Rusty Selix talks about the writing of Proposition 63…

The funding source was either going to be taken out of the state budget, and [we would] claim it would save money in law enforcement and prisons and hospital emergency rooms to pay for itself. Or do a tax increase. We were surprised. The state had a big budget deficit at the time we did the polling, and the polling said the tax increase was the preference of two-thirds of the voters. We were surprised by that. And the two types of taxes that came in high were tax the rich and then the sin taxes. And we knew that the sin tax would generate well-funded opposition… There's a sin industry. There's a tobacco industry, and there's an alcohol industry… we went with the taxing the rich as the way to fund it because the polling told us that was the way the voters wanted to go. They were afraid that even though we said it would pay for itself in savings in other programs, the voters were skeptical that that would really be the case, and fearful that it would lead to cuts in education and other things. [They also felt that] if you could find your own revenue source, that would be the way to go. So that's how it got written…

So we had to write it very tightly. We defined it just for the Children's and Adult System of Care, and then we put in a prevention early intervention piece, because focus groups told us that was something really important to [voters]. And they didn't want to fund all mental health, only people that had severe mental illness. But they also would fund a prevention early intervention program, which was something that I had learned with schizophrenia, that if you identified it early in its onset, it didn't run the normal course, people didn't become homeless. And so we wanted to fund those kinds of programs. That worked really well, and the voters liked that. So the money was very tightly drawn to just do these three things: Children's System of Care, Adult System of Care, and prevention early intervention, as the only things the money could be used for. That's what the polling told us…

…the first thing we did before we even did the poll was we had focus groups. We went to the focus groups, we put on the wall a flip chart with the words "mental health." And we asked people what comes to mind. In six focus groups, the first statement was the exact same thing in every focus group — it was street people. So when the interview asking follow-up questions, all the people said, "Well, of course, that's why we have street people. The state emptied out the hospitals, which was probably a good thing, but it never provided the community care these people need"…People had this knowledge. It was amazing how well. And we understood why they had that knowledge – it is [because] over 50 percent of voters knew somebody, either a family member or a close friend, who had a severe mental illness and had lived that experience…

READ THE FULL TRANSCRIPT BELOW.

INTERVIEWEE: RUSTY SELIX

INTERVIEWER: Howard Padwa

DATE: April 5, 2010

I. Start of Career in Mental Health Advocacy; Creation of a Powerful Mental Health Constituency; The Nickel-A-Drink Initiative; Realignment

HOWARD PADWA: Mr. Selix, for starters, can you tell me a little bit about your background, where you grew up and how you got into this line of work.

RUSTY SELIX: I grew up in San Francisco, and after being away for college I went to law school at Davis, and that basically steered me toward Sacramento for my career.

HP: You wanted to be involved in politics?

RS: Yes. As I was growing up and applying to colleges I actually thought I wanted to be the mayor of San Francisco. Between my first and second year of law school, I did some work for the City of Fresno and decided I didn't really want to be the mayor, I'd much rather be the city attorney.

HP: What was more attractive about that?

RS: Well, you didn't have to sit at city council meetings and listen for hours and hours and hours to people talking about things you really didn't want to hear about. The city attorney could focus on only the things that really mattered. You still had to go to the council meetings, but your role was a lot different. So I became a deputy city attorney for the City of Sacramento when I came out of law school. And as I was doing that work, I enjoyed the legislative part of it but didn't like the courtroom part of it so much. So I left that and became a lobbyist for the League of California Cities. Did that for six years.

HP: And what does that organization do?

RS: They advocate on behalf of local governments in front of the state legislature. And there's five-hundred something cities in the state. The issues of concern to cities are pretty wide-ranging. Most of my work was in land use housing and environmental issues. So I was involved in all the major state policies affecting those subjects during those years.

And then I left that not knowing what I really wanted to do. I liked those issues, but I was ready for something else and started my own business, my own advocacy business. Did a whole lot of things, consulting and lobbying, almost all for cities.

Two years into that I got approached by a guy who became a good friend of mine, whose office was down the hall. His name was Larry Briskin [Lawrence J. Briskin, former legislative advocate in Sacramento] and he had among his clients community mental health agencies that he'd had only for about six months, and he thought I would be a

good person to take those over. I told him I didn't know anything about those issues. He said, "No, I think you may know more than you think." He said, "You're trained as a lawyer," as he was, "and you'd know how to ask the right questions and learn the issues." He said, "More importantly, I think your personality's a good fit. You'll like these people. I think they'll like you and I think you'd do a really good job for them." I said, "Well, I'll at least meet them." And it turned out I did know more about the issues, because the issues really had much more to do with -- mental health is funded through local government, so I understood it more than I thought I did.

HP: Local government was really your area of expertise.

RS: That was my area of expertise, and I understood government contracts. Because these agencies got contracts with county government to provide mental health services and I knew a lot about local government contracts for service delivery and the rules of state funding and federal funds. So I really did know more about the issues than I thought, even though I didn't know anything about mental health at the time.

HP: And was this before realignment? [Realignment was the 1991 Bronzan-McCorquodale Act, which restructured funding for parts of the California social service and health systems, including mental health]

RS: Oh, yes. This was the end of 1986, kind of the beginning of 1987 is when I really got started doing it.

HP: Okay. And what did the organization look like when you started working with them?

RS: The community mental health agencies?

HP: Yes.

RS: Well, it was a fledgling organization. They had just hired their first real professional staff. They had met on an informal basis till then. And the state was not prepared for dealing with them. When I first started they wouldn't even meet with us. They insisted that we have a written agenda and that counties had to review it first, and the counties be there with us, and that they may or may not pay any attention to what we were doing.

HP: And why was such an agency necessary? Was this to represent the community agencies, their interests, as opposed to the county governments?

RS: At the outset, that was the case. I mean, I would say over the twenty-something years since, we've largely been on the same page with them. But also, at that time, they [the counties] didn't have an advocacy presence. They were viewed more or less as an arm of state government.

HP: The counties.

RS: The counties. They had a Conference of Mental Health Directors and it was designated in state statute. It had a lot of authority [so] that the state needed to basically gain their approval before it made changes in the community mental health system. But

it was simply that conference. It wasn't an advocacy organization like the California Mental Health Directors Association is now. So there really was no advocacy for publicly funded mental health services in Sacramento at the time I started.

HP: And what needed to be advocated [for] at that time?

RS: Well, the money was the main thing. As bad as it is now, it was so much worse then.

HP: What did it look like?

RS: Well, what it looked like was a single line item in the state budget for all of mental health, out of which the state hospitals took what they wanted off the top. The remainder was a single line item — again for county mental health — that was the easiest thing for a governor to cut if he wanted to reduce the total amount of money that got to him from what the legislature gave him. So during the 1980s mental health funding was cut in absolute dollar amount totals virtually every year.

HP: And what made it so easy to cut?

RS: Because it was a very big number, and it had no statutory protection versus almost all health and human service programs [which] were in statute, so in order to cut them you need actually the legislature to change the way the program worked. Realignment created that for mental health, but before realignment, community mental health did not have that type of protection.

HP: I see. So institutional protection.

RS: Right. Statutory protection. It was completely unprotected. It was just a number in the state budget.

HP: And politically was it easy to cut mental health compared to other things?

RS: Politically also very easy. There was really no strong advocacy community. NAMI [the National Alliance for the Mentally Ill, a family advocacy organization] was really just getting started and really was not much of a presence either at the time.

HP: Okay. So you walked in with this situation where there's a real need for advocacy, there's a lot of problems, it's very easy to dismiss. How did you handle it? What were some of the things you did?

