victory was short lived as conservative president Ronald Reagan, elected in 1980, quickly made his agenda known. His administration had a new agenda to put on the table, a new social problem that was going to be imbedded in the minds of the American public: substance abuse. Hence, the War on Drugs was born. Federal support for the mentally ill and programming died with the election of Ronald Regan, and we learned once again that depending on who is in office certain social issues will take a backseat to a new agenda on hand (Humphrey & Rappaport, 1993). Many in the mental health industry, including social workers, nurses, and educators felt betrayed by the actions of the Reagan administration.

Now with the passing of the Mental Health Services Act in 2004, California voters have proven that they had overcome the broken promise of the Reagan administration again showing that their progressive and controversial process will also influence the rest of the nation (Scheffler & Adams, 2005). Although there is victory, there are also unforeseen obstacles that nobody anticipated when writing the legislation for the Mental Health Services Act (MHSA). Cost cutting measures are becoming the norm especially in the area of public mental health care (Goodwin, 2005). With problems come quick attempts at solutions. People, specifically those in government, try to cut programs and funds where necessary in order to compensate for the large deficit which is now at a staggering $21.3 billion dollars (Mental Health Weekly, 2009). A poor
economic landscape, new underserved populations, and federal health care reform have all made those who advocate for MHSA and the counties’ job more complicated in trying to implement MHSA funds and give high quality services to underserved populations.

In effect, the need for Proposition 63 funding is at an all time high; and obstacles that put funds at risk are more complicated than ever. It is important to understand the groundwork of those who advocate for the counties and directors that implement MHSA. The primary goal of this study, therefore, is to understand how advocates perceive their job in relation to meeting and fighting for the standards that MHSA seeks to impose. In order to do that I have looked at one specific, smaller, more workable group, to see how their job is affected by this legislative initiative. Through this specific lens, the community outside of mental health can see what it takes to implement good public policy and how advocacy does pay off. This study, thus, seeks to answer a number of interrelated questions. First, given these complexities, how do the people who negotiate with both counties and legislators view their role in implementing Proposition 63? Second, how do they negotiate Proposition 63 with the State of California? Lastly, what is the specific role this group performs and how do they view this role in relation to the bigger issue of mental health? In order to answer these questions, I conducted six semi-structured interviews at a lobbying organization in northern California that works directly with mental health. In short, these on-the-ground workers view their roles in the following ways. First, they see themselves as bettering communication between various state and local agencies. Second, they see themselves as bettering the livelihood of those affected by mental illness. Lastly, they view their work as crucial to changing attitudes
towards those affected my mental health. Together, these beliefs constitute one key notion: on-the-ground workers are an essential part of local change, their ability to work with both counties and larger agencies are what mental health services need in order to continue current legislation and to support future legislation. In the next chapter, I discuss the historical context of mental health legislation in more detail, which sets the stage for my analysis of these themes and my findings that follows in chapter three.
Chapter 2

HISTORICAL CONTEXT

In order to understand the current mental health situation in California, this chapter looks back at the history of legislation and advocacy movements in mental health. First, I look at the early mental health history from the early 19th century to the start of the 20th century. Second, I explore in depth the time period from the 1960s, explaining how the progressive movement affected the mental health community. Third, I look at the 1980s and how the Regan administration changed the mental health movement, which ultimately gave strength to the current community mental health movement that is taking place. Lastly, this chapter covers current mental health debates that advocates are fighting for and how those debates relate to Proposition 63.

Early 19th Century Mental Health Reforms and Treatment

The Moral Treatment Model coincided with the rise of the Asylums, and was a movement that was pushed into effect by the reformist zeal of the Evangelical Protestantism (Morrissey & Goldman, 1986). This type of moral treatment, which is similar to today’s Milieu Therapy, was championed by figures such as Horace Mann, Philippe Pinel and William Tuke. As authors Paul & Lentz (1997) explain, the Milieu approach stresses the importance of increased social interaction, group activities, expectancies, and group pressure, directed toward normal functioning, goal directed communication and treatment of patients as responsible people rather than as custodian cases. As Morrissey & Goldman (1986) argue, the idea was to segregate the population
in small pastoral asylums where they would receive care and instruction by staff that was headed by a resident superintendent. This warm atmosphere encompassed games, religious exercises, occupational therapy and medical treatment (Morrissey & Goldman, 1986).

The early eighteenth century was characterized by superstition, moral condemnation, ignorance, apathy and fear (Jones, 1972). With the decrease in judicial executions, the lower class hung on to the belief that harsh treatment would drive out the devil (Jones, 1972). The insane were confined in the following ways: by the Poor Laws; under the criminal laws; under the vagrancy laws and those that confined people to private madhouses; and in hospitals or “single lunatics,” which we call solitary confinement today (Jones, 1972). Public records were not kept during this time and much of the details of how these laws and institutions were operated were under secrecy (Jones, 1972).

Many hospitals were prevalent during the early nineteenth century such as Bethlem and St. Luke’s. However, due to overcrowding many acute cases turned incurable due to delay in admission (Jones, 1972). St. Luke’s claimed to have the first teaching hospital in the field of medicine and quickly rivaled Bethlem in many areas (Jones, 1972). As more hospitals emerged, mechanical restraint was also a part of protocol to keep the clients safe from themselves and others (Jones, 1972). Although seldom used, mechanical restraint is still practiced today and has been reformed many times to fit the needs of the client and staff (Jones, 1972).
Early Mental Health Reform and Legislation

The early 19th century saw the passage of the Wynn’s Act that detailed specifications for the construction and maintenance of county asylums (Jones, 1972). The act was significant in the conception of treatment of a non-deterrent type as a public responsibility, and in the attempt to deal with the root cause rather than the symptom of anti-social behavior (Jones, 1972).

The Act of 1828 increased the number of commissions who oversaw the madhouses and county asylums (Jones, 1972). The act allowed visits at night and during the day. The commissioners also met more frequently to grant licenses and were also given the power to recommend to the Secretary of State for the Home Department that certain licenses be refused or revoked (Jones, 1972).

The latter part of the 19th century saw an increased attention to detail and listening to the patients’ grievances, and investigating them when necessary (Jones, 1972). The transition from the asylum to the outside world was now a focus area. The Act of 1842 emphasized the importance of a national system of inspection and supervision. With each act during this time an increase in care and concern for the patients was added as well as increases in the number of commissioners who oversaw the asylums.

Advocates such as Dorothea Dix came out in support of this movement, becoming another main lobbyist for mental health. This time period placed an emphasis on the social view, which related to rehabilitation and after care, leaving legal views of the mental health in the past (Jones, 1972). However, despite her advocacy and the lobbying
of others, which lead to funding for an expansion of asylums in the United States, the movement for asylums was quickly fading during this time and would be the first of many failed attempts at mental health reform (Morrissey & Goldman, 1986). The standard of living rose and so did the expectations of patients’ families about what should be in place (Jones, 1972). At the same time, over-crowding was also a challenge that tended to depress standards (Jones, 1972). The following movement, called the Progressive Movement, proved slightly more successful, taking a more humane approach and getting people to understand that the mentally ill were not to be discarded but should have the opportunity to be helped and cared for.

1960s and the Progressive Movement

Attitudes regarding social problems change with the seasons, where the public fervor for or against a policy or issue seems to disappear and is quickly replaced by another more intriguing social issue. Mental health is no exception, having a roller coaster history going back decades. In the 1960s mental health hospitals were plentiful, and the public seemed to have a grasp on the issue, recognizing that this vulnerable population needed guidance. The community mental health movement brought about many changes during this period trying to reorganize and add to what the previous reform failed to achieve.

The strength of the community mental health movement in the 1960s was driven in part by the Progressive Era, which believed that government should act as a benevolent parent rather than a punitive one in addressing its social problem obligations (Humphreys & Rappaport, 1993). The progressives at the time also believed strongly in civil rights as
well as protecting the rights of the mentally ill and the homeless populations (Humphreys & Rappaport, 1993). Both President Kennedy and President Johnson lead the nation with their message for a better society, fusing their political ideology with the community mental health movement to reinvest time and energy in making mental health a forefront issue (Humphreys & Rappaport, 1993).

Senator Edward Kennedy also spoke candidly about the issues surrounding mental health throughout the 1970s, and continued to do so throughout his career in the Senate. In one paper he wrote, entitled “Community-Based Care for the Mentally Ill: Simple Justice,” Kennedy reminded the American people what the Progressive Movement did for mental health.

Beginning in the early 1950s, new developments such as psychotropic drugs, therapeutic treatment communities, and the observations that long term institutionalization creates behavioral problems, brought a widespread consensus that confinement of the mentally ill should be replaced by a system of community care (Kennedy, 1990).

