

Mental Health and Public Policy Symposium  
Institute of Governmental Studies, UC Berkeley  
"Coping With Mental Illness and Crafting Public Policy"  
Saturday, January 12, 2002, UC Berkeley Wheeler Auditorium

**REMARKS**

I am honored to join the distinguished experts in the field of mental illness, public health, and economics who are here today. This symposium can bring the important scholarship of the university into the arena of policy development and political action. I want to particularly thank Fred Martin, Visiting Scholar, and Bruce Cain, Director, of the Institute of Governmental Studies for creating the opportunity for policymakers to call upon the “best and brightest” minds in our academic institutions. University resources can make an important contribution to help forge “best practices” in the treatment of mental illnesses—and help gather data to document the need for major system reform.

A **key question posed to this panel** is “What can be done to enhance coverage and service delivery for mentally ill people?” In my response to this question, because I am an elected politician, I will first address two factors—politics and data—affecting prospects for reform, and then report on three policy areas of

- (1.) **expansion of parity,**
- (2.) **reform of the mental health funding structure,** and
- (3.) **elimination of discriminatory practices.**

To begin with, **two underlying factors influence policy development:** **FIRST**, the political environment for change and, **SECOND**, access to data that documents the failures of the current system.

**On the political front**, the environment is much improved since I first took office in the State Assembly 5 years ago. When I first came to the Legislature, mental health was not on anyone's agenda, and the last group of legislative policy leaders Senator Nick Petris, Senator Dan McCorquodale, and Assemblyman Bruce Bronzan dated back to the 1980's. Prior to that, Senator Petris was a visionary who joined with Senator Short and

Assemblyman Lanterman to commit major legislative resources in investigations and comprehensive legislation that resulted in landmark reforms in the system. I am sure, however, that they never envisioned that the State would not follow-through with establishing the community mental health system intended to back up their reforms.

When I first came to the Legislature, I had to ask myself, "why do I want to make mental health a priority?" when there was very little interest in the issue—and no one believed there was any political payoff for taking on this policy area. But, my background as a psychiatric nurse and community activist in the Mental Health Association and 22 years in local public office compelled me to forge ahead. I asked then-Speaker Cruz Bustamante (a former staffer for Bruce Bronzan) to reinstitute the Select Committee on Mental Health and I begin hearings on the criminalization of mental illness. Our committee produced a report that is still a primary reference on this subject.

One advantage of term limits is that more members are coming from local government where they have had to deal directly with the consequences of a patchwork mental health system that finds it difficult to demonstrate results. They know from local experience that community mental health is inefficient, ineffective, and heart-breaking in its inability to serve needs.

In recent years, we have seen some progress as the number of legislative proposals increased, the number of legislators introducing measures increased, and the issue of mental health reform became an integral part of policy platforms for many more candidates running for the Senate and Assembly. There is measurable evidence that politicians are more informed about mental health and inclined to keep the issue on the action agenda. Also, the increasing political involvement of NAMI California members, I believe, has assisted candidates to become more informed.

- In the 1999-2000 legislative session, more than 30 substantive bills were introduced by 20 different authors proposing improvements or reforms in mental health. Fifteen bills passed both houses of the Legislature and were sent to the

Governor; nine were signed into law. In the “good times” budget of 2000, the governor increased mental health spending by \$150 million, much of it targeted to rehabilitation programs for mentally ill people coming out of the criminal justice system and for those who are homeless, and there was some additional funding to the base in the public mental health system. In 1998 and in 1999, mental health parity bills that I authored passed the Legislature over the fierce opposition of special interests. The first measure, AB 1100, was vetoed by Governor Pete Wilson, but we came back again with AB 88 that was signed by Governor Gray Davis, taking effect in July of 2000.

- This current session (2000-2002) of the Legislature, more than 50 mental health-related bills were introduced, but the economic downturn does not bode well for any bills that cost money.