RS: Well, the first things we were able to do was identify that we did have some supportive state legislators. Our lead champions, at that time we had one Democrat in particular, Bruce Bronzan [Assembly Member for California's 31st Assembly district, 1982-1993], and we had a Republican, Cathie Wright [Assembly Member for California's 37th Assembly district, 1980-1991 and State Senator for California's 19th Senate District, 1992-2000]. We basically worked through them to push a mental health agenda and push some things forward, and had a lot of success.

The initial work on behalf of the community agencies was to create some minimum protections in county contracts. And we were able to have legislative success, even

though the counties and the state didn't want to work with us. The fact [is] that the things we were asking for were such obvious due process, good government things that the counties really couldn't defend not having those things. Really, I don't remember there even being strong opposition. I mean, they didn't support the idea of having mandates in state statute, but they were so modest. So we got about a dozen things done that way, right away. Then the next thing we worked on was the Integrated Service Agency [ISA] legislation.

HP: This is the AB 3777? [1988 Assembly Bill 3777, legislation that authorized the creation of three capitated, intensive psychosocial rehabilitation programs in California]

RS: Yes, AB 3777, which actually was the Cathie Wright bill, although she had the county version of it. It was based on her Children's System of Care, which she had done about five years earlier, which was kind of an inter-agency coordination model that actually as it turns out never went anywhere.

HP: So these were people who were already pretty sympathetic to the cause of mental health.

RS: That's right. Although the real author of what became that bill was Bruce Bronzan, and I think it was AB 2505 [Assembly Bill 2505], if my memory serves me correctly. But in order to get it signed, it had to be in the Cathie Wright bill — we had a Republican governor, he wanted a Republican author. So they merged the two bills, and instead of having six pilots, there were three, two for the Bruce Bronzan model and one for the Cathie Wright model.

HP: And that was the one county and the two with private agencies? [one ISA program was operated directly by a county, the other two were operated by community-based agencies]

RS: That's right. You've done your homework.

HP: [joking] Yeah, I've been researching this for a while. So, now, a broad question on the art of advocacy, lobbying — how does it work? And then also, specifically, when it's an issue that's so traditionally marginalized, how do you go about bringing it into the forefront?

RS: Well, it took a few years to really -- first of all, realignment turned out to be a very fortuitous opportunity, and it hasn't produced the results we hoped it would due to an unusual feature of it, which nobody really understood what it did until many years later. I'll get to that in a moment. But I think the reason we got that dedicated funding was due to grassroots lobbying at its finest. And this is one of my favorite stories to tell. In 1989 we had a sixty million dollar cut, which was a huge amount.

HP: To the statewide mental health system.

RS: Statewide community mental health system.

HP: And this is out of how much?

RS: Out of about seven hundred million.

HP: That's almost 10 percent.

RS: Almost 10 percent. A huge cut. The biggest ever. And it was a blue pencil [cut by the governor]. I remember Cathie Wright arguing on the floor of the assembly against it, and against the Democrats passing the budget, saying, “If you pass this budget, we know the governor has told us this is what he's going to do.” And they were going to do it anyway.

HP: And who was the governor at the time?

RS: George Deukmejian. [California Governor, 1983-1991] So he had signaled that that was going to happen. I wound up — in those days you could do some things you can't do now – I was actually able to speak to Assemblywoman Wright on the floor, by telephone. I remember I was actually on my way back from vacation. Actually, it might have been 1990. It was 1990 actually when this happened. But he was still the governor then, so it was his last year.

As that was going on, we wrote letters to the governor complaining about it, trying to get the money restored. I think we actually got ten million restored in a cleanup bill at the end of the session. But the important thing was that the governor assigned somebody to answer all those letters, and the man he assigned was a man named Russ Gould. Russ Gould was like the number three guy in the Department of Finance at the time. Well, a year later we had a new governor, Pete Wilson [California Governor, 1991-1999], and Russ Gould became the Secretary for Health and Human Services [he was Secretary of the Health and Welfare Agency]. And this realignment program would be under his leadership. He had to decide what subjects would be in it. The reason for the realignment had to do with [that] the state was going to hit its spending limit. It was going to have money it wasn't going to be able to spend and was going to have to give it back to the taxpayers unless they restructured things, and they had to restructure things to county government.

Well, he made sure mental health was part of that because he was the guy who had to answer all those letters [written to Governor Deukmejian when he cut mental health funding], and those letters affected him personally. He said, "Something's not right here. We have to protect mental health funding. We have to change the way we fund mental health."

HP: These were letters from consumers and families?

RS: Yes. So [it was] one of those things that we did, without any apparent success at the time -- in other words, we didn't get the cuts undone in 1990. The next year we were able to get dedicated stable funding that looked like it would be much better than the funding at the time, as a result of that. So that was our first major success. We knew that the large letter writing made a difference.

We then also had large rallies at the state capital that we organized in the late eighties, and I think we had our largest one in 1990, when we took our biggest cut. Four or five thousand people we had. We made ourselves more of a presence than we had ever been.

HP: And how did you go about getting the people to come to the rally and getting them to write letters?

RS: Well, we got organized. There was a California Coalition for Mental Health that had thirty different organizations participating.

HP: Mostly community agencies?

RS: Well, no. The organizations were all statewide organizations. The Association of Community Agencies, the Association of Counties, and then you had NAMI — it was called CAMI [the California Alliance for the Mentally Ill] back then. It hadn't changed its name to NAMI California. And the psychiatrists and the psychologists and the social workers and the marriage and family therapists, hospitals, and group homes. There was a large group. So anyway, we had about thirty organizations. But the bulk of the letter writing came from the community agencies and from the NAMI members and consumers. And the bulk of the five thousand people [who rallied in Sacramento] were funded through the community agencies and represented consumers and family members that they served.

HP: [Funded] to bus them from all over the state?

RS: We had dozens of buses from Los Angeles, and the Mental Health Association of Los Angeles, now the Mental Health America of Greater Los Angeles, did the bulk of the work, organizing and all that. I remember their staff -- I don't know if you're interviewing Richard Van Horn [former Chief Executive Officer of the Mental Health Association of Los Angeles].

HP: Yes, we've spoken to him.

RS: He can tell you more about the effort involved and the buses and that. And then the person who was leading the coalition at the time, a woman named Susan Mandel [Chief Executive Officer of Pacific Clinics], both of them would recall that particular rally very well. They were two of the leaders of it. Areta Crowell [Director of the Los Angeles County Department of Mental Health, 1991-1998] was also very active in the coalition at the time. They could all tell you about those rallies. Those rallies, I think, were the really big turning point that established there really was a mental health community.

Then the other thing that happened is that in 1991 we decided to do a ballot initiative to fund mental health. We didn't get very far along before a group of people planning a broader initiative, so-called Nickel a Drink, came to us and said, “If you don't do your own [initiative] and you just be part of ours, we'll give you a hundred million dollars and a guaranteed COLA increase [Cost of Living Adjustment] in revenue that will come out of the alcohol tax” they were proposing.

HP: So you said this was to raise five cents on every drink.

RS: Right.

HP: And put it into mental health?

RS: Well, no. Mental health was [going to be] getting about 20 percent of it.

HP: Okay. It was for more broad social services.

RS: It was for a lot of things. There were obviously some alcohol and drug programs, and some emergency room programs. So we were part of a coalition with emergency room physicians and others. I don't remember who the others were. I remember the emergency room doctors being a part of it. There were like five or six groups that were funding it. We dropped our own measure and became part of that, and got the money earmarked for what we had hoped to do. But we were able to raise three hundred thousand dollars in that campaign.