The core idea was to move those who suffered from mental illness back into the community and to strengthen community resources for the prevention of a mental disorder (Smith & Hobbs, 1966). Advocates also supported the War on Poverty, headed by then President Johnson, which also included the social environmental and other social stressors as important components that paralleled mental illness (Humphreys & Rappaport, 1993). It was stressed that other social systems in which the person is involved, such as family, school, work, and friendship had failed to sustain the individual as an effective participant in the community (Smith & Hobbs, 1966). This viewpoint lead
to the idea that everyone is responsible for those in our community who suffer from mental illness and it is the main goal of the community mental health system to restore these social functions together as harmoniously and productively as possible in order to reunite the individual to the status quo of social functioning (Smith & Hobbs, 1966).

Still to this day, mental health is seen as an isolated problem, separate from the criminal justice system, health care, and any other social problem that citizens are faced with. The Progressive Movement sought to change this attitude blending mental health with other social issues so a variety of people and agencies would take part in the solution. Without including a variety of groups in the treatment of mental health, such as education, courts, welfare agencies, and recreational programs, the public deprives itself of gaining knowledge and opinions from other vantage points (Smith & Hobbs, 1966). This also leaves a gap in services and many populations underserved. Mental health, according to this model is so prevalent that it must be looked at as everyone’s business. No single profession can take on the daunting task of dealing with this issue alone (Smith & Hobbs, 1966).

This new philosophy took the responsibility away from the distant mental hospitals and placed it in the hands of the community in order to aid the citizen who is in trouble (Smith & Hobbs, 1966). In the early days of treating mentally ill, the philosophy was ‘out of sight out of mind.’ Nobody really thought normal social functioning could be restored to these individuals. Hence, the hospitals were a logical solution (Smith & Hobbs, 1966). The Progressive Movement sought to change this completely by focusing on a comprehensive approach to mental health in which group therapy; crisis counseling
and vocational training were key ideals of the community mental health system (Smith & Hobbs, 1966). This flexible array of services provided inpatient care, outpatient care, consultations, diagnostic service, rehabilitative service, training and research opportunities, which all tied into the community mental health movement that the Kennedy and Johnson administrations sought out (Smith & Hobbs, 1966). As the decades of the Progressive Movement ended, the “War on Drugs” quickly took over and mental health was left in the dust, starting in the 1980s with the Reagan Administration.

1980s and the Reagan Administration

Community mental health advocates and programs suffered a huge loss when Ronald Reagan was elected president. The Reagan Administration stressed that the primary role in domestic affairs belonged to the states. With this came an overhaul of programs that were once ran by the federal government (Rochefort, 1993). Reagan was not a supporter of the liberal policies like the community mental health movement, which preceded him. His administration set its sights on other social programs like the ‘War on Drugs’ (Humphreys & Rappaport, 1993). It seemed that overnight the community mental health movement was demolished and substance abuse programs dominated federal funding (Humphrey & Rappaport, 1993). A decrease in funding and advocacy did not diminish because of the demand or need was not present. It is currently estimated that between 50 to 75 percent of youth in juvenile detention and correction facilities have diagnosable mental disorders and this is only addressing youth (Cohen & Pfeifer, 2008).

The demise of the community mental health movement suffered due to it being a strongly liberal piece of politics in the midst of a conservative administration. Reagan and
his successor, both conservatives, were not going to put effort into this agenda (Humphreys & Rappaport, 1993). Reagan transformed some programs by changing how funds are allocated in addition to tightening the government’s grip on other programs, which, ultimately, affected the mentally ill population negatively.

The Reagan Administration’s Budget Reconciliation Act of 1981 scaled back community mental health centers dramatically and more than they anticipated at first (Humphreys & Rappaport, 1993). In addition to the budget, Reagan also pulled the plug on Carter’s Mental Health Systems Act, replacing it with smaller and less effective block grants (Humphreys & Rappaport, 1993). Block grants, which gave lump sums of funding to the states to reallocate, hurt mental health services in the end. The states attempted to make up for the shift to block grants; however, because of a weakening economy and high inflation, it only made matters worse. In addition, at times the state instead shifted money to other community providers that they felt would be better suited to serve the mentally ill population (Rochefort, 1993).

Other political moves by the Reagan Administration made that negatively affected the mentally ill included tax initiatives that strained the state’s financial caseload, leading to even more cut backs for mental health programs (Rochefort, 1993). Tightening of the Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) made qualifying for disability payments more difficult, which adversely affected the mentally ill community (Rochefort, 1993). The Reagan administration failed to factor in that cuts in these areas, even if they were not mental health specifically, ultimately hurt
the mentally ill population. In effect, the Reagan administration failed to realize that these social programs are necessary for social maintenance in the community.

Another obstacle that lead to the dissolution of the Community Mental Health Movement was the campaign for the “War on Drugs.” In reading about public policy, one can easily differentiate between the rhetoric of the Kennedy and Johnson administrations and that of the Reagan and Bush administrations. Imagery and rhetoric were key elements in Reagan’s offensive in the 1980s, a successful attempt showing the importance of the ‘War on Drugs.’ The Reagan administration used children and the idea of the ‘crack baby’ as important pieces in their fight for change (Humphreys & Rappaport, 1993.) They stressed repeatedly that the problem of drugs in the community was a moral issue that can be easily curtailed. As the Drug Abuse Policy Office (1982) explains, “Too often, ordinary citizens feel that they can do little to solve complex national problems. But drug abuse is different; here is a problem that can be solved through the efforts of individual Americans” (as cited in Humphreys & Rappaport, 1993.) The ‘Just Say No’ campaign proved to be the lightening rod that First Lady Nancy Reagan needed to push their campaign to the forefront of American politics, which essentially placed former First Lady Rosalynn Carter’s fight for community mental health programs out the door.

The Reagan administration shifted money to the social issue of drugs by creating the Office of Substance Abuse and Prevention in 1985, and passing the Anti-Drug Abuse Act of 1986 (Humphreys & Rappaport, 1993). Both the Kennedy and Reagan administrations used laws and rhetoric to push their agenda arguing that a particular issue
was of more importance than others (Humphreys & Rappaport, 1993). As the conservative administrations ended, those who still advocated for mental health legislation never forgot the broken promise of the 1980s. It was not until recent developments in both politics and legislation that mental health was on the brink of making a comeback in public policy and advocacy.

Current Mental Health Debates and Proposition 63

The dance between public policy, criminal justice, and the interworking of government is a delicate movement that varies depending on the cultural times in which we are living. Mental health is one primary example; depending on what period you are speaking about, the funding for this area changes. In recent years, mental health legislation and advocacy have been on the rise. One example of this is Proposition 63, also known as the Mental Health Services Act (MHSA), which was passed in California in 2004. The status quo for the majority of states to pass laws and change public attitudes is through legislation, votes and media campaigns. Proposition 63, however, took a step away from legislation and was put on the ballot as an initiative. California relies on both legislation and the controversial initiative process (Scheffler & Adams, 2005).

Initiatives can be proposed by anyone in California, and they cover a number of issues, and by and large do not raise taxes. However, Proposition 63 is one of a few initiatives that passed with the stipulation that raising taxes would be part of the plan (Scheffler & Adams, 2005). Two other initiatives have passed that have also raised taxes include: Proposition 99 (1988) and Proposition 10 (1998). In some circles, Proposition 63 is known as the Millionaire Tax (Bambauer, 2005). The proposition passed, according
to some, because less than one percent of the 35 million who live in California would be subject to paying the health related initiative (Bambauer, 2005).

Proposition 63 focuses on recovery, prevention, and early intervention for children and adults. This new money, which, by most estimates, guarantees $750 million per year, will go to expanding programs and would not be used to supplant existing spending (Hart, 2007). The approach is not to implement a one solution fits all drape for everyone, but to put an emphasis on programs that are already working and proving to be effective (Mental Health Weekly, 2005). Once supporters knew they would be receiving the money, the biggest overhaul was in the area of adult care where people want to see adults getting whatever they need when they need it, placing an emphasis on individualized treatment and outreach (Mental Health Weekly, 2005).

The idea is to move into a more proactive approach about mental health. In the past, we were accustomed to a ‘fail first’ mentality, which lead to homelessness, incarceration, and criminal sanctions (Mental Health Weekly, 2005). The initiative sets aside 55 percent of the funding directly to adults and children who suffer from untreated mental illness in the first three years (Mental Health Weekly, 2005). In the following year, that percentage jumps to 75 percent and goes towards support and treatment (Mental Health Weekly, 2005).

