

MANDATING TREATMENT FOR THE MENTALLY ILL: WHY SO
DIFFICULT?

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MANDATING TREATMENT FOR THE MENTALLY ILL: WHY SO
DIFFICULT?

A Thesis

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Abstract
of
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Mandating involuntary treatment for the severely mentally ill in California remains extremely controversial. Major tension arises from the polarizing debate between the advocates and decision makers who support the civil liberties of persons with mental illness and those who support greater efforts to treat patients involuntarily for their own protection and wellbeing. Although we have well documented psychiatric studies showing that some severely mentally ill lack insight into their mental condition, the forty year old law that ignores the problem remains in force.

Accordingly, we need to know more about factors that influence this quagmire. Drawing on the Kingdon “multiple streams” model, my thesis examined causal factors that might affect the reasons for the lack of action on involuntary laws. My research employed several methods, including reviewing existing documentation on the case studies such as reports, law reviews, and articles in psychiatric journals. I also conducted personal interviews with those knowledgeable about public policy related to mental health.

At first cut, my findings indicated that if the ideology of the interest groups coincide with the ideology of the decision maker, any attempt at reform is less likely to succeed, resulting in a continuation of the status quo. However, a more in depth analysis indicated that by being attentive to timing and successful organization, policy entrepreneurs can frame policy and involve diverse social partners to facilitate successful outcomes.

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Chapter 1

INTRODUCTION

Mandating involuntary treatment for the severely mentally ill in California remains extremely controversial. Major tension arises from the polarizing debate between the advocates and decision makers for civil liberties of persons with mental illness and those who support greater efforts to treat patients involuntarily for their own protection and wellbeing (Mechanic, 1994, p. 502). On the same subject, Geller (2006) believes that the advantages and disadvantages of involuntary commitment are obscured in the rhetoric of opposing positions (p. 235). An attempt to establish involuntary outpatient treatment resulted in Laura's Law, which unfortunately freezes the intolerable status quo (Herbert, Downs, & Young, 2003, p. 254).

According to well documented academic research, the limitations of California's Lanterman Petris Short Act (LPS, enacted in 1967) promote the "revolving door" syndrome for the mentally ill, resulting in homelessness and incarceration (Torrey et al., 1992; Durham 1989; Lamb et al., 1984; Teplin 1983, 1990, as cited in Wolff, 1998, p. 138; Herbert, Downs & Young, 2003). I have two chronically mentally ill brothers that lack insight into their disease. They both have suffered under LPS because of their right to refuse treatment. For thirty years, one has been in and out of the revolving door; the other, reclusive and not able to communicate with my family. They both lack awareness of their mental condition.

In the last forty years, well documented scientific knowledge recognizes mental illness as a physical disorder of the brain; new improved methods of

treatment allow mentally ill persons, with early and continual treatment, to lead productive lives (Jacobs, Galton & Howard, 1999, n.p.). In addition, research demonstrates that some mentally ill are not able to recognize their need for treatment (Amador et al., 1994; Fenton et al., 1997; Smith et al., 1999; Olfson et al., 2000 as cited in Smith, Hull, Huppert, Silverstein, Anthony, & McClough, 2004).

This thesis focuses on the developments that led to LPS and the events following that enactment. My aim was to determine how the processes in Kingdon's (2003) windows and streams model affect involuntary commitment reform. The purpose of my thesis is to identify factors in agenda setting that are significant to reform and to understand the agenda setting process for policymakers. By using the case studies cited, my hope is that a proposal to adequately treat the severely mentally ill might be enacted and implemented.

The organization of my thesis is as follows. In Chapter 2 I discuss the literature that was reviewed relating to the history surrounding mental health policy. In Chapter 3, I present the methodology for determining the factors that are significant to the passage of mental health legislation. My findings from Kingdon's window and stream model analysis are presented in Chapter 4. Finally, I discuss the model's results and present key factors that enable policymakers to move the policy formation process forward, making suggestions for further research in Chapter 5.

Chapter 2

LITERATURE REVIEW

Before scientific knowledge recognized mental illness as a physical disorder of the brain, Assemblyman Frank Lanterman, Senators Nicholas Petris, and Alan Short sponsored the law (LPS) that bears their names. Since then, improved methods of treatment offer better outcomes for the chronically mentally ill (Jacobs, Galton & Howard, 1999, n.p.). Despite much discussion in academic literature on the pitfalls of the law, the law still stands as written forty years ago.

This literature review will do a number of things. First, it will provide background about the LPS law itself, which is an important context for my thesis. Second, it will explore what is already known about the politics of changing the law. Third, it will review the academic literature on agenda setting which will provide the primary analytical tools I will use for further analysis of what factors may explain successful efforts to allow involuntary treatment of people suffering from mental illness.

Background

To provide the background which led up to LPS, Morrissey and Goldman (1986) trace the history of the major changes in public mental health care that preceded the enactment of LPS. They suggest that the cycles have come full circle and that involvement of the mentally ill in the criminal justice system is reminiscent of the pre-asylum conditions of the nineteenth century. The same authors describe

the three major cycles in the treatment of the mentally ill: the moral treatment and asylum of the early nineteenth century; the early twentieth century featuring the mental hygiene movement and the psychopathic hospital; and the mid-twentieth century featuring the community mental health center (p. 12).

The third cycle, community mental health centers, occurred as a result of World War II, when many young men were mentally unfit for military duty and veterans' war neurosis sparked interest in the prevention of mental illness. However, by the mid-1950s, new psychotropic medications led reformers to believe that chronic and long-term disability would render state mental hospitals obsolete. At the same time, the federal government created the National Mental Health Act to provide research and training. By 1961, a federal report, *Action for Mental Health*, promoted a new approach leading to the establishment of an elaborate system of Community Mental Health Centers (CMHCs) by President Kennedy in 1963.

Between 1955 and 1980, the population of mental hospitals declined by 75% (Morrissey & Goldman, 1986, p. 20). The passage of federal entitlements, contributed substantially to reducing state hospital population by encouraging construction of nursing home beds. Medicare and Medicaid provided a payment source for patients transferred from state hospitals (Grob, 2005, pp. 427-428). The influx of thousands of patients overwhelmed the local communities. Former patients found hostility and rejection by the public; community mental health and welfare agencies failed to assume responsibility for their care; former patients ended up in

various facilities and on the street (Morrissey & Goldman, 1986, p. 22). This provided the impetus for the enactment of the LPS Act (1967).

At the time, the state mental hospital system expenditures constituted the second largest expense behind the university system, and a report of the California Medical Association found state hospitals unable to provide state of the art treatment. The attention of the public and the legislature needed to focus on mental health reform. The need to use newly available federal funds to improve quality of care became apparent (Jacobs, Galton & Howard, 1999, n.p.).

According to Torrey (2008), the southern California conservative groups combined with northern liberal civil libertarians made the passage of LPS possible (p. 31). LPS served as a model for other states' civil commitment laws. At the time, the framers did not anticipate the new problems for the public and the mentally ill that the sweeping changes of the law caused (Mills, 1986, p. 31). Groups like the California Association of Mental Health, not wanting to criticize legislators, timidly endorsed the legislation (Torrey, 2008, p. 31).

Torrey (2008) goes on to say that LPS accelerated the discharge of mentally ill patients and made it almost impossible to get potentially dangerous psychiatric patients into hospitals (p. 43). For those involuntarily admitted, the average stay was just fifteen days, where previously it had been one-hundred and eighty days (Urmer as cited in Torrey, p. 43). According to the recommendations contained in the 1962 Long Range Plan for Mental Health Services in California by the Department of

Mental Hygiene, contained the limitation: a fourteen day holding of a gravely disabled or persons who exhibit destructive behavior (as cited in Subcommittee on Mental Health Services, 1966, p. 179). This restriction became Article IV, Section 5250 of LPS law. After enactment of LPS, judges were no longer able to order indefinite commitments to mental hospitals. The law mandated comprehensive evaluation and placed a fourteen-day limit on involuntary detention, ninety days for the potentially dangerous (Boyarsky, 2008, p. 161). The law led to an increasing number of homeless and incarcerated mentally ill (Torrey, 2008, p. 43).

Politics of Changes in Mental Health Policy

Prior to the enactment of LPS (1967), the Assembly Subcommittee on Mental Health contracted a private research firm, Social Psychiatry Research Association of San Francisco to publish a survey of the courts and to process and analyze the data. The leader of the research was a believer of Irving Goffman who denied that mental illness was anything more than a condition caused by institutionalization (Jacobs, Galton, & Howard, 1999, n.p.). The report, titled *The Dilemma of Mental Commitments in California* published in 1966, stated that “popular notions linking mental disorders and dangerous behaviors are unjustified” (Assembly Subcommittee on Mental Health Services, 1966, p. 177).

