**CAROL S. HOOD TALKS ABOUT THE STATE DEPARTMENT OF MENTAL HEALTH'S RELATIONSHIP WITH COUNTIES AS THE MENTAL HEALTH SERVICES ACT WAS BEING IMPLEMENTED**

At the beginning, the Counties were asking for direction. They were supposed to put on this huge, community planning process, and they said "get us a template or something." You know, "help us out." And so, we did. Then later they felt that was too directive. Well, it was never meant to be directive. It was meant to be assistive. So, over time some of the things that we were doing, we thought were at their request to help—like clarify what are the services and general system development, what are Wellness Centers, what makes it a Wellness Center, how do you know if you've got recovery or not, defining terms and some of those kinds of things. How do you know if you've got cultural competence? Some of those guidance things that I think were initially helpful to many people, over time many felt restricted by them.

In terms of approving the plans, we tried to transform our administrative processes just as the Counties were having to transform their systems. So we said, "there's no due date. You can submit whenever you're ready. We will keep your money here; we aren't gonna give it away. So, submit when you're ready." There was reversion, so if they waited too long, it would go away. But, it wasn't a rule created by the State Department of Mental Health. That was the statute. When Counties would submit, they would bring a team up to explain what it was that they were asking for, and there would be a dialogue with the State staff asking questions. "Is this what you mean? Is this what you're trying to achieve or something like that?" And, initially people felt that was a very good process, very supportive on both sides, very informative. Over time, we became more bureaucratic in asking for more and more detail in order to satisfy our administration, which wanted to be able to answer every question [about]…how they were using their money.

I remember one of the early ones that got people so angry was that we provided some money up front just for Counties to get going. Because how do they hire staff to even write RFP's? I mean, they were way down on staff the same as what we were. So, we put a bunch of money out there. And so how do you spend a lot of money? Well, you buy things. You know, it's not just for staff, but you buy things…And what they wanted was cars. So a lot of requests for a lot of cars were submitted, because there were supposed to be a lot more mobile services and stuff like that. Well, the concern was that if it became known that all this Mental Health Services Act money was to buy 200, 500 cars, whatever, what would be the public perception of that? And, would that end up closing down the MHSA? So we would ask the County "why are you using this number one car? What is your plan for the number two car?" And then, they'd come back, and we'd say "we've got some follow-up questions for you now about that number one car…"…and so it got discouraging. So initially, I think there was real positive feeling, but over time it got discouraging to Counties.

**READ THE FULL TRANSCRIPT BELOW…**

**ORAL HISTORY INTERVIEW WITH CAROL S. HOOD**

**INTERVIEWER: Howard Padwa**

HP: All right, this is Howard Padwa here in Sacramento, California, doing an oral history with Carol S. Hood for the project on the history of the mental health system in California. So Carol, before we get started, or I guess to get started, tell me a little bit about your background and how you got into mental health.

CH: I graduated from UCLA in psychology, and then I went into VISTA and to North Carolina.

HP: What's VISTA?

CH: It was the precursor to Americorps. The Domestic Peace Corps is what they used to call it, Volunteers in Service to America.[1] And then from there I was wandering, and ended up in Minnesota and stayed there for thirteen and a half years. I worked for the County in various capacities in human services and also for some direct service providers that provided emergency shelter for kids.

HP: Oh, so you were doing service provision as well as some administrative work?

CH: Yes, I ran a daycare center for about three hundred kids of new refugees—helping to provide the childcare in kind of a co-op type setup. And then I decided to come back to California and got a job with the State Department of Mental Health [DMH]. [I applied] just through the regular application process, and then I kind of went up through the ranks in various capacities at the department. Then I

[1] Volunteers in Service to America was founded in 1965 as a service program designed to fight poverty in the United States. In 1993, it was incorporated into the AmeriCorps network of programs, which engages volunteers in intensive services at nonprofit agencies, schools, public agencies, and community and faith-based groups.

became the deputy of community services, which is the community mental health policy and implementation division, and then I retired from there in 2008.

HP: So what was your initial role at the State DMH when you first got there?

CH: I was a County liaison to six Counties. So I was a person who was a generalist, anything that the Counties needed to do—I'd go to those Counties and figure out what would be helpful. So I spent a lot of time on the road. [I'd check] "Is everything going okay?" Those kinds of things. So, I was supposed to be the eyes and ears of the State, but I would mostly help the Counties with whatever they needed—if it was fiscal or if they needed program policy or if they couldn't get something certified, or needed help with another department.

HP: I see. Which Counties were you working with?

CH: Santa Cruz, Monterey, San Mateo, Sacramento, Yolo, and San Benito.

HP: Okay, so the ones all right around here [Northern California].

CH: Yeah, Bay Area and then right here, yes.

HP: And, this was in the mid-1980s, late eighties?

CH: Late eighties, yeah, I came in 1988.

HP: And what was the relationship between the State and the Counties then? That's something I know has kind of evolved over time.

CH: My opinion—and I was at a really low level, so I wasn't an executive level—but the Counties thought the State had nothing to contribute and typically felt that we were a barrier to getting things done that they needed to get done.

HP: In what way?

CH: [The Counties thought that] we had way too many rules, that we weren't responsive to things. There was an Oyster Point Resolution—they [County Mental Health Directors] were having a conference there [at Oyster Point, just outside San Francisco], and it was a vote of no confidence in the department [State DMH].

HP: And, what did that mean?