Proposition 63 is unique for many reasons: it was passed through the initiative process, and it raises taxes where very few initiatives are successful with this stipulation. This has changed the way in which people view mental health and regained momentum in advocacy for mental health. Those who funded Proposition 63 were prominent
citizens in the community, working as teachers, nurses, police and other groups of people. As with any political initiative, not all were on board and many attempted to bring down Proposition 63. Opponents feared that passing the MHSA would drive wealthy Californians out of the state in order to avoid paying the 1 percent tax on their income (Bambauer, 2005).

The Mental Health Services Oversight and Accountability Commission, which reviews the money spent and reviews the effectiveness of the program, also makes the county health departments responsible for allocating money and implementing the programs. Proposition 63 was to set aside funding for each county and must have a three year plan for how counties will make use of the funds and expand their services. By distributing annual reports to the board each year, the counties are accounted for (Scheffler & Adams, 2005). Other rules are in place, such as a check and balance system so that everything runs smoothly. For example, Scheffler & Adams (2005) explain that an additional 5 percent is put toward county planning and unforeseen administrative costs. In addition, the state cannot redirect money to other programs nor can the state change programs to increase the costs by a county without compensating the county itself (Scheffler & Adams, 2005).

Proposition 63 was and still is seen as the comeback for the mental health movement. In the years where the conservative force was the mainstay for politics and policymaking, it seemed that the fight for mental health funding and programs was a lost cause. However, those who worked in healthcare, education, and criminal justice never forgot the broken promise of the 1980s. Quickly there was a surge in support of mental
health care, which supported the theme of ‘fixing the broken promise’ of the Reagan administration (Goodwin, 2005).

Before the supporters put this idea on the ballot, the campaign polled thousands of Californians to get a sense of where the public was on this issue (Goodwin, 2005). Since many people realize that homelessness is an issue in cities, the results reflected this by showing that there is also an awareness that many of the homeless suffer from mental illness (Goodwin, 2005). These two connections gave the campaign a sense of how much the community understood about the relationship between homelessness and mental health. The homeless are a well-known vulnerable population that suffers from mental illness and are housed in correctional facilities and addiction centers, which have evolved into new asylums (Mellow & Greifinger, 2008). In some circles, estimates of mental health in the general population are upwards of 15 to 20 percent due to transinstitutionalization-- the movement of the mentally ill from mental health hospitals to nursing homes and correctional institutions (National Academy of Public Administration, 2006).

Not only was Proposition 63 the fight to regain control of the ‘broken promise,’ there was also a growing belief that people with mental illness could be helped. This was an acknowledgement by the California citizens that effective treatment and social programs are the way to proceed in order to combat homelessness and mental illness in both adults and children (Goodwin, 2005). Pilot programs were also effective in educating the public that programs like the ones under a passing of Proposition 63 could and would work. Outreach, short and long term housing, medical care, vocational
training, self-help and social rehabilitation showed repeatedly that positive outcomes were possible (Goodwin, 2005). The pilot programs, for example, showed a 56 percent reduction in hospital stays, a 72 percent reduction in jail stays, and a 65 percent increase in people with full time jobs (Goodwin, 2005).

Some may say this is similar to the movement of the 1960s; however, we must take into account different obstacles that we face now which did not exist back then. Our economy as a nation has declined and public programs, education, and corrections are at the forefront of the chopping block to pay back, or save money that California is in desperate need of. In modern times the national economic collapse and the decline in state tax revenue are unprecedented (News Bank, 2009). Take, for instance, just one of many cuts that California’s Governor Arnold Schwarzenegger wants to propose: reducing California’s prison population by 27,300 inmates (Stanton, 2009). According to the governor, this would reduce correctional spending by $1.2 billion dollars a year (Stanton, 2009). However, this will heavily overburden counties in ways the state is not taking into account. Davis et al., (2009) released a study that looked at the complex physical health, mental health, and drug-alcohol treatment related needs that many prisoners have when they are released back into the community. In their summary they noted that,

Prisoners returning to California communities bring with them a number of unmet health needs. But the likelihood of these individuals receiving adequate health care once they are released from prison seems low, given the high rates of uninsured and other barriers to accessing care and obtaining health insurance or Medi-Cal. Care for communicable and chronic diseases effectively falls under county jurisdiction; therefore, much will depend on a given county’s ability to meet these needs. (p. 142)
In effect, not only are we releasing prisoners in hopes of reducing the state’s budget but we are also not looking at other factors that affect prisoners, which, in essence will overwhelm various types of county programs.

Other cuts in mental health are also fighting for survival. Whereas before we had the backing and funding, we now have the backing by Californians, but the money is nonexistent. The numbers of those affected by mental health are prominent in correctional facilities, and now these prisoners are up against an indebted state whose public assistance and programs are lacking. Last year, Proposition 1E sought to amend the Mental Health Services Act by reallocating funds from Proposition 63 to the general fund to help the state balance the budget (“Prop. 1E,” 2009). In addition, there would be $225 million used as flexible funding for mental health programs; however, there is no guarantee as to what programs will be funded. Inevitably, programs funded by Proposition 63, such as community mental health programs, will be cut. Many agencies are taking these decisions to the state court, looking at the legality of moving funds around to help aid the state’s financial crisis.

The success of the Proposition 63 campaign, which raised well over $4 million dollars, is due to support from respected assembly member, now senator, Darryl Steinberg (D- Sacramento) as well as various health and educational leaders. This won the attention and support of the voting public in California. It was a fight that also had its limitations. Many newspaper editorials all over California were opposed to Proposition 63 based on the opinion that voting by ballot is problematic (Goodwin, 2005). In general,
there is an objection to legislating by ballot because there is a perception that, once on the ballot, the program is difficult to alter, does not address multiple interests, and lacks context (Goodwin, 2005). Every rule has its exceptions, which is how those who supported Proposition 63 based their argument, and mental health was an area that desperately needed to get funding despite this method. Opponents such as those based in the more conservative Central Valley, as well as Scientologists, who set up an anti-63 website, did not voice their opposition strong enough and had no effect on the finality of this proposition.

The increase in mental health advocacy also made note that it was important to mold the system into becoming more culturally competent, and recovery and person/family centered (Goodwin, 2005). The treatment of youth from different cultural backgrounds has been noted in other studies as well. For example, Rawal et al. (2004) suggest that there are differences in Mental Health Placement depending on the race of the juvenile. All youth are underserved; however, in African American and Hispanic populations, the disparities in services are more rampant (Sullivan, Veysey, Hamilton, & Grillo, 2007). Thus, the goals of Proposition 63 are more than just funding; MHSA includes providing treatment for youth, adults, as well as those from a diversified background. The importance of meeting the needs of these populations and meeting the funding goals is attributed to the work that lobbyists and advocacy organizations have done and continue to do. The mobilizing work of these groups has been key to the passage of Proposition 63. Leech, Baumgartner, La Pira, & Semanko (2005) suggest, that Government provides incentives for new groups to mobilize around a particular
issue. These social movements are a driving force behind regulation and spending (Leech et al., 2005).

Lobbying, Advocacy and Mental Health

While advocacy and lobbying groups are not new to politics, their influence has grown through the initiative process. This played a large role in how Proposition 63 successfully passed. Given the economic obstacles that California is facing, it is of increasing importance to understand how those who work in lobbying firms and advocacy groups view their jobs and the environment around them. They are up against a strong hold of politicians, the citizens of California, and their agencies that they represent to keep the funding they so adamantly fight for. Lobbyists represent all of these groups and are supposed to ensure that initiatives like Proposition 63 are implemented in the most efficient way.

Lobbyists are paid to work with government officials to try to influence legislation, bills and regulations (“Secretary of the State,” 2009). There are hundreds of registered lobbyists and lobbying firms in California. While large sums of money and political legislation are at stake, the Secretary of the State website offers financial disclosure notices that are dispersed on a quarterly basis per legislative term (“Secretary of the State,” 2009).

Interest groups have expanded enormously over the years, especially since the Progressive Era, and where they have gained a reputation as a strong force in government regulation and spending (Leech, Baumgartner, La Pira & Semanko, 2005). Where one can find interests and groups growing in the area of public policy, one can also see
growth in the area of lobbying and advocacy groups. Some research suggests that the relationship between government and lobbying is mutually dependent-- as government expands so does lobbyist groups (Leech et al., 2005). This expansion as suggested by Leech et al., 2005, which speaks to the combining forces of collective action, social movement mobilization and population ecology.

This particular area of research further suggests that mobilization occurs when a need or opinion is in high demand for attention (Leech et al., 2005). Going back to the issue of initiatives and Proposition 63 specifically, the need was there and very strong. Through political woes of the past, the voice of the people and the need was dismissed but still present. Hence, since it fought to fix the ‘broken promise’ of the Reagan years, Proposition 63 took full advantage of the lobbying process to pass their piece of legislation through direct democracy.