**To date in this session, notable bills** signed by the governor include:

1. Assemblyman Steinberg’s measure, AB 334 expanded existing demonstration projects for effective treatment of homeless people with mental illness—a measure that needs to be expanded to every county in the State—until a reformed system minimizes the need for this type of categorical funding;
2. My own bill, AB 1424 added provisions to the Lanterman-Petris-Short Act to improve the quality and consistency of information considered in commitment hearings, i.e. requiring that medical records and relevant information provided by family members be considered in court proceedings. This bill also prohibits insurance companies from requiring court commitment in order to cover in-patient mental health treatment.
3. Senator Perata’s bill, SB 1059, establishing a Council on Mentally Ill Offenders set in motion a very important project for effective changes to meet the long-term needs of adults and juveniles with mental disorders caught up in the criminal justice system;
4. A bill by Assemblyman Salinas, AB 328, takes a critical step toward analyzing and changing the funding structure for community mental health that has been in place for

more than ten years. This system, known as the Realignment Act of 1989, is in need of a major overhaul and the Salinas bill ensured that the Legislature would have some essential data by April of this year. For those not familiar with what we call “Realignment,” this is the law that shifted responsibility for community mental health services and other health and social services from the state to county government, and funded the shift by allocating a percentage of the Vehicle License Fee and one-half cent of dedicated sales tax to pay for those services.

**On the politics of mental health reform**, it is also important to consider **some polling data** indicating the level of public support for mental health. While we were waging the battle for mental health parity, a Field Institute survey reported that 90% of Californians agreed with the statement that “Mental illness, such as depression or schizophrenia, should be covered by health insurance plans in the same way as diseases such as diabetes, asthma, or other chronic physical diseases are covered.” In the same survey, three in four Californians said they were willing to pay more in taxes to make mental health treatment services more available for children and families in their community. Just a few weeks ago, a Field survey related to the State’s current fiscal problems reported that 88% of Californians oppose cuts in mental health programs.

Political prospects are quite good for keeping up the momentum for mental health reform because of greater public awareness and focused interest from foundations and news sources. But the Legislature and advocates have to aim high, reject Band-Aid solutions, and collaborate to take on the larger task of wholesale reform as our predecessors did.

**My answer to “what can we do” in the political arena** to further the possibility of major reform and adequate funding is to increase public demand for change. Make it politically risky to oppose major reform. Some of the methods are to:

- make sure political candidates in 2002 take a position on mental health issues;
- compile the facts that document the case for reform—and expand the grassroots advocacy that is educating both policymakers and the public;

- work with local print and broadcast media to keep them informed and don't forget to congratulate them on the excellent reporting and editorializing that they have been doing in recent years, increasing the visibility of problems and solutions in mental health treatment.

The **SECOND** underlying factor related to change is documenting current system failures--an even larger challenge than political obstacles. In addition to the U.S. Surgeon General's reports, at least six major, statewide studies of public mental health in California provide some data—the report of the Joint Legislative Committee on Mental Health Reform, the Little Hoover Commission reports, an evidence-based RAND study, the Mental Health Planning Council draft Master Plan, and the HealthCare Foundation study on the “State of the State of Behavioral Health.”

The data compiled, however, has not been synthesized in a way that adds up to a coherent story that can be communicated to the public. Much data is missing—and every one of the studies I mentioned—and some in great detail—identify the lack of accessible and useful data to characterize current conditions. We all know the general attributes of the public system—the chronic underfunding, the absence of integrated services, inconsistencies from one county to another, costly inefficiencies, criminalization of mental illness, and the crisis-driven nature of access and service delivery. But, we lack the statistical evidence to demonstrate that it is just as costly to deny treatment as to provide it. People in the system know this is true, but we cannot point to definitive studies that would prove this contention—and form the basis for effective advocacy.

A **key problem** is that there are no state standards to establish accountability and adequately measure success or failure. **There are many unanswered questions:** What exactly is the nature of the gap between what clients need for recovery and what clients actually get? What percentage of people in the public system is getting the level of treatment that they need? How many are getting less service than they need for recovery? How many are turned away and denied services? And the key question is "What are the fiscal costs and human consequences of denying appropriate treatment?" The public and

policymakers must have an answer to this last question in order to enact a comprehensive reform bill.

Right now, there is no central repository for answers to these questions, even though individual counties may have some of the data. Many do not have the resources to estimate the answers—and the Department of Mental Health does not have the resources to collect and process the data.

A sampling of **what we DO know about the public system**, is that:

No matter what the state's fiscal condition, in boom times or bad, mental health is not adequately funded.