CH: That they were just sick of us [State DMH]. You know, the resolution had no force, but it was really quite a statement of a total breakdown in the relationship [between the State DMH and the Counties].

HP: Now, at this point, the State was still directly funding services at the local level, because this was pre-realignment?[2]

CH: This was pre-realignment. What we had at the time [to fund mental health services] were some general funds that went out to the Counties for a variety of things; and we had a lot of grant programs.—competitive grants—so we would have an adult system of care. And Counties had to compete for that [funding], and they didn't always get what they wanted. Or some would get funded and some wouldn't. And then, we also had an older adult system of care, and there was competition for that [funding] as well. And so, there were, like, token amounts of money that became available.

HP: I see.

CH: And then we had to have a fair process, so those Counties that had more resources were better able to compete for that and became even richer.

[2] Realignment refers to the 1991 Bronzan-Wright-McCorquodale realignment Act of 1991, which gave California counties more control over resources to fund their public mental health systems.

HP: I see, and so the small Counties were really then kind of disadvantaged throughout those processes.

CH: Small Counties and what they called “under equity” Counties. Counties that got started in the public mental health system early typically ended up with more money. They got in early when money was easier, when it was voluntary.

HP: And, they were able to build up the infrastructure [to compete for State mental health funding] then.

CH: Yes, and other Counties that got in later, and that’s typically some of the Southern California Counties. So Riverside and San Diego were tremendously under equity. That meant that if you took any measure of poverty and population to see what you thought Counties should be getting [for mental health services], there were some Counties that by any measure were getting far less than what appeared to be equitable.

HP: Which were the over equity ones?

CH: [Counties in the] Bay Area.

HP: So, they got started [in creating their mental health systems] even before L.A. [County] then.

CH: Yes. And, L.A. because it’s so big, it kind of defined the medium. They typically just define the average because they’re so big.

HP: And, what were the kind of services that they [the Counties] were competing for? What were these grants to do?

CH: There were all kinds. I remember the older adult system of care. At the time, it was not a major focus of most of the Counties to give services to older adults, so

the grants were really figure out what—how to do it, how to blend the funding sources for older adults. Because so many of them [older adults] are on Medicare and it makes it more complex.

HP: Right.

CH: There were also competitive grants for the children's system of care, adult system of care, and I know there were smaller grants, but I'm forgetting those.

HP: And, when you talk about "system of care," was this talking about providing wrap-around services, things outside the clinic, or were these just traditional outpatient clinic based medication therapies?

CH: It depends what age group that you're talking about. I would say for all of them what the system of care was trying to do was to make the system responsive to the client's needs. For example, responsive to the child's needs rather than making the kid have to access services here, there, and everywhere. So, for children, children's services, are done through the providers most of the kids interact with—special education providers and social services through the child welfare system. So, the question was how can mental health be a service provider to help those other agencies achieve their goals so which are the same goals you have for kids in mental health? You want the kids to be at home. You want them to have friends and family, and you want them to do well in school. And so, how do you do that? Well, support them in school or help support their families. And, that was the theory of a children's system of care was to make it work for the kids by supporting the other agencies.

HP: Where they would be in their natural environment really.

CH: Right.

HP: For adults and older adults, what were—what would the equivalent philosophy have been?

CH: There weren't other agencies, really, that served those populations. The clients tended to only interact with mental health—well, other than law enforcement—

HP: Unfortunately, yeah.

CH: —but no other kind of administrative type agencies. And so, the goal was more to provide the broad range of services, and again looking at what do the people [clients] want? They want to have a good job. They want to have friends. They want to have, you know, contact with their family, and someplace to live that's safe. And so, it was working on all of those through, like, the Village[3] became the biggest kind of conceptual leader, I think, for that.

HP: So yeah, and I wanted to ask because before the Village and the model of providing services for a variety of things [beyond psychiatric medication and psychotherapy], what did services look like?

CH: Well, at first, it was like a clinic model. if you wanted to come for an hour of therapy, you could come for an hour of therapy. And, if you didn't come for that hour, then that clinician had an hour to do whatever other things that they needed to do, but it was a very scheduled, in the office type of a thing. And not a whole lot of services focused on housing or socialization or things like that. It was be more typical mental health outpatient types of services supplemented with the inpatient services and meds.

[3] The Village is a mental health agency in Long Beach that was one of the first to provide intensive wraparound services for adults with serious mental illness. It began serving clients as one of the three Integrated Service Agencies created by California Assembly Bill 3777 in 1989.

HP: Um-hm, so then what happened to people's socioeconomic needs? Did they just go unaddressed by the mental system before then?

CH: Yes, yeah. By the time I got here [to State DMH], the Counties were really changing and realizing that they couldn't meet everybody's needs. And so there was a big debate about should you focus on the target population [of people with serious and persistent mental illness]? Should you focus primarily or first on those with the most serious needs and then go down the scale if you had the resources? And there was a growing consensus that, yes, that's what you have to do except in small Counties where there were no other providers [besides the County]. So there was kind of an acceptance that in small Counties you had to also provide services to people who maybe didn't have a serious mental illness but needed care because there was nobody else to do it.

HP: I see. So how was severity determined? Was it simply by diagnostic criteria, or were there other considerations as well?

CH: I think it was pretty similar to what they do now so diagnosis and functional impairment. Both.

HP: And what was the other side of that debate, I'm curious? Like, in the big Counties, what was the alternative to prioritizing services for those with the highest level of need?

