Rose King talks about what a recovery-oriented mental health system should look like…

I think a recovery-oriented system is the best way to go, but it has to be from the get-go. That is, the person's first contact with the system. And it has to involve public education also, so that there is a knowledge and acceptance and expectation for the person who has been told that they have been diagnosed with a serious mental illness. So that they have an expectation, the clinician dealing with them has the expectation, that they will recover and have a life that might be challenging at times, but that they can identify what's going to maximize their recovery, and that this is not a life sentence of living in a hovel and without resources…

Even twenty-five years ago…a young psychiatrist just out of med school told me and my daughters that it was not beneficial for my son [who had a mental illness] to be around us a lot because it would remind him and reinforce his inability to measure up and to do what he'd like to do and to achieve what his sisters are achieving, and so forth. And that he wasn't going to go to college and wasn't going to be a homeowner, and blah, blah, blah. In fact, he did go to college. But this was just twenty-five years ago I was told that it wasn't good for him to be around us a lot. So the system and professionals in the system discouraged the person being integrated into the household and into society…

You have almost a million people, say, who pass through the system in any given year, and who've had negative feedback for some years. And it doesn't take very long for a person's confidence to be greatly diminished. So that would be a whole different challenge…trying to communicate that concept to people in the system.

READ THE FULL TRANSCRIPT BELOW.

INTERVIEWEE: ROSE KING

INTERVIEWER: Howard Padwa

DATE: June 16, 2010

I. Entrance into Politics; Early Lessons Learned about Campaigning; Family Experience with Mental Illness

HOWARD PADWA: This is Howard Padwa here on June 16, 2010, doing an oral history interview with Rose King in Sacramento. Rose, for starters, tell me a little bit about your background, where you grew up and how you became interested in issues around mental health.

ROSE KING: I'm a native Californian, born in the Bay Area, and I moved to Sacramento with my husband and three children in the mid-sixties. At that time Ronald Reagan [California Governor, 1967-1975] ran for governor, and not long after that an RN [Registered Nurse] from San Francisco filed a petition to recall him as governor.

HP: What was the reason to recall him?

RK: Well, there were many reasons to recall him, but among other things, he had been slashing Medi-Cal and health services for poor people, for the elderly, and for children. Now, it didn't have any direct impact on me. My husband was employed and we had healthcare. But the election before that I started getting involved in politics.

HP: What sort of groups?

RK: The Democratic Party. From my grandfather there was some tradition I knew from my mother from a young age that we were Democrats. I contacted the RN who had done this, the Sacramento Bee published my Letter to Editor, and I ended up being the Sacramento County coordinator for the “Recall Reagan” campaign.

HP: And was there a legal justification for it, or it was just that you were unhappy with his policies?

RK: Yes, you have to have a legal justification in order to actually get on the ballot, and we collected over four hundred thousand signatures.

HP: Wow. So what were the legal reasons?

RK: I don't remember. It was on the petition. We found a way to address what the law requires. You have to basically have broken a contract with the voters.

HP: And was this before he started emptying out the [state] hospitals? [Reagan’s administration oversaw the “deinstitutionalization” of California’s state mental hospitals in the late 1960s]

RK: Well, when we started getting out and collecting signatures, the people who showed up to work on it were senior citizens, other stay-at-home moms like me, and a lot of psych techs [psychiatric technicians]. So I found out that they were the ones that

were really the main push behind it, and this RN from San Francisco had been in mental health. So that was the first time I heard about the hospitals closing, or any of that going on. I learned from them.

HP: So you were becoming involved in these issues, then.

RK: I got involved in politics, and I learned from them about the closing of the state hospitals. And I had no idea that I would ever have a personal interest in mental health at that time. And then within two years my husband's depression became serious, and I drove him to a state hospital in Auburn, the nearest one that we knew of. And he was turned away because they said he wasn't sick enough. And besides, they were reducing the hospital population.

HP: And were there clinics or anything you could have gone to? Was the state hospital the only place to go?

RK: There wasn't much of anything, no. I mean, we had no idea what to do. We didn't know anybody -- we had Kaiser [an integrated managed healthcare consortium]. But Kaiser didn't have psychiatrists on staff in the sixties.

HP: So there was no --

RK: There was no psychiatrist. He went to see an allergy doctor. Whoever he saw about asthma for advice on treatment. So we were turned away -- - he died by suicide two weeks later, which was a complete and total shock to me. I knew nothing about mental health and mental illness. And really didn't learn much more about it until years later when my son was diagnosed, and he became ill.

HP: Okay. So you started on this recall campaign, and then after that you shifted to actually working on the hill here [in state offices in Sacramento], correct?

RK: Yes. Well, I was a volunteer first. And then after my husband died I went back to school and interned down at the Capitol. And I had a bunch of friends there because I had worked in the Bobby Kennedy primary campaign in '68 with legislative staffers, and more moms and seniors, volunteering because we thought we could make the world a better place for our children. [Robert Kennedy ran for President as a Democrat until his assassination in 1968]

HP: So who were some of the people you wound up working with?

RK: Well, early on, I was interning in a Moscone [George Moscone, California State Senator 1967-1976] and Dymally [Mervin M. Dymally, California State Senator 1967-1975] office. I think Moscone must have been the [Senate President] Pro-tem and Dymally was the majority leader, I believe. Then I left and went to graduate school. And I had a fellowship program through the Ford Foundation that Dymally brought to California, which transformed the workforce in the legislature. Leo McCarthy [California Assembly Speaker, 1974-1980] was Speaker, and in both Houses [of the state legislature], the composition of the professional staff was transformed between about 1973 or '74 and '80—from one composed of all white men to one with ethnic and gender diversity. So then when I first went to work there it was for Roberti [David Roberti, California State Senator, 1971-1994] in the Senate, after I'd gone to graduate school.

Then I worked for Leo McCarthy and Howard Berman [California State Assemblyman, 1973-1982]. I did campaigns, we went on and off the payroll all the time.

HP: So you did a lot of campaign work?

RK: I did a lot of campaign work, yes. For Art Agnos [California State Assemblyman, 1976-1988], McCarthy, Nancy Pelosi [Former leader of California Democratic Party, current Speaker of the United States House of Representatives]. Bill Lockyer [California State Assemblyman and Senator, 1973-1998], I worked for him at different times in his career. So I had the good fortune to work for some of the best and productive, and really accomplished politicians in California's history.

HP: Looking at your advocacy for the mental health system later on, what did you learn from that time when you were working on campaigns? Not specifically about mental health, but more generally about the political system and how to get things done?

RK: Well, you have to translate things for a mass audience. I believe that you can also inform people while you are winning your campaign. You don't have to run a vacuous campaign, and people don't have to change their values, as we see happening today constantly, in order to get elected. I ran a winning campaign in Orange County in 1978 and the candidate was pro-choice, and had some very progressive positions on issues. I thought many of my colleagues would take what I think is the lazy route of just advising the candidate to change her position to what they *think* is the most popular idea.

HP: To say what the people want to hear.

RK: So I did campaigns around the state. And learned also that you have to draw upon the local expertise. You can't come in from outside and be the know-all expert, while at the same time it is really an authoritarian structure and it has to operate that way.

HP: Right. So it has to be a real balance between the two.

RK: You cannot campaign by committee. Well, you have to be smart enough to know how to draw upon the wisdom of the people who know their constituencies there, and not ignore them.

HP: Yes. It does have to be difficult. I mean, a pro-choice candidate in Orange County in the seventies, I'd imagine that's got to be an uphill battle.

RK: Well, we found a way to handle it. So I learned not to take things for granted with the electorate, that people are much more open than many candidates or consultants think. That you have to tell people what to think.

HP: So you can actually tell people what to think?

RK: You have to tell people what to think -- candidates have to tell people what they think about priorities and problems. The voting public — people with jobs, families, the business of life — they do not have time to study policy solutions. That is the job of the people they elect. They have to offer a solid agenda. What’s happening today is that

they’re not. As far as I'm concerned, the dominance of Sarah Palin and the fringe groups is due to the lack of a forceful message on the other side. Democrats tend to do more preaching than uplifting, and lecturing. You can't lecture to the public, and they're not sitting in front of the TV taking notes on your statements.

HP: Right. But you said that the electorate is still very open.

RK: Yes they are. The positive thing about Obama to begin with is that he talked to the American people as though they were grownups.

HP: Right. And of the campaigns you worked on in the seventies and eighties, is there any one that sticks out where the candidate went in with an uphill battle and actually convinced the voters to swing their way?

RK: We did a lot of special elections in a Republican district. One was a congressional campaign in Visalia in the 90’s, where we defeated an incumbent, a Republican incumbent, and it's a very Republican area. First we had to beat the primary candidate, another Democrat, and then went on to defeat a Republican incumbent, in the Valley.

HP: So you had good experience doing this kind of work.

RK: Yes, yes.