- Less than half of those in need of mental health services in California are in treatment. The current unmet need is estimated at 600,000.
- The suicide rate in California is 150% of the homicide rate; more than 90% of suicide victims are people with a mental illness.
- The annual expense of criminalizing mental illness is estimated to be between \$1.2 and \$1.8 billion. Los Angeles County and cities within the county spend \$500 million a year in law enforcement costs alone, according to testimony provided to the Legislature by police and sheriff's officials at a hearing in 2000.
- The California Healthcare Association testified that mentally ill people are kept in hospitals for days, weeks, even months longer than necessary, at great expense, because of the lack of outpatient services.
- On a per capita basis, mental health agency spending declined 27.7% between 1981 and 1997, according to a California HealthCare Foundation study.

- Under the current state funding formula, the annual purchasing power of county mental health systems is \$50 to \$60 million less than it was in the mid-90's, according to the County Mental Health Directors Association.
- Federal actions are further reducing the availability of mental health services to the disabled and elderly on Medicare.
- We are spending more mental health dollars in prisons, hospitals, and homeless rehabilitation programs, while we are spending less on mental health services that could significantly reduce such costs.

**I will sum up by saying, we do not have the facts necessary to mobilize public opinion and get action in the political arena.**

In suggesting **what we can do** about this, I want to call upon the research and public policy resources available at university campuses. We need to integrate the knowledge of administrators, practitioners, consumers and family members who interact with the system, and providers, with the system experts in our public and private educational and civic institutions.

**(#1. PARITY)** I will turn now to the policy area of mental health parity.

On July 1, 2000, AB 88, requiring parity in insurance coverage for the treatment of severe mental illnesses and serious emotional disturbances of children, was enacted. That same year I co-chaired the Joint Committee on Mental Health Reform that held public hearings across the state and produced a report of findings and recommendations on the barriers to access to appropriate levels of mental health care.

On October 18, 2001, 17 months after the Governor signed AB 88, I chaired an informational hearing to examine the status of parity implementation by bringing together all those responsible for ensuring that AB 88 is, in fact, expanding access to affordable, equitable care for those with health insurance plans.

Now that insurance coverage is available for mental health services, we must look at the quality and effectiveness of those services. What AB 88 does beyond provide legal guidelines for insurance coverage is to give us an opportunity and the responsibility to better coordinate and integrate our delivery of services, especially for children, to evaluate the organization of our delivery system, the quality of those services for their effective outcomes, and to maximize access for eligible children and adults.

I would like to briefly share with you information from the interim Assembly Health committee hearing on AB 88 implementation.

There was consistent testimony from service provider organizations (Md.'s, LCSWs, MFTs, and Psychologists) that said that their members commented that access to mental health services increased with parity implementation.

Empirical data showing increased use of mental health services since AB 88 took effect was presented by clinical researchers. Of particular note is the pattern of increased utilization, migration toward increased care within the Managed Behavioral Health organization network and long term cost reductions.

**The political reality:** In order to get a parity bill signed in California it needed to be limited to severe mental illnesses and serious emotional disturbances of children. Those of us familiar with the research and real experience in other parity states know that there is no significant cost increase due to parity whether the parity law is for all mental illnesses or restricted to severe mental illnesses. However, the political reality of a powerful insurance and HMO industry lobby required us to impose limits that made the governor more comfortable with overruling the industry objections to sign the bill.

Fortunately, the implementation experience in this state, revealed at the AB 88 hearing, shows that parity laws, even those written to be limited, will be implemented realistically; that in reality it makes more business sense and is more economical to NOT impose artificial cost controls such as higher copays and visit limits based on diagnosis – which

is probably why such arbitrary cost controls were never placed on other physical illnesses. It doesn't save money – it just creates more administrative nightmare.

In the same hearing, plans testified about their concern that mental health services for children need to be evidence based and that there needs to be more coordination among other providers – schools, regional centers -- in order to ensure that current services continue to be available to children while mental health services become more accessible and comprehensive.