CH: I think the argument was that you shouldn't only serve those who are the least able to benefit, that you should provide services to those for whom if you provided a little bit of services, it would make a huge difference.

HP: I see, so they decided more toward those in the most need instead of the broader population.

CH: Right, and that was supported by realignment, which was in 1991. The first realignment was 1991 but the debate and kind of the shift was happening before realignment. realignment reaffirmed what was already going on.

HP: And, what was driving that do you think? What led to that decision [to prioritize services for those with the highest level of need] in the big Counties?

CH: The severity of the financial constraints. You couldn't do what you knew you should be doing, and so Counties had to say "Okay, with limited resources, what is our unique role, and what do we need to be doing with those resources given that we can't do everything we think we should be doing?"

HP: I guess as a precursor to that, there must have been a realization that the resources aren't coming. I mean had there been efforts to get the money that would have been needed to provide services for everybody?

CH: It was—in those days the [budgets were very tight]—because a lot of the money for mental health came from the general fund, and it was the biggest discretionary item in the general fund so—

HP: So, it was up to the governor, right?

CH: The governor and the legislature, but only about 8 percent of the budget was discretionary. And so mental health was competing against everything else that's discretionary, and they were the biggest. So, every year there were reductions [in the budget], and they were severe, and just kept coming year and year. Every once in a while if there was a little bit of money, they'd get $10 million [from the

State] for a new program, but they'd get $50 million or a $100 million cut from the overall base [mental health budget]. So, it was the way it was for many years, and then it finally became such a crisis they couldn't do it anymore, and they thought of doing realignment.

HP: That's when realignment came about.

CH: Um-hm.

HP: What were the other discretionary programs at that time that mental health was in the same pot [of money] as?

CH: I don't remember.

HP: And, why was it discretionary? I mean you would imagine that that would be more along the lines of regular health or other social services that would be mandated. What are the reasons for that?

CH: I don't really know; I mean I could speculate. Services for people with developmental disabilities are mandated; Medi-Cal is mandated. Social services are mandated. But mental health never was. I think there—you know, and you said this project's a part of the stigma reduction—but I think that's a part of the history of mental health. It was not like it was today. Today, we all acknowledge that we know somebody with mental illness. And there's more support for it. But back then it just wasn't talked about. It wasn't a population that had a whole lot of public support.

HP: Right, so it wasn't really seen as much of a public issue. So what led to realignment specifically? There was this problem in terms of the funds not being there because it was discretionary. What was it that actually led to the change?

CH: I think the budgetary situation got so severe that—and I'm not sure I'm right on this, but I always thought it was Terry Parker, one of the leading thinkers of the State who was a supporter of mental health. She was working at the Department of Finance, I think, and realized it just couldn't go on. And, she and some other just really big thinkers thought, "is there some way we can turn this around?" And, I think mental health was the primary driving force in thinking up realignment, and then as it continued then they added healthcare, indigent care, and the social services as well. But, mental health was the driver, I think, just because of the severity of what the budget was going to be in 1991.

HP: Um-hm, who was the head of the State Department [of Mental Health] at that time?

CH: I think it was Mike O'Conner, Dr. O'Conner.

HP: O'Conner, okay, so he was working with the finance people to help.

CH: I don't know how political he was at the time. I know that our deputy Tom Reitz who was overseeing Community Services functions—I know he worked a lot with the legislature. So there was a legislative committee that ended up trying to write it [the realignment bill]. And, he was working with them on the language and was over at the capitol a lot.

HP: I I want to backtrack for a second, but you mentioned the community services division as part of State DMH at that time. Could you provide a brief overview? Because that's something I'm unfamiliar with. What did State DMH look like at this time?

CH: I would have to guess a little bit here, but they had State hospitals—there were around five thousand beds that they were running in four State hospitals at a time. They had an administrative division which had, you know, all of the support functions, personnel, payroll, accounting, information technology—that kind of thing. And, they had community services. Whether they had another branch at that time or another division, I don't know.

HP: So, community services is the one that would work directly with the outpatient systems at the County levels?

CH: With the County systems, which are outpatient and inpatient. Just not State hospitals. State hospitals were State run, and the rest was either run or contracted by the Counties with State guidance, State oversight, and partial State funding.

HP: OK. Now, in terms of realignment, how did it work? How did it help fix the problem?

CH: What it did was take the funding for mental health out of the budget discussions between the legislature and the governor. So, it created a dedicated source of funding that would go to the Counties. And the thought was that because it was based primarily on sales tax, as the price of things got more expensive over time that the sales tax would go up, and it would have a natural increase.

HP: At least to keep up with inflation.

CH: Yes, over time. Well, then we went into a terrible recession right after they passed it. I mean it was kind of simultaneous with the realignment. So the realignment money, I think, actually went down for a little bit. I think over time

people felt that it was really good to get it out [of the legislative budgeting process]. The Counties could plan on the amount of money [under realignment]—they wouldn't lose it if they didn't spend it. It was their money, so they had control with general guidance by the State, rather than having a State grant program where the State had oversight. So, it was a fundamental shift in governance that I think took a number of years to really materialize.

HP: And were there any drawbacks to realignment in terms of giving the Counties more freedom or more power?

CH: The thought was that there would be an accountability that came with realignment that was based on outcomes, and that the State would monitor to ensure that the Counties were achieving outcomes. And, that never happened.

HP: What would the State have done if Counties weren't achieving outcomes?