HP: And this was in '91 you said.

RS: Ninety-one. And we were able to get people to go out and collect three hundred thousand volunteer signatures. That told me we had a real community and a real constituency, that we could do things. The alcohol tax failed badly. Anheuser-Busch spent forty million dollars, and we got 29 percent of the vote. There were a whole lot of reasons why we did badly. That particular ballot had forty measures on it that included a tort war between trial lawyers and insurance companies over car insurance or something. The voters were just confused and they tended to vote no on everything. So it was probably around the worst possible time. The alcohol industry actually put its own measure on through the legislature that was to confuse people as to what ours did and what theirs did. And nothing passed.

HP: And what was the initiative you guys [in the mental health community] were thinking about then?

RS: Well, there was funding for community mental health. The details of what it funded exactly, I don't remember that specifically, but it was increased funding. And a COLA, a guaranteed funding increase each year to keep pace with population and inflation. And realignment arguably gave us that.

[But] we discovered, as I said, many years later, that the funding formula had a flaw in it. There were three pieces of realignment. There was mental health, there was social services, and there was health. The way it was written is because the programs in social services were entitlement programs that the state was responsible for, they had to guarantee that it would be funded at the rate of growth of those caseload programs. So it got the first call on growth, up to the need of caseload programs.

Well, the analysis done at the time was this wasn't that big of a deal because over time the sales tax would grow at least as fast as the caseloads would grow. So we figured in some years we wouldn't get our growth, but in other years we'd get enough to make up for it and we'd come out fine. What we didn't anticipate was the change in one program called In-Home Support Services, which due to three factors grew at an exponential rate and took virtually all the growth.

HP: And what is that exactly?

RS: In-Home Support Services is taking care of disabled people in their home. And it grew because there was a movement towards in-home care as opposed to nursing home care. Nursing home care far more expensive. So there were a good policy

reasons to do it. The other reason it grew was demographics. There were a lot more people living a lot longer that would need this kind of care. And the third reason it grew is that as it grew then you needed to pay people more to get enough people to do the work. So it became a unionized thing and much better wage pay as opposed to minimum wage, which is what it had been before.
So the program grew from five hundred million dollars to two billion dollars over the first ten years of realignment.

And we didn't realize — because it was happening slowly and the economy was doing so well and we were still getting good growth — that this phenomenon was happening until the economy crashed in 2001 with the dot-com bust. Then all of a sudden our realignment growth wasn't happening. So we still thought it was a one-time thing, and it wasn't until 2004, literally a year too late, before we realized that realignment was not going to grow the way we thought, that we weren't going to ever get that growth, that In-Home Support Services would take most of it.

The reason I say a year or two late is because we then went back to the initial process in 2003, with Prop. 63 [2004's Proposition 63, the ballot initiative that created the Mental Health Services Act]. Had we known that realignment wasn't a stable funding source, we would have factored that in to how we wrote Prop. 63, but we didn't know that when we were writing Prop. 63. So that's another piece of the story. Right now you were back on how we got organized and how we became an organization and how we became a meaningful advocacy coalition.

II. Rose King; Assembly Bill 3777; The Importance of Flexible Funding

HP: So you were involved with AB 3777. Tell me a little bit about how this idea came about.

RS: AB 3777?

HP: Right.

RS: Well, you really need to interview a lady named Rose King. I don't know if her name has come up.

HP: Her name has come a lot. I've not --

RS: Okay. Rose King was a family member [of individuals with severe mental illness]. The tragedies she has endured are probably the worst of any family member. She lost both her husband and her son due to suicide as a result of schizophrenia. She now has two grandsons with schizophrenia that she is trying to help. She was a high-level staffer in the state legislature in the 1980s. She worked for the lieutenant governor at the time, Leo McCarthy [California Lieutenant Governor, 1983-1995], and convinced him to create a task force about community mental health. She said, "We don't have good programs."

She got them to create a task force, and out of the task force came the recommendations to create the Integrated Service Agencies. At the time the state of the art was something called ACT, Assertive Community Treatment. They took ACT and combined it with some housing programs that had come from other places and put the

two together, and came up with a more flexible model, [one] that certainly the people who developed [it] feel has worked better than ACT. Now ACT has matured over twenty-five years and it's very hard to distinguish the two now, but at the time the ACT model was a more rigid model that required a very high level of service. It was designed to take the first few steps to stabilize you in the community and keep you out of the hospital. But it didn't take the next steps of moving you towards recovery and independence and independent living and all of that, which is what the Integrated Service Agency did.

HP: So ACT didn't really have the housing component.

RS: It didn't, because it was designed to take people out of the hospitals as opposed to taking people that were homeless on the streets. The Integrated Service Agencies also were taking people out of the hospitals, but the housing piece of it and the promotion of housing and independent living was a piece that wasn't there in ACT as it existed in the mid-eighties. When you look at ACT programs now across the country, you'd see a lot of the same features. As I said, ACT has matured.

HP: Similar to FSPs [Full Service Partnerships, intensive programs created by the Mental Health Services Act] today?

RS: Yes. I have a very difficult time understanding the differences. Again, if you talk to Richard Van Horn or David Pilon [Executive Vice President of Mental Health America of Greater Los Angeles], or the people at the Village [an Integrated Service Agency in Long Beach run by Mental Health America], they could tell you the differences, but I can't.

HP: Okay. So they decided to create this program that was kind of a meld of ACT and housing as well.

RS: Right.

HP: And this came from this task force that was created.

RS: That's right.

HP: Was there any opposition to it? What were the politics involved in it?

RS: The only opposition was the idea of a direct contract of community based agencies with the state. The counties didn't like that. They wanted it to be run through the counties.

HP: How come?

RS: Simply that they felt that they were in charge of the community mental health system and that they should be doing this. And the community agencies didn't feel at the time that the counties were committed to this type of a model.

HP: Why wouldn't the counties --

RS: Well, the counties liked what they called the Children's System of Care, and the Ventura County mental health director and Cathie Wright liked that model, which was county run services. And this was a model where all the services could be run through a community based agency. Now, even though the counties contracted a lot with community based agencies, they weren't sold on that model to do this care. Many of the counties, particularly the smaller ones, didn't have community based agencies in their county, so this model wouldn't work in every county.

HP: And why did it need to be community based agencies that did this?

RS: Well, it could be a for-profit company as well. But the reason the model worked so well, and it wouldn't work as well directly operated by a county, is simply the rules of county budgeting. The concept of this is much the same as the concept of a Full Service Partnership. It's flexible, it's kind of “whatever it takes.” You have a case rate, dollars per person, but you don't spend the exact dollars on each person. Each person gets what they need. And a lot of the times what they need is not something that's a traditional medical type service.

Sometimes they need help moving their furniture. They've lost their lease. Or they're having some kind of a domestic issue and they need help with that. The bottom line is for somebody to recover, you have to help them with all aspects of their life. You have to help them learn how to live a normal life. That's not an easy thing for counties to budget line items for. And then even when they budget the line items for it, if you go over the budget on one item you've got all these approvals you've got to go through, and the staff has very rigidly defined things.

Now, counties have learned how to do this, and particularly smaller counties can do it probably fairly efficiently. But initially, it was much easier to do this through a community based agency. Even years later when we started the first really meaningful funding of these programs with AB 34 [1999 California Assembly Bill 34, which expanded on the AB 3777 model] and AB 2034 [2000 California Assembly Bill 2034, which expanded the AB 34 programs], the initial reports from the state were that the county operated ones weren't doing nearly as well as the ones that were run by community agencies and other independent contractors.