On September 18 and 19, 2000, Dr. David Satcher, Assistant Secretary for Health and Surgeon General, convened the **Surgeon General's Conference on Children's Mental Health: Developing a National Action Agenda**. Dr. Satcher noted that there is no mental health equivalent to the federal government's commitment to childhood immunization. Children and families are suffering because of missed opportunities for prevention and early identification, fragmented services, and low priorities for resources. Overriding these problems is the issue of stigma that continues to surround mental illness.

A study conducted by Dr. Steve Forness in California pointed out that identification of serious emotional disturbance of children was not being done accurately or on a timely basis in schools. Among 13-year-old children from 12 special classrooms for children with emotional disturbance, diagnoses such as depression (1/3), attention deficit hyperactivity disorder (1/4) and post-traumatic stress disorder secondary to abuse were made. Before these children got into special ed, parents reported recognizing a problem at mean age of 3.5. Outside agency records indicated problems at a mean age of 5, and the first documented intervention was at age 6.5 years of age. The first eligibility of special ed was at about 7.8 years, and in more than 50% of the cases, these children were placed in the category of Learning Disabled, not in the category of Emotional Disturbances. These children finally got the right services at age 10!!!!

Dr. Forness pointed out that the definition of emotional disturbance used in schools is seriously flawed. Learning disabilities (LD) and speech and language handicaps (SL) account for the majority of the 11% of school age children in special education. Less

than 1% of children are found eligible in the school category of emotional disturbance (ED). Compared to children in the two largest categories of special ed (LD and SL) who are mostly mainstreamed (over 80%), fewer than half the children under the ED category are mainstreamed. Under-identification or misidentification may also make it less likely that children will be referred to other agencies for needed mental health services. Cost-efficient systems for school mental health screening and methods for training regular and special education teachers in early detection of mental health disorders are available, but seldom used effectively, if at all, in actual school practice.

Clearly, countless studies that document the cost effectiveness and successful treatment outcomes of coordinated, integrated mental health care should motivate stakeholders to make the changes recommended. The administration and the legislature need to hear from the scientists as well as service providers and other stakeholders in the field and nurture discussions among them in order to ensure true success in fully implementing AB 88.

**Federal parity efforts:** On December 18, 2001, the Domenici/Wellstone federal parity amendment, attached to a labor –health and human services appropriation bill, was dropped from the bill when House GOP conferees unanimously voted against it. That action killed the parity amendment even though it had 66 cosponsors in the Senate and a similar bill had the support of over half the members of the House of Representatives even though the GOP House leadership had refused to allow hearings on the bill. However, the Chairman of the House Labor-HHS Appropriations Subcommittee and the key House conference leader pledged to work with fellow conferee and House parity champion Congressman Patrick Kennedy on report language directing the House authorizing Committees to take action on parity in 2002.

According to the Director of Governmental Relations (Jay Cutler) for the American Psychiatric Association: "opposition to parity has essentially been reduced to two groups: the Church of Scientology (and those with similar anti-psychiatric views like adherents to

the view of Thomas Szasz), and big business coalitions that generically oppose mandates, along with—on this issue—their dwindling allies in Congress."

Despite complaints of proponents that the White House played a passive role on parity last year, recent reports are that President Bush has pledged to work on parity in 2002. So in this year, we can look forward to a major lobbying push on the House where hearings on parity law have not been held.

## **(#2 PUBLIC FUNDING)**

### **Reform of public mental health funding should also start with parity.**

We do **not** have parity in the public mental health system. The funding structure is such that:

- State and federal programs that entitle eligible people to health care exclude mental health treatment from the entitlement. Medicare and Medi-Cal do not entitle people to necessary mental health treatment.
- California's funding structure under the Realignment Act limits mental health services through a spending cap. For more than ten years, state policy has been to deny mental health treatment when these limited funds are exhausted, whether people have Medi-Cal or not. No other medical condition is subject to this limit.
- The Realignment Act also authorizes counties to transfer state funds out of mental health accounts for other social services. In 1994-95, \$25 million was transferred out, and in the last five years, \$60 million has been transferred out of local mental health accounts.
- Current state law includes lengthy sections that describe effective, culturally competent standards of mental health care for children, adults, and older adults. **But** the standards are meaningless to all but a few people because the law also includes the provision that county mental health systems shall provide these services only "to the extent resources are available." In other words, state law spells out the elements of appropriate treatment, but then specifically provides that no one is entitled to this level of service!