Frank Lanterman, one of the authors of LPS, for years represented Pasadena, “the heartland of the anti-mental health movement” (Torrey, 2008, p. 29). Senator Petris, an ultra liberal Democrat, believed in Thomas Szasz, author of the book, *The*

Myth of Mental Illness (p.30). During the negotiations for the LPS Act, the civil libertarian groups objected to the commitment process and the lack of due process for patients' rights. Opposing that view, the medical and treatment oriented group objected to the court process because it resulted in a serious obstacle to treatment (Bradley, 1976, p. 220). The compromise offered to civil libertarians an end to indefinite commitments and more attention to due process. The medical group gained the right to treat patients for seventeen days without court interference (p. 221). According to Mechanic (1994), the points of contention between the civil liberty advocates and supporters of involuntary hospitalization are unnecessarily polarizing. The advocacy group known as National Alliance for the Mentally Ill (NAMI) emerged during the 1980s and became a major participant in mental health policy encouraging treatment. At the same time, Substance Abuse and Mental Health Services Administration (SAMSHA) became the new mental health agency in the federal government (p. 510). In 1986, Congress created the national Protection and Advocacy for Individuals with Mental illness Program (PAIMI) to curb abuse and neglect of patients in institutions. SAMSHA funds the PAIMI program (\$34.8 million in 2008). Legislative efforts to facilitate mandated treatment for the mentally ill, following a series of violent crimes, led PAIMI advocates to blunt these efforts (Bernstein & Koppel, 2008, pp. 16-17). In fighting over priorities, all the mental health advocates ignore the potential advantages of proposals. To focus on achieving

the mental health agenda, Mechanic (1994) suggests that instead of emphasizing differences, advocacy groups focus on points of agreement (p. 503).

Lessard v. Schmidt, 349 F. Supp 1078 (1972)

In 1972, this watershed case, brought on by civil libertarian lawyers, declared Wisconsin's civil commitment statute unconstitutional. Nationwide, states followed the Lessard decision and commitment statutes changed so that commitment became more difficult, and tragedies involving individuals with severe psychiatric disorders increased significantly (Erickson, 2008, p. 106). According to Torrey (2008), the decision resulted from a strong influence by the theories of psychiatrist Thomas Szasz, just as the influence of Szasz on LPS, five years earlier (p. 78). After Wisconsin vacated the Lessard decision in 1996, involuntary civil commitment laws in most states changed toward adopting assisted outpatient treatment (AOT), although the "imminent danger" standard stays in the law in a few states (Pfeffer, 2008, p.290).

New York's Kendra Law

Among other tragic events, the death of Kendra Webdale, pushed to her death in front of an oncoming subway train by a diagnosed schizophrenic, Andrew Goldstein with a history of violence, became the focus for the proposed AOT legislation (Watnik, 2001, p. 1181). After the incident, media frenzy fueled public outrage (Cornwell & Deeney, 2003, p. 209). The law established an involuntary commitment program known as Kendra's Law. Critics point out that Goldstein had

repeatedly asked for treatment and support services and the state failed to respond to his requests (Flug, 2003, p. 105). “Under the New York law, ... assisted outpatient treatment is authorized for people who, because of failure to comply with treatment, have been in a mental hospital, prison, or jail within the last three years or have committed an act of violence in the last four years” (Harvard Health Letter, 2006, p. 4).

The New York Treatment Advocacy Coalition (NYTAC), formed to mobilize support to make AOT available statewide by renewing the New York’s Bellevue Pilot Program, an AOT program, set to expire June 30, 1999 (Torrey, 1999, p. 4). The newly elected Attorney General Elliot Spitzer sought a means of helping individuals with brain disorders and TAC helped Spitzer pursue passage. A New York Times article states that an unlikely coalition made up of psychiatrists who believe in beneficial effects of new medications and the “law and order” conservatives both wanted to get the mentally ill off the streets (1999, p. B.3). At this time, the public criticized Governor Pataki for proposing elimination of beds in psychiatric hospitals amid another violent event (Torrey, 1999, p. 4). After Pataki signed Kendra’s Law, he promised \$126 million dollars for state psychiatric centers, following a state investigation critical of New York’s mental healthcare system (Tully, 1999, p. 4).

The constitutionality of Kendra’s Law concerned legal writers. Gutterman (2000) wrote an article in Fordham Law Review claiming that the law “infringes on

the constitutional rights of the mentally ill and fails to address their mental health needs” (p. 2404). However, the Court of Appeals of New York State decided on February 17, 2004, “that Kendra’s Law did not violate due process or equal protection rights” (Geller, 2006, p. 242). In 2005, the New York State Office of Mental Health issued a final report on Kendra’s Law and described it as a success (Harvard Mental Health Letter, 2006, p. 4). Geller (2006), Professor of Psychiatry, University of Massachusetts Medical School, is hopeful that studies of OPC from North Carolina and New York can lead to “further refined studies” moving toward an “evidence based practice” (p. 243).

Events Leading up to and Following Laura’s Law

A combination of factors came together resulting in the legislation. A major shift occurred in 1991, authority for mental health and other health programs devolved from the state to the counties (California Legislative Analyst Office, 2000, pp. 1-2).

In 1995, the Los Angeles County Affiliates of NAMI and the Southern California Psychiatric Society put together a task force to explore the growing problem of the difficulty of obtaining treatment for the mentally ill who because of mental illness require *involuntary* treatment. The group became the LPS Reform Taskforce. On August 6, 1998, Los Angeles County Board of Supervisor Michael Antonovich and Assemblywoman Helen Thomson, co-sponsored a hearing entitled “*Mental Health Laws: Is Reform Overdue?*” attended by over four hundred family

members, professionals, and mental health consumers. The five hours of testimony, which pertained to the subject, resulted in a transcript of nearly 200 pages (Jacobs, Galton & Howard, 1999, n.p.). Testimony included that of Dr. Edward Titus, who stated that under present law unless acutely dangerous, immediately suicidal, or so mentally ill that they cannot eat out of garbage cans, mentally ill individuals cannot receive treatment. Even though excellent treatments are available, legal restraints make it impossible (Martin, 2000, p.1).

In 1998, Assemblywoman Thomson introduced the parity bill, AB1100 requiring health insurers to cover the same level of treatment for mental illness as they do for other ailments. Even though the bill passed both houses, Governor Pete Wilson vetoed it (Bee Capitol Bureau, 1998, p. A4). In February of 1999, after Governor Gray Davis assumed office, Assemblywoman Thomson and Senator Don Perata introduced Assembly Bill 1800 making it possible for families to commit loved ones who refuse their medication or who become dangerously deteriorating (Kowalczyk, 1999, p. A1). In addition to California Treatment Advocacy Coalition (CTAC), Assembly Bill 1800 supporters included: the Board of Supervisors for San Francisco City and County; San Francisco Mayor, Willie Brown; California Association of the Mentally Ill; American Association of Retired Persons; American Nurses Association, California; California Judges Association; California Medical Association; California Psychiatric Association; and California State Sheriff's Association. Most importantly, California leading newspapers, including the San

Francisco Chronicle and the Los Angeles Times ran editorials calling for Assembly Bill 1800's passage (California Treatment Advocacy Coalition, 2001, p. 1).

September 1999, the Little Hoover Commission, an independent state oversight agency whose function is to investigate state government operations through reports, make recommendations, and legislative proposals, initiated its work on mental health policy with a public hearing on the mental health system and the challenges the system faces in California. A year later the report issued in November 2000, stated that California has criminalized mental illness and "the jail has become the crisis center." Rather than spending for treatment, California spends billions dealing with the consequences of untreated mentally ill. The Commission recommended major systematic and fiscal reforms (Little Hoover Commission, 2000, n.p.).

Assembly Bill 1800, reforming the 1967 LPS Act, passed the Assembly. When the bill went to the Senate, President Pro Tem John Burton declared, "There would be no forced medicine in California." He held the bill in the Senate Rules Committee rather than moving it to a policy committee for a vote (Martin, 2000, p.1). The Rules Committee commissioned Rand to issue a report on involuntary treatment. The report concluded that there were no cost-effectiveness studies to determine the return on investment for developing an involuntary outpatient treatment system (Ridgely, Borum, & Petrilu, 2000, p. xx).