HP: So it's basically a matter of, in the county budget you would have to have a line for helping someone move furniture.

RS: Right. And you've have to get the number right. You'd have to get the number just right, because if the number was wrong and you'd go over that, then you'd have to go back through the county budget process to spend an extra dollar.

HP: So it would be impossible for someone at the county level to go through and do this, whereas an agency that just says you have this much to spend on a person --

RS: Much easier. It's not impossible at the county level, it's just harder, so it's not going to work as well. And the mindset of this also required a twenty-four-seven mindset, and the mindset of county is nine to five, Monday to Friday. So if you needed the extra thing and it happened on a Saturday, then the county offices aren't even open, so how do you do it?

HP: Also does the union issue play into this at all as well?

RS: The union issue is a different kind of issue. Some of the community providers have unions, so a union doesn't necessary stand in the way of that. But a union may stand in the way of redefining job responsibilities and other things that work. Of course, again, it's not an insurmountable barrier because there are directly operated ones, and there are unionized providers — you can't say unions are a problem in that regard. Politically, it may have been a factor in terms of the counties' attitudes, but it may not have been. I don't know the answer to that. This was a long time ago, so it's hard to judge that. The bottom line is the unions at the state capital were not opposed to the legislation, and not opposed to community based agencies getting the contracts. This was a very small pilot thing. It wasn't an issue at the time.

HP: Right. And was there thinking that it would expand if it worked?

RS: I don't remember that particularly, but it happened. It did work and it did expand.

HP: Right. That was with AB 34 and --

RS: Well, the first expansion actually was before that. The first expansion was for the next major thing that happened after realignment, which was called consolidation.

HP: Oh, I'm not familiar with that.

RS: Okay. In 1994 the state wanted to move Medi-Cal recipients into managed care. So the mental health piece of it wound up being given to County Mental Health [Departments], so that consolidated the County Mental Health program with what was a fee-for-service Medi-Cal program that the state was running. The dollars for that were then moved over to County Mental Health. They consolidated that. Well, the state fee for service, because it was completely unmanaged, was spending 70 percent of the money on inpatient care. So it turns out that two counties that had the AB 3777 pilot, Stanislaus and Los Angeles – as well as a third county that was following that, Sacramento — decided to take the consolidation dollars they got, which were flexible dollars, and move people out of inpatient care and into basically an expansion of the Integrated Service Agency [ISA] model. Those three counties, that was the first real expansion of it.

HP: And this was after a couple of years?

RS: Yeah. The bill passed in '88, the pilots probably started in '89, so this was '94, '95, so yeah, it had been five years.

HP: Okay. And what were the lessons learned from these early days in terms of what works with an ISA, and what doesn't work?

RS: You know, I don't ever remember hearing anything doesn't work. What I remember being the problem from it was, with this expansion, the expansion was with county directed dollars. And the other thing with the expansion was we then were going to try and get federal dollars, Medi-Cal dollars, and federal funds wouldn't pay for everything.

HP: Why wouldn't they?

RS: Because they won't pay for certain aspects of transportation and housing and socialization --

HP: It would have to be strictly medical.

RS: Not quite strictly. One of the other things we had done just before then, we had shifted from the clinic option to the rehabilitation option under Medicaid.

HP: Okay. Tell me about that.

RS: Well, the clinic option is very strictly medical in terms of the services, and they have to be delivered at a clinic, and what you can pay for. The rehabilitation option brings in case management and some other services that are not as purely medical. I'm not the expert that can tell you exactly what the clinic option paid for and what the rehabilitation option paid for, what the differences were, because it's been so long. I probably knew it in 1993.

HP: So this was a formal policy shift on the part of the state?

RS: Yes. It required a Medicaid plan amendment that the state did. And because all the dollars were county dollars, the matched dollars, it didn't matter to the state whatsoever. It didn't cost the state anything.

HP: I see, so it was just the decision that “we're going to try to build this way instead of this way.”

RS: That's right. It allowed a lot more money the counties were already spending to be reimbursable federal funds.

III. Darrell Steinberg; Assembly Bill 34; The “Housing First” Philosophy; Assembly Bill 2034

HP: Now tell me about how AB 34 happened.

RS: AB 34 is a story, again it's a personal story, just like the other one was Rose King's story. This one is Darrell Steinberg's story [Darrell Steinberg, Assembly Member for California’s 9th Assembly District, 1998-2004]. In 1997 or '98, when Darrell Steinberg was a member of the Sacramento City Council, there was a fight between the city and a homeless service agency known as Loaves and Fishes. The city wound up suing Loaves and Fishes over some problems they were having with the neighbors, and Darrell Steinberg said, "This is the wrong answer." He was one of two members of the council who voted against that lawsuit. He said, "This is not the right response. These people need help and they need services." He found out the city doesn't provide the type of services that the county did, and he went to the county and the county said, "We don't have control over these dollars, it's state dollars."

So when Darrell Steinberg ran for the legislature in 1998, he declared in his campaign that one of his highest priorities was going to be doing something for the people who were homeless with severe mental illness. That became one of his top priorities. In fact,

his top priority. He said it would be his first bill to introduce. So through an unusual quirk, his best friend from law school, who was the guy who got him into politics, was someone I knew. So he told him. And he happened to be on the board of a community mental health agency, too. Just a weird coincidence, this guy named John Atkinson. John and I had worked on some environmental stuff back when I was with the League of Cities. Everything's connected.

So Darrell, even before he was in the legislature, he had won the primary which meant he knew he would win. It was a Democratic seat. And before he was even elected he came and started meeting with me and wanted to know, "What ideas do you have to deal with this?" Well, I gave him a few, and then I consulted with some other people. I remember consulting with Areta Crowell and with Catherine Camp [Executive Director of the California Mental Health Directors Association]. We had taken the Integrated Service Agency thing, and Cathie Wright had run a bill led by Richard Van Horn to put in statute something called the Adult System of Care, that took the Integrated Service Agency model, that by that time those three counties had put a lot of money into. The answer [to Steinberg] was, well, we should fund the Adult System of Care.

HP: And that would be then an expansion of the ISAs.

RS: An expansion of the ISAs. To expand the ISAs is the best thing you could do. Then Darrell appropriately asked the question, "Well, have these ever served the homeless? Do you have any success outreaching the homeless?" I remember talking to the Sacramento County Mental Health Director at the time, Tom Sullivan. He said, "Well, we can engage the homeless, but it takes months." So we started looking around for model programs for engaging the homeless, and we found a model program in San Mateo County that teamed a social worker with former homeless with police, and they were having great success. San Mateo being a relatively well-funded county. They didn't have exactly the ISA model there, but they had real good success in engaging the homeless.

HP: And it's interesting, this idea of having a former homeless individual involved in it. It kind of presages the idea of having consumers do the work now.

RS: Right. So we put that into legislation, that you would have outreach teams. That element transformed the ISA model into the AB 34 model, because that wasn't in the ISA model and the ISA model hadn't been targeting the homeless. They had been targeting people coming out of state hospitals. We were told by the psychiatrists, by the police, and by the NAMI members that about half the people would want the help. The other half, [they said] they aren't interested in being helped. They don't want to be treated. To everyone's surprise, we had a 90 percent success rate.

HP: And how was success defined?

RS: As being interested in wanting the treatment, and not resistant to treatment at all. But the doctors said they're treatment resistant, the police said they're treatment resistant. And what was discovered is, they had never been offered an ISA. They had never been offered housing and non-medical care and other things to help them put their lives back together. They all wanted that.

HP: So that was the real hook.

