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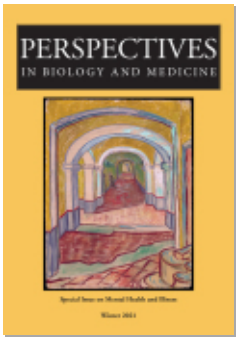


Joel T. Braslow, Sarah L. Starks, Enrico G. Castillo, John S. Brekke, Jeremy Levenson

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# Recovery in Context

## *thirty years of mental health policy in California*

**Joel T. Braslow,* Sarah L. Starks,† Enrico G. Castillo,‡ John S. Brekke,§ and Jeremy Levenson‖**

**ABSTRACT** Over the past quarter century, Recovery has become the hegemonic model guiding mental health policy. Advocates presented Recovery as a radical departure from the past, with the promise of dramatically improved outcomes for those with serious mental illness. This article looks at the implementation of Recovery-based policies in California from the 1990s to the present and interrogates the ways these policies emerged out of and reinforced many of the problems they were intended to solve. Against the backdrop of welfare reform, managed care, and a growing belief in market forces and individual responsibility, California policymakers pivoted from rigorously studied pilot programs that were intended to provide intensive, long-term treatment to Recovery-oriented programs that, while initially intensive, promised to "flow" increasingly independent and self-sufficient patients to less-intensive services. Moreover, these new programs promised to produce cost savings by reducing homelessness, hospitalization, and incarceration. Reported outcomes from these programs have been overwhelmingly positive but are based on flawed evaluations that lean more heavily on belief than on evidence. While proclaiming a comprehensive, patient-cen-

*Department of Psychiatry and Biobehavioral Sciences, and Department of History, UCLA.

†Center for Social Medicine and Humanities, Jane and Terry Semel Institute for Neuroscience and Human Behavior, David Geffen School of Medicine, UCLA.

‡ Department of Psychiatry and Biobehavioral Sciences, UCLA; and Los Angeles County Department of Mental Health.

§Suzanne Dworak-Peck School of Social Work, University of Southern California, Los Angeles.

‖Department of Anthropology, UCLA; and Icahn School of Medicine at Mount Sinai, New York.

Correspondence: Joel Braslow, BOX 951759, B7-435 Semel, Box #62, 760 Westwood Plaza, Los Angeles, CA 90095.

Email: jbraslow@ucla.edu.

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tered approach, Recovery's embrace of independence over long-term care and social supports has justified a system of care that systematically fails the sickest patients by abandoning them to the streets and jails.

Those with serious mental illness (SMI) have not fared well over the last the last half-century—especially from the perspective of overall outcomes. Individuals diagnosed with the most serious mental illness, schizophrenia, die 20 to 25 years sooner than those without SMI, a gap that has widened since the 1970s (Lee et al. 2018). The number of unhoused individuals with mental illness has risen to unprecedented numbers, and American jails and prisons lead the world in housing individuals with SMI, outstripping the number of patients housed by state hospitals in their 1950s heyday.

In response to these failures, over the last 25 years, mental health policymakers, advocates, and clinicians have adopted a new rationale to guide public mental health policy, the organization of care, and the goals of treatment. This new approach is guided by a movement optimistically named "Recovery," which, while related to the use of the term in substance use treatment, has distinct meanings, history, advocates, and policy implications when used in the context of mental health policy and SMI.[1]

First embraced by states such as California and New York, Recovery now pervades federal discourse on SMI and guides mental health policy in nearly every county and state mental health department in the country. No longer lauded as revolutionary or heralded as the cure for a failing mental health care system, Recovery is largely taken for granted, part of the "natural" order of how we understand SMI and organize our systems of care. Building on previous work we have done on the history of Recovery, the aim of this essay is to explore in greater detail the social, political, and economic forces that led to its adoption, using California as our case study (Braslow 2013).

In the late 1960s and '70s, California led the country in a headlong rush to empty state hospitals, along with an accompanying rhetoric of community care. As a result, not only did homelessness and incarceration of those with SMI become evident earlier in California, but California found itself with the largest unhoused and incarcerated population in the nation. In the mid-1990s, Recovery entered mainstream policy discourse as the promised antidote to California's ever-worsening problems with incarceration and homelessness. With the passage of California's "millionaires tax" in 2004, Recovery came to define mental health policies for the entire state.

We will follow California's use of Recovery up through the present, aware that California's use of Recovery differs to some extent from states like New York, where the social safety net is less porous and frayed, especially when it

[1] We capitalize *Recovery* when referring to a specific set of ideologies, values, assumptions, clinical relationships, and policies.

comes to homelessness, than in California. As the political birthplace of Ronald Reagan, California has led the country in dismantling many of the institutions relied on by those with SMI. What follows is a cautionary tale. Embraced as a system of belief that mirrored and drew upon the larger political and economic commitments of dismantling the welfare state, Recovery in California illustrates the ways mental health policy reinforced the circumstances that had made the state home to the world's largest population of homeless and incarcerated individuals with SMI.