Thousands of bills and initiatives are created each year in hopes that they will pass and change the way our state does business. Interest groups put forth a strong effort for Proposition 63. They gained insight, support, and most importantly, funding from many sources including but not limited to, California Council of Community Mental Health Services, the California Teachers Association Issues PAC and the Services Employees International Union Committee on Political Education (Scheffler & Adams, 2005). The number of groups that mobilized was large, diverse and all together unprecedented (Scheffler & Adams, 2005).

Not only are initiatives important in the state in which they are passed but they can also set a standard for further legislation in other states. California is often a model
and innovator in controversial pieces of legislation. What California does, many other states take note. Dr. Kara Z. Bambauer, for example, explores whether other states should follow California’s example in implementing mental health legislation to expand services. Although other states have the initiative process, our political dynamic is unique in comparison to others. Even proponents of Proposition 63, as noted by Bambauer (2005) are weary of what message taxing certain income groups sends to fund a cause of another interest group. Economists further suggest that, if people want money for an issue, it is of better use in a general fund rather than a specific cause (Bambauer, 2005). As mentioned before California is unique in not only its political process but also its income distributions. California has the greatest disparity between rich and poor (Bambauer, 2005). We may have many millionaires, but we also show that we have the highest rate of those who seek mental illness services, often times those being from a lower socio-economic status. This showing may not be the same for other states and thus this type of initiative would prove unsuccessful (Bambauer, 2005).

Lobbying is about checking what and where the demand lies in a particular state and gives new light to controversial topics that state legislatures tend to hide from. Lobbying is growing as many groups are sprouting up each legislative year (Leech et al., 2005). Everyone is vying for top resources to get their legislation passed. It is unclear, however, how those who lobby and advocate for issues such as mental health feel when it comes to their role in politics, public policy, or how they view their negotiating powers in their field. How do the people who negotiate with both counties and legislators view their role in implementing Proposition 63? In what ways do they negotiate Proposition
63 with the State of California? Lastly, what is the specific role this group performs, and how do they view this role in relation to the bigger issue of mental health?

This study, therefore, aims to fill that analytical gap by examining how on-the-ground workers view their jobs in relation to mental health, legislation, and serving counties’ needs. Through in-depth interviews with a lobbying-advocacy group and observations of staff meetings, I hope to present a detailed account of the various ways in which real advocates understand their crucial position within the ever-changing environment of mental health advocacy. In the next chapter, I discuss the most prominent themes that emerged from my research, after briefly outlining how the project first developed.
Chapter 3

ANALYSIS

The organization is a six person lobbying-advocacy firm that works with counties and legislators at the state level to improve mental health services. Currently their job focuses on the MHSA, its implementation, and defending its funding in a weak economy. In order to gain access to this group, I first contacted a family friend who is the Executive Director, and assured contact ensuring her that all information would be in accordance with the protection of human subjects procedures required by California State University, Sacramento, where I am finishing my masters degree in Criminal Justice. After receiving permission from Mental Health Alliance (MHA), to both interview and observe, and after having my human subjects’ application accepted, I began setting up times to interview staff and observe meetings over a month’s time. Data were collected through two primary processes: interviews and observations. Interviews were in a semi-structured format and tape recorded with consent forms signed prior to the interview process. Consent form and interview questions are located in Appendices A-D, along with permission letter, and script used with each participant.

The goal of these interviews was to gain basic ethnographic data to see what specific role the staff at MHA play in relation to the bigger issue of mental health. I looked at the organization and functions of their employment during the course of a typical day, and how they spend the majority of their time. Through the interview process I wanted to get a feel for how the staff members operate while on the job, what their daily routines are, and how that reflects back onto their own perceptions of the
community in which they advocate and implement policy changes. I asked questions such as, “how do you think your role in advocacy work affects the larger mental health community?”

Over the course of four months, I interviewed everyone employed by the firm, which included six staff members. I also attended and observed six bi-weekly staff meetings, and took notes on everything from agenda items to cross conversation between staff members. After transcribing all the interviews, I analyzed all the data according to a method of qualitative data analysis adopted from “grounded theory,” which uses a system of “line-by-line coding” to develop themes from the data. The themes that emerged fall into five primary categories: what is Proposition 63, the role of MHA staff, challenges of Proposition 63, the role of criminal justice, and, finally, the role of health care. In effect, through these themes, staff members see themselves as a part of an informational organization which allows them to be a voice for those who do not have the resources to speak for themselves. They are a vehicle for change between the counties and state legislators, and educators who work with both ends to advocate for more efficient mental health services.

What is Proposition 63?

According to most, Proposition 63 is much more than a funding source for Mental Health. As one staffer noted, The Mental Health Services Act (MHSA) is a new philosophy or “civil rights point of view if you will.” MHSA is a new way of getting things done and a complete transformation of the system. Where the mental health community felt they had been the low end of the totem pole for so long, they now feel
empowered and see opportunity even in the scarce economy. MHSA is a ground level, community-driven network that incorporates a service element in order to get things done and give people a voice in the counties that did not have that before. The core values of MHSA are as follows; recovery, cultural competency, consumer, family driven ideals, and integrated services. These ideals resonate far beyond the money even in times where the fight to keep MHSA dollars where they were originally intended to be spent seems like the only conversation taking place. In effect, despite budgetary challenges the core values of MHSA are still present in the everyday actions of those who give services in the community.

One staff member, for example, looks at MHSA as an ideal to which people can aspire. MHA is a strongly member driven organization that is a force to be reckoned with by agencies and the legislature on the outside. MHSA created revenue and opportunity and has engaged folks in decision making and planning in areas that were never seen before. Staff members note that since the passing of MHSA, mental health has really transformed into a unique community mental health perspective and as a local government issue that has broadened the group of people who are involved in mental health.

In the minds of the staff at MHA, MHSA is successful for many reasons. As the five year anniversary of its passing approaches, the staff at MHA has really looked at what has been done, what still can be done and the challenges that the counties have been facing. To the staff, success is defined in three key ways, bettering communication,
bettering the livelihood of those affected by mental health, and changing attitudes towards those affected by mental illness.

Bettering Communication

MHSA has been successful, according to the staff in the area of communication between agencies and about mental health in general. They all pointed out various areas where the Act has made an impact even in the five short years that it has been implemented. According to one staff member, for example, there is more dialogue about mental illness where years ago it was taboo to speak about. “I think it has engaged communities in the mental health dialogue; 10 years ago you couldn’t even talk about mental health, it’s no longer taboo, people talk about it openly.” In addition, there is more dialogue between agencies, which did not previously exist. For example, there are now conversations taking place between mental health, health care and those in the criminal justice system. According to one staff member, the Act “opened up a dialogue, us and stakeholders and communities which are changing, like we added a social justice committee. We need dialogue with others besides ourselves.” In summary, these dialogues are happening and producing results, especially increases in communication, collaboration and relationship building that were not present before.

Bettering the Livelihood of those Affected by Mental Illness

In addition, employees believe MHSA is unique because it can fund things such as healing centers that not only address the needs of different ethnic populations but normally would not be billable my medical. Thus, MHSA brings to the table new ways of meeting the needs of clients where other state or federal programs cannot. According
to one staff member, MHSA is nothing short of a revolution: “I don’t know if any of us really had any idea of how much it would really change everything from the time that it passed.” Staff members note that even in the short period of time that services are better, they are working with underserved populations that have never been reached before and increasing the number of youth served. In addition, the whole delivery system has changed: gone are the days when people would sit in a chair have a conversation with their psychologist type up notes and be home by 5:00pm. “That world of delivery is over, which is a good thing.” In effect, with MHSA funds, the counties are meeting their clients where they live, hearing their voices and changing the rules according to how they see fit, making a purely community driven, bottom up organization.

Changing Attitudes Towards those Affected by Mental Health

Staff members also noted in many of the interviews that with MHSA money there are campaigns to fight stigma, discrimination and suicide prevention at the local, regional, and state level. Stigma surrounding mental illness is a constant struggle; however, with the flexible funds that MHSA allows, public awareness, education, speaker series’ are all making an impact in changing the ways people view mental illness.

Training the workforce is another aspect of MHSA in which one particular staff member is involved. Although hiring is difficult in times like these, she notes how they are “growing their own,” getting folks who are going to stay in the community who are young, and will eventually be in the field. Workforce and training is where the change is going to happen; the MHSA is a whole new way of doing things and the workforce is the catalyst for all of this change, a new way of providing services”. These success stories
and various factors taken into account all produce the goals the MHSA was set out to complete.