RS: What they didn't want was to take psychotropic medications and still be homeless. The families, the doctors, and the police hadn't put the dots together. They hadn't figured out that the reason they were resisting the medication is that while they were homeless they wanted to be high. They wanted to self-medicate with something that made them feel better in a different way. And they didn't want to be sober, they didn't want to really know what their life was like because their life was horrible while they were homeless. But if you got them off the streets, and you got them into a stable environment, then they wanted to be treated, they wanted to take the psychotropic meds, they wanted everything. They wanted to get a job. all the things that the doctors, families, and police didn't think they wanted, they really did want. But first you had to get them off the streets.

HP: Housing first.

RS: Housing first. But it had to be supportive housing. You had to provide housing -- because that was the other thing. Housing programs didn't want these people.

HP: Because of the fact that they were afraid they'd blow it? [that homeless mentally ill individuals would squander opportunities given to them if given housing without other supports]

RS: They *would* blow it. They needed treatment. They needed housing plus services. Because of my work with the League of Cities, I had met with all the housing providers. I said, "Why can't you get housing for these people?" They said, "Well, they need services and the counties can't guarantee that they can provide services to them. Their money's really limited." So with AB 34 we brought new money, so then you could serve them because it was successful.

So we had an incredible success rate and that led AB 34 to AB 2034 the next year, taking from the three counties, which were those same three counties that were already doing it. They were hand picked.

HP: And how much did AB 34 expand it? Like in L.A. for example there was the Village before. What did AB 34 do?

RS: Well, AB 34 was ten million dollars a year, and half of that was L.A. County so I think they got five million, or roughly five hundred people. They already had -- the PARTNERS Program is what they called the ISA expansion. They already had twelve providers with varying numbers of people. So those same twelve providers got the initial AB 34 money, so they just added additional numbers to their slots.

So in terms of service delivery, nothing was changed. What was changed was the outreach and engagement piece of who you contacted. Actually, L.A. did it a little bit differently. They went to people mostly that were about to be released from jail and were going to become homeless the next day. So they weren't homeless at the time, but they were going to be homeless the next day.

HP: Imminent risk of homelessness.

RS: Yes. I mean, it couldn't be anymore imminent than the people they chose for their initial enrollment. That was their main target. Sacramento County and Stanislaus actually went out to the streets and found truly homeless people. My favorite picture — somewhere in this office we have this newspaper photo — of homeless people surrounding the van, a police van, hoping to qualify for the program, hoping to be deemed to have a serious enough mental illness to get one of the slots in this program. The relationship between the police and homeless is not normally one that you view as very friendly.

HP: They don't normally seek out the police.

RS: That's right, but they did for this police van. They knew that this was something very different.

HP: So it really sounds like a win-win.

RS: It was. Everybody endorsed the program, and when the Director of the Department of Mental Health went to the governor to seek the expansion from AB 34 to AB 2034, he took the county sheriffs from three counties with him. He said, "You guys are going to sell it to the governor. You're going to tell him what a difference it makes in your jails, and the people that aren't there now because of this program." And they did, and the program succeeded.

I remember Darrell Steinberg and I organizing a press conference, and we had no mental health people at the press conference. It was all law enforcement people in uniform. The police saying, "Yes, finally we have the right answer. We shouldn't be dealing with these people. They're sick people."

HP: Right. Now, as you were pushing AB 34 through, I guess the same question since it was much bigger, was there opposition in terms of spending this kind of money?

RS: I believe the Church of Scientology had surfaced by this time and had expressed opposition. It was not opposition that meant anything. I mean, they weren't picking up any votes in the legislature. But no, there was no real opposition. It was a budget issue. We're competing with other people wanting limited dollars, and how much of these limited dollars are we going to get?

HP: Right. So you were able to push that through. So, as you were trying to push it through, you mentioned that people saw it worked, but was that once the programs were in place, or was that beforehand?

RS: Well, when we did AB 34 it was pretty much just me and Darrell Steinberg doing it. He was able to get John Burton [Senator representing California's 3rd Senatorial District, 1996-2004], then the president of the [California] Senate, behind it. John Burton, you know, representing San Francisco, where homelessness is a huge problem, and with his own experience with alcohol and drug addiction in his own personal past — he understood the issues and was a real strong supporter. The housing stuff was really important to him. He actually intervened to get the governor to sign the ten million dollars to get the program launched.

The counties I think got involved and helped us in the writing, but they were I think largely skeptical that this was really going to work and going to go anywhere. Remember, it was only for three counties, there was only ten million dollars and they weren't sure. But the next year was a totally different story. Once they saw that it worked as well as it did — because the Village pilot was a long time ago, and nothing had really happened. This was much more visible. So the next year when we went with AB 2034 to expand it statewide and to take it from ten million to fifty million [in funding statewide], the whole mental health community was really involved. They were involved, and NAMI was involved, and we had law enforcement support because they saw what it did. So we had this huge coalition of support, and it was a much more visible thing. We pushed it and did a lot better. The 2034 expansion was the one that was more of a team effort.

IV. Polls, Focus Groups, and the Crafting of Proposition 63; The Politics of Proposition 63

HP: All right. So let's move on to Prop. 63.

RS: Okay.

HP: How did it happen? Tell me about where did the idea had come from, how were the specifics written, how did the campaign build?

RS: Okay. Well, in 2000 we got AB 2034 and we got fifty million. In 2001 we wanted to go to a hundred and fifty million. We believed that the success we were having should give us money. The problem was the state was not in expansion mode with its budget in 2001, and we got ten million [more]. We got from fifty-five million to sixty-five million.

That was when I thought “We're not going to get there through the legislature.” And I talked to Rose King. We didn't talk about this — it was her idea to do what became the Nickel a Drink, and we were going to do our own initiative. She came to me in 1991. Again, small world. She and I knew each other. We were part of the same social set of friends back in the late seventies and early eighties. We both liked the Grateful Dead, and that was kind of our connection.

So Rose knew that I was kind of becoming this mental health lobbyist. She came to me and said, "You should do an initiative to fund mental health." This was in 1991. I said, "How do you do an initiative?" And she had done this stuff, and she gave me all the steps. So I went to my organization and said “This is what we’ve got do.” So we got started on that.

But more importantly, she showed me some polling data from 1986. The polling data, that she made sure mental health was part of, asked the voters, “Would you rather have a tax rebate or would you rather have government spend more money on X?” And there were fifteen different Xs. Because she was in a key position on the legislative staff at the time, she made sure that mental health was one of the Xs. And mental health came in second in terms of the ratio. How many people said spend more money on X, and how many people said give the voters a tax rebate.

HP: That is really surprising.

RS: Right.

HP: Was it mental health or mental health to get people off the street? I guess that would be the question.

RS: I don't remember the details, but I think it was just mental health. We found out later why that was true. But in any event, it was ahead of education, ahead of public safety, second only to helping the frail elderly. And that was what convinced me we could do an initiative, that the public understood that this issue was under-funded.

Then in 2001 Rose was working for our current mental health champion at the time. Besides Darrell Steinberg there was another mental health champion named Helen Thomson [Assembly Member for California's 8th Assembly District, 1996-2002], and she had gotten the legislation through to mandate insurance parity in California. That was signed in 2000 [California Assembly Bill 88, ending discrimination in insurance benefits for individuals who suffered from mental illness]. That had been her main priority, so then the next year she was ready to turn to other things. And in the mental health community she's more famous, or notorious, for taking on the issue of involuntary treatment.