CH: There are a number of things that you can do. I mean the first thing you do is just go talk to them, and sometimes that's enough. You know, if you just provide the information, most people want to do a good job when you say "look, you're not doing so well in this area. Is there something we can do to help?" Or "we saw that so and so is doing really good. Do you want to partner with them?" So, sharing information is [important].

HP: Technical assistance kind of work.

CH: Some technical assistance, some just sharing information is terrifically helpful. If that doesn't work, you can make it more public. You can make sure that the [County's] Board of Supervisors knows that the State doesn't believe that their Department of Mental Health is doing a good job. That's generally pretty

effective in a County. Also, and I don't know if you could have done this with realignment, but with one of the Counties we actually were going to withdraw their Medi-Cal certification. And, Medi-Cal is a major funding source.

HP: Yeah.

CH: And so, the County withdrew it themselves before we withdrew it. There was another County where, before I came to California, the State actually ran the County [mental health department] for a few years because it was in such deficit. But typically, there are ways to get it resolved. It can get extreme and, you know, that's when everybody loses. But typically, if you give a County information, they want to do a good job. And if they have barriers, you can help them over the barriers.

HP: So you mentioned that there wasn't really oversight from the State as anticipated.

CH: There wasn't oversight based on outcomes, right.

HP: I see. What were the outcomes the State was going to be looking at?

CH: The State never finished defining what those outcomes or completing a database to monitor. That continues to be an ongoing effort. So, the commission right now is even trying to do the same thing along with the planning council.

HP: Wow, so still today it's still—

CH: It's still not done.

HP: Wow, what were the outcomes you guys had in mind when this idea came up? What were the outcomes that were being considered?

CH: I think for people with severe mental illness, it's, you know, what do they want? They want a job. They want, you know, some way to feel productive. They want

to have friends and family, and they want to have a safe place to live. So those, especially, for intensive programs, make sense. There are other things like, how quick is your readmission to a hospital? How quick do you get linked with medication or follow-up care after discharge from the hospital? How many crisis visits do people get and, what is the proportion of crisis services to regular outpatient services? How much institutional care a County is using? So, there are a lot of things that could have been selected. When you're looking at outcomes, like housing—and in the 1990s housing was going crazy and very expensive—to hold mental health accountable for people that they serve who are extremely poor to have a house in some areas, like Los Angeles, how do you accomplish that?

HP: There it would be difficult.

CH: So, if people don't have a house, is that mental health's fault? And how do you hold mental health accountable for the housing being too expensive for poor people?

HP: And that's still an issue today I would imagine as well.

CH: Definitely. Same thing with jobs. When unemployment in Imperial County is in excess of 20 percent, how do you hold them accountable for getting people with mental illness employed, you know? So, sometimes what you're wanting to achieve, you're not in control of. So how do you hold people accountable for something they're not in control of?

HP: And, in particular with realignment, and I suppose the same thing could have been true with MHSA as well, if the funding is tied to prosperity. If the mental

health system loses funding when the economy suffers, then it's gonna be very difficult to improve on the socioeconomic issues like homelessness, like joblessness.

CH: Right.

HP: What about the indicators that could have been within the mental health system's control, the things like reduced wait times, things like that? In your opinion what kept those indicators from really being implemented?

CH: In my opinion, every time we got close, evaluators would argue over ideological constructs. It would stop the effort for a number of years because evaluators who were respected and thoughtful couldn't agree on a construct.

HP: By construct what do you mean?

CH: Like, how you approach it, what is the paradigm on which you're going to base the evaluation system. Even if you could have agreed on the things that you were going to measure, if you couldn't agree on how you got there, then there would be these arguments, and it would stop progress. And then, you'd start over again in a couple of years.

I think there was also no organizational or kind of overall commitment to evaluation in mental health. It's not a part of our culture where, like, in education you say you're going do a program, you ask "how are you going to evaluate it?" In public health, if you're going to do a program, you ask "how are you gonna evaluate it?" It's just a part of what you do. In mental health, you ask "who are you going to serve?" "How are you going to serve them?" You don't ask "how are you going to evaluate it?"

HP: Huh, why is that do you think?

CH: I don't know.

HP: That's very curious. I never thought about that because you hear all the discussion about accountability.

CH: Right.

HP: And, you'd think that would be there. Going back to the evaluators, who were these evaluators? Were there people within the State, or were they—

CH: Yes, there were people within the State, and then they would always have a committee. So, there would be someone in a leadership role from the State Department of Mental Health and the California Mental Health Planning Council who has a role. And then, they would get people from the Counties and clients and family members and [people] like that.

HP: So, it was a stakeholder process basically.

CH: A stakeholder process, right.

HP: I see, so it was the stakeholders couldn't necessarily come to agreement on these basic things.

CH: Right.

HP: Okay, interesting. We'll come back to that under the MHSA actually because I'm curious about that. So with realignment, in your opinion, what worked with it and what didn't? I guess we've already talked about some of this, but—

CH: I think what worked with it is Counties really felt like they were in control and could plan for their own communities. I think in California that's the right way to go, and I think that really strengthened it for most of the Counties, that they were

able to work within their local systems and know what the priorities should be and how best to implement and how much to implement and how much risk to take. Counties never knew from year to year and how many programs to implement. And, my opinion is most Counties really try to do an excellent job. Realignment put the control back at the local where they actually knew what was needed in their communities and what was going on.

HP: Were there problems with that before in terms of the State being out of touch with the local communities?