Early last year, I introduced a bill (AB 1422) that would extend parity in mental health coverage to the public sector by establishing an entitlement to standards in systems of care. The bill would phase in the entitlement over several years to allow the State and counties to restructure and prepare to meet the standards for everyone—during this same time we can act on proposals to address the workforce issues and housing shortages—no small task! The bill also shifted responsibility for paying the match for federal Medicaid dollars from the counties to the State, thus lifting the discriminatory spending cap for mental health dollars, that is not present in other medicaid expenditures.

This was not a piece-meal bill. The bill gathered bi-partisan support in the Assembly and rallied the California Coalition for Mental Health. Opposition to the cost of implementing the bill (the best estimate was \$500 million for a full entitlement) made us amend out those provisions to keep the bill moving. I am working to see that these provisions are reintroduced in another bill this year.

Nothing less than an entitlement to quality standards of care will create parity for those in the public mental health system. Nothing less than an entitlement to care will create opportunities for cost efficiencies that will reduce spending on expensive and inefficient care in the criminal justice system.

I want to stress that it is not necessary to transfer program responsibility back to the State in order to improve service delivery and programs. Local control can be maintained and quality standards can be the norm if we fund an entitlement to standards of care.

An entitlement to tailored, quality services is fundamental to **what we can do** to improve quality and accessibility to services when people need them. With standards, we can evaluate the systems of service delivery and the quality of treatment, and continuously improve programs. With an entitlement, people will have a right to early treatment, which is the most effective approach to recovery and cost-effectiveness. Like any other common illness, early intervention produces better long-term results.

### **(#3 DISCRIMINATION. )**

Finally, we cannot discuss mental health and public policy without acknowledging that the history of policies on mental illness is marked by discrimination, which is also the unfortunate foundation of our funding systems. These policies flow from the myth and mystery and misunderstanding associated with mental illness.

#### Discriminatory practices are long-standing and persistent:

Mental illness is the most prevalent health problem in America. Cases of mental illness outnumber illnesses related to cancer, lung disease and heart disease combined, **and yet** every level of government finds a rationale for short-changing mental health in research dollars and treatment programs.

#### **We have to label mental health policies in a straightforward manner as**

**discriminatory.** The American people must hear from their leaders that we are practicing systematic discrimination against people with mental illness. This discrimination is not acceptable to the people of our state or country, but they are not being informed of these policies.

One of the underlying beliefs that I think justifies discrimination in the minds of many people is that mental health is a private problem, not a public one. The policies we live with today are rooted in old, mistaken beliefs that people can cure themselves of mental illness with home remedies, that mental illness is not an authentic medical condition, that mental health treatment does not work, and that most people will not recover.

Our culture still tells us in many ways that mental illness is a sign of weakness—a character flaw that should be kept under wraps. As a result, many people with mental illness fear seeking treatment, even when they have health insurance benefits, and suffer in silence in order to avoid the shame associated with psychiatric illnesses. The secrecy surrounding mental illness also keeps mental health low on the priority list when it comes to public funding because our culture tells us not to talk about it.

**The costs of discrimination** are extraordinarily high in human and economic terms. As the state's Little Hoover Commission pointed out, in the private and public sector, California spends billions on the consequences of untreated mental illness rather than spending on adequate care. Direct and indirect costs to the public and private sector are estimated at almost \$20 billion annually in California, including workplace costs such as lost productivity.

In a poignant comparison between how we respond to physical and mental ailments, the Commission report stated that if we applied mental health policy to other medical conditions, we would tell someone with a cancerous tumor to come back for treatment when the cancer had metastasized.

**What we can do is** invest private and public dollars and enlist public relations and media experts to develop effective education campaigns, and bring mental health into the mainstream of health care. We can integrate education about mental illness into school curriculums. We can motivate political leaders at every level of government to reveal the true picture of mental health services in their communities and states. We must **Stop the cover-up that keeps the scandal and disgrace from public view!**

**In closing**, I want to say at this symposium, sponsored by an impressive number of educational institutions, that I want to look to all of you to make mental health a priority in research on health economics, systems of delivering services, and evaluation of program outcomes.

We cannot tolerate the status quo and I ask that you help build momentum for change.

Thank you.