But what she also did was a bill to basically fully fund the Children's and Adult System of Care. Actually, that piece of legislation I believe was AB 1422 [California's 2001 Assembly Bill 1422]. That actually was the first draft of the initiative. She came to me and we started writing it. It was several hundred million dollars a year of funding. And I said, "Rose, we're not going to get this through. Do you think maybe it's time to revisit the initiative idea?" And she said, "Yes, it is." So she and I then peddled the idea, and we took the bill to Helen Thompson and Darrell Steinberg, and neither one of them would support it at the time.

HP: How come?

RS: They both felt that it would undermine our efforts to get more money through the legislature. They thought we still had a chance to get more money.

HP: For AB 2034.

RS: Right. We got a little bit in 2001, but what happened is that in 2002 then we got nothing. We actually went back from sixty-five to fifty-five because the state was in a real deficit situation. At that point, Helen Thomson was termed out of the legislature. She was done in 2002. So she no longer was involved. But Darrell Steinberg changed his mind. He said, "No, I will support you now in doing an initiative."

HP: What do you think changed his mind?

RS: It was that he became convinced that we weren't going to get the funding through the legislature. That we had nothing to lose. So I went to the community mental health agencies [California Council of Community Mental Health Agencies]. Actually, this was before Darrell had signed on to it. This was in the summer of 2002. And I convinced them to do a public opinion poll to see if there really was support for this idea. And it came in unbelievably high support, like 80 percent for more funding for mental health.

HP: Did it say how that would come about?

RS: No. At that point we didn't know about the tax versus the taking it out of the state budget, or whatever, as to how we were going to do it. It was a very simple poll. In October I went to the board of the community mental health agencies and I said, "Are you guys committed to doing this? You're going to have to come up with the money." They said, "We will come up with the money to go forward if you have a public opinion poll done by a major campaign firm that says that we can win." So at that point we were ready to go forward and do that.

Coincidentally, at almost the exact same time, within weeks, is when Darrell Steinberg's chief of staff, a woman named Andrea Jackson, came to me and said, "Darrell's ready to do another initiative, do the initiative now." And they together said, "And we've got a campaign firm for you." So I didn't even have to go interview a campaign firm. They said “so we’ve got the firm.” It turns out they had been talking to a couple of different firms and found the one to work with.

At that point we went forward, and we were on two tracks. The funding source was either going to be taken out of the state budget, and [we would] claim it would save money in law enforcement and prisons and hospital emergency rooms to pay for itself. Or do a tax increase. We were surprised. The state had a big budget deficit at the time we did the polling, and the polling said the tax increase was the preference of two-thirds of the voters. We were surprised by that. And the two types of taxes that came in high were tax the rich and then the sin taxes. And we knew that the sin tax would generate well-funded opposition.

HP: Because there's a sin industry.

RS: There's a sin industry. There's a tobacco industry, and there's an alcohol industry, and gambling I think was the third one. I don't remember if there were any besides those three. Marijuana legalization wasn't on the table at that time as it is now. That's the new sin tax that's being approached.

But in any event, we went with the taxing the rich as the way to fund it because the polling told us that was the way the voters wanted to go. They were afraid that even though we said it would pay for itself in savings in other programs, the voters were skeptical that that would really be the case, and fearful that it would lead to cuts in education and other things. [They also felt that] if you could find your own revenue source, that would be the way to go. So that's how it got written.

HP: Now, was there fear of accusations of raising taxes —just fast-forwarding to today’s political climate — the idea of a tax even on the very, very wealthy. Was there a risk of provoking a lot of opposition by doing that?

RS: Well, we knew that there was a segment of the voters that would vote against any kind of a tax increase, that just did not believe in that. And we knew there was another segment of the voters that just didn't like initiatives and weren't going to go forward for it. And none of those were the main fear. It turns out the main problem was a third segment of voters that were skeptical that government could spend the money on the right things.

So we had to write it very tightly. We defined it just for the Children's and Adult System of Care, and then we put in a prevention early intervention piece, because focus groups told us that was something really important to [voters]. And they didn't want to fund all mental health, only people that had severe mental illness. But they also would fund a prevention early intervention program, which was something that I had learned with schizophrenia, that if you identified it early in its onset, it didn't run the normal course, people didn't become homeless. And so we wanted to fund those kinds of programs. That worked really well, and the voters liked that. So the money was very tightly drawn to just do these three things: Children's System of Care, Adult System of Care, and prevention early intervention, as the only things the money could be used for. That's what the polling told us.

And also, to go back to why that 1986 poll was valid, is the first thing we did before we even did the poll was we had focus groups. We went to the focus groups, we put on the wall a flip chart with the words "mental health." And we asked people what comes to mind. In six focus groups, the first statement was the exact same thing in every focus group — it was street people. So when the interview asking follow-up questions, all the people said, "Well, of course, that's why we have street people. The state emptied out the hospitals, which was probably a good thing, but it never provided the community care these people need."

HP: It's amazing people had this knowledge.

RS: People had this knowledge. It was amazing how well. And we understood why they had that knowledge – it is [because] over 50 percent of voters knew somebody, either a family member or a close friend, who had a severe mental illness and had lived that experience.

HP: Of homelessness?

RS: Of homelessness due to a severe mental illness.

HP: Oh my goodness. And this was across the state?

RS: Across the state. Virtually everywhere.

And the key was to avoid funded opposition because we knew that the vulnerable part was people's fears that the money wouldn't be well-spent. We feared that a well-funded campaign could try to confuse voters as to how the money would be spent and cast out [doubt]. But we were fortunate in that there never was well-funded opposition.

HP: And why do you think that was?

RS: Well we went and met with a business leader, a man named Allan Zaremberg, president of the California Chamber of Commerce [1998-present]. Not someone I know very well, but our campaign manager knew him well. Our campaign manager said, "He's an honest, trustworthy man. He will tell us if the business community is going to come out and spend a lot of money against this." And I said, "Before we even get started we have to know if they will, because if they will, we need to know we can raise a lot more money to fight that than if they're not." And he said, "No, we're not. This is not an issue.

This tax on millionaires, it's not a tax on businesses, it's not going to drive businesses out of the state." He said, "I'm sure my Board will oppose it because we've never supported a tax increase for anything, but that doesn't mean there's going to be an organized business community opposition campaign on this." And there wasn't. I trusted that he knew the people he worked with. He knew his community and that this was not something that --

HP: They wouldn't support it, but they wouldn't rally against it.

RS: That's right. Actually, we found that some people actually tried to help us. He even told us that the L.A. and San Francisco Chambers [of Commerce] might support it. So he understood that it's a separate funding source, it would help with the state budget. He had worked in the government and understood that we wanted government to work and thought that this would help state budget problems. I think, more importantly, he figured it would help head off other tax increases that *would* hit businesses hard.

HP: To build more jails and hospitals.

RS: Right. And that this was a good thing. I was really kind of a bystander in the conversation, but with Darrell Steinberg in the room, they had this conversation. So that was how we went forward, thinking there wasn't going to be well-funded business community opposition.

And we had learned from a friend of mine named Lenny Goldberg [Executive Director of the California Tax Reform Association], who represents public employee unions on tax issues, who had done a similar tax in the past, that this is not an organized opposition. That [for] the main anti-tax groups, this is not their funding source. Their funding source is kind of, mom-and-pop, small landlords. You know, Howard Jarvis [anti-tax advocate who was instrumental in the passage of California's Proposition 13 in 1978] was a landlord. It was more of a grassroots thing, and that they weren't the people that made over a million dollars a year.