CH: Yeah. I mean, how could an analyst at the State know what a local County mental health director would know about what was good for Monterey County or somewhere else. You know, it's just not possible. I think also the State went away from clinical people or and went to more generic staffing. So we had generalists at the State. And so, they were supposed to be advising County Mental Health Departments on things, but they had no background [in mental health] to be able to do that.

HP: Why would the State have non-clinical people?

CH: Too hard to hire. We didn't really have the mechanism to hire them.

HP: In terms of the qualifications, they were overqualified—like, it was difficult to hire PhD's or MD's?

CH: Oh, even just people that had experience in County mental health.

HP: That had worked in mental health.

CH: Right.

HP: So the people who you got, were they from the accounting office or—

CH: It could be or just a generalist like myself. I didn't have a background in mental health. I had a background in human services, so I had worked—

HP: Well, you were a psychologist at least, though.

CH: No, no, no, I had a BA in psychology.

HP: Oh, a BA in psychology, huh?

CH: Yeah. But I had worked with people with developmental disabilities and worked with child protection. So I was more of a generic human services person.

HP: Right.

CH: So, I brought that, and I had worked at a County. It was actually in Minnesota but I worked at a County level and had done service provision. Not mental health services but still to vulnerable populations. But, for a lot of the people [at the State DMH] it was just, you know, coming out of college. Or maybe they didn't go to college and they wanted to work at the State. And, mental health happened to have an opening, and they thought it sounded interesting and—

HP: Huh. Were there ever moves to try to change that or get people with more local experience involved?

CH: Yes. But I don't think our salaries were competitive with the locals [County mental health departments].

HP: Hm, interesting. Okay, and the other thing is you mentioned were the positives at the local control. Were there people at the State department or in the legislature that felt otherwise? That perhaps there were down sides to giving more control to the local communities?

CH: Yeah, I think some of the Counties were very cautious about spending money, so while they were denying care they had huge mental health bank accounts—because they were very conservative in their approach. And so, I think there was a question of how much you should really do to save money when people are out there hurting right now, you know?

HP: I see, so to have, like, a rainy day fund.

CH: Right, to have a rainy day fund, but should it be double or triple your annual budget?

HP: Uh-huh.

CH: And so, how much that should be? I think that was one of the questions. I think there was a feeling like that we had no idea what was really going on in Counties. There were huge reductions in State [department of mental health] staff. So the job that I had with County operations where we'd go out and try to be the eyes and ears of the State—they cut way back on the people that were doing that. So, we really didn't leave our administration building very often because there was no travel because there was no money.

HP: Right.

CH: So, I think people [at State DMH] felt really out of touch with what was going on [in the Counties], and uncomfortable that they didn't know whether things were OK or not.

HP: But, the impression you had was that generally things went well and that the local communities did well with this.

CH: That's my impression.

HP: I forget when CIMH [the California Institute for Mental Health][4] came on the scene, but were there other groups like that that sort of helped fill that gap of serving as a liaison?

CH: CIMH started, I think, around 1993, and it was just Sandy then, Sandra Naylor Goodwin, who is still there. And she was working with Catherine Camp who was head of the CMHDA [the California Mental Health Directors Association].[5] Before that CMHDA had a different name before realignment. I don't remember what it was, but it was kind of it was retooled as a different agency. And, in fact, it was different, difficult for people to know the difference between CIMH and CMHDA in those early days. Sandy and Catherine worked so well together that it was very unclear whose job was what, and then it became that CMHDA was the support and lobbying arm, and CIMH was kind of the training arm.

HP: Right, and was the State Department of Mental Health coordinating with these groups as well, or were they working more directly with individual Counties?

CH: We would work with CMHDA all of the time. Because it was kind of a joint effort to resolve problems, we were on their committees. And, we would go to their executive board or their governing board, and they could ask us questions and we'd ask them questions to keep communication going. We wouldn't be there the whole time, so they would have time to talk among themselves. CIMH was funded by the State, so we would specify what services they were to provide.

[4] The California Institute for Mental Health (CIMH) was established 1993 to provide training, technical assistance, research, and policy development for mental health system stakeholders across California.
[5] The California Mental Health Directors Association (CMHDA) is a non-profit advocacy association representing mental health directors from each of California's 58 Counties, as well as two cities.

HP: I see, so they helped fill some of that role. What were some of the issues that you and the CMHDA would work with, work on together? What were some of the issues that they brought to the table for the State to address?

CH: Sometimes, in order to get Medi-Cal money you had to have a facility that was certified, and they couldn't get these facilities certified because we [State DMH] were so short staffed. So, it was having a negative impact on their [Counties'] revenue because we couldn't get them certified fast enough. So it could be a mechanical thing like that. Sometimes, the Medi-Cal billing system wasn't working very well, so we would work through that. Sometimes, it was policies, how best to provide services to kids, and so a variety of things. Whenever there was money to dole out, we would work with CMHDA to decide what factors to consider. How do you decide how much each County gets out of some large pot that you get?

HP: So it [CMHDA] helped make the relationship more of a collaborative one whereas before realignment it was kind of hierarchical.

CH: Yeah, I hadn't thought about it like that, but yeah.

HP: Can you think of one example of something, like in a specific County, or a specific program came about because of realignment? Something where the State was able to get out of the way because of realignment, something that directly came from it? Does anything come to mind? I know this was a while ago.

CH: Yeah, and I don't know that realignment did it, but to me the clients would let the Counties know what they needed, and then the Counties would start adapting to

what those changing needs of the clients were. And then, the last step would be the State reacting in policy to what those clients had told the Counties to do—

HP: Uh-huh.