*Role of Mental Health Alliance*

Another critical aspect of the MHSA involves those who do the work on the ground level. The staff members at MHA are the messengers between the legislature and those who work in the counties to serve communities. The staff at MHA sees themselves not as a lobbying organization but as an information organization. According to one staff member who works specifically with small counties,

> MHA is unique, it is not a traditional lobbying organization, we don’t use money we use information. Information has to be accurate and based on good public policy. We need to get the word out, and the kind of trust that is necessary to disseminate good information for our members. We need that to be broadly disseminated.

The information is the biggest piece and is seen in a number of areas. Aside from technical work, the MHA sees their role as a combination of information sharing and educating people on pressing mental health issues. For example, the staff member quoted above further explains his role as,

> Bringing information to others to show what mental health services look like what the people look like. People do recover. Some things the county is doing are holding speaker series so that people affected by mental health can talk about it, like recovery. They see the hospital side and the recovery side on the horizon.

The work that MHA does on a regular basis is technical, informational, and incorporates the values of the MHSA to ensure that people and agencies alter the way they think about mental health which in turn serves the communities better.
One staff member, who works in training and technical assistance, sees her role as more of a liaison and a facilitator, getting counties whatever they need. Her importance, in other words, lies in “being informed about the issue and conveying those facts, taking something that a county brings like an issue or challenge and bringing it to the decision makers. It means trying to solve the problem through who you represent.” In the area of workforce and training, she explains that “workforce is the catalyst for all of this change; a new way of providing services is going to happen.” In her mind, MHA wants to be seen as the forefront of change for county mental health departments, as providing leadership examples, and as a resource for counties. Working alongside other agencies the staff at MHA is constantly engaging others in productive conversation about MHSA and other issues surrounding mental health, like the issue of corrections and health care reform. In effect, these conversations are producing relationships and later down the road staff hopes it will produce positive change in addition to what is already happening.

The main role that resonated with all staff is constant discussion, especially around policy, challenges, and the needs of counties. Another key element is education, in the area of workforce specifically. As one staff member explained, “For my project its working with counties, if they are doing work with education it’s to make sure people who are educated can go to a different field. Making sure their education is portable when they do have a degree, training and education makes them marketable in other fields.” Training can also mean working alongside other agencies to help them understand the mental health field better. Examples may include education and public awareness on stigma and discrimination campaigns, or working with law enforcement on
how to deal with people who have a serious mental illness. The education and training means MHA is expanding the role of what they do and whom they work with, thus benefitting more people at the local level.

One staff member views her role at MHA as having more of a service element. Leaving the legislation and lobbying work to other co-workers, this particular staff member gets to the details of issues and knowing the information around it. Enjoying the service element that comes along with working with the counties and the staff, she wants to provide, “on the ground good service, and good treatment.” She realizes, however, that telling the “simple story of the impact you are making” is often behind layers upon layers of information. She explains how all fifty-eight counties, are knee deep in issues trying to figure out what the challenges are.

Is it an expertise problem, like staffing or resource where they can’t hire the staff or do they not spend money in that area? It is complicated but important, the things I like about my job is trying to figure out what we do in terms of rules that we have to abide by like outcomes. I am most closely linked to the training because I guess if it was like public policy, advocacy or training it all makes up the triad of what we all do.

Whether it is one of the aspects of the triad, of advocacy, public policy and training, she further explains the attitudes of those in advocacy work

I don’t think anyone goes into this field that does not have a passion for fixing a problem and representing a group that truly and honestly, because they have not had the ability to have a voice for themselves. It is about trying to be a tool for a community that does not have access to having their voice be heard. My background is social work, a part of that is learning that you always advocate for your clients, rather than imposing your views on what the clients need you are really just a vehicle for that client to have a voice.
Hence, the passion for the community is an underlying root that drives the staff at MHA in the work that they do every day.

That vehicle is seen everyday even when high expectations seem burdensome. According to one staff member, there is a spectrum with politics on one side, advocacy on the other and public policy in the middle of the two. She believes there is a high responsibility, and that others need to look at the big picture on a daily basis to determine how people are affected. “Working with MHSA, you have to look at the bigger picture before making a decision. Hopefully taking 1-2 steps forward but realizing you might also take a step back.” The MHSA in their eyes is a transformation of the system; it represents what the system should look like and provides a reason to continue in the field. Although at a time when it seems the budget is the main issue, being a voice for the community and fighting things like stigma, still prevail both at MHA and in the counties with which they work.

The staff has a responsibility to good public policy, which depends on them spending a lot of time researching problems and looking at the root of it. As one staff member explains,

Sometimes the solution would not be popular with our members, but it is still our responsibility to bring it to them and tell them that strategically, it is in the best interest of our clients and the people that we serve, and we may need to figure out a way to serve a particular population in a particular way. There are tough decisions that people have to make. It just shows that we are thoughtful about the problem and we are in it to have a good community mental health system not just a system that fits the needs of the directors and having power.
Defending MHSA against new legislation is another critical piece of the work they do. It is a complicated and tedious process and the results vary from year to year.

At some point legislation is created that I do not feel in my opinion, did the public policy piece, they did the political piece. So, we bring in the public policy piece and try and educate the person who wrote the legislation to show them other ways to solve the problem here is the ways we are already solving the problem and here is the larger context of the public policy piece.

In other words, education is essential in their relationship with legislators as to produce effective public policy.

The network of agencies and organizations that the MHA work with strive to make good public policy for the communities. One staff who works with lobbying identified the roles they take each year when working with legislation. They can propose new legislation, stop someone else’s bill, or support a bill that would benefit their members. The process also includes attending hearings at the state capitol and communicating on a regular basis with legislative staff. Each aspect deals with a number of committees, documentation, and research. It takes a lot of back and forth communication and education both to their members and the legislators who are doing the political piece. In these discussions and with all of the research, they are seeking to “maintain a safety net of services that people need in the community,” making them as “pure of an advocacy organization that you are going to get.”

The support from their members is essential to their success and apparent in the work that they do.

The staff does not make up positions on issues, they are fully committed by our membership and supported and we do not just go and do what they want us to do. Many times organizations will come and want MHA to support something or do
something; I always say it is not up to me it is up to our membership. We are very much a member driven organization. Therefore, if you want us to do something it is going to be fully debated by our membership.

One staff member primarily focuses her time on advocacy work. An average day for her consists of analyzing a problem and other issues for the purpose of the organization. She views her role as “standing up for people or a group of people that can’t always speak up for themselves. For me it’s about speaking up for people who do not have the resources to do that.” This employee and others in the office see their role as a liaison between government and the community. According to one employee, “a lot of it is keeping people informed about what is going on in politics and the legislature that could affect them for the better or for the worse. I think we’re definitely being successful and I am in keeping people apprised of things that they should know about and get involved in.”

Another staff member is involved in the everyday operations at the office, keeping up on the website, taking notes for meetings and filling in where necessary. Even though she does not work with public policy much, she still keeps herself educated on what is going on around her and sees the work her co-workers do on a daily basis and making a difference. For her, advocacy her means this: “educating and understanding issues and having a good staff that understands all of the implications. Without someone putting it in context, it is just numbers on a page. Without the stories, this is what we are working on, all the positive things that MHSA is doing.” This staff member sees the educational aspect and advocacy as well as being an important factor in what the agency does, in addition to the passion that goes along with it. “It’s good to know that the way
they act was written, it truly was to transform mental health through the use of the act. I think if all the bureaucracy gets out of the way and you can see that one of the neatest things is the hearts of the people who get into this, it is not a job for them. They really care about the people that they serve the heart is to really help people, there are things that can improve someone’s life.”

Challenges

Challenges come with any overhaul of a system, be it at an agency or a completely new act of legislation such as the MHSA. The staff at MHA saw challenges beyond what they ever expected in 2004 when the act passed. According to some staffers, these challenges can and have been an opportunity for more creative ways of doing things, such as how money is spent, being more innovative in the way they do business within their organization and at the local level. As one staff member explains,

> It can make it very difficult at times especially times like this with the economy. We know where we should be going but the impediments to getting there are official and sometimes unreal, but it is time to be smart and be doing efficient things when there are hard times. Getting folks to think what efficient things can mean and what they can be. It is more of an opportunity if you look at it that way.

However, unforeseen challenges remain, such as the state budget crisis, unexpected populations needing MHSA money, implementation obstacles, and stigma- which have always plagued the mental health community. These have placed added stressors on the agency and the counties at the local level.