I think the other thing we discovered is that the people who do make over a million dollars a year, they don't want to draw attention to themselves. It doesn't look good for them to be opposing a tax on them [themselves]. And we met a lot of people in that category that were supportive. They said, "This isn't going to bother us." The governor being one of them. Now, he ultimately opposed it, but it was much like the Chamber [of Commerce]. He said, "I'm the leader of the Republican Party, the Republican Party is opposed to tax increases. I'm going to oppose it." But he also didn't fight hard against it as he did against others, and was recognizing this isn't such a bad thing. And didn't want to attract attention to himself being someone who is in that income category.

HP: Exactly. Now, you said it had to be written very tightly, so I'm wondering, was there an idea, not just of the FSPs because that was clearly the centerpiece (of Prop. 63], but these ideas of Wellness Centers, Field Capable Clinical Services which offer some of what FSPs can offer. Were those ideas in the initiative then? [Wellness Centers and Field Capable Clinical Services are lower intensity programs created by the Mental Health Services Act]

RS: No. The FSP was the only thing in the legislation for adults, but it was a very loose concept of an FSP. We knew that as people recovered, the real rich array of

services they need initially they don't need. So in our minds, those things were all [related to] FSPs. They were just dealing with people at a lower intensity of need. The Wellness Centers, in our mind as writing it, should have been tied to an FSP. The same organization should be embracing it so that people who needed one could get the other. The idea of those things being independent was not something that we envisioned.

HP: Okay. So it was envisioned that the agencies that had the FSP would see people all the way through [as they no longer needed to be in an FSP, but still needed mental health services].

RS: The important thing was, it was the people who needed to be part of an FSP who the focus was on. And the people who needed to remain part of an FSP as they recovered, and that the Wellness Centers might be all they would need as they recovered. But we envisioned it being a continuum of care that was all part of the FSP. We didn't envision them being separate in any way.

V. Impressions of the Mental Health Services Act Thus Far; Contracted vs. Directly Operated Services; On the Future of the Mental Health System in California; On the Need to Reform California's Budget Process

HP: So now that the proposition has passed, and it's been a few years obviously, what have been the major successes, and where has it fallen short?

RS: Well, the answer to that is really simple. The model that we knew worked, works.

HP: The FSP part.

RS: [nods yes] And it's serving far more people, and they're doing really well, and we're getting the results we thought we would get.

Where it has fallen short is that we didn't anticipate the underlying instability of mental health funding. That realignment wasn't a stable foundation growing at a rate of population plus inflation. It hasn't grown at that level, so in real dollars, the number of people that realignment could serve with community services has gone down every year. We didn't see that coming, the result of which is that we haven't served nearly as many people as we thought we'd be serving by this time.

HP: Serving them overall in the system, between realignment plus MHSA [the Mental Health Services Act].

RS: Right. So the number of people in the FSPs is a far smaller number than I thought it would be at this time.

HP: What's the relationship between realignment and having people in FSPs though? I figured as realignment shrank you'd try to get more in FSPs.

RS: We have gotten more in FSPs, but the fact is there were things like FSPs, that the ISAs, that realignment was funding. And there was a lot of other care. It wasn't as good, but it was still something. So the fact is MHSA has had to carry a much heavier burden because of that underlying funding.

HP: I see. And the original purpose of MHSA was to supplement.

RS: Was to supplement that funding. We required a plan that we would ultimately convert the realignment funding to the MHSA FSP model. That was envisioned. We didn't anticipate it would happen the way it's happened, which is that the realignment funding would disappear and MHSA would be all there would be. We thought that you would still have realignment dollars and you would simply convert those programs to the better model.

HP: So the idea was that MHSA would become a model then for the entire system.

RS: Right. Which it has, but it's also become the only funding source, so it's kind of happened. So we've had faster success in converting to the better model than we anticipated, but slower success in reducing the unmet need. And it's arguable that we're no better off now than we were before the act passed, when you look at the magnitude of hits we've taken due to the current recession.

HP: In terms of overall funding in the system.

RS: In terms of how many people we can serve as a percentage of those that need care.

The other area where we've fallen short is a temporary one, which is that prevention and early intervention programs took a lot longer to get up and running than we anticipated. So here we are five and a half years after passage of the act and those programs are just getting started. We have no information as to what good they're doing. We thought those would get up and running right away as well, and that's been a major disappointment, that it took so long to get those up and running.

HP: Right. Now, in terms of where the programs have been successful, in what ways have they been successful?

RS: Well, they've been successful in the same ways that the AB 34 programs were successful, which is reducing hospitalizations and incarcerations of adults. And then we also of course have FSPs for kids. The kids thing was a little different because most of the funding for kids was really unaffected by Prop 63. It’s Medi-Cal entitlement funding, which is much stronger for kids than state funding, and it's not affected by realignment. Realignment doesn't fund the kids' services to the same degree. But it fills in the gaps, and it required a model of what's called “wraparound,” favoring in-home care as opposed to group home care for kids with severe problems. That's also been very successful. It hasn't been talked about as much, but that's another area of the success that's happened. So the result is less kids out of home and less adults in jail or hospitalized.

HP: Right. I want to ask a couple of more questions, specifically about your role and then some more general ones to wrap up.

RS: Okay.

HP: One thing that's interesting is that in your role as a representative for the contract agencies, you advocate for the contract agencies, but you're also an advocate for the system as a whole.

RS: That's right.

HP: How do you balance the two? Do they ever conflict?

RS: The balance of the two is the community agencies themselves have board members that they're accountable to who are interested in the system as a whole. So they want the system as a whole to benefit. They believe that they are the best bang for the buck, and the counties believe that too, because by definition, these are the providers the counties choose to contract with. They wouldn't be contracting with them if they didn't think they could get good value for contracting with them.

HP: I see. Better value than running the operations themselves.

RS: Right. Counties can always operate directly, but if they contract out, they think it's a better model. I don't know of a single county right now that contracts out and thinks that they could do better doing it in-house. The ones that do it in-house, it's kind of like they've always done it in-house and so the politics of converting from doing it in-house to contracting out would be very daunting. Because you'd be displacing county workers, and right now protecting county jobs is really a huge thing with the cutbacks that are taking place. But I think some of those counties may choose to expand -- and some of them did when we were in expansion mode -- using contract agencies even though they didn't have a history of having them. They had to import them from other counties where they existed.

HP: What are the relative advantages and disadvantages of contract agencies?

RS: The advantages are the flexibility that I spoke about much earlier why the ISA worked as well, and the flexibility is a huge factor. So it's a culture that —there's a book right behind you [pointing]. Yeah, there it is, right behind you, that book right there.

HP: [reading the title aloud] *Reinventing Government: How the Entrepreneurial Spirit is Transforming the Public Sector*, by David Osborne and Ted Gaebler.

RS: Right. Written in the early nineties. It points out that there are three ways that government can fund anything. It can do it itself, it can contract with nonprofits, and contract with for-profits. And it lists the kinds of things that are best done by each of those three models. It says [something] like a hospital is best in contracting with for-profits because you need to raise a lot of capital. They've got huge capital facilities. Whereas the rest of healthcare is best done by contract with nonprofits because you have no profit motive.

Of course, government operated doesn't have a profit motive either. But because it doesn't lend itself to a twenty-four-seven but is nine-to-five and it doesn’t lend itself to the flexible spending and has the strict discipline and civil service and all the rules of government, it's going to be more efficient done contracted out than it's going to be done in-house. Because when you do it in-house there's a huge command and control structure of government, that results, in a health and human services area, in some inefficiencies that aren't there in a contract model. You can take the same worker and put him out in a contract model versus in a county model, and you will get far more billable units of service from that same person.