## Defining Recovery

*Recovery*, in the context of mental health services, has at least three different, interconnected meanings. First is its everyday meaning of "the restoration of a person . . . to a healthy or normal condition" or the "regaining or restoration of one's health or a mental state" (OED). When advocates use the word in this sense, they acknowledge that it does not necessarily entail complete recovery. A 2003 federal mental health commission defined Recovery as "the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms" (New Freedom 2003, 5). Recovery also is described as a "process," or a path with existential connotations. Underlining it as a "deeply personal, unique process," William Anthony (1993) writes: "the vagaries of recovery make it a mysterious process, a mostly subjective process" (18). Even more enigmatically, Jacobson and Curtis (2000) praise the "ineffable magic of recovery" (339).

Finally, Recovery explicitly ties together a web of values and beliefs about the way individuals and services *ought* to be. This third meaning is best expressed by the 2004 Substance Abuse and Mental Health Services Agency's 10 "guiding principles" for Recovery: (1) self-direction; (2) individualized and person-centered; (3) empowerment; (4) holistic; (5) nonlinear; (6) strengths based; (7) peer support; (8) respect; (9) responsibility; and (10) hope (SAMHSA 2006). As we discuss below, these commonsense principles are not unique to policy around SMI; rather, they are values that have become central to the ideology of modern American political economy, used to justify the shrinking of the welfare state, privatization of social services, and increasing faith in market forces to promote the social good.

In practice, Recovery serves as a guide to policymakers and administrators on how to organize clinical services, a set of beliefs to guide clinicians in their relationships with their patients, and a set of beliefs that patients need to accept in order to recover. Though presented as revolutionary, it does not provide us with new therapeutic tools, nor with a new conceptualization of mental illness. Though Recovery advocates and policymakers readily acknowledge subjectivity and social context, treatment within a Recovery-oriented mental health system

remains consistent with the modern medical model, in which psychiatric disease is separate from its social, cultural, historical, and subjective context. These factors may be conceptualized as modifiers of disease and treatment, but are not constitutive of the disease itself nor essential for formulating its treatment. Keeping this model of disease and treatment in mind as we explore the implementation of Recovery in California provides insight into the seeming contradiction between the patient-centered ambitions of Recovery and the implementation of Recovery-based interventions in the most inhumane circumstances, namely homelessness and repeated incarceration.

## Recovery Created

Many of the arguments for Recovery depend upon a flawed (though commonly held) understanding of psychiatry's past, a complicated history that we have covered in detail elsewhere (Braslow 2013). Recovery presents itself as a radical departure from the psychiatric dark ages where, at the 1955 peak, 559,000 psychiatric patients occupied state hospital beds. Reflecting an antipathy towards dependency, state intervention, and long-term care, these institutions have been characterized as having iatrogenically manufactured dependency and chronicity: "rather than curing or reducing the illness," state hospitalization "led to role dispossession, skill deterioration and demoralization and rendered people less capable of managing life in the outside world" (Davidson, Rakfeldt, and Strauss 2011, 154). In fact, most state hospitals succeeded at their core functions: providing refuge, care, and meaning for people whose psychiatric illness made it impossible for them to survive without intensive care (Braslow 1997). Despite periodic lurid accounts of abuse and the use of since-discarded therapeutic measures, historical evidence suggests that state hospitals generally provided humane and comprehensive care. The importance of a comprehensive approach to care is underscored by worsening outcomes (including death rates) for those with SMI since widespread state hospital closures.

The crucible that gave rise to Recovery included the civil rights movement of the 1960s, the antipsychiatry movement of the late 1960s and '70s, the consumer rights movement of the 1970s, and the psychiatric patients' rights movements of the 1970s and '80s. Ironically, much of the intellectual energy of the Recovery movement came from a critique of a caricatured view of psychiatric practices that no longer existed: by the late 1970s and '80s, the characteristic clinical reality of those with SMI was their abandonment by the mental health system, not their mistreatment at the hands of a dependency-creating, chronicity-inducing system of care. By the end of the 1980s, a coherent Recovery ideology had emerged to which state departments of mental health began to declare allegiance. "I take great pride," Michael Hogan, then the director of the Ohio Department of Mental Health, wrote in 1995, "that the mental health system in Ohio is embracing

the concept of recovery" (Beale and Lambric 1995, 4). By the end of the 1990s, from California to New York, nearly every major department of mental health embraced Recovery principles. The federal government followed suit and, with the 2003 publication of President George W. Bush's New Freedom Commission's report, validated Recovery as the guiding principle of federal mental health policy.

A number of forces propelled Recovery into prominence in the 1990s. Community mental health was clearly failing, as homelessness and incarceration of those with SMI continued to spiral out of control. At the same time, with a looming economic recession in the late 1980s and '90s, states and the federal government sought to stem growing health-care costs. With the introduction in the 1990s of managed care in the public sector, policymakers, administrators, and clinicians found in Recovery an intellectual justification for limiting services, encouraging patients to become "independent and self-sufficient." For example, in the mid-1990s, the New York Office of Mental Health introduced managed care to stem "spiraling health care costs" (NYOMH 1997, 4). Recovery provided a crucial therapeutic rationale for linking service reduction to the best interests of patients. According to New York's strategic plan for 1997 to 2001, "As the public mental health system moves into a managed care environment, the development of recovery-oriented services becomes increasingly important," (NYOMH 2007, 3). Recovery reinforced managed care efforts because both assumed the same ends: "Managed care's emphasis on cost-effectiveness and accountability will reward approaches that foster positive outcomes, and will provide disincentives to approaches that keep people for lengthy periods in services that cannot demonstrate good outcomes." Moreover, "Recovery is the ultimate positive outcome, and services that enhance the likelihood of recovery are the most cost-effective" (NYOMH 2007, 3). Like New York, states across the country found in Recovery theoretical justification for managed care.