The staff is confident that, despite the economic times they are doing their best at being a part of the solution. As one staff member notes, “the system is still running efficiently despite the state budget problems, although there is still a long way to go for
Californians to better services.” With the budget crisis, it is the worst people have ever seen, according to one staff member. However, the theme that came across was the importance of being creative with the money they do have. “Budget takes precedence over everything right now; it’s a priority locally and it is important that counties and people have to be strong in all different areas to maintain stakeholder involvement.” This is a one shot deal, after the money is used; it is up to the counties to use their service dollars for workforce but with the economy the way it is, thinking that far ahead right now is difficult, explains one staff member.

The misconception about MHSA money is another battle those at the county level and more specifically MHA are up against at the state level. One staff member explains the issue, “There is a misconception of the funding that is available and what it can be used for. Getting those dollars to reach 80 percent of California rural counties is another daunting task, as well adjusting to their needs, which are far different from the needs of the bigger cities.” The staff realizes these misconceptions and is ready to go on the defensive on a regular basis.

The budget has also decreased the amount of time that the staff gets the opportunity to travel to the counties to see and hear firsthand what their challenges are. Travel is seen as an important part of their job, and it reflects back to the importance of the client’s voice and working from the ground up.

MHSA really did sell a fantastic story, it expanded services and to serve people and serve them in the best way. It is just not possible to do it all, creating tension due to the high expectations from the counties. However, this does not mean these high expectations are out of the question, it is something the staff and those at the county level continue to strive for each day.
The budget has produced other smaller challenges that affect the tasks of the staff at MHA.

The staff explain how everyone wants a piece of MHSA dollars, not realizing that, although there are large reserves of money, that money is to be used for programs over the next few years, a misconception that the MHA is constantly trying to explain. The primary issue is this:

Protecting MHSA dollars ensuring that the state continues to provide funding to the programs that they are supposed to fund for us, there are a lot of legislators that do not understand Proposition 63 and thinks that counties have a lot of money. We often have to play defensive and keep people from interfering from the idea that Proposition 63 is a top down structure rather than a bottom up community driven organization.

The state continues to try to take money for MHSA fund to redirect it to the state general fund not realizing the money is already planned for programs down the line.

There are also huge administration costs that nobody foresaw, both for the counties who implement the program and for MHA, which are picking up additional costs that were planned for. As one staff member explains, “there was a study done by the State Office of Audits, which identified all the issues with how administration costs were wasteful and burdensome.” With the new administration, staff hopes that some of these will be streamlined a bit. All of this is a constant education process: “to keep them up to speed about what is happening in the community and that we are doing good things and why it is not a good idea to take money.” The main goal that all the staff expressed is protecting against reductions, and making sure that we do not lose any more groundwork.
Another unforeseen challenge that plagued the community is two new populations that seek MHSA money. These populations include the returning veterans from the war and parolees, who are being released at alarming rates.

I don’t know that we thought much about primary care or veterans, this was passed almost five and a half years ago and the Iraq-Afghan war didn’t really have the number of people coming back that we do now. So that has changed we also did not have the state budget that we do now where the state is looking to dump people on the counties so they do not have to pay for them. So we could not have predicted the influx of state prisoners into the community.

It is important as one staff member explained, to work with the legislature to let them know what our needs are what we can and cannot do with our current funding.

Also, working with the department of corrections and the local department in the community to try to absorb those people and protect public safety. Any time when you have insufficient resources to deal with people the people who are already there so it is prioritizing around that. These additional stressors add a burden to the other different ethnic and cultural communities that also need services, we want to do outreach for them, which is a goal of the Act, but we are doing it at a time when there are dwindling resources. It is difficult to serve people that are currently in the system and you have new people from different areas.

It was thought that these two populations would be served by other agencies. Unfortunately, the burden seems to be falling on mental health agencies to cover the costs of the services that they need. As one staff member explained,

It is not that we do not want those people because they do suffer from mental illness but we have never had the resources to serve them so that is a big public policy issue. Therefore, it is hard on us because if there is an expectation that we serve those people how do you serve them, training wise they are very different from what we are used to. It becomes a staffing issue, finding people to do wraparound services in tough neighborhoods, not that they do not deserve support but if they are going to be released early we need to find the right people who will work with them.
These prisoners are coming back into the community due to overcrowding, and they are overloading the mental health system with no additional funding to support them.

The returning vets are a particularly interesting group. They are often in a quandary, facing both stigma from the military and the challenges that are at times imposed on them by the federal government.

They may not realize or admit that they have mental health issues right away so they may not access through the VA what they need, they get sicker and sicker and they may not want to use government programs because they may feel there is a stigma attached to it. So sometimes, they seek out community programs instead because they feel they are anonymous. Another problem is that those who have PTSD or drug and alcohol issues are dishonorably discharged for one reason or another, then they are unable to access VA benefits so whether they wanted to or not they cannot get services that they need. So even though they have done all of this service for our country the federal government turns its back on them, this is affecting younger generations more and more.

Implementation has raised some issues for the counties that were not accounted for when the Act first passed in 2004. California’s view of Proposition 63 is that it is a grant program rather than a real opportunity for the counties to design their mental health programs. It seems the state wants to have control over what happens with MHSA dollars, rather than giving the voice and power to the communities, which is one of the main visions of Proposition 63. Once the obstacle of getting Proposition 63 passed was over, the next challenge involved making sure the people implementing it were following the law. “When it passed it created a lot of statutes that needed to be followed. We have to work with the legislators because they do not have a direct talk. When you take the legislator out, it can come back and bite you. It is important to keep them involved.”
Another issue with the implementation was that it stayed here in Sacramento. As one staff member explains.

There were lot of people involved that were not directly involved like those filling out the paperwork that designed the requirements and they were so out of touch with what was going on down on the ground. So they created a bunch of stuff that those folks, were not successful in responding to and there was a major disconnect rather than going into the communities and asking them how we should do this they designed it really without a lot of involvement from MHA.

Costs associated with implementation and the infrastructure was a burden that some had to undertake. The State of California gets 5 percent to pay for their administration costs of implementing it and MHA gets nothing. “So all of a sudden there is all this new work to be done and we don’t have the revenue source to pay for any of it so we ended up assessing the county for additional dues to pay for our end.”

Additionally, the Act, as written, was meant to expand services that were already known to work. These additional services included adding funding for early intervention, prevention, and to cater to underserved populations while building some infrastructure that did not have funding and support housing. As one staff explained, “It was not meant to keep parallel services going, keeping it separate from traditional mental health program, the State however saw things differently and then decided to cut programs that were originally intended to be expanded once the Act passed.”

Another relationship that at times is a source of tension is with the media. The media has a tendency to sell the dramatic because it sells stories often leaving success stories, like what MHSA is accomplishing in the dust.

The media is the average person’s education and information about all things mental health. On the public policy side of the media stuff, people write stories
because they want to get reactions about things, and sometimes I get frustrated because it is an expose article or sensational story. That is why we decided to have a relationship with a public relations firm to help us get out positive stories and no one really wants to read positive stories anyways I mean it is human nature. Therefore, it is frustrating but some people like human-interest stories.

It seems from the staff perspective that the media plays a large role in exacerbating into the stigma that surrounds mental health, putting agencies like MHA on the defensive where the staff find themselves working extra hard to educate others about mental illness and fight the discrimination and stigma that surrounds it.

Although attitudes around mental illness are improving, there are still a lot of myths to overcome. As one staff member adds, “nobody wants to be the champion for the crazy people, they are so stigmatized.” It is really about the language that is used when speaking to the community and strengthening those relationships with media outlets and the public that gives a new attitude about mental illness. Additionally, it is important to see news stories as opportunities rather than letting them put a damper on work that has previously been done, one staff member sums up.

Criminal Justice

The criminal justice system is another important component of mental health services, as many of those in the system face mental health challenges. Though dialogue between the CDCR and other public safety agencies has gotten better, growth in this relationship is still necessary.

All relationships can be strengthened. Most directors will tell you that they have tried, there are some good feelings on the ground level between law enforcement and communities, and frankly, they interact more with the populations we serve. However, there is a lot of relationship building that needs to happen between our
folks and the CDCR, I think ultimately it has always been seen as a criminalized population.

Another staff member notes that positive change from this dialogue has already happened and future successes will be seen: “it has definitely has been a positive change, I think once we see the outcomes, we will see dramatic reductions in jail utilization in full service partnerships.”

There is also a shift taking place. One staff member mentioned that the State is moving away from public safety business where the local communities are going to feel the burden. Unfortunately, they are already feeling the pressure of this burden without the resources to support this population. This quandary the staff and the counties have to figure out is whose responsibility it is to fund and support the parolees that are being released.