II. Experience with the Mental Health System in the 1980s

HP: Now, at this time -- I guess we're talking about the seventies and the early eighties -- were you following the mental health system still? Were you keeping track of what was happening there?

RK: Not particularly, no. In the mid-eighties my son was diagnosed and was very ill. Through a good part -- well, for about five or six years –- of the eighties I had to get a crash education in the mental health system. I really had no idea. I knew nothing about it, as is the case for most families and consumers.

HP: And this was in the mid-eighties.

RK: This was about '84, because I know I was going to San Francisco to work for Pelosi. I had worked for her in '81 to '83. I was Executive Director of the Democratic Party when Nancy was chair. And then in '84 I was going down there to work for the Host Committee. The national convention was in San Francisco and Nancy was the chair of the Host Committee. And I had to change my plans and stay in Sacramento since my son was so ill.

So I quickly made the decision that this was not something to keep hush-hush about, as people often do when someone is diagnosed with mental illness. And [so does] the family, really, if it’s the first time they know anything about it. I didn't even know anybody that knew a psychiatrist. So in a very short period of time I had contacted Art Bolton [a state legislative staffer who had been involved with mental health legislation].

HP: And you had connections with him through your work?

RK: Through the legislature, yes, uh-huh. And Steve Thompson, who was really an outstanding policy guy. He had been Willie Brown's chief staff person, and ran the Appropriations Committee, and was an expert in health also [Willie Brown was a California State Assemblyman, 1964-1995]. Sometime in that year I heard about NAMI [the National Alliance on Mental Illness, an advocacy group for family members of individuals with serious mental illness]. I went to a local NAMI meeting and asked them what to do. I was just trying to figure out the system. And I had private healthcare at the time my son was ill. But this was pre-parity [before mental health services received the same insurance coverage as physical health services].

HP: So it was not really covered then?

RK: Well, they covered the doctors' visits and medication and hospitalization. That was it.

HP: And was that enough?

RK: No. You know, it wasn't. And the doctor visits were limited. It was like three or four a year.

HP: I see. So it was really maybe OK for something very mild. That's really all it could properly address.

RK: You can't put a person on psychiatric medications --powerful psychotropics , mood stabilizers, and medications developed for seizures, and all of things that could have tremendous side effects -- and tell him to come back in three months, which is what's done today in the public mental health system also.

Anyway, I didn't have any idea what to do. So I had to try to become an expert and figure out what the public mental health system was. I mean, today there is parity, but it's still difficult for people whose adult child might be covered under their insurance to determine whether or not to stick with the private health coverage, because once you drop it, he or she may never get insured again. Is it better to go with the public health system? Is it better to go with Medi-Cal and perhaps some other services, because the private insurance generally doesn't provide case management?

HP: So that was sort of the dilemma you were facing when your son fell ill.

RK: Yeah, without [mental health] parity.

HP: And what did the public system look like then? When you looked into it, what did you find?

RK: Well, I didn't look into it for a few years. Not until I finally stopped insuring him on my policy—

HP: And his services there were seeing the psychiatrist four times a year and --

RK: Yeah, and hospitalizations, numerous hospitalizations, and short-term hospitalizations. And the hospitalization part was certainly much, much better than what

public mental health had to offer in that regard. He had services he wanted in a private hospital —- and he could admit himself.

HP: What did public mental health offer?

RK: Well, at that time -- I mean, they've only ever had what we call SCMHTC, Sacramento County Mental Health Treatment Center. Then they contract out with private facilities when they are under extreme pressure.

My son was hospitalized in the public system a few times also. In the 80s, he was in San Francisco General after a suicide attempt, slashing both wrists on a bus. They stitched up the wounds in the emergency room, and the hospital was ready to release him a few hours later with a Greyhound bus ticket to Sacramento. I was in [Washington] D.C., somehow they reached me and I was only able to persuade them to let him stay until his sister could pick him up. I will never forget the fear and despair, hearing the RN who insisted he could leave say: “He’s not really crazy!”

The treatment center that Sacramento county operates was like a 1950s movie, *The Snake Pit*. I mean, it was terrible. And it still has become worse and worse and worse.

HP: And how about the outpatient options at that time?

RK: Well, they were better, until the nineties when the state had a deficit, a gigantic deficit, when Wilson was governor, which led to Realignment [the 1991 restructuring of how public mental health services were funded in California]. But prior to that the funding had been somewhat adequate in Sacramento, and my son had a social worker who had a caseload of forty to fifty.

HP: That's actually not bad by today’s standards.

RK: Well, by today's standards, many case managers have a hundred to a hundred and sixty seriously mentally ill individuals, which is just out of the question. I mean, why bother with that? All they’ll have time to do is fill out the Medi-Cal forms, and perhaps to attend to crises. If they have a hundred and fifty clients, let's say twenty of them at any given time are going to be getting in and out of the crisis clinic, or lost their medications, or got thrown out of their board and care, or room and board, whatever -- are in crisis.

HP: So back then, though, with caseloads that were relatively low, what kind of services did they give?

RK: It was better. The case manager was a mental health social worker, for one thing, a credentialed social worker. And that was the case in the Bay Area counties and in the other counties around here, too. If the person was in crisis they could come to your home. They could 5150 or persuade them that maybe it looked like time to get a med adjustment, that maybe they should go to the hospital. [5150 is the code for putting an involuntary hold on an individual who poses a danger to themselves or others] And it was possible for my son to actually get into a hospital voluntarily, which is no longer the norm.

HP: You have to be committed now?

RK: Yes. I don't know a county where someone can be voluntarily admitted. I see consumers forced to go through a humiliating, and sometimes dangerous, process to get 5150'd in order to get hospitalized. They risk jail or abuse to get involuntarily admitted.

HP: So the system wasn't as clogged [back then]. How was it in terms of therapy, housing, and employment services? Were those things offered?

RK: It was minimal in that regard. I mean, a person had to be in a position to ask for those things, and of course not everyone is. It was not organized, and it was not an integrated system in any way. I learned when I went on the county Mental Health Advisory Board. I was on there for two or three years. That was when I learned and where it became evident to me that all the money went to people in crisis. And they didn't spend anything on people prior to them being in crisis.

HP: So if you look at it that way, people getting better could never happen if the system was only putting out fires.

RK: It could never happen. And it's still that way.

HP: So you saw it from your work on the Advisory Board and also your personal experience?

RK: I saw it from my work from the Advisory Board and here in Sacramento County, "oh, wow, that's what they do." Like most advisory boards, they aren't staffed, they don't have resources, they don't have a secretary, they don't have anybody to help them do anything. So the county administrators come in and do a dog and pony show and people aren't equipped to challenge them. Some of them are able to do more. It depends on the wealth of the county.

So anyway, I did get some of that experience, of having a little more education of how the public mental health system was organized, which I did not know. And it's still very, very, very confusing for people, extremely confusing.

HP: Especially if you're having a hard time [with mental illness], it can be very hard to figure out.

RK: I mean, you look in the Yellow Pages under "mental health" and "county," and it does have access line, which is really a misnomer. You know, they're the gatekeepers. In many counties -- it's been this way on and off for years. -- they'll ask you if you have a substance abuse problem, and if you do then they send you over to substance abuse. And then the substance abuse people ask if you have a mental health problem, and if you do, they send you -- so people are sent back and forth. That happened twenty years ago and it's still happening today.

HP: So at that time, as you were learning this, were you thinking "this needs to be changed, that needs to be changed?" Were there specific things that you were thinking needed to be different and did you have ideas of what that would look like?

RK: No. I didn't know how to fix it. I had no idea how to fix it. I just challenged the county budget, and this idea of investing all of the money in hospitalization and not enough in helping people and giving them enough time and attention in the initial and

early stages of their illness, and when they were healthy so they could maintain their health. And people could recover and get out of the mental health system. It was that funding, and the categorical funding, I objected to that.

HP: Categorical, meaning…

RK: The revenue is separated into categories for specific services or programs, not necessarily a priority for individuals or the system. As in education, where a pot of money is set aside for math, for science, and this silo funding continues independent of changing student needs or advances in academic knowledge.

HP: So within mental health, for example, there was a certain amount set aside for hospitals.

RK: Yes. There was some categorical funding. Well, and special programs that the legislature does all the time. Part of the reform that supposedly took place was to reduce the categorical funding, and that's what the MHSA [2004's Proposition 63, the Mental Health Services Act] was supposed to do, but it just created more. Voters were told the MHSA would improve existing systems. Instead, Prop 63 proponents and the state implemented MHSA as an independent add-on to the existing system. All the parties involved publicly acknowledge that this "categorical" funding approach created a separate, two-tier system.

Anyway, so those were two things I learned from family experience and serving on a mental health board. I could see that all these different funding streams didn't make sense. And that it didn't make sense for people to have to shop around. For someone who has a serious mental disability, that they have to figure out how to get themselves to their primary care doctor, and over here for housing, and on the other side of town and maybe get a transportation pass. And Department of Rehab, which is really not tuned in to assisting people with mental illness. If they wanted those services, they had to go from one place to another to another.