The embrace of Recovery and managed care reflects the culmination of systemic changes in American social policy and political economy that have their origins in the late 1960s and '70s with the gradual shrinking of the welfare state, privatization of social services, and a growing belief in market forces and individual responsibility. Scholars have described these economic, political, and ideological changes as neoliberalism (Goonewardena 2004; Harvey 2007; Lomnitz 2008). Presaging and driving these changes, in 1966 Ronald Reagan was elected to the California governorship on a platform that decried "big government," high taxes, and profligate spending by his predecessor, Pat Brown. His sustained attack on state hospital care fit perfectly into his political philosophy and desire to dramatically curtail the welfare state (Putnam 2006).

## Recovery in California

As one of the first states to employ Recovery widely as an explicit guide to mental health policy, California provides a good example for observing Recovery in action and in relation to the larger political, economic, and ideological forces that animate mental health policy. Recovery-oriented policies, like all mental health policies, depend upon the context in which they are deployed, the social supports available, cost of housing, support from families, and tolerance by local communities. In this section, we examine how California and Los Angeles have implemented Recovery-oriented policies and programs, illustrating how Recovery promised to transform a failed mental health system while, at the same time, affirming the very conditions that have made Los Angeles home to the largest unhoused mentally ill population in the country and the largest incarcerated mentally ill population in the world. We look first at the historical context in which Recovery was implemented in California—a context characterized by the failures of community care post-deinstitutionalization—and then at the programs implemented to address those failures.

### *Efforts to Replicate Hospital Care in the Community*

California felt the failures of community care in the aftermath of deinstitutionalization with a vengeance. At the forefront of anti-tax sentiment, California was especially aggressive in slashing public funds. In 1978, voters passed Proposition 13, a ballot measure that cut property taxes by 57%, dealt a severe blow to educational funding, and eliminated the budgetary cushion that made social funding possible. The effect on mental health was particularly brutal. Governor Jerry Brown's January 1978 budget had included an additional $82.6 million for mental health; when Prop 13 passed, this increase was withdrawn and replaced with a 20% reduction from the existing level of funding (Du Bois, Elpers, Crowell 1981, 3).

Despite tight budgets, throughout the 1980s California policymakers clung to the therapeutic logic that had shaped state hospital care for nearly two centuries. As long-term psychiatric hospitalization become increasingly endangered as a therapeutic intervention, policymakers envisioned a community mental health system that attended to all aspects of a patient's life—social, psychological, and medical. For them, the failure of deinstitutionalization represented a failure of the community to subserve those former state hospital functions.

The last major mental health policy shaped by the same therapeutic logic that guided state hospital care was the 1988 California State Assembly Bill (AB) 3777, known as the Adult Systems-of-Care Act. Committed to community-based, comprehensive, and indefinite care, the bill provided funds to test the effectiveness of "Integrated Services Agencies" (ISAs) that, if successful, would be deployed throughout the state as an antidote to the state's increasingly fragmented mental

health system. ISAs were modeled on assertive community treatment (ACT), developed in the 1970s in the early wake of deinstitutionalization. Composed of small, interdisciplinary teams of case managers, social workers, psychologists and psychiatrists, ACT teams provided intensive treatment in people's homes and other community settings to reproduce the care that state hospitals had provided, with small caseloads (commonly about one staff member for every 10 patients) and ready accessibility of the treatment team for patients in crisis.

Between 1990 and 1995, AB 3777 funded two pilot ISAs, and the state contracted with Lewin-VHI to evaluate the impact of ISAs and the feasibility of expanding the ISA model. Lewin-VHI was a Virginia-based health care policy, accounting, and econometrics company that performed the major 1993 analysis of President Clinton's Health Security Act (Lewin-VHI 1993). Lewin-VHI undertook a rigorous three-year evaluation of the AB 3777 pilot programs, examining both client outcomes and program costs. This evaluation was notable for a rigor that has not since been duplicated in mental health policy evaluations paid for by the state or counties: from the outset, the implementation of AB 3777 resembled a randomized controlled trial, with applicants randomly assigned to receive ISA services or to be followed as part of a comparison group receiving usual care from county mental health departments. Overall, the evaluators found that those receiving care in the ISAs had better outcomes than those in usual care. Due to the relatively low caseloads, round-the-clock availability, and funding flexibility, ISA clients were more likely to know how to reach providers in cases of emergency and to receive help from their service providers when they were hospitalized, and less likely to report feeling that their material and emotional supports were insufficient (Lewin-VHI 1995). Client retention also was significantly higher in the ISA programs (Chandler et al. 1996).

The evaluators acknowledged that intensive, long-term treatment in ISAs would require substantial funding that was unlikely to be fully offset by savings elsewhere. They noted that "the ISA model, when implemented well with . . . higher-than-average funding, produces an improved service system," and that "decisions about the success of the ISA model ultimately depend on whether the value one places on the benefits to clients justifies the added public costs" (Lewin-VHI 1995, 46–47).