The case of Laura Wilcox also attracted an unusual amount of media attention. She was a nineteen-year-old Nevada County college student who was shot to death in early 2001 by Scott Thorpe, a delusional schizophrenic, refusing treatment, also attracted an unusual amount of media attention. Six days later, a paranoid schizophrenic, drove his truck into the California State Capitol, knocking down the wall of a senate hearing room, exploding and killing him instantly (Torrey, 2008, p. 65). Assemblymember Helen Thomson and Senator Perata introduced Assembly Bill 1421 on February 23, 2001, that became “Laura’s Law” in memory of the deceased young woman, and patterned after New York’s Kendra’s Law. At the same time, with the budget deficit (a shortfall of \$34.6 billion announced by the governor) funding became questionable, if not impossible (Broder, 2002, p. 24).

Herbert, Downs & Young (2003), analyzing Laura’s Law, equate the law to a demonstration project that expires on January 1, 2008. However, a subsequent bill extended the law’s expiration date. To win the support of those who sided with patient rights’ activists, the authors compromised. As a result, the law lacked enforceability and left up to cash strapped counties to fund AOT programs themselves, if they chose. The law cannot utilize voluntary mental health programs with its implementation, which means lawyers will quickly file suit (p. 253). In Los Angeles County, a pilot program of AOT was initiated. A California Network of Mental Health Clients, an advocacy group against involuntary treatment and Laura’s

Law sued the County Board of Supervisors and the County Department of Mental Health over inmates not offered services on a voluntary basis (Scherer, 2007, p. 381).

The difficulty of funding Laura's Law prompted Senator Leland Yee to introduce Senate Bill 1606 in 2008, transferring revenue from Proposition 63(MHSA), to be made available to implement assisted outpatient treatment (Laura's Law). However, the bill failed to pass. Darrell Steinberg took the policy proposal to the voters when proposals in the legislature passed unsatisfactory compromise legislation (Shrag, 2006, p. 147). The Proposition passed in 2004, provided funds to expand and develop programs and services for the mentally ill, by imposing a 1% tax on taxpayers on personal income above \$1 million. Some have begun to question whether this constitutes good social policy or relieves the "legislature of responsibility for establishing priorities in policy and spending?" (Shulz & Medlin, 2006, p. 2). Along with media support, the initiative received support from a very large and diverse group and with little visible opposition (Scheffler & Adams, 2005, p. 216).

Outpatient Commitment Alternative: Pro and Con

According to Geller (2006), outpatient commitment (OPC), also known as AOT, concentrates more on opinions than facts. Unfortunately, with the practice of involuntary outpatient commitment (IOC), the advantages and disadvantages are obscured in the rhetoric of opposing positions. Mental health professionals began to focus on the topic in the past twenty years. Along with psychiatrists, legal scholars

wrote some articles on balance and some polarized the issue. The twenty-first century brought “a veritable explosion in interest in OPC” (p. 235). One of the arguments about OPC is that coercion would not be necessary if the community mental health services budgeted more resources and facilitated better coordination of treatment.

Table 2.1 lists the organizations that strongly advocate positions for and against OPC, and the groups that are in the middle:

Table 2.1

List of Supporters and Positions

Supporters	Positions
Treatment Advocacy Center (TAC)	For
National Alliance for the Mentally Ill (NAMI)	For
California ACLU Members	For
California Medical Association	For
California Psychiatric Association	For
California Association of Marriage and Family Therapists	For
Numerous California Police Organizations	For
Mayor of San Francisco	For
Several California Church Organizations	For
State Department of Finance	Against
Bar Association of San Francisco	Against
California Judicial Council (the judges' lobby)	Against
California Association of Mental Health Patients' Rights Advocates	Against
California Chapter of the National Association of Social Workers	Against
California Psychological Association	Against

Table 2.1 continued

National Mental Health Association, the Bazelon Center	Against
Californian Network on Mental Health Clients	Against
National Association for Rights Protection and Advocacy	Against
National Council on Disability	Against
<i>Seeking more outcome data:</i>	
American Association of Community Psychiatrists	Middle
American Psychiatric Association	Middle
National Association of State Mental Health Program Directors	Middle

Geller, J.L. (2006, September). The Evolution of Outpatient Commitment in the USA: From Conundrum to Quagmire. *International Journal of Law and Psychiatry* 29, 234-248; Herbert, P.B., Downs, L.L., & Young, K.A. (2003). Assisted Outpatient Treatment Comes to California--- or Does It? *Journal of the Academy of Psychiatry and Law* 31(2), 249-254.

The pro argument states that most refusal of treatment is part of the mental illness and because the systems of mental illness prevent an individual's autonomy, some coercion actually increases freedom. Freedom to be underserved and psychotic often leads to existence behind a locked door, for example, a psychiatric hospital, jail or prison. OPC induces more participation that is active and enhances rehabilitation; OPC is cost effective because it reduces inpatient recidivism, decreases involvement in the criminal justice system and improves the quality of life.

The con argument calls OPC another social control mechanism; forced treatments of questionable value on troubled individuals. These groups claim that community treatments have not succeeded in the past. It is too expensive and too intrusive for monitoring treatment because the professional cannot predict the mental

capacity of the inpatient. OPC reduces the standard for involuntary treatment and a slippery slope from OPC for the need for a treatment standard. OPC does not improve the quality of life (p. 236). Geller (2006) noted in his paper that the opposing viewpoints consist of “individuals talking past one another rather than to each other” (p. 243).

Allen & Smith (2001) representing the Bazelon Center for Mental Health Law, cite the law that has “established a person’s right to make his or her own medical decisions... and should not be interfered with absent a compelling state interest” (p. 343). They maintain that evidence fails to prove the effectiveness of outpatient commitment, and conclude that outpatient commitment shows short sightedness and hinders efforts toward improvement of the public mental health system (pp. 342, 345).

Geller (2006) points out in his review of OPC research that there are three generations of studies. The case study analysis explains the first-generation research, the quasi-experiential and surveys represent the second-generation research, and recent third-generation studies involve control studies. Third generational research consists of controlled studies on OPC in North Carolina, New York and California. Geller (2006) suggests all three studies caused a great deal of political fallout because the studies presented shortcomings in their design (p. 237). Because of a lack of sufficient evidence on either side of the debate on OPC, the situation “has deteriorated from a conundrum to a quagmire.” Geller suggests a “moratorium” on

the debate and more research designed to determine the efficacy and effectiveness of OPC (p. 243).

Public Mood

According to Borinstein (1992), deinstitutionalization and the problems with the community-based mental healthcare became more visible to the public. In the 80s and 90s, the public began to resist the locating of housing for people with chronic mental illness in residential neighborhoods, the “Not In My Backyard” (NIMBY) attitude. However, the majority of Americans believed that the number of mentally ill has increased over the past twenty years and they recognized that it is a serious health problem (p. 187). Most Americans agree that a person with mental illness will get better and be able to return to a productive life with treatment. Most do not believe that the best way to handle the mentally ill is to keep them locked up. However, the public hesitates to have a variety of mental health facilities in their communities. The NIMBY factor maybe a real barrier to opportunities for the mentally ill. Unless these attitudes change, says Borinstein (1992), the hope of permitting the mentally ill to be an accepted part of a neighborhood or community remains questionable. Borinstein (1992) goes on to question the role that the news and entertainment media play in determining public attitudes and adding to the conception of persons with mental illness (p. 195).

Streams and Windows Model

In this thesis, developments that led up to the adoption of LPS, Kendra's Law, and Laura's Law are analyzed using the streams and windows model developed by John Kingdon. Using Kingdon's model, I will show that the policies overtime are an outcome of previous policy steps and significant influence of advocacy groups on policy outcomes.

In his 2003 book, *Agendas, Alternatives and Public Policies*, Kingdon suggests that the three processes make up agenda setting: problems, policies, and politics. These separate streams come together at certain times. Solutions solve problems when favorable political forces exist. Windows of opportunity open because of a compelling problem or focusing event. Agenda and policy change occurs when the joining of three streams open a window of opportunity (p. 20). Often it takes a skilled entrepreneur who knows more about the process than anyone else. They can frame issues to increase the possibility of successful outcomes or use symbols to mobilize support or opposition (Zahariadis, 2003, p. 166).

Zahariadis (2003) bases his model on Kingdon's work: problems, policies, and politics. The problem stream contains various conditions that policy makers and citizens want addressed. The means used to find out about these conditions includes indicators, focus events and feedback (p. 153). Birkland emphasizes that recurring focusing events draw attention to problematic conditions. Jones says that attention is fixed by the media or policy entrepreneurs (as cited in Zahariadis, 2003, p. 154).