We know there are so many people that experience criminalization because mental illness is untreated. The advocate in me says it is sad because we know that upwards of 25 percent of the prison population has a severe mental illness. Therefore, that is a failure of many things including the public mental health system to help those people. I think that is sad. I think that if we had the resources we could get those people out of prison and in to the community being served.

It falls upon the counties now to figure out if MHSA money can be used for parolees that are being released. The MHSA language reads that funds cannot be used for parolees because that is the responsibility of the state. However, as one staff member explains, “On the other hand, the criminal justice system took away that status from them. Which is a cheap shot that means they took a population of people and took away their entitlements to services?” This all boils down to a public policy issue for mental
health directors in all the counties. On one hand, you do not want to dismiss a population that needs services. However, on the other hand, “in policy or politics we have the Native American groups saying, ‘hey you promised us to pay for our healing center, what are you doing serving ex parolees?’” As of now, the MHA has not taken a stance on the issue and has only discussed it internally; however, the pressure is being felt from all ends-- local police, board of directors and supervisors. A thoughtful process needs to take place and explaining it to people is another challenge because there are so many factors that are involved.

Since they advocate for those who are coming out of prison, staff reflect on how hard it is for parolees to get services.

Well it is an interesting thing in the United States, that the legislature feel they always have to be tough on crime and there are all these exclusions about people that have a criminal history that keep you from being able to be eligible for food stamps, welfare, and mental health funding. Because a lot of times to make it sellable to the public you have to limit it to people who deserve it opposed to the criminals who don’t deserve our help, in the eyes of the public. I see that in a lot of different programs, where criminal history bars you from getting employment and other services.

There is a general attitude from other communities that “we deserve our services more than them.” This is where education and collaboration is essential in the eyes of the MHA. Staff mentioned that the days where the state just looked for people with problems and moved them into jail, simply could not happen anymore. “Instead we shifted with CDCR which has had a tremendous impact, we do not always agree but at least we are talking. We have significant leadership coming to meetings and the open dialogue has been great.”
Rather than dumping the prisoners at county hospitals in the middle of the night, as one staff explained, “We have been working with the State department and corrections for the past couple of years to try and figure out a way to most effectively deal with them. What their background is what their medical needs are and not just drop them off and expecting us to know what services they need.” A tension still exists between the two groups but things are getting better. Like other groups, though, public safety organizations are also vying for MHSA funds. However, “We were pretty successful at keeping money out of their systems and instead promoting working with them and training them like law enforcement, on how to deal with people who have serious mental illness. How to support people in the community that would have been in jail or prison and keep them out. It has allowed us to forge better partnerships with law enforcement at the local level.”

Health Care

Another main issue that surrounds mental health is its relation to health care at both at the federal level and at state levels. “It is very complicated, the public doesn’t understand it. I think it gets back to serving those cultural groups, as specialty service for life in the community. There is a growing recognition that we need to stop keeping it separated from your overall wellness.” Many of the staff agree that mental health needs to be thought of in terms of other health conditions, “Like if someone had heart disease and they didn’t have a home or a job they would not be in a good place either but the difference is that they have more resources, maybe to help that person with their heart.”
With health care reform being a big issue with the new administration right now, staff fear what that might mean for mental health. “So I guess my biggest fear around health care reform is that we go back to mental health being just a medical condition where for many populations it is a social condition and so I think our people are passionate that it is a social condition so it is important to know what health care reform means for them.” Parity is an essential aspect of health care reform that will place those who seek out mental health services on the same playing field as other health conditions notes one staff member. It is often the case that when those who have mental health conditions go to emergency rooms, they are not seen as having a health care issue, but as a separate issue at hand, explains staff. There is a “not in my hospital” mentality that that staff at MHA and those at the county level seek to change. “We are always trying to roll a rock up hill, because in general folks don’t understand mental illness they don’t understand from a social or psychobiological perspective, if it was treated more like heart disease I think people would find more resources and more people getting treatment and access to treatment and fewer stigmas in the community.”

With all the obstacles, staff members are optimistic that conversation is taking place. Fortunately, as staff explained during interviews, the health care field is comprised of multiple agencies, including hospitals, private practice, institutions, physicians and insurance companies. This diverse dynamic will force people to come to the table, discuss the issues and make changes like parity that will benefit the mental health community. Thus, through MHSA, criminal justice and health care factors, workers at MHA see themselves as having a passion for the community, and for being a vehicle for
making a truly community driven bottom up organization, while not losing groundwork that has already been made. Given the complexities of these relationships between counties and state government, there are a few key areas in which we will see growth in the future. More specifically, the ways in which MHA uses other challenges that may arise and turn those into an opportunity for positive change as well as how the larger implications of mental health play out in the areas of criminal justice and health care will continue to define the relationship between county and state governments. In the last chapter, I discuss these key issues, and suggest how health care, different levels of government, and continued collaboration can carry on the values and missions of Proposition 63.
Chapter 4

DISCUSSION

In reviewing the interviews conducted, my research suggests a number of things about the role of the staff members at MHA and Proposition 63. First, the interviews significantly show how the staff members’ role at MHA influences Proposition 63. Second, the interviews give an in depth view of how the staff members’ jobs work with the State of California on business that is imperative to mental health treatment. Lastly, the interviews show how the staff sees their position in the larger context of mental health.

Influencing Proposition 63

The staff members at MHA, mainly view their role as a liaison between counties and government. They are working tirelessly on a daily basis to address questions about Proposition 63. In addition, their job entails hours of training both technical and informational to a variety of agencies in diverse counties all over California. They adapt to these diverse counties by making sure that cultural and other needs are met. Their work also stresses the importance of good service and good treatment, which can easily be seen in their passion for their job, which reflects back to the implementation of Proposition 63. In effect, their work brings the main values of the MHSA to fruition.

Working with the State

The State of California has posed many challenges to the area of mental health in the last few years as the economy took a downturn. The staff at MHA has taken this
challenge and turned much of it into an opportunity. Creativity in running programs, training counties, and altering the budget has allowed staff to think outside the box in dealing with the state and local agencies. Meetings with legislators and community stakeholders allow the staff to keep a balance between meeting the needs of the counties while understanding the obstacles in the state level. Education and research are also important; whether opposing, defending or supporting legislation staff members at MHA are meeting with others to educate others about issues facing mental health and the community.

Regardless of what legislation is out there, the staff at MHA views their role in working with mental health policy as an essential part of their job. Proposition 63 has allowed them to create programs in the areas of discrimination, developing an educational speaker series about stigma in the mental health community. Aside from being an advocacy-lobbying organization, they see themselves as an informational organization, which allows them to be a vehicle for the community. They have found innovative ways of working with other cultural groups whose needs have not been addressed elsewhere and have made strides in working with sensitive populations. In effect, their role with the State, in influencing specific legislation and in the area of mental health suggest that MHA is a role model for other organizations as the future of mental health unfolds in California.
Mental Health in Context

Additionally, themes in the interviews suggest other larger implications for mental health. Davis et al. (2009) addressed the following research questions regarding prisoner reentry in California:

(1) What are the health care needs of prisoners upon their release and return to the community? (2) What is the geographic distribution of state prisoners who return to local communities in California? And (3) what types of health care services are available in these communities, and what is their ability to meet the need of returning prisoners. (p. iii)

Their findings suggest implications that parallel issues which Proposition 63 addresses.

Davis et al. (2009) show in their findings that,

Our analysis of the distribution and concentration of parolees across California and within the four counties demonstrated that certain counties are disproportionately affected. And within counties, there are distinct clusters of parolees, which have implications in terms of targeting reentry resources to these areas. (p. xvi)

The work that MHA does with counties is essential in meeting the needs of the counties; their work allows them to address specific counties that are disproportionately affected by reentry as many of them suffer from mental illness.

Access to resources is another obstacle that the staff at MHA seeks to overcome. Davis et al. (2009) notes that,

Our geographic mapping and accessibility measures suggest that parolees’ access to health care resources varies by facility type, by geographic area (across counties and within the county), and by race/ethnicity. One issue that stands out is that, in all three of the large urban counties (Alameda, Los Angeles, and San Diego), the majority of parolees resided in areas with the lowest levels of accessibility to general acute care hospitals. (p. 20)
In effect, the work that MHA continues to do in the area of providing quality service and treatment addresses the findings by the RAND Corporation that currently affects the State of California.

Lastly, Davis et al. (2009) suggests that counties need to be served differently depending on population, which correlates with the work that MHA currently does.