### *Cost Savings and Independence*

Those who designed AB 3777 made no mention of Recovery, nor had Recovery become part of the lexicon of California mental health policymakers or administrators. By the late 1990s, AB 3777 would be reinterpreted as a Recovery-based experiment, justifying AB 34 in 1999 and its expansion, AB 2034, from 2000 to 2007. Reported outcomes from these expanded programs, in turn, provided the rationale in 2004 for the California Mental Health Services Act (MHSA), the largest increase in public mental health funding in California his-

tory. This proposition to increase personal income tax by 1% for those earning over $1 million to fund mental health services was approved by voters because its advocates promised to end homelessness and incarceration of those with SMI by remaking the entire public mental health care system and, most importantly, "saving" taxpayer dollars in the process. Cited as proof were the spectacular successes claimed for AB 34 and AB 2034, which were never evaluated with the rigor applied to AB 3777.

The backdrop for Recovery-based mental health policy, and why Recovery so effectively captured the imagination of California policymakers, are the changes to US welfare policy that preceded it. Welfare policy increasingly focused on individual transcendence of poverty and away from long-term dependence on state support. As the Reagan administration's ideological values and economic policies aimed at reducing "big government" came to dominate federal and state governance, Aid to Families with Dependent Children (AFDC) and other entitlement programs were attacked as causing more harm than good. In 1985 California created the Greater Avenues for Independence Program (GAIN), a jobs training program to help AFDC recipients become independent of welfare (LAO 1988). Congress used GAIN as a model for the Job Opportunity and Basic Skills (JOBS) programs mandated by the Family Support Act of 1988. Senator Daniel Moynihan (D-NY) anticipated that welfare "will 'no longer be a permanent or extended condition' . . . the new system will stress work, child support, and last-resort cash supplements while encouraging the needy to get the education and training needed to avert long-term dependence" (qtd. in AP 1988).

In 1996, pledging to "end welfare as we know it," President Bill Clinton signed into law the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA). PRWORA replaced AFDC with Temporary Assistance for Needy Families (TANF), limiting lifetime benefits to five years. It also shifted responsibility for administering welfare to state and county governments through block grants with few restrictions, further weakening the safety net (Martin 2009). As the *Brookings Review* noted in 2001, "[PRWORA], the welfare block grant, has fundamentally transformed the roles of national, state, and local governments, as well as thousands of nonprofit and for-profit groups in the field of human services" (Nathan and Gais 2001, 26). California legislators implemented PRWORA in 1997 by replacing AFDC with the California Work Opportunity and Responsibility for Kids Program (CalWORKS). CalWORKS imposed a lifetime limit and work requirements, with the explicit aim of moving welfare recipients from dependency to independence and self-sufficiency (Haider et al. 2000).

### *Embrace of Recovery*

Loïc Wacquant (2010) describes this transformation in US welfare policy as the "replacement of protective welfare by disciplinary workfare" (198). We see similar impulses in the embrace of Recovery by California administrators, policy-

makers, advocates, and an increasingly powerful lobby of contract providers. Like pre-1996 welfare policy as embodied by AFDC, AB 3777 was predicated on a "protective" view of mental health care and treatment, in which the goal was to provide the same level of exhaustive care that characterized state hospitalization. A few short years later, driven by the same political, economic, and cultural forces that would "end welfare as we know it," California Recovery advocates promised a radical transformation of public mental health care.

Passage of AB 34 in 1998 not only made possible the 2004 MHSA, which would be the crowning moment for Recovery in California, but also elevated Recovery as an unassailable guide for shaping policy and for defining outcomes. At first glance, there is little to distinguish the programs funded by AB 3777 and AB 34 except for expanded funding, a more focused target population, and, most importantly, the explicit claim that AB 34 was rooted in Recovery. Like AB 3777, AB 34 and AB 2034 employed ACT as the core treatment intervention. AB 3777 funded two ISA teams at a cost of approximately $1.8 to $2 million per year, and these teams cared for about 200 patients each. Allocations increased to $10 million with the passage of AB 34 for fiscal year 1999–2000, and to $55 million per year with the passage of AB 2034 in 2000 (DMH 2003), until the Governor vetoed the line item in September 2007. At its peak, AB 2034 funded 53 programs across 34 counties (Mong, Conley, and Pilon 2009).

Beyond the increased budget, AB 34 is notable for its fundamentally altered goal: namely, recovery and independence rather than chronic care. In addition to the altered political and policy landscape that welfare reform had inaugurated, a number of state and federal policy and economic changes specific to mental health care had helped create the scaffolding that made Recovery an integral part of mental health policy. Chronic instability of California's general funds and an economic recession led legislators to shift most of the state's mental health funding to state sales taxes and vehicle license fees in the early 1990s, which led to further unanticipated financial uncertainty (IDEA Consulting 2000). In 1993, California's Department of Health Services began instituting managed care, carving out Medicaid mental health dollars from physical health dollars. In 1996, the state began the process of welfare reform. Antipathy toward government social spending and insistence on cost savings as a precondition for social spending increasingly became the primary justification of mental health policy. In arguments for AB 34, cost savings (as distinct from cost benefits) justified expenditures far beyond ostensible benefit for those with SMI. Recovery provided the logic behind the cost savings, as a new means to transform chronic patients "from tax user to taxpayer" (Little Hoover Commission 2015, iii).