The model in that book actually is a school system. It describes Boston. It describes the Catholic schools and the public school system. It says that they each are responsible for about the same number of students, Boston being a very Catholic city. The Catholic school system has five administrators outside of the people in the schools. The Boston public school system has three thousand.

HP: So with the contract agencies you can cut the fat, so to speak.

RS: Exactly. You can cut a lot of the fat out.

HP: So in the ideal mental health system, would it be divided or would it be all contract work?

RS: Well, there's this perception that some of the counties have, that there are certain people that the contractors won't take [clients that contract agencies are unwilling to serve]. Or that there are places they [contract agencies] won't go, places in the community where they won't set up a facility. You can't state that universally. In some counties that's not the case. But in counties where it is the case, there's a need for something that the county operates. To the extent that there are places that you can't find a contract provider, or there are people that the contractors won't take, you need something. But for the most part, I think that is not the case, and for the most part, I think the better model is to contract with a private provider.

Now, there is a risk, and two counties have had corrupt private contractors. One was Kern County and one was Riverside County. And L.A. has one provider that was poorly run. Basically, in all three cases, the private provider went out of business. In Kern County they actually went to jail, the people running it. They were skimming money from it.

HP: And that has real consequences for the consumers who are receiving services there.

RS: Exactly. So there's a risk contracting out that you don't have in directly [county] operated — that you can have a bad apple. And the numbers of bad apples have been very few and far between, so it's a risk that I think every county that contracts out feels that they have enough control [over], they have enough management. In L.A. one just simply went bankrupt with its debts. It spent more than it was taking in, and the county had to take it over and then basically spun it back off to another provider in L.A. In Riverside, it was a long time ago, and I don't know the details, but eventually the county stopped contracting with those entities.

HP: And in terms of the quality of service, beyond the efficiency, are there differences?

RS: That's one of the other disappointments of the MHSA. We don't know that yet. I talk to the providers, and I can tell they each do things a little bit differently, even though on the surface they're all doing things like an FSP. They've all said, "Unless we're doing an FSP, you really can't measure the quality because we don't have enough control over the person's life to really be held accountable for the results." But they do all do FSPs now. And what the providers would love to know is who does a better job? And yet that

data is still not available. That's been another disappointment, and the [California] Department of Mental Health has fumbled that badly. And they'd admit that.

There were huge turf battles within the Department of Mental Health, and with the commission we created for Prop. 63, and with the Mental Health Planning Council, and with the counties, as to who's responsible for what in terms of collecting outcome data. And the result is, we haven't collected it yet. We've actually collected it, but we haven't developed a reporting mechanism. The data is there, but it's not there in a reportable form yet. We're hopefully within a year of getting that. That's the real question.

I think that all of the providers, both county operated and community agencies, deliver good quality. But some deliver better quality, and some deliver more efficient quality. And we don't have that information yet and we need that information I think. The counties want it and the providers want it.

HP: Right. But given the efficiency factor, if you're looking at the system as a whole, it makes more sense to go with as efficient [a system] as possible, hence --

RS: Well, yeah. You need to find that out. You need to find out how much more efficient is a provider versus the county, and how much more efficient is contractor provider number one versus contractor provider number two. And how much more efficient is county directly operated A versus county directly operated B. You're going to get different answers, and we don't have the answers to those questions. Those are very important questions, and we don't have them.

Also, the quality. What are the results? Provider A gets a 60 percent reduction in hospitalization, provider B gets a 90 percent reduction. Why? Provider A gets 80 percent back to work, and provider B only gets 30 percent back to work. Why? Those are the things we want to find out. Maybe provider A spends more per person, and then it's a tradeoff, quality versus cost. But maybe it's not a tradeoff, maybe the costs are the same. So those are the things we need to find out.

HP: Okay. Where do you see the mental health system going? And where would you like to see it go? I guess those are the two questions.

RS: To me, where I see it going is expansion of what we have. The FSP model is the model, it will expand. National Healthcare Reform, in 2014, will bring in a huge infusion of federal funds that we don't have now, which will help enormously. By that time, I expect the economy to be much stronger, and we'll be back in a significant growth mode and we'll maybe be then where I thought we'd be now, you know, five years later. So we'll begin to start to serve everybody we need to.

We also will have the prevention early intervention programs really working well, and we'll know a lot about those. Hopefully, we'll have the comparative models, [know] which ones make the most difference. Where I'm hoping we'll be is where schizophrenia will not be the cause of disability it is now — it will be unusual for it to lead to homelessness and incarceration and hospitalizations as it does now. That we will most of the time catch it early, and people will lead normal lives.

Now, where I'd like to see it go is the next step beyond all of that. That to me is the unknown. Will we erase stigma? Will be get to a place where no one's afraid to seek treatment for a mental illness, and where everyone understands how important it is that you get help at the earliest possible stage, when anybody you know is showing the slightest signs of trouble. That's not the case [now].

You know, the polling showed that people understand that mental illnesses are real and need to be treated. But polling also showed that if you ask somebody, "Well, you believe that this is really needed, but suppose you or a family member had a severe mental illness, would you seek treatment?" Only 20 or 30 percent say yes, and that's because of the fear of the label. They are so afraid of the label, and they don't understand how high the risks are of their lives falling apart if they don't seek treatment, that they don't seek treatment until it's too late – until it becomes a life destroyed with a really difficult and time-consuming and expensive process of trying to put people back together again.

So that's the hope — that that will end, that society as a whole will accept mental illness as being a normal medical condition and we will put in place universal strategies for early identification and treatment, and no one will resist the labels. It'll become a normalized thing, and then who knows? The ultimate goal is that there is no mental health system, it's simply a part of healthcare and it's not a separate system. That it's all built in. That's the ultimate goal.

HP: So equality with other healthcare.

RS: Yeah.

HP: Just one add-on. With recent things — the ending of AB 2034 [in 2007], Prop. 1E [a 2009 initiative to divert some MHSA funds, which voters rejected] – is there a fear that we might be taking steps backwards rather than forwards?

RS: Absolutely. The state legislature, and more importantly and directly the State Department of Finance, only have one goal, which is to balance the state budget each year. Any chance they get to steal money from a program that they may see is doing better than other programs, they're going to take that chance. In spite of the fact that over five years taking money out of community mental health and putting it in prisons, or anything else, is not going to be a cost-effective investment, the budget structure doesn't allow them to think long term.

The budget structure of the state legislature and the State Department of Finance requires them to balance the budget each year. Unless and until we come up with the ability to do multi-year budgets, three years or more budgets, we're not going to be out from under that. If we get to the point where the state can do a three-year budget and look at long-term costs and savings, we'll be out from under that fear. Until we get to that point, those concerns of a "son of 1E," or something like that, is always going to be in the back of my mind.

HP: Right. And that's something that's just more of a structural thing. And is there anything that the average voter, or just the average politician, could do to try to keep these things from happening?

RS: Well, the average voter, actually, is better off than you think they are. They understand these things, and they would vote for these reforms if they were given a chance to. So what you really need is the politicians — there isn't funding for good government, that's the problem. To put an initiative on the ballot costs two million dollars. And there were good government reforms that had some bipartisan support, but they didn't have enough bipartisan support in the state legislature to get on the ballot through the legislature. So as a result they didn't get on the ballot. And the group that was organizing them, it's called California Forward, was not able to raise the money to do it through the initiative process for this year. They may keep trying, and maybe in 2012 it'll be different, but for now, that's the case, so there just isn't enough money behind all that stuff. I think groups like us will have to become part of that effort in a stronger way and help financially to get some of those things forward.