Feedback from previous programs helps to show what works and what may not (Zahariadis, 2003, p. 154). The politics stream includes political parties or coalitions that compete to affect the policy process. They include the policy makers who will make the decision on whether to adopt a specific item. The policy stream includes the mixture of ideas that compete to gain acceptance in policy networks (p. 155).

Kingdon's (2003) model, by incorporating policy windows gives multiple streams a dynamic quality that makes it different from more determined policy styles or rational choice models. A combination of all three increases the likelihood that the desired outcome will succeed. Policies may change or be reversed resulting from different combinations of problems, solutions and politics (Zahariadas, 2003, p. 9).

Conclusion

The literature I have investigated has led me to believe that there is still no perfect solution to obtaining treatment for mentally ill patients who lack awareness of their need for treatment. However, when the processes for Kendra's Law in New York and Laura's Law in California are compared, it is apparent that a policy entrepreneur in an authoritative decision making position, with dedicated support from advocates and family members of mentally ill patients, plays a vital role in achieving success.

Chapter 3

METHODOLOGY

Why is it so difficult to mandate involuntary treatment for the severely mentally ill who are unable to seek treatment on their own? In this thesis, I am attempting to investigate that question using what social researchers often call case studies, focusing attention on more than one instance or phenomenon (Babbie, 2007, p. 298). I use the case study method because the design permits a deeper understanding of causal processes, especially for politics and political processes such as statutes and initiatives (Johnson & Reynolds, 2005, p. 88). The purpose of this analysis is to explore the windows of opportunity for placing on the agenda and enacting legislation reflecting advances in scientific knowledge that would be a radical departure from the status quo.

Research questions most applicable to case studies address the “how” and “why” questions that focuses on the process, have a causal “nexus between the independent variables and the phenomena to be explained” (Yin as cited in Kaarbo & Beasley). Focusing on the question can help in dealing with too many variables at once, a crucial first step that avoids the danger of losing the likelihood of discovering controlled relationships (Lijphart as cited in Kaarbo & Beasley, 1999, p. 378).

In the prior literature review, the independent variables or conditions found to explain the dependent variable specify which existing theory should be singled out. From this assessment, I focus on a set of independent variables to investigate: budget

constraints; strength of pressure groups; court decisions; focusing events; and public attitudes. Tracking the explanatory variables, a case study approach lends itself to discovery of other relationships that might be important later (King et al., as cited in Kaarbo & Beasley, 1999, p. 379).

In a case study approach, it is often not desirable to rely on a single case study (Benbasat et al., 1987; Lee 1989; and Yin 1994, as cited in Dube' and Pare', 2003, p. 609). Controlling for the relationship between two or more variables is necessary for minimizing the variability in other variables that may affect the relationship in question. "Control for the comparative case study method is achieved through case selection. Choosing cases comparable on similar dimensions distinguishes important factors and isolates the variable in question" (Kaarbo & Beasley, 1999, p. 379-380). Since different time periods and different political systems may affect the outcome due to the strength of pressure groups, the cases chosen need to be comparable on time periods and political systems to focus on the effect of these groups. Yin (2004) suggests that using multiple cases could help strengthen the findings of the study since multiple cases can be compared and contrasted (p. 6). Important aspects of New York and California's civil commitment laws indicate major differences that resulted in effective implementation in New York, which is lacking in California.

Data Collecting Procedures

My research employed several methods, including reviewing existing documentation on the case studies such as reports, law reviews, articles in psychiatric journals, and direct observation. Additionally, I interviewed people close to decision making in mental health policy. Interviewees included: a deputy county counsel; a prosecutor; a legislative consultant; and a former legislator.

Each interview consisted of nine major questions concerning political entrepreneurs, interest group pressures, political turnover, funding, and initiatives. Some of my questions attempted to discover why passage of legislation does not guarantee implementation, and if respondents knew the consequences of compromise. Among the pertinent questions were the following: “Do you foresee any reconciliation of the differences between the opposing views on involuntary commitment? Why? /Why not?” This could be a measure for how much closer the major stakeholders are to a practical solution, with both sides agreeing. (See Appendix for a complete list of questions). A few additional questions were asked, where probing or clarification was needed.

Each respondent was assured of confidentiality if desired. Respondents consisted of those individuals especially involved with the day to day operations of the laws that govern the mentally ill as well as staff involved in the legislative process. I chose the deputy county counsel, who is involved in supervising

conservatorships under LPS. The prosecutor, who deals with the accused mentally ill in court, presents another perspective. I chose to interview a legislative consultant, assistant to the sponsor of mental health legislation, who provided verification of researched documents. Lastly, the former legislator interviewed co-sponsored some of the mental health proposals that formed the basis of my case studies; she provided the details involved in the process.

The first three interviews took place in the interviewees' respective offices. To ensure accuracy I used a tape recorder and transcribed the information. Interviews usually lasted no less than half an hour, sometimes up to two hours. The other interviewee preferred to participate via e-mail. The interviews provided important perspectives on the technical details and important information on both sides of the policy discussion.

In addition to the interviews, I conducted an on-line search for answers to specific questions that relate to my overall theme:

- What led up to the introduction, text, and enactment of LPS?
- Since LPS is still the law today, do the interest groups have any influence on maintaining the status quo?
- What led states to broaden their civil commitment laws?
- What led up to the changes in the law besides caselaw?
- Were there any pilot projects or laws in the general area?
- How were California and New York different in regard to enacting laws?

- What did New York officials base their information on to implement Kendra's Law?
- What was the fate of AB 1800 in California that would allow a family to have a person committed?
- If the involuntary civil commitment laws are different in other states, how did they get that way?
- Would the budget act as a constraint, holding the bill up?
- Who were the important governmental actors and non-governmental actors?
- Did the balance of political forces change at this time and did it make a difference?
- Were there advocacy groups playing a different role in the enactment of the legislation?
- How successful was Kendra's Law? Was it adequately funded?
- Did it pass judicial scrutiny?
- How did the turnover in key personnel affect the legislation?
- Was there extensive media coverage about Laura Wilcox, the person whose name appears on the law?
- Was there a degree of interest group pressure unique to New York and California?

My descriptors included: Lanterman Petris Short Act, mentally ill, incarceration, involuntary civil commitment, civil libertarian advocates, advocacy, Kendra's Law, Laura's Law, and Proposition 63 (MHSA). Aware of the rates of incarceration of the mentally ill in jails and prisons, one of the reasons for writing

about this subject, I searched for statistics on incarceration rates in ProQuest, JSTOR, a report from the Bureau of Justice Statistics and PsycArticles (EBSCO).

Searches in JSTOR for academic articles and Lexis/Nexis for law review articles produced pertinent information. Lexis/Nexis Academic listed a reference which led to *The Dilemma of Mental Commitments in California*, done for the Assembly Subcommittee on Mental Health Services, a background document that led to the passage of LPS. The law was described as the “Magna Carta for the Mentally Ill” (Assembly Subcommittee on Mental Health Services, 1967, n.p.). This led to searching for the various advocacy groups who might influence any attempted reform. Searching on the advocacy websites, ProQuest newspapers, JSTOR, and Lexis/Nexis, produced information on the aims of each group. Involuntary civil commitment reforms broadened overtime in California and New York, starting in the 1990s. I searched California Legislative Information (leginfo), ProQuest newspapers, JSTOR, and PsycArticles (EBSCO).

I looked at caselaw in Lexis/Nexis and JSTOR. Caselaw then led me to look at California and New York involuntary commitment laws, researching New York Times Archives, Lexis/Nexis, and ProQuest newspapers. A search of ProQuest newspapers on California legislation led to information about the Rand Report, which was available at the California State Library. This report led me to look for newspaper articles on the process after the report came out.

Articles about Kendra's Law in the New York Times listed the press release by the Attorney General, who was the sponsor of the legislation. Several newspaper articles mentioned that the Attorney General had just been elected, a possible motive for his advocacy of the proposal. The Harvard Mental Health Letter in EBSCO HOST quoted the New York State Office of Mental Health Report that described the law as a success. I was skeptical and found scholarly work on the research on AOT laws through SCIENCEDIRECT (Elsevier). JSTOR and SCIENCEDIRECT (Elsevier) listed law reviews and journals on the subject. Because of the publicity surrounding Kendra Webdale, several articles in the New York Times Archives and Lexis/Nexis had information on the focus events.