The major advocates for AB 34 were not directors of county departments of mental health, nor the state Department of Mental Health. The primary author of AB 34 and later the MHSA was Rusty Selix, Executive Director of the California Council of Community Mental Health Agencies (CCCMHA), which lobbies the

state on behalf of mental health contractors. In the wake of deinstitutionalization, nonprofit and for-profit private organizations had grown increasingly important in public community mental health in California and throughout the US, both in the volume of services they delivered through public contracts and in their political influence. The rise of Recovery in California is indebted to this history and to broader neoliberal trends. As California attempted to shift care from state hospitals to outpatient community services, the state increasingly delegated financial responsibility to the counties. Counties, in turn, provided services (funded with a mix of state, county, and, after the passage of Medicaid and Medicare, federal dollars), either providing care directly or contracting it out to a growing network of private nonprofit and for-profit provider organizations. Negligible prior to the 1960s, by the late 1970s privately contracted public mental health outpatient services accounted for a third of publicly funded outpatient visits (LACDMH 1978).

This growth was not without conflict. Described as "a state of war" during the 1970s by a Director of the Los Angeles County Department of Mental Health (LACDMH), the growth of the private sector reflected fundamental differences in the ways social services ought to be provided. Questions over whether privatization degraded the quality of care or whether private providers could be held to account to the same extent as public employees fueled concerns about this trend. Nevertheless, by the 1980s, private contractors had become a natural part of the public mental health landscape (Elpers 1979). Privatization of public mental health services continued throughout the 1980s and '90s, justified largely by claims—rarely, if ever, proven—that the private sector could provide the same or better services with greater efficiency. The cost of these claimed efficiencies did not go unnoticed. Contract providers, unhindered by labor unions, county hiring laws, and strict hiring standards, could, indeed, provide services more cheaply, regardless of quality. Many continued to question whether privatization of care could be done without sacrificing the fundamental needs of those with SMI (LAC Grand Jury 1982).

By the 1990s, the logic of community care, privatization, and cost savings had become common sense for those in the public sector and for contract providers. This common ground did not alter the fact that contract providers are driven by many of the same forces as other private sector service industries—namely, the imperative to increase market share and marginal profits or face extinction. Recovery presented an especially compelling model that, while not foregrounding cost savings, made them an inherent part of the model, especially in its promise to create independent and self-sufficient consumers. Modeling AB 34 on AB 3777, Selix believed that contract providers were especially well equipped to provide intensive treatment services, thereby demonstrating their capacity to save the state millions, if not billions, in cost offsets. The engine of such savings would be Recovery, which would efficiently move seriously ill patients out of costly treatment programs and solve the mental health system's most visible and glaring failures:

homelessness and incarceration of those with SMI. A devotee of David Osborne and Ted Gaebler's 1992 book *Reinventing Government*, Selix believed that role of government—including departments of mental health—was to facilitate the private sector in solving social problems (Selix 2010).

Central to the successful passage of AB 34 (as well as the MHSA) was demonstrating cost savings. As Selix wrote to the California Governor's Deputy Director of Policy, "I recognize that while what we're asking for is a dramatic increase in funding and that the Governor does not want to make long-term financial commitments that create financial risk if the state's fiscal fortunes turn. We believe that what we are proposing pays for itself" (Selix 1999, 1; original emphasis). He argued in bold caps "**THIS ISN'T HEALTH CARE EXPANSION AS MUCH AS IT IS PRISON COST SAVINGS**." Elsewhere, AB 34 advocates were more specific: $200 million investment would save the state correctional budget $800 million, the state hospital system $400 million, and local law enforcement and county governments another $1.1 billion (Access 1999). A Recovery-based system of care would "enable adults with [SMI] to reduce symptoms which impair their ability to live independently, work, maintain community supports, care for their children, stay in good health, not abuse drugs or alcohol, and not commit crimes" (California SB 659 1995, 2).

California administrators found in Recovery a guide and justification for implementing more stringent cost controls, especially by moving patients as rapidly as possible through decreasing levels of care and, hopefully, out of the public mental health care system. Though driven by financial exigencies, a 2000 report shows how the turn towards managed care was reformulated in patients' best interests:

> As a result of excellent leadership within the Department, as well as a strong vision for improving care, promoting community based services, and strengthening consumer voice, a plan for managed care was created. This focus of a recovery model was the foundation of this plan. . . . This [Recovery/managed care] involved shaping the system to begin moving clients from "higher," more invasive levels of care to developing a supportive, community-based service system that maintained clients at the lowest, and most independent, levels of care. (IDEA Consulting 2000, I-5)

This "flow" of patients from high to low levels of intensity would be central to the Recovery-based system funded by California's MHSA.