HP: I suppose the question is, if they had case managers back then, wasn't the case manager's job to help with that kind of thing?

RK: Well, to give them the resources, yes, uh-huh. And to guide them. To tell them how to find out this or that.

HP: But they wouldn't go with them to the [social service] offices?

RK: They were in like twenty-five different places. Now, my son always kept going back to school and kept going back to work. He would get out of the hospital, and within a week or so he'd be back to work. And then he also had an extended period of relief and stability -- of being very healthy. So I don't know -- I can't tell you how much case management they did. All I know is that when my son had a really odd reaction to something and he was very different from how he usually was, I could call the case manager and he would come to the house.

HP: Wow. So it was almost more of like what an FSP [Full Service Partnership, an intensive case management program under the MHSA] is envisioned to be. It actually was a lot of the system back then.

RK: Um --

HP: Well, not completely, but in terms of the idea of being able to come into the field and—

RK: The ISA [Integrated Service Agency, an intensive case management program that began in California in 1988] is really the model. In the Integrated Service Agency there was a team of people working. There was not a team at that time. I mean, you had one contact with the system, and that was the social worker.

HP: And if that social worker was on vacation and you needed someone?

RK: Well, then someone else took his caseload, but -- There wasn't wraparound services, but people did help you get information on getting housing, whatever. And there was a residential place here in Sacramento County for young people, I don't know, eighteen to twenty-three years old. I actually ended up on the board of directors helping them for some years into the 90's. That's where he [her son] went to live for some period of time.

III. The Lieutenant Governor's Task Force for the Seriously Mentally Ill and Integrated Service Agencies

HP: Now, it was in the mid-eighties that the taskforce [Lieutenant Governor Leo McCarthy's Task Force for the Seriously Mentally Ill] got formed, correct?

RK: Yes. I left the legislature and I went to work as Leo's chief of staff in the Lieutenant Governor's office. I went there in '85, I think.

HP: Tell me the story about how the taskforce happened.

RK: Well, there was a woman who worked there for Leo -- whom I had known from the Democratic campaigns -- and she introduced me to Grace McAndrews, who was Executive Director of NAMI California. And Grace talked to me about their [NAMI's] president, Dan Weisburd, and then she came back and said, "Dan would like to meet you. Can we put something together?" I said, "fine." So Grace organized it. And this other staff person, Ellie Peck, was with us there in the beginning.

So Dan told me his family story and just that there was -- his experience was that nothing worked. [Weisburd had encountered many difficulties trying to find services in Los Angeles for his son, who had a serious mental illness] Nothing that was being offered at that time was working. And I could certainly say that that was the case in my family situation as well. His son was probably around the same age as my son, who was in his early twenties then. And clearly, nobody knew what to offer, or what to relate to. People weren't educated and everything was fragmented. It still is the core problem today.

HP: So he was having the same problem down in L.A. that you were having up here.

RK: Yes. So with the chaos of the system, nobody could tell you what they thought really worked, and nobody had a model program that was being celebrated. So it was

Dan's idea to do this statewide taskforce and to get some people together who could make a contribution. And we really both wanted it to be community-wide, because one of the problems that we identified, and I felt strongly about myself -- and still do -- is that everybody is a stakeholder in this. That's why I'm not fond of the term “stakeholder” when it excludes a wider community. Mental health and mental illness -- certainly today because there's so much neglect -- it is a community-wide issue. So we needed to have people from the business sector and other areas of politics, who may or may not have a family member [with mental illness], or may or may not be a consumer.

So, Dan identified some top people. Someone from IBM and someone from Levi Strauss, I believe.

HP: If we could just pause for one second before we get to the composition of the taskforce, was it hard to convince McCarthy to support this? How did you guys convince him that this was something worthwhile?

RK: Well, he was originally with the issue. One of his passionate policy areas was nursing home reform when he was Speaker and when he was in the Assembly. So he was really familiar with health institutions, and he knew that my son had a mental illness. And his office, unlike other Lieutenant Governors' offices, was very activist. They did reports on energy, they did reports on the environment, they did something on mental health. He had a policy agenda the whole time he was Lieutenant Governor. And the Lieutenant Governor was the chair of the Economic Development Commission.

So no, it didn't take a lot of convincing in that he knew very well that it was an issue and that it was under-funded. He'd been Speaker for five years. But the dilemma was, well, how can we fund that? What is the rationale? How can we do that? I suggested that we look at whether or not it would make sense to do it through the Economic Development Commission, given that it's a huge workforce issue, and there are many, many reports that don't get enough attention about the cost to business and to productivity.

HP: Caused by untreated mental illness?

RK: Yes. Whether it is the people themselves who are absent from work all the time, or family members who are absent because they're dealing with the chaos of system failures. So there was a good rationale for doing it. So as soon as we identified that, we could make sense of it for the Lieutenant Governor to get involved in it, and how to fund it, and how to explain that this was a priority. So we just had to get that data together. But there wasn't enough money to rely exclusively on the Economic Development Commission budget. And I knew Art, like I said, from years before.

HP: And what was Art's role at this time? What was he doing?

RK: He was a private consultant. I knew about Art and Art's work on LPS [the 1968 Lanterman-Petris-Short Act, a major piece of mental health legislation]. So I just called him and asked him if he'd be interested, and if could he figure out any way that we could get some more money. And we had to have someone do the research and determine how a government entity could accept foundation money. So Dan and Art put together the foundation money. Leo’s office could put together enough to pay for hearings around the state but we couldn't put together enough to hire a consultant like Art. And I

really wanted Art there, because I couldn't do it. I was chief of staff and had four offices to manage. Plus, I was about to take a leave and run his [McCarthy's] reelection campaign.

HP: So you decided to make this taskforce, and you were starting to mention how you decided who would be on it. How did you decide that? What was the process for that?

RK: Well, it was just maybe one or two other staff people, and Grace was probably with Dan. It was just deciding the parameters, really. There were a few people that I recruited, and I knew which legislators I thought were going to be interested. So we knew what we wanted. We did not want anybody with an axe to grind. We wanted people who could agree upon the nature of the problem, first of all. That was the beginning, that was part of the qualifications. And then there was some kind of application process. And we wanted people that could actually really contribute independent of their employer or their advocacy affiliation, and so forth.

HP: Why did you want people who were independent of an official capacity?

RK: Because we wanted a good product.

HP: Could you expand on that a little bit? Why wouldn't it be good if you had people who were involved in the system already?

RK: Because it's a very long tradition, which I had identified quickly even by that time, and it still exists today in mental health. Perhaps because there isn't enough money, I don't know what -- that if you have a pile of money or if you're going to generate some money, too often issues get resolved by giving everybody a little something, so that everybody's bright idea would have merit because they were from SEIU local number blah, blah, blah, and labor had an interest in blah, blah, blah. [SEIU is the Service Employees International Union, which represents many workers in the field of mental health services]

HP: And they would wind up serving the service of labor on the taskforce instead of the service of creating better services.

RK: And pushing an agenda. Even though, like I said, NAMI and client advocates had people on the Task Force, like Jay Mahler [one of the leading mental health consumer advocates in California]. But they had to be people that we'd had some experience with, who we thought could work with a diverse group of people too. There was a psychiatrist from UCLA, a woman who was really fantastic I remember. Someone from Irvine. Anyway, a very diverse group of people. So [we wanted] someone who could work with diversity and someone who could really make a contribution and not be accountable to some organization or paycheck.

HP: Right. Now, in your work on the taskforce, what did you actually do?

RK: Well, they held hearings around the state. I went to a couple of taskforce meetings. It was really very well organized, because we had hired Art, who did the staff work, and Dan was the Chair. So they would have an agenda that would identify the problems. And then a good investment of time was getting a statement identifying the obstacles to a functioning system, and articulating this, which was really important,

because people usually don't do that. Step 1A for problem solving is to articulate the nature of the problem.

HP: And what did you find the nature of the problem was when you all got together? What was the consensus on that?

RK: Well, it was this fragmented, chaotic [system], both in access and delivery of services. I mean, people didn't know how to get into the system. The children's system was even worse. And there was no communication between the parties who might be involved with assisting the person.

HP: So the substance abuse case manager might not be in touch with the social worker at the mental health clinic.

RK: Yes, and the psychiatrist never talked to the social worker. It was the silo thing that's been around for a long time. So their objective was to figure out how to address that. And they had a much more ambitious plan than was practical. It would have taken some federal legislation to realize what they wanted to do, which was an excellent idea, but -- so they had to modify it to put it into a bill form that a legislator could carry and the State of California would pass, and [make it so the governor would] sign the bill. That would be it, and then create these pilot programs, which was all you could get money for at that time. That was 1989. I mean, it went on from '86 through '89, really. It was quite some time.

HP: And then you guys also did these hearings across the state.

RK: Yes.