CH: So, I know that in one of the Counties that I worked with in Monterey, by the time I came to California, they had already done a housing survey of all of their adult clients—asking them where do you want to live in the next five years—so that they could do a housing plan for clients. That wasn't talked about in those days. Today it's just a regular thing.

HP: Right.

CH: And, today everybody is worrying about it. In 1988 I don't know of another County—

HP: That's—that was really kind of ahead of its time—

CH: And, Monterey was a high cost place to live. They had a very innovative housing provider, and a mental health director who was really committed to the needs of seriously mentally ill adults and just really planful. And, that's some of this stuff that you would see where the Counties were in charge and could determine what the priorities should be.

HP: Right, so then I could definitely see that being a positive overall. I suppose from the perspective of the State DMH though, it becomes a very different task because suddenly instead of overseeing a system of fifty-eight branches, you're overseeing fifty-eight systems. Is that kind of how it became? Did it become difficult in terms of oversight and providing help when you're dealing with all

these different systems with different approaches and different needs that they were addressing?

CH: I would say yes, and I'm not sure how much realignment changed that. I think that was true prior to realignment as well.

HP: Oh. So realignment let the Counties take care of it, but of from the State's perspective, that was always kind of the case.

CH: Right.

HP: Great. So in talking about innovative things, um, you were there right when AB 3777[6], the Village and all those programs, were just taking off, correct?

CH: Yeah, I reviewed the responses to the RFP (Requests for Proposals) to help select the 3777 providers.

HP: Yeah, so tell me a little bit about that when from what you remember and from the State DMH's perspective.

CH: My recollection is that Cathy Wright, an assemblyman from Ventura worked with the Ventura children's coordinator on children's system of care and really had worked on that for several years. She then became interested in adults and was trying to do follow up. And so, that's where to me it was a lot of Cathy's leadership. And then all of the people—I'm sure a lot of people influenced her that brought about 3777.

[6] California's Assembly Bill 3777 (1988), also known as the Wright-McCorquodale-Bronzan Mental Health Act, funded three pilot projects to combine treatment and rehabilitation in Integrated Service Agencies (ISAs). One was in Los Angeles County (the Village, located in Long Beach), one was in Stanislaus County, and one was in Ventura County.

HP: Right, and for 3777, what was the RFP? What were you looking for at the time when you were reviewing the proposals? What was the idea? What was it that you were trying to get?

CH: Two integrated services, there was an argument about whether it should be done by a County and under a County system, or should it be done by private agencies?

HP: What were the pros and cons of each?

CH: People thought it was more likely to have that amount of innovation if it was a private organization, but if you really want to influence a whole County, shouldn't you start with a County? I would say those would be the two sides of it.

HP: Why would a private agency be able to be more innovative than a County?

CH: Oh, they can hire new staff, the—just the 24/7 (able to provide services 24 hours a day, 7 days a week). How do you get County workers to work 24/7? Oh, my goodness, that was a terrible problem. How do you give people spending money, just because it's gift of public funds? How do you just give somebody some money because they did well or because they need some for something?

HP: So, there's bureaucratic inflexibility if—

CH: Yeah, tremendous! How do you hire peers?

HP: Um-hm, were they hiring peers back then?

CH: It did develop into it, and the one—I really never went to the Stanislaus [County] one, but I used to go pretty regular to the agency in Long Beach. They would always take us around and tell us what was going on. And, did they have peers at the time? I don't know.

HP: Okay, okay, so that was the debate. How did that impact the shape that it eventually took?

CH: So, they split it. They said they'd fund two integrated service agencies—these private ones, and then one County one. So, they funded Ventura and a Stanislaus agency and the Mental Health Association of L.A. for the Village.

HP: And, how did you wind up choosing those? Do you remember what you were specifically looking for that those applications had that other ones didn't? Was there variation in the proposals you got?

CH: Oh yeah, and my recollection is that the—out of the agency ones there were three really good ones. Usually some rise to the top and then the question how do you sort between those top ones. You have an RFP and then you have scoring, and it's a very prescribed process. So, you look and, okay, you ask this question, and then that gets five points. And, you ask that question, and that's eight points, and then you have three people scoring. And then, you're arguing among yourselves to try to get consistent and stuff, so—

HP: So, do you remember any of the variation? Like, what were some of the—were there any things that were radically different from the Village that looked good or—

CH: I don't remember.

HP: I mean, I know it's—

CH: Yeah, that's forever ago.

HP: —and thinking about it now, it's like, oh, "I can't remember what I had for breakfast this morning I tell you."

CH: (laughs) Yeah, yeah, I remember it was a passionate process of scoring those [RFPs}.

HP: Were there a lot of Counties that applied [in response to the RFPs] as well?

CH: I don't remember if there was just a selection of Ventura, or if there were other Counties because that [Ventura] was Cathy Wright's county. So, she may have just specified it was gonna be Ventura. I don't remember.

HP: Was the State excited about the pilot, or was there concern because it was pretty radical at the time compared to this clinic based system that you were describing?

CH: I would say that the group at the State Department of Mental Health that was working on this project was very were beside themselves with excitement, but the rest of us, we had our regular jobs. It was, like, "oh, that's nice," you know. But it didn't affect our day to day because we had our jobs to do.

HP: Right, and especially with being so understaffed relative to the demand that was on you, I'm sure.