The fact that parolees in more rural counties tend to be more dispersed suggests that a different strategy for providing health care services to these individuals is needed. In addition, Los Angeles County (the county with the largest proportion of parolees) is a combination of both urban and more sparsely populated areas. Los Angeles County had a large number of distinct clusters of parolees, with these clusters covering a broad geographic area. This suggests that strategies for providing services to the parolee population will need to be tailored by supervisory district and SPA. (p.144)

MHA tailors their work to specific counties, recognizing that rural and urban counties have different needs. Therefore, their work will positively affect parolees and other sensitive populations in addressing their mental health needs because they already recognize the diversity of California. Going forth in the future, MHA’s work will continue to stay on the fast track of providing quality services to local communities, whether it is through legislation, training, education, or groundwork with communities.

In conclusion, MHA’s work points to the continued importance of one key issue: de-stigmatizing mental health in order to help those in need. Thus, mental health advocacy should not be limited to people in one particular field; the more diverse network of workers involved will only improve and expand the quality of services that people who live with mental illness receive, turning challenges into opportunities.
To ensure quality expansion in services there are things that can take place in the community both locally and at the state level. First, health care needs to recognize that mental illness is equal to that of other health conditions. Second, the federal government needs to do its part in reducing stigma both in the community and with veterans, teaching others that it is okay to get help, and, hence, reducing stigma across the board. Conversations are already taking place in these areas and continued collaboration will only further the message that Proposition 63 originally set out to accomplish: paving the way for a stronger, community driven, bottom up mental health system.
APPENDIX A

Script for Consent Form

[Researcher]

Thank you for taking the time to participate in this study. Before we can start I am going to read aloud the consent form that I have just given to you. At the end I will give you time to read it over yourself and ask any questions you may have. After you have read and asked any questions I ask that you sign the bottom portion. I will leave you with a copy should you have any follow up questions or concerns after the interview is complete.
APPENDIX B

Consent Form

Sacramento State University
CONSENT TO ACT AS A HUMAN RESEARCH SUBJECT

Perceptions and Implications of Proposition 63

You are being asked to participate in a research study. Participation in this study is completely voluntary. Please read the information below and ask questions about anything that you do not understand before deciding if you want to participate. A researcher listed below will be available to answer your questions.

RESEARCH TEAM
Lead Researcher: Christina Oliver
Criminal Justice
650-302-0935

Faculty Sponsor: Dr. Dimitri Bogazianos
Professor
Criminal Justice

Study Location: California Mental Health Directors Association

PURPOSE OF STUDY
The purpose of this research study is to examine the interworking of a specific group that works in advocacy and public policy to analyze how the workers understand their role in Proposition 63. The goal of these interviews is to see what specific role they play in relation to the bigger issue of mental health.

SUBJECTS

Inclusion Requirements
You are eligible to participate in this study if you are a current employee of the California Mental Health Directors Association

Number of Participants and Time Commitment
This study will include approximately 6 subjects and will involve approximately one hour of your time.

PROCEDURES
The following procedures will occur: One tape recorded interview will take place that lasts approximately one hour, at a time of your choosing, the interview will take place at 2125 19th Street, 2nd Floor, Sacramento CA 95818. In addition the lead researcher, Christina Oliver will be observing various staff meetings. During these observations, the staff at the California Mental Health Directors Association are not required or expected to ask or answer any questions. It is simply a time for the investigator to take observational notes.

RISKS AND DISCOMFORTS
This study involves no risk. There are no known harms or discomforts associated with this study beyond those encountered in normal daily life. None of the questions ask will be related to sensitive information about your job. All questions are opinions only and will not adversely affect your job in any way.

BENEFITS
Subject Benefits
You will not directly benefit from participation in this study

ALTERNATIVES TO PARTICIPATION
The only alternative to participation in this study is not to participate.

COMPENSATION, COSTS AND REIMBURSEMENT
Compensation for Participation
You will not be paid for your participation in this research study.

WITHDRAWAL OR TERMINATION FROM THE STUDY AND CONSEQUENCES
You are free to withdraw from this study at any time. If you decide to withdraw from this study you should notify the researcher immediately. The research team may also end your participation in this study if you do not follow instructions, miss scheduled visits, or if your safety and welfare are at risk.
CONFIDENTIALITY

Subject Identifiable Data
- All identifiable information that will be collected about you will be removed and replaced with a alphabetical code. A list linking the code and your identifiable information will be kept separate from the research data in a locked filing cabinet for three years.

Data Storage
- The audio recordings and observational notes will be transcribed and stored in a secure location for three years; then erased.

Data Access
- The researcher and the Thesis committee members are the only ones that have access to your study. Any information derived from this research project that personally identifies you will not be voluntarily released or disclosed by these entities without your separate consent, except as specifically required by law. Publications and/or presentations that result from this study will not include identifiable information about you.

Data Retention

The researcher intend to keep the research data for approximately 3 years

NEW FINDINGS
If, during the course of this study, significant new information becomes available that may relate to your willingness to continue to participate, this information will be provided to you by the researcher team listed at the top of the form.

IF YOU HAVE QUESTIONS
If you have any comments, concerns, or questions regarding the conduct of this research please contact the research team listed at the top of this form.

If you are unable to reach a member of the research team listed at the top of the form and have general questions, or you have concerns or complaints about the research study, research teams, or questions about your rights as a research subject, please contact the Office of Research Administration, at, (916) 278-7381
VOLUNTARY PARTICIPATION STATEMENT
You should not sign this form unless you have read it and been given a copy of it to keep. Participation in this study is voluntary. You may refuse to answer any question or discontinue your involvement at any time without penalty or loss of benefits to which you might otherwise be entitled. Your decision will not affect your future relationship with Sacramento State University. Your signature below indicates that you have read the information in this consent form and have had a chance to ask any questions that you have about the study.

I agree to participate in the study.

___________________________________________________  __________________
Subject Signature       Date

___________________________________________________
Printed Name of Subject

___________________________________________________  __________________
Researcher Signature       Date

___________________________________________________
Printed Name of Researcher
APPENDIX C

Interview Questions

1. How long have you worked at this agency?

2. How did you originally get involved in this kind of work?

3. Do you find yourself devoting more time to public policy, or advocacy?

4. What does the term advocacy mean to you?

5. What does the term public policy mean to you?

6. At the recent governing board retreat, I learned that this agency is known more for advocacy work. Why do you think it’s so important to get the word out that this agency is geared toward public policy as well?

7. How do you think your role in advocacy work affects the larger mental health community?

8. How do others outside of advocacy or policy frame the issues that surround mental health?

9. How does your role affect policy?

10. How does policy alter what and how you do things?

11. In your opinion, what are the larger implications of the work that you do?

11.1 Do these implications go beyond mental health?

12. What do you think are the main issues surrounding mental health right now?

13. How do you think Proposition 63 changed or altered your job?

14. How do you think Proposition 63 has changed or altered the mental health community?
15. Is direct democracy a new trend for social services?

16. How do you think ballot initiatives have influenced the mental health community?

17. How do you think that new voting trends, like direct democracy that we saw in the passing of Proposition 63, affect your job?

17.1 How do you adjust to these changes?

18. In your opinion, what are some of the challenges that came along with Proposition 63?

19. In your opinion, are the guidelines and goals that were promised in Proposition 63 been met? If not, why is that so?

20. Since 2004, the economic landscape of the state has changed significantly. How does your job adjust to the changes that have taken place?

21. How do you see the relationship between Criminal Justice and Mental Health?

22. What do you think the future holds for corrections and mental health?

23. Is this relationship already happening?

23.1 If so, is it working or can it be strengthened?

24. How do news media and public opinion affect your job?

25. There is often stigma in the community regarding mental health. How do you confront any issues of stigma in the mental health community?

26. There is a lot of literature about stigma regarding mental health and misconceptions in the community. How does that play into public policy and advocacy work that you do?
27. How do you handle operational deficiencies, i.e. funding, breakdown of communication between agencies and lack of resources?

28. What other challenges does your agency face in advocating and creating public policy?
February 8, 2010

Division of Criminal Justice
California State University, Sacramento
c/o Christina Oliver
1049 Bell Street, #3
Sacramento, CA 95825

Attn: Human Subjects Committee

To Whom It May Concern:

As Executive Director of the California Mental Health Directors Association (CMHDA), I give permission for Christina Oliver to interview CMHDA policy staff and observe staff meetings for her Master’s Thesis as a California State University, Sacramento graduate student.

I understand all discussions will be kept confidential, and that the interviews will take place at CMHDA’s offices at 2125 19th Street.

I can be reached at 916-552-5677, ext. 108, or pryan@cmhda.org if you have any questions.

Sincerely,

Patricia Ryan
Executive Director

California Mental Health Directors Association
2125 19th Street, Sacramento, CA 95818
TEL 916-556-3477  FAX 916-446-4519  www.cmhda.org
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