After implementation of New York's Kendra's Law, California legislators introduced Laura's Law. I gathered information on these laws from ProQuest newspapers, Lexis/Nexis, and Los Angeles Times (ProQuest). Lexis/Nexis and ProQuest indexed many articles on the event, published in newspaper and journal articles. I discovered in ProQuest newspapers that the budget deficit climbed steeply. A check of the amendments of the bill indicated that the bill was stripped of funding. A search in SCIENCEDIRECT produced articles on the advocacy groups and by checking citations in the bibliography of one article, another article supplemented the list of pro and con groups. To maintain an objective attitude, searches on Lexis/Nexis and SCIENCEDIRECT produced articles on the pro and con arguments.

By tracking initiatives over four decades and by developing an understanding of the forces that determine policy formation, I attempted to determine why such a significant issue remains unresolved. By using the case study method including data collection and interviews I hoped to find answers to the descriptive and the explanatory questions, that is, what happened, and how or why did it happen (Yin, 2004, p. 2). I hope to get an in-depth understanding of the substantive policy issues and their value acceptability and technical feasibility. They are important criteria in improving the chances that a proposal will be prominent on the agenda. The case study method also resulted in a better understanding of the integration of the networks which leads to developing a suitable policy (Zahariadis, 2003, p. 155).

In summary, my two major sources were interviews and on-line searches. The interviews concentrated on specific policy initiatives that helped determine which issues the respondent considered significant. From Internet searches I developed a collection of academic writings, government documents, and media coverage to trace the developments in the case studies covering policy changes over the past decades (Kingdon, 2003, p. 5).

Chapter 4

RESULTS

The results of the case study analysis are presented in this chapter. I will report the results of the predecision making processes that culminated in LPS, Kendra's Law, and Laura's Law. The purpose of this analysis is to explore the windows of opportunity for placing on the agenda and enacting legislation reflecting advances in scientific knowledge that would be a radical departure from the status quo.

Lanterman Petris Short Act of 1967

The 1966 election produced a major change in California politics. For the first time since California became a state, the balance of political power in the legislature shifted from northern to southern California (Anderson & Lee, 1967, p. 535). The political stream produced a greater Republican strength in the legislature, opening a window for more conservative policy directions. This set the stage for the enactment of the Lanterman Petris Short Act.

Assemblyman Frank Lanterman, a powerful Republican represented Pasadena, "the heartland of California's anti-mental health movement." The movement was made up of political forces such as the Minute Women U.S.A., the Daughters of the American Revolution and the John Birch Society who branded mental health treatment as a "Marxist weapon," part of a communist plot to control

people's minds. This politically conservative culture made it natural for Lanterman to distrust psychiatry and especially involuntary commitment (Torrey, 2008, p. 29).

What about the problem stream? By the mid-sixties, a number of problems relative to state hospitals came to be recognized as pressing. The fiscal conservative Governor Reagan played a key role in expediting the process of reducing the population of the state hospitals (Bradley, 1976, p, 223). The financial outlay for the state hospitals happened to be the second largest expenditure in the state budget (Jacobs, Galton & Howard, 1999, n.p.). Unfortunately the state hospitals closed prior to the implementation of the federally proposed system for Community Mental Health Centers (CMHC). Former patients ended up in various facilities and on the streets (Morrissey & Goldman, 1986, p. 22).

When asked about the biggest challenge to addressing the issues of the mentally ill, a respondent who handles mentally ill patients in the criminal justice system replied: "The biggest challenge I see is to get over the mindset that was seen in the movie 'One Flew Over the Cuckoo's Nest.' There seems to be this American and Californian notion that if we just allow people to be completely free that they will be okay" (Personal interview, March 17, 2009).

At that time, policy entrepreneurs Jerome Waldie, Democratic Majority Leader of the California Assembly (Chair of the Assembly Subcommittee on Mental Health) and his Chief Aide Art Bolton, had been developing their ideas that could be translated into legislation that might be advanced when the moment was right. They

recognized that managing the commitment process offered the solution to the problem. Their strategy involved: first to issue the report, *The Dilemma of Mental Commitments in California* (1967) that heightened the tension between the advocacy groups, then to offer a compromise (Bradley, 1976, p. 220). It is important to note that in May 1966, Jerome Waldie won a special election to fill a congressional seat; Nicholas Petris won a Senate seat, so the co-chair of the subcommittee fell to Frank Lanterman, who assumed responsibility for the project (Jacobs, Galton & Howard, 1999, n.p.).

Meanwhile, there was a deepening conviction that involuntarily committed persons should be accorded due process safeguards mandated by the Supreme Court during the 1960s. Various civil libertarian groups argued for the rights of the mentally ill, categorizing the issue as due process for patients' rights. The opposing medical groups advocated a community treatment model (Bradley, 1976, p. 217).

Before LPS became law, specialists in the mental health area – legislative staff, the Department of Mental Health, medical specialists and interest groups formed the policy communities. An unlikely combination of interest groups, contributed to the LPS enactment including the southern California civil libertarians and the northern liberals. Reformers managed to integrate the principles of patients' rights into the proposal. In this case, the conservative civil libertarian/liberal coalition along with organized client groups representing a solid “front” facilitated the move toward a limited involuntary commitment law. The medical and treatment-

oriented groups promoted the need for fewer restrictions on the commitment process, although they were successfully discredited (Bradley, 1976, p. 219). The policy of termination paired with policy development enabled the proponents to gain broad based support from their colleagues and the entire body was committed to the change ensuring that the direction of the policy would be continued in future years (p. 221).

Denis Zilaff, Supervising Deputy County Counsel for Sacramento County, describes the mental health treatment system:

You have this system out of control with no rights at all for the mentally ill. Then you have Lanterman, Petris and Short who come in and say we have to stop this nonsense.... It costs a lot of money...you had all these ... state funded mental institutions ... all of these people are going into locked facilities....There is no freedom for individuals. Lanterman, Petris and Short ... say we are going to write this legislation. The pendulum swung from one end to all the way across....Then you have these decisions that came down from the [California] Supreme Court ...The opinion [says] you have a right to a jury trial...the same as in criminal law. A jury of twelve people and it is beyond a reasonable doubt standard.... It is a unanimous jury. [It] takes all twelve to hold that the person is gravely disabled. That is just like a criminal case, even though these are civil in nature.... a person has a right to go to that jury trial within ten days ... you don't see that in criminal cases. Well, that harms people with mental illnesses. This whole system is totally wrong.... Frankly, I don't think they should be in the court system. I think they should be in front of a hearing officer who understands mental illness (D. Zilaff, interview, March 9, 2009).

As the respondent who handles mentally ill patients in the criminal justice system puts it:

Unfortunately, right now there is little or no system in place. The LPS system is absolutely ineffective in my opinion. I am in favor of involuntary commitment for the mentally ill. I see them wandering around the streets of downtown in the alleys and it is a scandal. They suffer in the weather. The food they eat is garbage, I see it.... (Personal interview, March 17, 2009).

According to Frank Lanterman, as cited by his administrative assistant, Elaine

Deweese, years after LPS was enacted: "I wanted the LPS Act to help the mentally ill.

I never meant for it to prevent those who need care from receiving it. The law has to be changed” (Legislation for the Mentally Ill, 1987, p. 9).

New York’s Kendra Law of 1999

A key to the commitment standard reform in New York was the coupling of the two streams of politics and policies in support of proposals that would give officials more authority to force mentally ill individuals into treatment against their will. The recently elected attorney general entered ready to propose initiatives, and the policy stream had produced the initiatives for him to propose. But important to placement on the decision agenda, in this particular case, the agenda was problem driven. The violence by mentally ill individuals became “the” problem rather than the attention to civil rights of the mentally ill. At any rate, the public mood, over the number of mentally ill homeless living in the streets took a turn, rooted in fear (Foderaro, 1994, p. A 1). The death of Kendra Webdale became the focusing event that called attention to the problem of insufficient mental healthcare due to cost cutting measures (Winerip, 1999, p. B 1). Governor Pataki had financed no new supervised community residences for the mentally ill during his first four year term, adding to the number of mentally ill homeless (Winerip, 1999, p. 44).

The actions of the Attorney General Eliot Spitzer further advanced the issue onto the decision agenda. Immediately after Kendra’s tragedy, Spitzer contacted the TAC about helping mentally ill individuals and the communities in which they reside. TAC recommended that Spitzer pursue enactment of a comprehensive AOT

law (Torrey & Zdanowicz, 1999, p. 4). Spitzer acted while the “iron was hot” by introducing the bill that became Kendra’s Law immediately after this widely publicized tragedy (Spitzer, 1999, p. 1).