HP: So you'd gather evidence from various people across the state, and it was based on what you heard from them that you identified this was the unifying problem?

RK: Yes. Well, the people who came to the table had a great deal of expertise to offer. And if a problem was identified and they didn't know the answer, then they knew someone who did to consult. So they would bring in other people.

HP: So you did this work, and then how did you go about getting it into bill form and getting funding for it and getting it passed?

RK: Well, they got more -- I say "they" because, again, I wasn't involved particularly with passage of the bill, just its content and purpose. It was '87 when they did that. Leo was reelected. Like I said, I was running his reelection campaign. So we dedicated more money from the Economic Development Commission, but Dan and Art got the foundation money together. And I knew that Art knew how to write a bill, how to take the concepts and put them into the language. He was a staffer in the legislature when I first went as an intern.

HP: And then how about finding someone to carry it?

RK: Well, it wasn't too difficult because there had been some people on the taskforce to begin with, and then Cathie Wright [California State Assembly, 1981-1993] already had this children's system of care concept out there [a proposal for an integrated mental

health system for children]. And they got some Republicans. They did a terrific job of getting Republicans on board and getting bipartisan support for it.

HP: And was it difficult to get people from the other side of the aisle?

RK: No, not at that time, no. I mean, because mental illness is not a partisan issue. It really crosses party lines.

HP: It can affect anybody.

RK: Ethnicity, economics, neighborhoods. And there were some terrific independent Republican Senators and Assembly Members at that time, too. It was a very different atmosphere at that time. There were some good ones. And Bronzan [Bruce Bronzan, California Assemblyman 1982-1993, a big supporter of the mental health system] was there, and Sandra Naylor Goodwin [a leading advocate for the mental health system in California] worked for Bronzan [at that time].

HP: Is that how he [Bronzan] became interested in mental health issues?

RK: I don't know how Bronzan became interested. But Art did the legwork. I mean, he knew legislators, he knew the staff people. And then Dan and Grace organized NAMI members to do the lobbying, and they worked on it for almost two years.

HP: Oh, so it took a while.

RK: Yes, it did; they had to find more co-authors. And they did a good job of doing that. Leona Egeland [California State Assembly, 1975-1980] was also a strong advocate for children in mental health who paved the way.
So there were some who knew the issues, probably came from local government -- a lot of them had been there for fifteen, eighteen years at that time.

HP: Right. So they remembered [Governor Ronald Reagan's unfulfilled promise from the late 1960s to fund California community mental health system].

RK: They'd been around a long time. Not like today. I did not do networking. Dan and Art did that work getting that bill passed and signed.

HP: And once it was signed, what was it you were looking for when selecting the providers?

RK: I was not involved with that.

HP: Were you involved in the evaluation, or did you follow the progress of it?

RK: Well, yeah. I did a tour in Los Angeles and was interested in what Ventura [County] was doing. I would ask around and get reports on it, and knew the concept was absolutely on target and was working.

HP: What was it about it that was working?

RK: The team part. And that you could demonstrate that people who were costing the county a lot of money, and the whole range of people, could be served. Programs had the flexibility to emphasize services based upon a person's level of need. They had a pot of money to operate with and not a rigid category of revenue resources. --

HP: Silo funding.

RK: Yeah, and not silo funding. So they were able to save money and serve a lot of people and get the right service to the right people.

HP: How did you guys even come up with the idea for the capitation scheme? [the idea of having a set amount of money to provide all services to a client, one of the hallmarks of the ISA model] That seems like one of the real innovations of it.

RK: It was key. It was just really so smart. I credit Art. I knew silo funding was a failure. I didn't really know anything about the mechanics of bureaucratic changes. But it made a lot of sense. I mean, I knew enough from being on the county [mental health] commission here about how it was funded. So it all came together. It was essential to the concept.

HP: The concept being that --

RK: The integrated services, and having the flexibility to fund what is needed -- not just offer what is funded. This is a basic problem —- and it is exacerbated by operating on competitive grants. Services are not necessarily based upon consumer demand, science, or evidence. Instead, consumers are offered whatever gets funded in their county. In the ISA concept, if this person needed more investment in therapy and had adequate housing and medication support, what you could emphasize for the person what their individual needs demanded.

HP: Tailor it to them.

RK: Yes.

IV. Polling and Public Support for Mental Health Funding; Nickel-a-Drink, Realignment, and Assembly Bill 34

HP: I want to know about something that Rusty [Rusty Selix, Executive Director of the California Council of Community Mental Health Agencies] mentioned to me when I spoke to him, and that was about polling you did in the 1980s regarding mental health. Could you tell me a little bit about that?

RK: Well, I did a lot of polling doing campaigns. It never occurred to anyone [to ask about mental health]. And so I was doing work on some Senate campaign, and I put it on the list. Also, when the state was considering doing a tax rebate with the budget surplus and Deukmejian [George Deukmejian, California Governor 1983-1991] wanted to send it back to the taxpayers. This was in '85 and again in '87.

HP: So you were thinking, "instead of a refund, what would voters approve this money being spent on?"

RK: Yes. So we did one poll in '85 and one in '87. And they were the issues that were coming up in campaigns, for the most part, that we listed. I had been working for the Pro tem in the Senate, Roberti. So the legislators wanted to know how to make the case for the programs that were under-funded, that were perhaps functioning properly but were not funded. And issues that had no funding that people cared about, like toxic contamination and the environmental issues that were just becoming hot at the time.

So we wanted to know from voters "would you rather have the money back, or should it go to A, B, and C." I came up with the A, B, C list, and the Senator approved it. Even when I was working for Leo in '87, I still worked on this just on my own time, seeing to it that that was on there. In fact, I talked to Mervin Field [a pollster in California] one time to get him to put it on his list. Because when they did a field poll, mental health was never there when asking "of the following issues what is your priority or what is most important to you?"

HP: What were the issues that they generally would ask about?

RK: It would be all the kinds of things you would expect. And whatever was going on at the time -- we had drugs in schools, toxic waste dumps, whatever was hot at the time. Education, always education. And always the elderly. Roads, transportation, all that kind of stuff.

HP: So you put mental health in, and then what was it you found from this data?

RK: Well, it was like fifteen or sixteen issues. In both cases, anyway, it was in the top two or three issues. It was very close. It was virtually dead even with the top three, and that took a lot of people by surprise.

HP: Yeah. You wouldn't expect it, especially if it was an issue that politicians weren't talking about.

RK: Yes. Well, politicians -- it was very, very hard to market. And my theory about that is that it was still an extension of stigma. Even with all the evidence that there is a great deal of concern about mental health and the lack of services, politicians are still reluctant to make that an up front issue.

HP: And did the polling go into detail, or did you find out or have ideas on why that was the case, that it was so hot. Was it just that so many people were being affected by it?

RK: We didn't ask them that. It was just straightforward community mental health funding. It was to find out if the state did not send you back two hundred and fifty dollars, "would you rather have the money go to this or that?" And what things do you think are particularly under-funded. So people knew that the state hospitals had closed, and that we had done that a long time ago. It's amazing that people today know that the state closed the state mental hospitals and they were supposed to then shift the money to community mental health and they never did it.

HP: And they remember that was the legacy of your buddy Reagan, I guess.

RK: Yes, uh-huh.

HP: Okay. So what I'd like to ask you about next is how you came to work with Rusty Selix and with [current California State Senate President Pro-Tempore] Darrell Steinberg.

RK: I knew Rusty socially for some period of time, and in the Capitol as a lobbyist for mental health providers. I had worked on a campaign -- the first thing was that nickel a drink alcohol tax to try and generate some funding [a ballot initiative that would have raised taxes on alcohol to support government programs]. I, at that time, had my own political consulting firm and was not working in the legislature. I was with a partner running campaigns and looking for business and looking for contracts. I heard they were talking about this and --

HP: This being MHSA?

RK: No, no. No, this was in 1990, I think, or '91. It was a long time ago. It was quite a success in raising money, more than anybody ever thought, because it's not a wealthy population, as you can imagine. But we did a decent job of collecting signatures and raising money, so they contracted with me to run the campaign.

HP: For nickel a drink?

RK: For nickel a drink. Not the whole campaign, but to represent that group. There were like four organizations, and the League of Conservation Voters [an environmentalist group], I believe were the ones who were organizing the signature collection. My job was to organize and direct the contributions of the mental health community to the collecting signatures and raising money. They did -- really, Rusty did -- a lot of the raising money part of it, but I would meet with their coalition board of directors regularly and talk about strategies for getting money. I knew a lot about raising money. I didn't do it personally.

HP: And where did the idea of going the initiative route to fund mental health come from?

RK: Well, I forget what the primary issue was. It might have been the environmental one. But Don Perata [member of the Alameda County Board of Supervisors] was involved in it with a number of legislators from Oakland. The pitch would just be that these are critically under-funded issues, so this tax will take care of these issues that everyone shares an interest in.

HP: And this was before Realignment?