As Selix had hoped, AB 2034 "proved" that the legislation's mandate of Recovery-based intensive treatment programs "payed for itself" by decreasing hospitalizations, incarcerations, and homelessness. Aware of the importance of proving that the programs produced positive outcomes, Selix had written into the legislation an ongoing evaluation component. Throughout the program's history, the California DMH presented enormously positive results, including in this 2003 report:

> What California has accomplished with AB2034 programs has never been done before in California's adult community mental health system. . . . Currently (as of 2003) 4,071 of the 4,881 persons enrolled in these programs are in some type of housing rather than on the streets. The success of local programs in helping individuals move from homelessness to community housing situations is one way that this demonstration program has broken new ground. As in previous years, evaluation data continue to show dramatic reductions in the number of days of incarceration and inpatient psychiatric hospitalization experienced by individuals in this program. And, for the first time, the data reflect significant increases in the number of persons involved in employment activities. (DMH 2003, 1)

The quantification of outcomes was critical to the success of the program and, ultimately, the passage of the MHSA. Elsewhere in the 2003 report, the authors reported that enrolled patients experienced 983,709 days of homelessness in the 12 months prior to enrollment, and 321,667 days in the 12 months after enrollment, a decline of 67.3%.

Despite apparently rigorous data collection and analysis, the data raise more questions than answers. Lack of comparison groups and regression to the mean (homelessness or release from jail were criteria for enrollment) are readily apparent methodological flaws. The final (2007) report reveals deeper problems. Analyses in the text, which echo earlier positive results, are based on the 3,888 patients who remained enrolled in the program as of January 2007. Buried in Appendix H, in a table innocuously labeled "Benefits, Disenrollments, and Other," is the total number of patients enrolled in AB2034 through 2007 (Mong, Conley, and Pilon 2009). Of 10,887 individuals, 7,024 had "disenrolled" by the end of the program. Of those disenrolled, 48% had disappeared, 18% had "moved to another county/service area," and 8% were in jail or prison. Most notably, only 386 individuals, or 5.5% of those disenrolled, "successfully met his/her goals such that discontinuation . . . is appropriate." Given the high rate of attrition and very low rate of treatment success among those no longer in the program as of 2007, restricting analyses to the 35% of enrollees who remained in treatment dramatically overstated the effectiveness of the program.

### *Proposition 63: The Mental Health Services Act*

While AB 2034 proponents had hoped that it would be expanded and reshape the entire system of mental health care for California, the legislature was unwilling to increase its funding beyond $55 to $65 million per year. Selix realized that a voter-based initiative was the only way to provide the necessary budget increases to forge a new system of mental health care based on Recovery, in which he and the CCCMHA believed private contractors would provide the lion's share of care. The campaign for Proposition 63, the California Mental Health Services Act (MHSA), was funded largely by contributions from the CCCMHA and individual private contract providers.

California voters approved Proposition 63 in 2004, increasing by 1% the state personal income tax for those earning over $1 million. In addition to dramatically increasing state funding for public mental health care, the MHSA enshrined Recovery as the philosophy of California mental health policy: "Planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers . . . to promote concepts key to the recovery for individuals who have mental illness: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination." It also mandated that 51% of all clinical funds be used for intensive, ACT-like treatment teams modeled on those used in AB 2034. Named "Full-Service Partnerships" (FSPs) in the legislation, these teams were required to have a staff-to-client ratio of 1:15, consisting of a psychiatrist, other mental health providers (most commonly social workers), and housing and employment specialists. Admission criteria were similar to AB 2034: eligible patients had to have a diagnosis of a serious mental illness and a history of homelessness, multiple hospitalizations, or incarceration.

Based on AB 2034 costs, the projected average cost per FSP patient was estimated at $15,000. Even with the massive infusion of funds from the MHSA, eligible patients would outstrip the number of FSP slots. Administrators and policymakers did not see this as an insurmountable problem: a fundamental tenet of Recovery is that, as patients recover, they become increasingly independent, requiring fewer and fewer services. California was not unique in the practical translation of Recovery into the movement of patients from higher to lower levels of care. The Connecticut Department of Mental Health claimed that "Progress within a recovery-oriented system of care involves becoming less reliant on the services of providers and becoming interdependent with and among one's 'natural supports' (i.e., family, friends, neighbors, landlords, employers, grocers, etc.)" (DMHAS 2002, 5), and New Jersey declared that "In a recovery model, consumers progress through the system, relying less on services" (NJDHS 2007, 15). Yet, AB 2034 programs failed to move a substantial proportion of patients into independence, a fact never publicly acknowledged by policymakers or the evaluation team.

Privately, this failure of patients to conform to expectations of independence deeply troubled clinicians, administrators, and policymakers. In 2003, Richard van Horn, President and CEO of Mental Health America in Los Angeles (MHALA)—among the most influential private contract providers in the state and home to The Village, established as one of the two AB 3777 ISA pilot sites—wrote to Marvin Southard, Director of LA County DMH: "[W]e are beginning 'Village Next'—a step down to deal with the issue of 'flow.' I know that this is an issue that must be researched and solved if we are going to have any long-term success with integrated services: AB34 or ACT or whatever" (van Horn 2003). This problem—moving patients through the system—posed the most significant threat to Recovery.