CH: Right. But there was a specialized unit that worked on that and then the AB-34 and the 2034 programs[7], and the head of that, Vince Mandella, was a very articulate person. He didn't like rules. He could bypass any rule that anybody ever set up if he thought that was needed to make the project work better.

HP: Was Vince with the State? What was his role?

CH: Yeah, this was with the State.

HP: And, he was working on the AB 3777 and the follow ups.

---

[7] AB 34 (1999) and AB 2034 (2000) were assembly bills that expanded the ISAs beyond the original three pilots that were in AB 3777.

CH: Yeah. And passion, oh my lord! He'd get this team, but they were in a different part of the building, and it was kind of like a just a different group that was over there, rather than it [AB 3777, AB 34, and AB 2034] infused the whole department. It wasn't like that.

HP: Were you involved with the running of the program or the oversight once it was running, or you were just helping with the RFP's?

CH: Just helping with the RFP's. I changed positions and changed levels over time, and so at some times I was over Vince but kind of in theory.

HP: Right.

CH: Vince was always going to do his thing and you know, he had the passion. He had the vision; he was going to get it done.

HP: Now, when you talk about the passion and the vision, what was it that differentiated it from the business as usual?

CH: So consumer focused. [The programs asked] "what does the person need?" And then, you go from there. It was a follow up; you go and ask the person. And, it wasn't the clinician telling the person, "you need to get on meds, and then when you get stable, then you can go and work in a sheltered workshop." It wouldn't matter. Instead, you'd go to the person [and ask them] "What is it that you're wanting to achieve in your life?" "Well, I want to get married." "Well, what's a barrier for that?" Well, probably bathing, you know, or whatever it is. And then, the job was to help that person figure out how to get to what they wanted for themselves.

HP: Did that approach raise some eyebrows because at the time, the traditional, "disability" model held that mental illnesses were impairments that impaired people's ability to think for themselves to set their own goals?

CH: Right.

HP: Was there resistance to that change?

CH: Yeah.

HP: What were those discussions like?

CH: Well, what do you do when somebody wants to be president? Isn't that stupid? I mean you'd hear stuff like that, and Dr. Mark Ragins[8] did a lot, I think, to help people think through some of those things and just to get a little more practical. And now, you wouldn't be having those discussions. I mean that it's a world away from where it was then.

HP: So let's say the patient says "I want to get married. " Well then, what's the first step to that? In some respects, is that just flipping around the clinician having an idea of what the client wants and maybe just kind of using the client goals to motivate? To what degree is that truly client driven, I wonder? I mean, I suppose that I'm not sure if I'm being clear.

CH: Yeah, and that sounds more like a clinical issue to me.

HP: Yeah.

CH: But, to me it's whether you believe it. Are you manipulating to get to what you want? I want you on meds 'cause I want to quit getting those calls from your landlord at night, and I'm gonna turn around what you say so that I can get my

[8] Dr. Mark Ragins is a psychiatrist and head of the Village, one of the original ISAs from the AB 3777 program.

goals done and not be honest about it, or I'm really going to listen to you, and it's a partnership. I'm going to help you do that, but you need to help me get my goal done. And, I want your landlord to quit calling me at night. So, to me it's about honesty in the relationship.

HP: Yeah. Were there times when there was concern that it [AB 3777] wasn't going to work? And, was there a time when it became clear, "oh, we're really on to something here?"

CH: I don't know that anybody thought that it wasn't going to work.

HP: Really?

CH: No, um—

HP: Because with how radical it was—

CH: Yeah, but it was more like "those are nice programs. " I don't think anybody thought it would be a way of changing County mental health or *the* way of changing public mental health, where you pick up the philosophy of recovery and client centeredness and that kind of thing. But, I don't remember people thinking it wasn't going to work.

HP: So there wasn't really fear of the dangers, the potential pitfalls?

CH: Not that I remember.

HP: So how successful were these programs, the pilot programs? I know that there was an evaluation written up, but from the State's perspective, what was learned in the AB 3777 experiment about what worked and what didn't work?

CH: To me AB 3777, AB 34 and AB 2034, they all kind of mesh together.

And so, I may be mixing some of those, but I think it was pretty dramatic in terms of reductions of inpatient utilization and clients getting much more stabilized. So very positive. And that then became the basis for getting Steinberg's[9] support to go and get more money for the Counties through AB 34 and AB 2034. But, even before that, like in L.A. County through Areta Crowell[10] who was the director before Marv [Southard][11], she was already starting to do this. Under realignment, she redirected the State hospital money to intensive local services because the State hospitals cost more than it would cost to serve somebody locally. And so, she would buy out some of the State hospital beds and be able to fund more ISA's without State grants.

HP: Oh yeah, yeah, I remember seeing—I forget. There was Partners [an ISA program in Los Angeles County]; was that one of them?

CH: Partners, yes.

HP: And was there local innovation elsewhere in the State trying to really build upon the success?

CH: Yes.

HP: You mentioned the move from AB 3777 to AB 34. That seems like a pretty dramatic shift. What did AB-34 do precisely that was different from three triple seven, just expanded it?

CH: That's the way I think of it.

---

[9] State Assemblyman Darrell Steinberg, the legislator who authored AB 34 and AB 2034, and also was the state legislature's strongest supporter of the 2004 campaign to pass the Mental Health Services Act. Steinberg is currently serving as a State Senator, and is California Senate President pro Tem.

[10] Areta Crowell was the director of the Los Angeles County Department of Mental Health from 1992 to 1998.

[11] Marvin Southard has been the director of the Los Angeles County Department of Mental Health since 1998.