RK: Yes. It was right around the time that Realignment was under discussion. So it was a long shot because there was guaranteed to be an opposition.

HP: Because you were going to be going up against someone [the alcohol industry].

RK: Yeah. I mean, it was always a long shot because of that, because there was going to be some paid opposition, and I didn't see how we would ever have the money to wage a positive campaign, or to combat the attacks. So that was not successful. But

we learned from it that this community of mental health advocates and consumers and family members can be organized.

HP: And who was this community? I'm imagining NAMI would have been one key member.

RK: Yeah. And the Mental Health Association [now Mental Health America], and providers. Providers were very active, too. And the organized consumers, they did voter registration and really were true to consumer involvement throughout the state.

HP: And had it passed, was it envisioned to build on an ISA model, or would it just have put money into the mental health system?

RK: It just would have put money in the mental health system. It wasn't restricted to expanding the ISAs. We all wanted to expand the ISAs. We had tried to make a case for it and had positive evaluations for ten years before they decided try the same kinds of things with homeless population.

So that didn't go anywhere. And then Realignment was right on the heels of that. I recall at the time that I was in the Capitol enough to know to be in touch with NAMI and other folks who were involved. And it was talked about for some time. A lot of people in NAMI were split over it. Among other advocate groups, not everyone was really gung-ho about it and some were very leery of this, because of the structure of it. It's very, very complicated.

HP: Because of the structure of the --

RK: Of Realignment.

HP: Oh, of Realignment. I didn't think that there would have been opposition within the mental health community.

RK: Oh, absolutely.

HP: Who lost from Realignment? [Realignment created a new funding stream for the public mental health system, but shifted responsibility for mental health services from the state to the counties]

RK: Yes, it was a guaranteed pot of money, you had a guarantee there, but then the state dumped any kind of responsibility for it. It would all go to counties, even more fragmented. And the counties would have this revenue coming in, yes they would be guaranteed some revenue. But then there was no guarantee what any county would do with it, or that they would do a good job. And then you had fifty-eight counties to be concerned with.

HP: So instead of worrying about one system you had to worry about fifty-eight.

RK: And the legislature, for them they could just say, “OK, it's out of here.” They don't care about it anymore. It's not their job. And the [State] Department of Mental Health has had nothing to do with community mental health since that time. The MHSA is the

first time since that the department has been in the business of local mental health. They had nothing to do with running the county operations.

HP: Hmm, interesting. Okay. So you had this constituency, and you worked with Rusty on the nickel-a-drink?

RK: Yes.

HP: And were you involved at all in AB 34 or AB 2034? [1999 California Assembly Bill 34 and 2000 California Assembly Bill 2034, both of which created funding to expand programs similar to ISAs for the homeless]

RK: No. I had been working out of town. I was in San Francisco a lot working for Pelosi when she was in Congress, and doing campaigns. And then I came back to the Capitol in '99, and I recall Rusty explaining AB 34 to me, and being very enthused about it. I was trying to understand what they were going to do, how they wanted to do it. I asked what was the bottom line: "what is this going to do to improve the quality of services in the current mental health system?" And he said, "nothing." After I made the rounds of lobbyist friends in mental health, I realized that no one had an ambitious agenda; funding AB 34 was the best shot at getting anything.

HP: What were the holes in it?

RK: Well, it was going to go out and find homeless people who were not in the system. It was not doing anything for the half a million people who were already being served.

HP: In the system and not getting the services they needed.

RK: Yes. It was an add-on. It was another categorical funding.

HP: And you already had plenty of those. But the concern was the people languishing in the current system, the people sitting in the board and cares.

RK: Yes. Everyone was concerned about the board and cares, IMDs [Institutes for Mental Disease, a type of institution], room and boards, the sleazy residencies, those hotels. All of *those* people. So it wouldn't do anything for them. It was a good idea, yes. I think it was beneficial to try the concept of, "would ISA serve people who are homeless?" We had demonstrated for ten years they were serving people who were housed and who had the whole spectrum of needs and demands from the system. You know, high-end expense people and low utilizers. [individuals who used a lot of mental health services and those who used very few] So that had been demonstrated for some period of time, and you could get creative with it, as San Joaquin County did. So they said, "okay, will this work with people who are homeless?"

HP: And behind that there was an assumption that there was a very large overlap in that population. It added the housing component that wasn't in the original ISAs. That's where it was new?

RK: Well, the ISAs helped people find housing if they needed help.

HP: But it didn't have the outreach. That was the difference.

RK: Yes. It [the original ISA programs] did not go look for people who were homeless, yes. It served people who had found their way to the system somehow or had been admitted through hospitals or jails or high school counselors.

HP: So a lot of growing the system, but not necessarily to benefit the people in it.

RK: Yeah. It was an independent program and it was expanded to many counties. What was good about it is that a lot of counties came to be familiar with the systems of care process [systems of care is a philosophy embodied by the ISAs]. The quality of service and standards, and all of that, were put in the [California Welfare and Institutions] Codes.

HP: What do you mean by that? How do you put quality of service in the Code?

RK: You identify the minimum services that should be in a functioning mental health system. You list the range of treatment options that should be available to everyone. You identify things like assessment and a tailored recovery plan. I'll be glad to show you the fifteen pages of Code sections. It's very, very important, and that's what the MHSA funded, and it's been totally ignored. [When the MHSA was being implemented] I asked why the state was recruiting new clients for new programs, when clinics were already crowded with desperately underserved people. DMH Director Dr. Mayberg was the one who had the courtesy to answer me, and said they determined to prioritize services to "those most in need." He did not elaborate on the process.

HP: Right. But, I guess I was just curious because I imagine that those kind of things would have been in the Code before 1999.

RK: Well, yeah, before '99 it started with -- it started with Realignment. But there were many amendments over the years, so it was a product of many small bills and events, debates and planning councils, master plans.

HP: Right. So it was gradual.

RK: Yeah, it was incremental.

V. Problems with Mental Health Funding; Assembly Bill 1422; Creation and Passage of the Mental Health Services Act

HP: So where did the idea for MHSA come from. What was the thinking behind it, what was the timing, what instigated it?

RK: Well, I would say that what instigated it was the Little Hoover Commission reports. [the Little Hoover Commission is an independent state oversight agency] At the same time John Burton [California State Senator, 1996-2004] introduced a resolution creating a Joint Committee on Mental Health Reform. I was working for the Speaker at that time, and he ended up letting me work full time on this joint committee, so I was the lead Assembly person and editor of the report.

[telephone interruption]

The origin of it [the MHSA] was this body of work and research that was done in this very short period of time. The Little Hoover Commission had one report out in November of 2000 on the adult system and a second report in 2001 on the children's system. Then, at the same time, the [State] Joint Committee on Mental Health Reform was going around the state having sometimes twelve hour meetings of testimony. Helen Thomson [California State Assemblywoman, 1996-2002] chaired the Assembly portion and Chesbro [Wesley Chesbro, California State Senator, 1998-2006] the Senate portion; Steinberg also served on the committee. So we identified key issues through testimony, which further documented the state of emergency in the 2000 legislative committee report.

Then Helen became chair of the Assembly Health Committee, and I went to work for the Health Committee. She held a special hearing on the Little Hoover Commission report. What it really emphasized was the lack of leadership from the State, and the discrimination that denied entitlement to services to people with mental illness.

HP: What forms did that discrimination take? On the ground, what did that look like?

RK: It's very clear in that the amount of reimbursement from Medi-Cal is capped for mental illness. It's carved out. This is an insurance matter. If you have Medi-Cal you have insurance. And if you have a chronic heart condition or diabetes for any other kind of medical condition that requires long-term care, or surgery, or whatever -- you might have to be aggressive about finding it -- but you can get the treatment that you need if you have Medi-Cal. And the state matches it. If you have your Medi-Cal card, you just have to go to an HMO [health management organization, a type of managed care organization that provides health services], or fee for service, and get your health care. That is not the case for mental health.

HP: What was it like for mental health?

RK: Well, it's still like that for mental health, since the mid-nineties and consolidation [a 1995 change in how Medi-Cal paid for mental health services], where counties contract with the State of California to provide what they call "specialty mental health services," and they get this [funded by] Realignment. They get this certain amount of money, and they provide services *"to the extent resources are available,"* which is what it says in the code. It does not say that about your varicose veins --

HP: I see. So it wasn't mandated, in other words.

RK: There's no entitlement to services, even if you're Medi-Cal insured. You're not entitled to appropriate mental health services. It's official, legal, codified discrimination.

HP: And it's also a lack of parity. It's not viewing mental illness as seriously as physical illness.

RK: Exactly. This is what I wrote about at the time. Helen passed parity in private mental health, and then she was going to introduce the bill to essentially create parity in public mental health. And we today do not have parity in public mental health. Someone who has Medi-Cal, they have two different insurance plans. They have one over here for their physical health, and then they have this one over here, with a limited

amount of money, for their mental health. Over here, the state and feds are going to pay a matching amount for whatever they need. If you have congestive heart failure and you have to get this medicine all the time, you're going to get treated.