What about the problem stream? An alarming number of highly publicized violent incidents involving people with mental illnesses rekindled the debate on involuntary outpatient commitment in New York (Allen & Smith, 2001, p. 342). Residents’ anger about mentally ill homeless people in their neighborhood was fueled by the publicity concerning acts of violence. On one side of the argument were civil libertarians and mentally ill people who want to stave off any effort to make involuntary commitment easier. An assortment of groups on the other side: the residents who wanted something done about the mentally ill homeless in their neighborhoods, the “not in my back yard” syndrome; psychologists and mental health officials; and families who wanted their relatives to get treatment (Foderaro, 1994, p. A1). As one respondent stated:

The “not in my backyard” syndrome would have to be confronted. The reality that mentally ill can affect and occur to anyone (one car accident, one stroke) needs to be stressed so that we can embrace individuals within our neighborhoods and cities as our neighbors, brothers, sisters, parents, and children (Personal interview, March 17, 2009).

By the end of the 1990s, a number of problems relevant to the commitment law came to be recognized as pressing. The report by the New York Commission on Quality Care about Andrew Goldstein, who had pushed Kendra Webdale in front of a subway train indicated that he had been discharged when he was “simply too sick” (Tully, 1999, p. 4). The report called attention to the dire lack of services for the

mentally ill (Winerip, 1999, p. B 1). In addition, several other highly publicized violent cases fed their fears. Eventually, as the situation developed, participants realized that services needed to be augmented (Foderaro, 1994, p. A1). As I noted in the last case study, fiscal conservatism loomed large. The public criticized Governor Pataki for proposing elimination of beds in psychiatric hospitals (Torrey, 1999, p. 4). Some argued that the commitment standard needed to be changed because of the growing violence. Others argued that enforced treatment violated civil rights and a regression to the old way of thinking that fostered the insane asylums of the past (Schmemmann, 1999, B 3). Regardless of the conceptions of the problems that brought people to the issue, there was a widespread conviction that the legislature faced a serious mental health problem.

As to the policy stream, a lot of prior work had been done. In 1989, NAMI proposed the first AOT policies. In 1994, in New York, momentum began to build in the legislature advocating AOT in varying degrees with the introduction of five bills. NAMI convinced the New York legislature for the need of AOT because of growing public frustration and fear over the numbers of mentally ill homeless who have lost touch with reality. In response, the legislature enacted a three year pilot called Bellevue Pilot Program, recognizing that some mentally ill individuals often reject care and treatment. That program expired on June 30, 1999. It appeared that New York legislators lacked the political will to extend AOT. But, an unlikely coalition made up of psychiatrists who believe in beneficial effects of new medications and

the “law and order” conservatives organized to get the mentally ill off the streets (Torrey & Zdanowicz, 1999, p. 4). Taken together, these policy networks proved more effective than many critics predicted.

Most advocates of reform came to favor AOT which would include treating individuals with schizophrenia, bipolar disorder, and other mental illnesses who do not make headline news. Most severely mentally ill individuals are not violent. The solution became the justification for providing care for severe mentally ill individuals subject to recurring problems that lead to deterioration, but who might not volunteer for treatment (Appelbaum, 2001, p. 347).

Indeed, the Attorney General’s office did organize an impressive group who were sent out on meetings with newspaper editorial boards, reporters and legislators. Support was expected from the conservative papers, but support came also from the liberal papers. Following this momentum, Assembly Speaker Sheldon Silver who supported Kendra’s Law and Attorney General Eliot Spitzer held a press conference and invited the families of the victims and TAC advocacy group. That same day Governor Pataki introduced a slightly different version of Kendra’s Law (Torrey, 1999, p. 4). As efforts culminated, the TAC, the Webdales, and Rivera traveled to Albany to pressure the Governor. Edgar Rivera, a thirty-six year old father of three young children, had lost part of his legs after having been pushed in front of a subway train by an untreated schizophrenic (Hernandez, 1999, p. B1). An hour later,

the Governor and the leaders held a press conference announcing they had agreed to pass Kendra's law (Torrey & Zdanowicz, 1999, p. 4).

With the concept of commitment reform finally accepted on the decision agenda, the original law had to be amended to be consistent with both sides. Under Kendra's Law, a judge can force treatment on mentally ill individuals who are not complying with a treatment regimen. In the past, this applied only to institutionalized individuals (Allen, 2008, p. 178). The framers used caution to shape Kendra's Law so that it demonstrated legitimacy and belief in the value of mandatory outpatient treatment. As a result, the law met the challenges from opponents concerning the law's unconstitutionality in the New York Superior Court and Court of Appeal of New York State (Geller, 2005, p. 242).

California's Laura Law of 2002

From my interviews, it seems that the mental health commitment standard is not a hardy perennial like other policy issues, since it barely made it onto the California agenda in 1999. However, interest rose only because of a policy entrepreneur.¹ A lot of what is called "softening up" had gone on for some years—developing proposals, generating public discussion about the inequities and, introducing bills, holding hearings, making speeches, and reports. Despite the remaining differences among the various plans, this softening-up process had produced some central agreements on the desirable approaches. Most advocates of

¹ Most of the information about this case study is drawn from my interviews and from contemporary reports.

reform came to favor a broadening of the commitment law. A series of hearings and parity legislation became the precursors to AOT.

Because of Assemblymember Helen Thomson's background on mental health issues, mental health legislation became her objective. Thomson started with parity legislation for the mentally ill, but her real goal was the prospect of helping the mentally ill who lacked insight into their disease. As she commented in an interview:

One of the things that always has bothered me was ... the people most seriously mentally ill couldn't get any care unless they volunteered for it and yet their volunteering wasn't possible due to their illness.... it seemed to me the sickest people those who were homeless on the street, digging out the food from the garbage cans. I couldn't understand why the advocates and the patient rights' advocates particularly did not see this as a problem (H. Thomson, personal interview, March 17, 2009).

In the sequence of events, a problem regarded as pressing on the national level: discrimination of insurance coverage for mental health treatment became an issue with advocates. With this, Thomson felt that the resources of the private sector needed to go into mental health treatment. As her first move, she introduced the bill providing parity for mentally ill.

The fact that people who were mentally ill were aced out of their insurance [bothered me].... The Alameda County NAMI had been pushing for quite a number of years on parity. It seemed to me that we needed to do that first. We needed to have the resources of private sector going into mental health. We needed to get rid of what felt as discrimination, when you were mentally ill and you had an insurance card you still had to pay more money for co-pays, you still had people who said, from the insurance industry, 'sorry but you have thirty days or six visits or thirty visits for your program.' You paid more money for your medication and to see your provider. We took on that issue.... It was being taken on nationally—the Domenici bill had failed at the national level at that time ... We worked really hard and got lots of support for it ... it brought people from the east (H. Thomson, personal interview, March 17, 2009).

The parity bill established the principle that mentally ill patients deserve the same access as physically ill patients, thus eliminating the stigma which existed. It is important to emphasize that there was consensus on parity. According to former Assemblymember Helen Thomson:

There were so many people on the parity stuff people did have experience -- even one of the sergeants would say keep going — we really need to have our insurance changed. Or I am a mom that needs some help -- but on the involuntary — no — didn't want to deal with that unless you had the experience (Personal interview, March 17, 2009).

To pave the way toward mental health reform, in 1998, Assemblymember Helen Thomson and Mike Antonovich, Los Angeles County Supervisor, held a hearing entitled “*Mental Health Laws: Is Reform Overdue?*” Holding hearings can focus the public’s attention on a problem. The number attending and the amount of testimony gave witness to the extreme interest and discontent with the mental health system in California (p. 129). As former Assemblymember Helen Thomson related the scenario:

Out of that hearing in L.A. we proposed a whole menu of bills of changes and AB 1800 was one of those. We took on the world when we took that on. There were rallies at the Capitol, people in purple shirts, they bussed clients in from all over the state. They gave them lunch and had the rally and they took all the seats in the hearing room so that our witnesses had no seats. It was just amazing. I was called Nurse Ratchet.... My colleagues would ask what this was all about (Personal interview, March 17, 2009).

In spite of all the attempts at blocking, AB 1800 passed the Assembly, 53-16 (Martin, 2000, p. 1). When it reached the Senate, Senate President Pro Tem Burton held the bill in the Rules Committee instead of sending it to a Policy Committee for a vote. Instead of using the Hoover Commission Report that had taken more than a

year of investigation into the state mental health system, Burton commissioned the Rand Corporation to prepare a report, which concluded that involuntary outpatient treatment is no more effective than voluntary alternatives (Bailey, 2001, p. A 3).