The psychiatric medical director of the MHALA Village, Mark Ragins, poignantly reflected on the irresolvable and impossible dilemma Recovery put both patients and clinicians in:

> Creating flow was the single hardest thing we ever had to do; that's what I think. . . . The program had already been in existence for ten, fifteen years—good culture, strong, and all this stuff—before we started really trying to move them on their way. And the problem was that the Village was doing very well, and people were doing well, and we had a waiting list that took about one new person every two months, because there's no dropouts in programs like this . . . people don't drop out. They just stay. (Ragins 2010, 31–32)

Through intensive efforts of a small army of social workers, case managers, housing and employment specialists, combined with a brick-and-mortar miniature community where Village clients worked, played, and developed meaningful relationships, the Village illustrated that care and treatment were intertwined, and that it was a mistake to conflate successful treatment of individuals with SMI with independence. Ragins's lament that there were no dropouts (and, therefore, none of the "flow" promised by Recovery) was precisely because "people were doing well" in the Village community.

Acknowledging that the legitimacy of Recovery-based systems was predicated on the promise of flow and independence rather than long-term care, California administrators and policymakers devised a clinical system in which patients would move efficiently from high-intensity FSPs to other outpatient programs and ultimately into Wellness Centers, which were also newly developed using MHSA funds and were to serve as the lowest levels of care in the public mental health system. In a 2005 memo to clinic directors, LA County DMH administrators wrote, "In the initial months of system change, ACT-like programs and Wellness Centers will be developed. . . . A full range of services in every community will encourage flow of all clients to a more recovered less intensive level of care" (LACDMH 2005, 2). In a training provided to DMH-operated (non-contract) clinics on "transformation," the first priority for "organizational structure and process" was to "[c]reate client 'flow' and movement towards 'graduation' by organizing personal services into goal-oriented tiers, including ACT [FSP] and the Family Wellness Center." Graduation could mean movement from an FSP to a less intensive treatment program or graduation from the clinic. In a 2006 meeting of the seven largest LA County mental health clinics, clinicians discussed strategies for Recovery-based transformation: "establish client's 'stage of recovery' at intake screening. Identify a subcommittee to establish internal recovery transformation criteria. Criteria should include general time limit suggestions to encourage client movement" (LACDMH 2006, 43).

Instilling belief in Recovery in staff as well as patients was seen as essential to creating California's Recovery-based system of care. Echoing historian Charles

Rosenberg's (1977) writings on the necessity of a "shared faith" or "conspiracy to believe" between physician and patient in 19th-century medical therapeutics, an administrator at a Village Recovery-training workshop on "Flow" stated: "If we can develop an understanding of flow and enthusiastically believe, then we can make our members believe." According to the workshop organizers:

> Flow is consistent with our belief in recovery. Progress in recovery suggests that members at some point will not require intensive case management and mental health services. . . . Flow suggests that services are not indefinite, which can "drive" the recovery process and goal setting process. This is in contrast to indefinite services, which may create a "warehousing" effect. Almost all staff agreed that membership should not be indefinite since we believe in recovery for everyone. (MHA Village 2004, 3)

Despite the claim "almost all staff agreed," clinicians did not easily convert to the doctrine of flow. During the first year of MHSA implementation, staff transformation occupied as much effort as clinic transformation. While flow measured a patient's progress, it also measured the clinicians' belief in recovery. Patients were emphatically reminded to tell themselves, "I am responsible for my own recovery," but clinicians were responsible for shepherding their patients on to lower levels of care and ultimately toward graduation out of the clinic.

### *Resilience of Recovery*

Recovery in California has proven enormously successful in terms of revenue available for care for SMI. From 2004 to fiscal year 2020–21 (projected), the state has raised $25.5 billion in MHSA funds (DHCS 2020). To prevent state policymakers from using MHSA funds to replace (cut) other state mental health funds, the authors explicitly forbade the use of MHSA dollars for services already being provided, including inpatient and involuntary care. When state general funds shrank during the 2007–2009 Great Recession, California's county mental health departments' non-MHSA budgets dissipated, leaving them with few options but to "transform" more of their clinical services into Recovery-based programs that would make them eligible for MSHA funds and Medicaid matching dollars. This accelerated the MHSA's impact on the overall system. After general funds recovered post-recession, MHSA funds accounted for about 20% of California's public mental health budget. In fiscal year 2017–2018, the total public mental health budget was $9.8 billion, including $2 billion from MHSA, $2.8 billion from California sales tax, and $4.3 billion from Medicaid (California Budget and Policy Center 2020, 69).

Over the last 15 years, the state and counties have reported remarkably positive outcomes from MHSA-funded Recovery-based programs (Ashwood et al. 2018; UCLA Center 2013). Since the MHSA mandates that counties use at least

51% of MHSA clinical funds for the operation of FSPs, administrators have been especially keen to report the success of these programs in decreasing homelessness and incarceration. LA County DMH's Annual Report for 2019–2020 reported reductions of 29% in homelessness, 17% in justice involvement, and 25% in psychiatric hospitalizations (LACDMH 2020). Mandated, contracted third-party evaluations have uniformly reported positive outcomes for MHSA-funded programs and especially FSPs, but have relied on less-rigorous evaluation methods that echo the flawed evaluation of AB 2034, often lacking comparison groups (therefore unable to control for regression to the mean) and failing to define inclusion and exclusion criteria or include clients who disenroll in analyses.