HP: So with physical problems, everything from high cholesterol through heart surgery are covered no matter what, whereas for mental health, resources can be capped, and there is just a set pot of money.

RK: It was not always that way. But that's what Realignment did. Well, and then after Realignment, actually, was the Consolidation, where they carved out mental health from health coverage for people insured by Medi-Cal. And you know about private carve-outs. Well, this is the same kind of thing. So no, there is no parity in public health. If someone on Medi-Cal has multiple sclerosis, they're going to get the care that they need, and they're insured for that. Not so for mental illness.

HP: Right. So you diagnosed this discrimination in the way that services were being provided.

RK: Yes. So we had this huge body of evidence, these remarkable, very, very credible reports from the Little Hoover Commission. What was so good about them was that they were very, very readable, and so people could consume them. They were organized in a really coherent way. And then we had the report of the Joint Legislative Committee on Mental Health Reform. And then we had a huge report funded by the Health Care Foundation on the state of behavioral health in California. And then we had in 2003 the California Planning Council Master Plan for Mental Health, the official master plan. So there's this huge body of evidence.

And we had the Legislative Analyst Office putting out a minor report, too. It was widely known that the state of mental health was a disaster, that Realignment was not funding appropriate services, and that this carve-out was just "rationing services," as the Little Hoover Commission put it. The California Mental Health Directors Association also affirmed the Little Hoover Commission conclusions that people do not get needed services until their illness is advanced and they are in crisis.

So the concept came, in my view, from the Little Hoover Commission, and they were very helpful in coming over and helping me write the draft of a bill for Helen, which was an Omnibus Comprehensive Mental Health Reform, and it struck the language *"to the extent resources are available"* from the Codes [meaning that it would have made mental health services an entitlement, on par with services for physical illnesses and disabilities].

HP: Was that a bill that passed?

RK: No.

HP: Which one was that?

RK: AB [California Assembly Bill] 1422, and it was amended fifteen times because it was too expensive. It struck that line "to the extent resources are available" from the Codes.

HP: And then the reason AB 1422 didn't pass, why do you think that was?

RK: Well, the money.

HP: How expensive would it have been?

RK: Oh, a billion or so. It was not calculated. But there were studies that also had demonstrated that providing mental health services cost about the same amount of money as delaying treatment. So eventually there would be -- the savings could be there to fund it.

HP: Yeah. I mean, those were some of the lessons learned from the ISAs and from the success of AB 34.

RK: Yes, uh-huh. The Little Hoover Commission launched this expose. So we had all of these huge reports that got some coverage. An expose of the criminal negligence, really, that went on in the public mental health system. And that we didn't have any information about it, which is still the case today. I remember Toby [Toby Ewing, of the Little Hoover Commission] saying that the magnitude of neglect cannot even be characterized because no one has to report on it. So everyone knew Realignment was not properly funding mental health, and the system was a disaster

HP: And even though there was recognition, the officials in the legislature weren't willing to spend the money.

RK: Right. I mean, they hadn't been since the sixties when Reagan started closing the state mental hospitals. That's why we went to the ballot, and Prop 63 was supposed to deliver on the promise of funding community mental health.

HP: Was it a close vote [on AB 1422], or did anything come of it?

RK: No. I mean it got out of the Health Committee because Helen chaired it. But the first Fiscal Committee meeting, it did not get out of that Committee without us taking out the really costly provisions. So what finally did pass was the creating of the commission that the Little Hoover Commission had recommended.

HP: What was that commission?

RK: It was called the Mental Health Advocacy Commission. The state needed a body of people who were spokespersons who could essentially make the case to the public, and to the politicians. You know, the public was there, but the politicians were not there. And the [State of California] Department of Mental Health was not providing any leadership, as you can imagine. They were quite critical of these reports.

HP: That's what I'm curious about. Why was the Department of Mental Health not a good advocate for improving the mental health system?

RK: Well, because like every other department, their job is to keep the Governor happy, and the department director is not going to bring any bad news to the Governor. Certainly, they're not going to promote any kind of bad press about the quality of services. And it happens at every level.

HP: So change really had to happen from outside the system.

RK: Yes. It's like today in every county. Let's say that you start with a non-profit contractor who provides mental health services through any sort of funding source from the county and mental health Realignment money. So they have to do their annual reports to the County Board of Supervisors and they write "we've done just great, we've performed all these wonderful things." They put the best light on it.

HP: They never write "I did a crappy job."

RK: No! No one ever says, "you would not believe this, but people are dying and how many people we've lost by suicide," to the mental health director. And the mental health director, of course, paints a glowing picture for the County Supervisors.

HP: So there are institutional inertias built in.

RK: Yes, an institutional conspiracy of silence, really.

RK: So that's why the department director is not going to. But it's possible not to totally sabotage yourself. And be an advocate in bringing some things to the Health and Human Services secretary or --

HP: But they didn't do that.

RK: No, they weren't doing that, and there wasn't any education of the public about the need, or education of politicians. The State of California Mental Health Planning Council issued a mental health master plan in 2003, which is consistent with everything in the MHSA, and all of the research and stakeholder input. But the Legislature did not invite the Planning Council over for a briefing, and the Department of Mental Health didn't ask to be heard either.

HP: Right. So Helen Thompson's bill—

RK: Yeah. Well, the bill passed when it was amended down to simply creating an advocacy commission, and the Budget Committee actually appropriated the money for it. Then Gray Davis vetoed it, with some lame statement about it. But it was basically, "why should I create some commission that's going to criticize the quality of services that we're providing? Why would I want some critics over here? We already have the Little Hoover Commission. Who wants another one?"

HP: Right. So Gray Davis tabled this, and then how did that then lead to the initiative?

RK: Well, it was supported by everybody in the world, this Omnibus reform bill. So it was the working draft to do an initiative. And we'd had some meetings when the bill was going to pass, and we were just going to have the advocacy commission. We had some huge meetings. The Little Hoover Commission people came to talk about how we could create a Commission that was going to be productive like the (Lieutenant Governor's) Task Force was, and not just another collection of special interests.

Rusty and I had serious discussions about effective commissions: How could we create an oversight or advocacy commission that was truly independent? What criteria would ensure a commission with a primary allegiance to the best product, not an organization or belief system? It would be a real challenge with language creating the MHSA commission.

So there had been a lot of activity, and there'd been all of these reports condemning the system, and exposing the failure of Realignment. Rusty and I had talked on and off kind of in the course of this bill going along for a year and a half before it finally passed and Davis vetoed it. Before the bill had even been passed and vetoed, we had started talking about an initiative and did a poll, a very early poll.

HP: And this was like in early '03 or so?

RK: No, before then. It was before then. It was more like '01 or '02. It was really early on. And there had been some public polling about parity that showed ninety percent of the electorate believed that private health insurance should cover mental illness. That was another evidence of tremendous support.

So Rusty took the Omnibus bill, and he had all of these reports also, and he started writing a draft of an initiative and trying to find someone -- a politician -- that would go for it. We needed someone to raise money. There wasn't a lot of enthusiasm for that in the beginning, but finally he got some money together to do this early poll. That's where the -- you know, that one question that showed sixty-seven percent of the people said they had direct experience with, or knew someone who had experience with -- mental illness. It just showed how many people had been exposed to the issue and knew about it from a friend or personal experience.

HP: And you had that data from the eighties that showed that people still remembered Reagan.

RK: Yeah. This first poll was just tremendous in showing that yes, that it would pass. It just showed the initiative would pass. The '03 survey confirmed it.

HP: And as you were drafting it, were there thoughts of the shape and form of the services? Was it to be an expansion of ISA's? Was the idea of recovery in there at all? Was that part of --

RK: It's all in the Codes, it's all in the Codes. All that stuff is in the Codes in Systems of Care. So it's all been written, and what's in the Code is consistent with the [Mental Health} Master Plan. Everybody and their brother had input into writing these code sections and the Mental Health Master Plan. So all that is already codified, so there was no need to invent anything.

HP: It was just to say that there's going to be new funding, and it's --

RK: For Systems of Care, yes.

HP: For Systems of Care. And the Systems of Care, which piece of legislation had that been that created it?

RK: Well, it was kind of an incremental thing.

HP: That was built piecemeal?

RK: Yeah, it was piecemeal, but it was also the AB 34 bill, organized under this Systems of Care. It didn't apply only to AB 34, it applied to all services "*to the extent resources are available*."

HP: If we could talk a little bit about the campaign, and the time leading up to the initiative passing. The idea of taxing millionaires, tell me a little bit about that.

RK: Well, in the second poll that was taken, the professional poll, different options were tested. Where in the world do you get the tax from? What are people going to go for? At that time, in 2004, we had to think "are people going to take a nickel out of their own pocket? How in the world do you pay for this?" So it was tested, and of course it showed that that was the most popular one. Or some kind of sin tax. There was already a cigarette tax, and then if you did alcohol it would be the same thing.