As Thomson said, “Again it is timing. As we started this, Kendra’s Law had just gone into [effect. It was] very similar.” When Thomson introduced AB 1421, Darrell Steinberg, the Chair of the Assembly Judiciary Committee, made the case for voluntary services instead of involuntary treatment (Former California Assemblymember H. Thomson, personal interview, March 17, 2009). After the bill passed the Assembly and reached the Senate, Senate Pro Tem John Burton objected to any forced treatment. To garner support, Thomson went to see the Mayor of San Francisco, Willie Brown, former Speaker of the Assembly, who pledged one hundred percent backing for the bill. She also received a letter of support from the San Francisco Board of Supervisors.

As previously mentioned in Chapter 2, Laura Wilcox’s tragedy provided the focusing event for Laura’s Law. Six days later, to compound the problem, Mike Bower, a delusional schizophrenic who had refused treatment, drove his truck into the State Capitol. The truck demolished the hearing room in which Thomson’s bill was to be scheduled.

Thomson continued in the interview to say:

I went in to see John Burton, before one of the hearings he had taken the bill and set it for hearing ... that truck crashed into the hearing room. That was into the hearing room where the hearing would have been. So I used that as a wonderful symbolic example of what happens when somebody with mental illness is unable to be treated. Well, John held the bill that would have been [heard in that] hearing

room ... my effort at that time was to get the bill heard. I said to him: members have a right to have their bills heard even if you don't like them.... He said I suppose you think you got a lot of support, at that point sitting in his office, just the two of us. I pulled out those two letters from the San Francisco Board of Supervisors and the Mayor of San Francisco, and I thought he was going to explode. He was very angry that I had this support. I said even your own community Senator, believes that this is the right thing to do. You're just surrounded by people that don't understand about what's happened in the last 25 years. Things have gone way too far this way (H. Thomson, personal interview, March 17, 2009).

After Laura's Law passed the Assembly, civil libertarians fought to kill it in the Senate committee. However, the watered down version passed the Senate, with several amendments, in addition to providing comprehensive civil rights protections for mentally ill patients (Helping People, 2002, B 12). According to Kiyomi Burchill, Consultant for Senator Darrell Steinberg President Pro Tempore, "Senator Steinberg supported Laura's Law and what was important to him in those legislative negotiations was a provision that was included in Laura's Law which provides that a county must first provide a system of care on a voluntary basis to a certain degree before it creates a necessary outpatient treatment" (Personal interview, March 12, 2009).

In answer to the question about groups who have opposing views, according to Denis Zilaff:

There are two groups: family advocates who want to see good things happen to loved ones; and on the other side, the so called advocacy groups (civil libertarians) for the mentally ill who demand that the mentally ill have a constitutional right to be free and not to be helped. They really think they are doing good, but actually they are causing more harm than good by far. Civil libertarian attorneys think about individual rights -- rights at this moment and not about placement of the mentally ill individual.... (Personal interview, March 9, 2009).

In 2004, Proposition 63 (MHSA) passed with strong support from a variety of interest groups, including organizations in favor of assisted outpatient treatment and organizations in favor of voluntary services as opposed to involuntary services.

However, Proposition 63 (MHSA) faces challenges in implementation (Scheffler & Adams, 2005, p. 212). Kiyomi Burchill, a consultant speaking on behalf of Senator Steinberg recalls:

I think they were able to do so in part because they did focus on the expansion of voluntary services. It is where everyone could agree and I think without that, I don't know if they would have had the necessary support to really push something like that through (Personal interview, March 12, 2009).

Former Assemblymember Thomson recalls a phone conversation:

When they were negotiating for Proposition 63 ... Steinberg ... called me for my support. I said well I'd like some of that money to go to being able to implement Laura's Law. Oh, nothing will stop Laura's Law -- this money can be used for Laura's Law, he told me.... So they did some more iteration of this damn thing, and no it can't be used for Laura's Law (personal interview, March 17, 2009).

According to Thomson, when Proposition 63 went into place for people who volunteer for treatment, the money for the regular base programs went out the door. We cannot use that money for the regular programs. There is such a disparity in what is happening in California that it is even worse than it was before (Personal interview, March 17, 2009). Even though Proposition 63 amassed \$760 million in 2005-06, this funding may not be used for AB 1421 because such programs are "viewed by the California Department of Mental Health as being inconsistent with the prevailing philosophy of California's mental healthcare system" (Segal, 2008, p. 4-5).

As mentioned in Chapter 2, Laura's Law lacks enforceability and it is left up to cash strapped counties to fund AOT programs themselves, if they chose. The law cannot utilize voluntary mental health programs with its implementation, which means lawyers will quickly file suit (Herbert, Downs & Young, 2003, p. 253).

Regarding the current state of commitment laws, Denis Zilaff, Supervising Deputy County Counsel for Sacramento County has this to say:

LPS should be terminated, taken out of the Welfare and Institutions Code and replaced with a conservatorship under the Probate Code, [and] making the system more like juvenile dependency. The probate system works with people that can't help themselves [emphasis added]. LPS can work the same way using the dementia petition....

[Right now] a person comes into the treatment center, receives treatment, then leaves. Then they come right back in. With LPS this is a revolving door, patients "bounce" after getting stabilized and then go back out into the community, get worse, and come back in for treatment. By the time they've done it -- twenty to thirty times or up to one hundred, eventually they get so bad, they have to be institutionalized. We need to get them early on. Under my plan, if the mentally ill individual failed informal supervision, that is, they go right back out and don't take their medications, this should be grounds for them to be put on conservatorship, because it shows that they lack insight into their mental illness.... (Personal interview, March 9, 2009).

As the respondent who handles mentally ill patients in the criminal justice system puts it:

The State of California fails to acknowledge that there are individuals who suffer from significant mental illness. There are individuals who suffer from degrees of mental illness that should require them to be taken into care for their own welfare without their permission. Right now individuals are "free" to live on the streets and by the rivers where they are neglected and victimized. Many of the individuals who come through the court system lack the ability to choose this lifestyle.... If I had to settle on one problem, I would have to say that California legislators lack the courage to design a system that acknowledges the necessity for a comprehensive mental health housing and treatment plan (Personal interview, March 17, 2009).

I will discuss the case study results and present key factors that enable policymakers to move the policy formation process forward, making suggestions for further research in the final chapter.

Chapter 5

CONCLUSION

By exploring previous enactments across various stages through the lens of Kingdon's window and streams model, this thesis focused on how to use this process to reach a desired goal based on scientific knowledge: to get the mentally ill who lack insight into their condition off the streets and out of jails and prisons into appropriate care. In the cases studied in California, the entrepreneurs honed the problem definitions and policies but have so far failed to tap into the political stream necessary to radically change the status quo. The factors identified for study were based on the literature I review in Chapter 2. The methodology for the case study analysis was presented in Chapter 3. The results of the analysis using the three streams model by Kingdon are presented in Chapter 4. The present chapter reviews the main results and addresses implications for further research.

Summary of Windows and Streams Model Results

The results of the case study analysis were surprising. All three cases (LPS, Kendra's Law, and Laura's Law) featured different outcomes from what I expected. Specifically, during the LPS negotiations, categorizing the problem of the mentally ill and involuntary commitment as a civil right became cemented so that the people's perception of the problem made a tremendous difference. This perception has persisted over the years, ignoring the fact that many mentally ill patients lack awareness and are unable to seek treatment voluntarily. The shift of power in the

legislature from northern to southern California gave the civil rights' coalition greater influence than the opposition. The policy issue was not on a liberal/conservative dimension, but on the concepts of equality and efficiency, values that policy specialists held at the time had greater influence on what resulted. In LPS, what looked like a compromise became a law so strict that the severely mentally ill fall through the cracks. As Denis Zilaff, Supervising Deputy of Sacramento County Counsel who handles thousands of LPS conservatorship cases states: "Put LPS Act in the trashcan. Don't even try to take parts of it, just dump it completely" (Personal interview, March 9, 2009).

At first glance, Kendra's Law in New York and Laura's Law in California appear to be similar, in that they were both precipitated by a focusing event. However, there were significant differences. Kendra's Law passed and is in force, according to the New York State Office of Mental Health report (2005) and subsequent reports. Ironically, while in New York the policy specialists manipulated the solution to fit the problem at hand, in California the appropriate solution actually fit the problem definition. In New York the policy network, including the Treatment Advocacy Center, Attorney General Eliot Spitzer, the media, "law and order conservatives," and the families of the victims, presented a united front by coming to a consensus in the policy stream. In California, the organized forces with access to decision makers blocked AB 1800 in the Senate and tried to block AB 1421 which later became Laura's Law. Even after the focusing events, when unable to block the

bill, the forces resorted to amendments which crippled the law. In California, the window opened in the problem stream only because of Laura's death and the State Capitol incident. In the politics stream, there was an array of interest groups whose major purpose was to protect the existing program and to resist any change.