In a 2013 state-funded UCLA evaluation focusing on FSPs, the authors wrote, "The robust results attained by the California [MHSA], combined with the ability of California's model to pay for itself, in terms of savings elsewhere in the public system, was deemed highly desirable for replication elsewhere" (UCLA Center 2013, 4). The same team had reported in 2012 that "These results are quite favorable when compared to AB2034. . . . The final analysis reported a percentage of costs offset of 49.8 percent. Overall, these results suggest a very positive treatment outcome, and return on investment, for FSP clients" (UCLA Center 2012, iv). In an interpretation of this evaluation, the Mental Health Services Oversight and Accountability Commission was less sanguine, writing that "results of the Trends Reports must be interpreted with extreme caution due to significant limitations with the currently available data" (MHSAOC 2014, 3). In particular, the Commission noted that "the large amount of missing or incomplete data make it difficult to draw comprehensive conclusions regarding the impact of MHSA or confidently make comparisons across years or between service areas" (4).

After 20 years of AB 34, AB 2034, and the MHSA, we don't have rigorous evaluations of whether these programs accomplish what their authors promised they would deliver. Report after report uses data analysis to affirm the belief that Recovery-based systems work, with *working* continuing to be defined in terms of reducing costly hospitalizations, incarcerations, and homelessness.

### *Recovery and Inconvenient Facts*

Claims about the success of a MHSA-funded Recovery-based system of care in California are at odds with the growing humanitarian crises of homelessness and incarceration of those with SMI. At historic highs across the country, these crises are especially severe in LA County. The unrelenting growth of homelessness has made the streets, parks, and underpasses of LA County home to the largest population—over 60,000—of unhoused persons in the nation (LAHSA 2020). With a much higher proportion of its homeless individuals unsheltered on any given night, LA County also accounts for the largest number of deaths of homeless individuals in the country, with over three times the number of homeless people dying on its streets than New York.

The MHSA has likewise failed to stem the ever-growing numbers of individuals with SMI incarcerated for "crimes" that often are directly attributable to their mental illness. Since the early 1970s, Los Angeles has been an epicenter for criminalization of those with SMI, a phenomenon that 19th-century crusaders thought they had abolished with the creation of state asylums. Despite 20 years of Recovery-based mental health policies, LA County Jail's population with SMI has grown significantly faster than its general population, continuing to grow even when the jail general population began to decrease. At over 5,000 on any given day, the number of individuals with SMI housed in the LA County Jail has doubled since 2010. That number constitutes a third of the overall inmate population and makes the LA County Jail the world's largest psychiatric institution (LACSD 2019).

It is difficult to look at these realities and not think back to claims made about the Recovery model and two belief systems that underpin it: a narrow medical model of mental illness, in which a patient's disease is treated without consideration of his or her social context; and a neoliberal philosophy in which treating SMI will remove obstacles to independence—the same philosophy that influences the minimal economic safety net within which individuals with SMI attempt to survive. Far from providing a hospital without walls, we continue to provide treatment to individuals who frequently find themselves incarcerated or unhoused, trying to help them achieve recovery and independence in circumstances unquestionably as horrific as some of the worst claims about state hospitals.

## Conclusion

A conclusion about whether Recovery actually "works" is beyond our scope. Instead, we have tried to understand Recovery's origins within the political, economic, and historical contexts that gave birth to it and have allowed it to flourish. It is a philosophy rooted in and reinforced by contemporary neoliberal political economy and its supporting ideology. Central components of Recovery—individual independence, empowerment, self-responsibility—are mainstays of citizenship in an economy driven by market forces, paralleling the beliefs that rationalized the transformation of welfare in the 1990s. In a historical moment where poverty was largely seen as a problem of the individual and the welfare system was believed to perpetuate it, Recovery similarly affirmed a system of care that abhorred dependency, measured therapeutic success against a metric of independence, and acquiesced to the expectation that mental health services justify themselves by delivering cost savings elsewhere, rather than simply showing that they improve patients' lives. Notably, our critique is focused on the structures and rhetoric of a Recovery-oriented system of care, rather than on-the-ground treatment of individual patients; as we heard from staff at The Village, providers struggle with the idea that they should "flow" clients who are doing well with FSP services into a lower level of care that might not meet their needs.

Psychiatry has been beset by an increasingly myopic view of its patients, losing sight of the ways in which patients' social and psychological contexts are as much a part of psychiatric disease as is biology. Recovery has contributed to a similarly myopic public mental health care system. While proclaiming a comprehensive, patient-centered approach, Recovery has justified a system of care that systematically fails the sickest patients by abandoning them to the streets or turning a blind eye to the incomprehensible inhumanity of caging those with SMI. Ironically, the declaration of optimistically positive outcomes implies that those who fail to recover ultimately have themselves to blame, rather than a social system that values profit, cost savings, and independence over care and the alleviation of suffering.

To be sure, we do not see this as a critique of any particular treatment, be it ACT or psychotropic drugs. The clinicians among us (JTB, EC) prescribe both and have seen these interventions work, sometimes remarkably well. However, Recovery is not a treatment intervention. It is a philosophy that values belief over evidence and avoids responsibility for addressing our woefully inadequate safety net, worsening housing crises, and justice system. Policies and treatments are always deeply embedded in and shaped by the social, cultural, psychological, and biological matrices in which they are implemented. As such, our essay is less an overall critique of Recovery and more a cautionary tale of the ways in which a treatment philosophy, no matter how well meaning, can reinforce the very conditions it ostensibly aims to cure.

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