HP: Well, it'd be the same thing as nickel a drink also, you'd have an opposition.

RK: Yes. You'd be generating an opposition. So this was the least likely to have organized opposition. I mean, well maybe chambers of commerce --

HP: Or Howard Jarvis [the Howard Jarvis Taxpayers Association, a statewide anti-tax group].

RK: Yes, that kind of thing. But were they really going to put a lot of money into that?

HP: So that's one piece of the tactics. Then the other piece is, how did you get Steinberg's support? I know that AB 34 was his thing already, so he was a natural candidate. But what was the process in terms of getting him to become the spokesman?

RK: Rusty did that, really. I mean, he had drafted legislation for Steinbeg before and had a close working relationship with him. So he's the one that persuaded Steinberg to do it, and Steinberg and Rusty really -- once the language was decided upon, they're the ones, and Steinberg really, the ones who raised the money. It was very costly to get the signatures, and then run a decent campaign. I knew Bill Zimmerman -- I worked with him before on different things -- and Jim Gonzalez, who were the consultants that they hired. They were people that I had worked with and were quite good. They did a good job and they just played it right. They did just the right thing, and I was very happy with it. But Rusty and Steinberg were the ones who really raised the money and ran the show. In mean, there were a lot of small fundraisers going on, and I helped with some of those, but I was doing something else

HP: Was having a face for the initiative, someone like Steinberg, important? Would it have passed without a leader like that?

RK: Well, it was good to have someone like that. We wouldn't have raised the money [without him], that's for sure. And he was able to get other politicians on board, local people. That's something that you need to do. And it was important because he was able to get the editorial boards [of newspapers], all those kinds of things that wouldn't

necessarily be responsive to a faceless group like the board of directors of NAMI California. An elected official is going to have greater access, so it was very important strategically, yes.

HP: In terms of the specifics of the act [the MHSA], you mentioned how the decision to tax the millionaires was thrown in, and a lot of it was just reiterating what was already said. So what was new about it, given that a lot of it was just reiterating what was already known? Was there anything specific --

RK: Creating the Oversight Commission was new, having a component for prevention, and the investment in the infrastructure, because the Planning Council had put out a report on human resources, which we knew was really a problem. If we were going to actually provide more services, we didn't have the people to do it. And the information technology was essential to produce outcome measures. Anyway, so creating the infrastructure that would support this integrated agency.

There were definitely some controversies and disputes in the drafting. For instance, the concerns about creating a two-tier system were discussed and debated at a drafting committee meeting. Speaking for the NAMI California Board of Directors, I stated that we did not want to fund a separate tier of quality services for one class of people new to the system, and forget about the inferior, substandard tier of services in the existing system.

The issue was resolved on paper when Rusty changed the language and used existing codes to define the target population. The proponents and the state, however, created the two-tier system anyway through their implementation policies. Three Department of Mental Health studies and three statewide surveys of NAMI members report that development of a two-tier or “dual system” is the chief complaint of stakeholders.

VI. Problems that Continue Under the Mental Health Services Act

[Interruption, continued the following day]

HP: So talking about the MHSA, we were discussing why we needed something new if it [the idea for Systems of Care] was all in the codes? Was it just the funding?

RK: The law didn't call for something new. The law just called to fund what we knew worked. I mean, that was the whole premise of developing and launching the fundraising and initiative drive and campaign to pass Prop. 63. That we know what works, we just need the money now to do it.

HP: So the reason it wasn't being done before was because of that "to the extent possible" clause in the Codes.

RK: Yes. And Realignment did not provide adequate funding and was never intended to provide all of the funding for community mental health.

HP: Okay. Could you tell me a little bit more about Realignment and its intentions and shortfalls?

RK: Well, in the beginning the anticipation was that Realignment was going to produce over a billion dollars I think at the time, in the '91-'92 Fiscal Year. First of all, the

very first year it did not produce the anticipated funds. It started out as [being funded by] about twenty-five percent of the [California state] vehicle license fee, and some sales tax.

HP: Right.

RK: In a couple of years it did start producing the amount that they had hoped for. But by the mid-nineties it started to flatten. And then, also, the caseload-driven responsibilities that Realignment had to fund also started to drain.

HP: What do you mean by "caseload-driven?"

RK: By caseload-driven I mean like [care for] foster children, IHSS [in home supportive services for older adults], public health and human service caseloads that were also funded by Realignment. If need increases, there is pressure to increase revenue to meet certain of these needs. The amount of money available for mental health services does not grow with the number of "cases" in the system.

HP: Okay. So the fact that those took up a lot of the Realignment monies, and mental health --

RK: Yes, and counties, from the beginning, were given authority to transfer ten percent of the mental health money out of that pot into these other services.

HP: About how much of it was -- was any of it earmarked for mental health, or was it --

RK: Yes, uh-huh. There were certain amounts earmarked for each of three pots of money that went to the counties. However, again in the mid-nineties when they did this consolidation [of the Medi-Cal system], it really closed the door on any caseload-driven expansion of mental health services because with consolidation the state contracted individually with counties, and it was a boiler plate contract. And it did not declare any standard of service such as you see in the Codes for Systems of Care, where it says the legislature has found Systems of Care are beneficial to our communities and our residents who have a serious mental illness.

HP: So basically what you had was, you had the right ideas written in the Codes, but the code said this was with one pot of money. And then there was another pot of money that wasn't subject to those rules in the Codes.

RK: Yes, mm-hmm.

HP: Got it.

RK: Even people insured with Medi-Cal are not guaranteed adequate mental health services for their diagnosed condition, as they would be if they had a different medical condition.

HP: And that was the idea that there was kind of a cap on mental health services.

RK: That's right, yeah. There is a flat amount of money, and it's like each county is their own little private HMO.

HP: Now, I guess there's a double-edged sword to that. From the state perspective there's a question of, “well, we can't be sure what you're doing,” but on the local level where the actual services are delivered, wouldn't that have given more flexibility to the counties? For example, L.A. County and Modoc County [a rural county in Northern California] would have very different needs, so then they could design programs to meet those needs.

RK: Sure. It would give them flexibility, but there's no framework for that flexibility, and there's no standards. And there are known standards that are worth funding regardless of whether you're living in the great Wild West or a city of eight to ten million people.

HP: Those standards being the System of Care.

RK: Mm-hmm. Yes.

HP: So what did counties that drifted away from the Systems of Care model do with their money?

RK: Nobody knows. (laughs) No one has developed any kind of substantive profile of what each county is doing.

HP: With their Realignment money.

RK: Right.

HP: And is that a good thing or a bad thing?

RK: Well, it's a ridiculous thing. I mean, as the Little Hoover Commission stated, there are no methods to even characterize the magnitude of neglect, because there is no central information source, or data source, for what's going on. There's a checklist of things that Systems of Care says, for instance, that constitutes a functional system that produces results that clients benefit from, and that clients support and desire. It's culturally competent, it's client-driven, it's all of the kinds of things that are in the [ISA] pilot programs.

HP: So then why wouldn't counties just do that?

RK: Because it costs money that the state promised 40 years ago and never delivered.

HP: Interesting. So if I'm a mental health administrator at the local level, if I can go to my Board of Supervisors and say I've served a thousand people instead of a hundred, the supervisors aren't going to say, “well, what kind of service was it,” they're just going to look at the number. Is that kind of what happened, and how the system has provided less services than the Systems of Care model, but to more people?

RK: Oh, yes. They have a certain level of demand, and some people do ask “how long does it take from the time you call access [access services] to when you meet with a live professional?” Some people ask questions like that, within the county. There's no central reporting place for that information. They've never managed a way to move away from the crisis-driven system that has been going on for as long as I've been in contact with it. Prop 63 has not changed that.

HP: So given the lack of resources, if I were the head of a County Department of Mental Health, is there anything I could do in this situation? Because it seems like I'm faced with the choice of either not serving everybody or serving more people but serving them very poorly.

RK: Well, it's not exactly that choice today, and it's never been exactly that choice. For one thing, what you can do is to break the conspiracy of silence and talk about the conditions and the magnitude of neglect and the quality of services and the discrimination. As the Little Hoover Commission reports point out, in both the children and adult investigations [investigations into the children’s mental health system and the adult mental health system], that there's a lack of leadership in that regard. The State Department of Mental Health does not point out these shortcomings.

HP: Right. And that gets back to the point you were making, that if you're the head of the California Department of Mental Health, you don't want to go to your boss and say, “hey, we're not doing a good job.”

RK: Right. Yes, no more than a contract provider wants to tell that to the mental health director, or a mental health director wants to tell the county supervisors. They all have to put a happy face on everything. So there are people who have to be the skunk at the picnic, which seems to be my job now and then.

HP: And I guess the question is, how does the skunk make a change?