According to Thomson,

An important piece to know is who had a toe hold in those issues in the legislature at that time were all of the social rehabilitation model facilities. So anyone who had a contract for the social rehabilitation home or recovery center or any of those things were nonmedical, they didn't want any medical interference. They wanted this to be a social problem (H. Thomson, personal interview, March 17, 2009).

In New York, all three streams—politics, problems, and policies—were positioned to join. What people saw as the lack of services for the homeless mentally ill and the increase in violence aroused a lot of public anger. The governor's cutting of the funds for psychiatric hospital beds became the problem. In addition, the evolution of proposals in the policy stream had reached the point of significant agreement at least on general approaches and even on important specifics. Confluence among the three streams made it likely that the issue got on the decision agenda and that the legislation pass in New York.

Former Assemblymember Steinberg placed Proposition 63 on the ballot in 2004, because he was frustrated with the requirement of a two-thirds majority in order to fund any expenditure. So he took it to the voters. As his consultant stated:

One of the keys to success to the passage of that initiative was the broad based coalition they were able to build. Whether it was the counties or community mental health providers, pretty much family consumer groups, everyone was really on board. I think they were able to do so in part because they did focus on the expansion of voluntary services (K. Burchill, Consultant for Senator Darrell Steinberg President Pro Tempore, personal interview, March 12, 2009).

As the initiative read, there was no restriction on involuntary treatment. A common thread prevails ever since the enactment of LPS. It was after the initiative passed with all the support from across the spectrum when the Department of Mental Health made the regulations limiting funding to voluntary services. As Chapter 4 mentioned, involuntary commitment was “viewed by the California Department of Mental Health as being inconsistent with the prevailing philosophy of California’s mental healthcare system” (Segal, 2008, p. 4-5). Steinberg promised Thomson that there would be no problem funding Laura’s Law to gain her support for the proposition. However, according to the California Code of Regulations, Laura’s Law, because it is for involuntary treatment cannot be funded (CCR, Title 9, Section 3400). Although it isn’t central to my story, the aftermath was remarkable. It was not clear whether this result was Steinberg’s original intention, to put heavy pressure on voluntary only, or a product of the result of unanticipated consequences. But the result of the substantially more stringent use of funds for involuntary commitment was unmistakable.

In future studies, researchers should consider investigating the federally funded advocates, Protective and Advocacy for Individuals with Mental Illness (PAIMI) to determine what influence they use to lobby legislation in the states and to deter mentally ill patients from accepting treatment. To further look into the advocacy group, it may be necessary to conduct an organizational case study. If my supposition is correct, the organizational case study would show their sphere of

influence and how they affect legislation in the states promoting AOT. A case study could determine if PAIMI was able to influence California's AOT legislation.

For subjects to rise on the agenda depends on the presence or absence of key participants. Some items never rise on policy agendas, not because participants do not recognize real problems but because alternatives that might be possible solutions are not apparent to participants. Some items, such as mental illness, did not have powerful constituencies in the political stream and failed to get on the agenda because of the lack of such advocates (Kingdon, 2003, p. 208). For almost four decades, LPS remained in force, even though in the words of my respondent who deals with the mentally ill in the criminal justice system stated, "The LPS system is absolutely ineffective in my opinion" (Personal interview, March 17, 2009). Finally, the appearance of a key individual interested in LPS reform prompted action in the 1990s.

In the problem stream, not every problem has an equal chance of getting on the agenda. For example, it took a focusing event, such as Laura's death and the truck incident for high agenda status. In California, the proposal was ready in the policy stream, but the political conditions limited the coupling possibilities. Unfortunately, the proposal that surfaced did not meet value acceptability or politicians' receptivity. The skilled entrepreneurs in this case had a clear idea of how to get what they wanted, enabling them to manipulate part of the process, skewing the outcome away from involuntary outpatient commitment.

In two of the three case studies, “strange bedfellows” supported the policies. In LPS, the southern California civil libertarian groups allied with the northern California liberals against involuntary treatment. In support of Kendra’s Law, the treatment advocates allied with the “law and order” conservatives who wanted to get the mentally ill homeless off the streets. It is important to note after the enactment of Laura’s Law, Proposition 63 (MHSA) received support from a broad spectrum of all groups. Entrepreneurs manipulated information in an effort to make the package attractive to the broadest audience. However, the final outcome became a considerable and skillful compromise which only satisfied some.

Another commonality among the case studies was the occurrence of focusing events. In each case, the event became a symbol for placing the policy on a higher level decision agenda and finding a receptive political audience. Published in 1962, Ken Kesey’s *One Flew Over the Cuckoo’s Nest* became a symbol to attract attention and mobilize opposition against hospital commitment, prior to LPS. According to one of my respondents, this symbol is still seen as a challenge almost fifty years later, since the mindset it created still exists. During the negotiations for Kendra’s Law, the use of symbols focused on the problem of the lack of safety, especially the ease with which one could be pushed in front of a subway train. The presence of Rivera at the press conference in Albany, presented a powerful symbol that called attention to the problem. Prior to Laura’s Law, during deliberations for AB 1800, people in purple shirts and Assemblymember Helen Thomson depicted as “Nurse

Ratchet” provided powerful symbols for those who opposed the bill. Later during Laura’s Law negotiations, the powerful symbol of the truck crashing into the State Capitol helped put the policy high on the agenda. These symbols evoke a strong emotional response.

This sequence of events provides an occasion for reflecting on what important factors might explain differences in other social policy outcomes. According to my findings, the combination of social partners, framing policy, and successful entrepreneurial organization facilitate methods for improving social policy outcomes. The case studies show that more than likely the integration of diverse policy networks can enhance the policy outcome. For example, the “law and order” conservatives and the treatment advocates in New York, and the southern California conservatives and the northern liberals who succeeded in passing LPS.

How a policy is framed can place events into a context that gives them meaning. Symbols facilitate the coupling process because they promote the interpretation of a problem definition. This, in all cases studied, and how framed, led to the placing of policies on the agenda. The case in New York especially illustrates the effectiveness of the framing process in that the familiar context in which the incident was framed was used to address the problem.

Symbols enable the policy entrepreneur to couple problems and solutions to the politics stream. For example, in New York “striking while the iron was hot” clearly underscores this point. Spitzer seized the opportunity to promote AOT. By

being attentive to timing policy specialists in trying to couple all three streams, take advantage of the opportunity by bending ideology to suit the circumstances at the time. In California, Thomson clearly took advantage of the opportunity to push AOT.

My findings have implications for those who advocate change in mental health policy. Specifically, it would be beneficial to issue information on other policy alternatives that can provide solutions, even though they are not fully developed. A policy would fare better if press conferences with influential supporters and testimony from local government stakeholders were held in Sacramento. In addition, my findings showed that enlisting allies whose goals not apparently germane would give greater support to a successful outcome. Be prepared for other groups using symbols. Be proactive by using your own symbols to get information across. And finally, enlist extensive support from media coverage from conservative and liberal sources.

Conclusion

I have made some progress in understanding some of the unclear factors and conditions of this particular policy area. Tracing the timeline of mental health legislation in California and the policymaking process has helped clarify a general understanding of the forces that move the policy formation processes in one direction or another. Studying the three stream process by which agendas are set and alternatives specified, the broader purpose of the thesis was to show policymakers

and outside specialists the importance in recognizing the timing of opportunities for getting alternatives recognized and enacted.

APPENDIX

List of Interview Questions

1. What do you see as the biggest problem or problems for the mentally ill?
2. In your opinion, what is the best way to address the issues of the chronically mentally ill? What are the biggest challenges to implementing such a policy?
3. Who do you think has most influence over public policy regarding the mentally ill? Why?
4. Let me focus now on the specific question of involuntary commitment for the mentally ill. What do you think public policy should be with respect to involuntary commitment?
5. Different people have very different views about involuntary commitment. Do you foresee any reconciliation of the differences between the opposing views on involuntary commitment? Why/Why not?
6. Why did you choose the initiative process to fund mental health treatment? Was this to fund Laura's Law? What concessions did you have to make, if any?
7. What have been the positive consequences, if any, of changing the law? Negative consequences? Unintended consequences?
8. What are the keys to successful implementation of changes in commitment laws?
9. What are the most important lessons for California to learn from your experiences?

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