RK: (laughs) Well, it's by talking in a straightforward way about things, letting people know. You'd have to get very heavily involved in politics, and I've been heavily involved in politics for a long time and it's really -- it's all political. So the only thing you can do is create a demand for the change.

HP: Kind of what you and Dan Weisburd did.

RK: With the taskforce and the Lieutenant Governor, yes. There's evidence from many, many sectors in this diverse group of people that we know what would be cost efficient and client effective. So those two factors are what the ISA produced, and what we've known for a long time.

HP: Right. But it just isn't done because of the investment it would take, and it would cause a disruption.

RK: Well, yes. I mean, it costs money. And the state and the counties have not been required to make that investment, and they've been allowed to legislate discrimination, which is what the Welfare and Institution Codes do. And as the federal government does -- Medicare, reimburses psychiatrists at fifty-five percent and other physicians at

eighty percent -- there's codified, legislated discrimination that exists today, but no one is talking about it. Why aren't elected officials talking about that?

HP: Wasn't there a mental health parity in 2008? [the 2008 Mental Health Parity and Addiction Equity Act]

RK: Yes, there was. -- it's been a very, very, very incremental slow process at the federal level. Many states now have mental health parity. California has it in the private system, but not the public system.

This is one thing we talk about, exactly that point, and that I tried to hammer home as part of why we needed an initiative. Yes, we finally had parity in private insurers, but we do not have parity in the public mental health system. We have discrimination. We have legalized, official, legislated and codified discrimination. Insured or not.

HP: Right. Within the public system.

So then MHSA was designed, in your thought, to create an initiative to make a pot of money that goes exclusively to go to what we know works. That was kind of the idea behind it?

RK: Yes. And as I said, many counties by then had been introduced to the concept of Systems of Care. Many have since sent staff down to the Village [an ISA in Long Beach] to get trained. They've had a training operation for some time, in integrated services.

HP: Right. So counties, even though they didn't have to use Realignment funds in that way, some of them were.

RK: Well, and they had AB 34 money and then more AB 2034 money to serve a very, very small -- less than five percent of their population. But nevertheless, they knew what Systems of Care and integrated services were. So the counties were fully prepared to expand that and build upon that and take their existing clinic system and enhance it. You see the range of treatment options in systems of care, for instance, is two or three pages long in the Codes. So any county could look at that and say, “well, we can't do all fifteen of these items today,” so then the stakeholder process is what they could draw upon then to set some priorities among those. Which items among the Systems of Care services would be funded first across the board?

HP: Right. So this is talking pre-MHSA.

RK: No, I'm talking about MHSA. This is not saying that “okay, this five percent of the people will get a hundred percent service.” They didn't have enough money to see that all hundred percent get a hundred percent service, but they didn't have to take the option of saying, “okay, this five percent gets a hundred percent service.”

HP: The two-tier system.

RK: The two-tier system, yes. Here is how it happened. The state and proponents told counties that MHSA money had to be spent for new programs to serve new clients.

This requirement was announced after passage of the law, and is a product of state-contrived regulations. There is no such provision in the MHSA.

But, as a result, counties are trying to create a separate, high-quality tier of new programs for newly recruited consumers. The existing, lower tier programs continue to ration services to at least 90% of the people denied recovery and treatment for years or decades. Counties have other options -- and there is no evidence that this new top tier measures up to Systems of Care. It's an expensive experiment.

VII. On Recovery; Implementation of the Mental Health Services Act; Concluding Thoughts

HP: I want to ask a few more things before we wrap up. One general one, just clinically speaking or thinking from your experience as an advocate. What is recovery? What's a recovery-oriented system? And is that necessarily the best way to go?

RK: I think a recovery-oriented system is the best way to go, but it has to be from the get-go. That is, the person's first contact with the system. And it has to involve public education also, so that there is a knowledge and acceptance and expectation for the person who has been told that they have been diagnosed with a serious mental illness. So that they have an expectation, the clinician dealing with them has the expectation, that they will recover and have a life that might be challenging at times, but that they can identify what's going to maximize their recovery, and that this is not a life sentence of living in a hovel and without resources.

HP: Now, is that different from how things were say twenty years ago, forty years ago?

RK: Yes, very different. Even twenty-five years ago: a young psychiatrist just out of med school told me and my daughters that it was not beneficial for my son to be around us a lot because it would remind him and reinforce his inability to measure up and to do what he'd like to do and to achieve what his sisters are achieving, and so forth. And that he wasn't going to go to college and wasn't going to be a homeowner, and blah, blah, blah. In fact, he did go to college. But this was just twenty-five years ago I was told that it wasn't good for him to be around us a lot. So the system and professionals in the system discouraged the person being integrated into the household and into society.

HP: At a policy level, was some of the goal of the MHSA to help remedy that? Or at the policy level, what started to change that?

RK: I think that if they had followed the expectations of those people who worked for passage of the law, including the voters, and expanded and improved the existing system, then those people working in the existing system would have had to get an education. I mean, they would have had to understand themselves that their interactions with patients need to change, and they need to adopt a new vocabulary perhaps. And that the environment in which they work is going to change, and if they didn't like the environment, then they could find work elsewhere. Now, that's happened for people trained to work in these new programs, so there's been a population of people trained.

HP: So that's also been a slight positive [of the MHSA] then, I guess.

So if you could go back to 2005 and become the queen of the MHSA, what would you have done? What would you have done in November 2004 how would it have been different?

RK: I would have hired professionals to write an implementation plan for the whole works, to implement the entire law, because prevention is supposed to be integrated with Systems of Care. Because the infrastructure supports, the workforce and so forth, are supposed to relate to the objectives of these other investments. And I would have seen to it that enough people were hired to write the requirements for a three-year integrated plan. I mean, they didn't come out with their requirements until August. It could have been done by then.

And I would have invested in a database of knowledge of existing systems so that MHSA plans could be evaluated in a context. Today, the Oversight Commission and the Department of Mental Health approve spending and program plans with no context.

HP: So every plan would say "this is what our county has," therefore you'd have an idea of what the county could use the MHSA for --

RK: Yes, exactly. Today, that's missing.

HP: That would have been worthwhile to add.

RK: Yes. So that there's some context to measure the merits of a program. Today, the evaluation process operates in a vacuum -- policymakers have no idea whether or not a given proposal fits into the existing system. Does it relate to it in any way? Does it fill a vital need? The failure to seek this information is more evidence of MHSA operating as a separate, categorical program. Anyway, I would have required that that be done immediately and invested in that.

I would have done a broad public education campaign about Systems of Care with local officials, as well as the mental health directors, so the county supervisors understand this is what they're getting the money for. So they know whether or not their mental health director is doing the right job.

I would standardize ethics guidelines for stakeholder participation, standardize the recovery model, what that means, standardize definitions. I would see that there's broad public understanding of the objectives of the Mental Health Services Act. And then try to forge some agreements about utilizing proven methods for stigma and prevention, to gain some agreement on that, because the state is not in charge of the money, totally. But they have the ability to influence.

HP: And when you say standardize definition of recovery, if I could ask you to expand on that. The lack of definition of recovery, has that had some negative impact?

RK: Yes, I think so. Everybody invents their own notion of what that means. I mean, SAMHSA [the Substance Abuse and Mental Health Services Administration, a federal agency that oversees the public substance abuse and mental health treatment systems] or the national organizations have little pamphlets on what the recovery model is. We haven't standardized this in California, except in the Systems of Care codes that are ignored.

HP: So recovery should be defined.

RK: Yes. And a lot of things should be defined.

HP: And the definition of recovery kind of being the one that you gave before, this idea of giving people a chance to move on, or forward, and hope for reintegration into their families?

RK: Yes, and from the start. You have almost a million people, say, who pass through the system in any given year, and who've had negative feedback for some years. And it doesn't take very long for a person's confidence to be greatly diminished. So that would be a whole different challenge of trying to communicate that concept to people in the system. And then just integrating it, and utilizing the resources that are already there. At the federal level, all the research has been done. At the state level, the research has been done. Bring in the researchers and create a clearinghouse, a state clearinghouse for information such as some of the questions you're asking. What do we know about these things?

I would inform the legislature of the starting point. . This is the “state of the state,” as the Health Care Foundation's title of their study was called. This is the state of the state of behavioral health in California today. This is our starting point. This is the quality of care provided today. The MHSA is going to move us toward this goal here, and this is what we're going to do. And we need your full backing to get there. Because they've cut the vehicle license fee [which helped fund mental health], and they’ve undercut Realignment and they’ve undercut --

HP: Undercut AB 2034. So all of those things.

RK: Yes. And they were going to backfill it in the budget. Well, I mean, the failure to do that was very predictable.

HP: Yeah. So where do you see it going? I mean, not just the MHSA but the MHSA within the broader system, where do you see it going?

RK: The economy is forcing some integration of MHSA programs into the base system. But the waste and disappointment are heartbreaking -- and costing lives. I think it'll be a long haul of raising issues to make any significant changes and make better use of the money.