HP: Was it difficult? How did the process of getting legislators behind it work?

CH: Steinberg, who was then an assemblyman had been a city councilman in Sacramento. I don't know that he was a proponent for mental health before he became a city councilman, but then looking at our downtown area it just became a passion of his to do something about people that are homeless. And so, when he got to the State Assembly he took that and tried to figure out, well, what can you do? And so partnered with Rusty Selix[12] to figure out what he could do, and he involved Dr. Mayberg.[13] Dr. Mayberg's an innovative administrator I would say. And, they just picked three Counties, and the expectation for Dr. Mayberg was get these implemented and evaluated and data coming in, like, in less than a year. And, it happened.

HP: And, it happened, and then it was expanded again with AB 2034.

CH: Right.

HP: In the course of all this was there recognition that there were areas that needed improvement? Were there areas with the ISA experiment where it seemed there were things missing that needed to be improved upon?

CH: I think throughout the whole time and even through the end of AB 2034, employment [outcomes for clients] was terrible. I think it was running, like, at seven percent. Seven percent of the enrollees had any employment. But throughout the whole thing they had these groups of Counties, then it was supported by State staff as well. And, they'd get together and just problem solve, so if they couldn't figure something out, they'd just go and share and build on

[12] Rusty Selix, the Executive Director of the Mental Health Association of California and the California Council of Community Mental Health Agencies.
[13] Stephen Mayberg, Director of the California Department of Mental Health from 1993 to 2000.

each other's expertise. And, they had the data on the outcomes. So it was mainly "now do have friends, family? Are you going to be getting a home? Are you employed or have some kind of productive thing in your life?" And, looking at those, data was produced so people could tell how well they were doing, and then manage to that.

HP: Do you remember any issues that individual Counties or providers were having that got resolved, or solutions that the group was able to come up with during the evolution?

CH: I don't.

HP: Because it seems like that would have been a really critical, formative time in terms of this. Okay, so employment was a challenge. Now, tell me a little bit about how this then led into the MHSA[14] and what your role was in this.

CH: This, meaning the MHSA?

HP: In the development of the MHSA first of all, and then we'll talk about the implementation as well.

CH: Steinberg, I think, wanted to do more for mental health. He had the AB 34 and AB 2034, but it was still serving just five thousand people. And, he wanted to have a bigger impact. I think Rose King[15] was a part of it, or she may have got him interested. I don't know the background. And Rusty [Selix] developed something. It was difficult for State staff to get involved in the proposition process because it was outside of the administration, so we were not allowed to work on a political thing like that.

[14] The Mental Health Services Act, which was approved by California voters as Proposition 63 in 2004.
[15] Rose King, a legislative analyst and family member of several individuals with severe mental illness. King has been one of California's leading advocates for comprehensive mental health services.

HP: Oh, so legally there had to be a barrier.

CH: It almost felt like ethical or something.

HP: Thinking about it, that makes sense, actually, that you wouldn't want State administrators to do that kind of advocacy.

CH: Yeah, and so it got going. And then as they were getting closer to where they were finalizing the language, there were some obvious problems. At some point I became involved, but it was to provide technical assistance. So, it was not about should this proposition pass or not, but I could provide a perspective [from the State's point of view]. [For example, I would say] "if you do this, like the original way it was written, there will be no role for Counties." It was going to set up a new organization, and then funding would go directly to providers. So, there would be no system of care. I mean it would be a secondary system to what the Counties were doing that was uncoordinated at all with the Counties.

HP: Oh, wow.

CH: And so, I could provide that perspective on, you know, how would this work? How would you ever get Medi-Cal, because Medi-Cal all goes through the Counties? So, I could ask questions of things that I thought that could be problematic, and so I was involved in some of the discussions. And, some were really, really heated.

HP: I bet. That touches upon one that I was curious about. Given the fact that one of Rusty's main roles was representing the private agencies [as head of the community clinic association], to what degree was the MHSA shaped to benefit private agencies versus the County operated systems? Was it designed more to

fund what private agencies could provide? I guess would be one way of phrasing it.

CH: I would say from where it originally started to where it ended up was very different in terms of that respect. Rusty also represents the Mental Health Association of California which is just more of a broad—

HP: General advocacy.

CH: —yes, looking out for people with mental illness. But there had to be a lot of compromise in this because if the Counties couldn't accept some of the language that was in it [the MHSA], the proposition probably would not have passed.

HP: By accept you mean implement?

CH: No, just the question of would they support the proposition with the language [that was written in it]? What do you do about supplantation? Or realignment flexibility to move money among sub-accounts? And, that was a great interest to CSAC [California State Association of Counties]

HP: Tell me a little bit about that. So first the supplantation aspect. How was that of interest to the County historically?

CH: It gets complex depending on how you word it. How would you know if something was being supplanted or not? So, it can be very bureaucratic to follow a dollar because that's just not how mental health works.

HP: Especially if it's flexible dollars.

CH: Right, which is how is the MHSA different than realignment, really.

HP: Yeah.

CH: So how would you know whether it was a realignment dollar or an MHSA dollar? It was about that and some of those kinds of things. But there was some language in there about realignment, and it was going to change some of the flexibility that Counties had as part of the original realignment deal. And, if that stayed in, the Counties would not have supported Prop 63, and it wouldn't have passed. So, that was taken out.

HP: I see, so under realignment, Counties had flexibility to kind of do what they wanted with the money they had?

CH: They do to some extent, with most things. It was [in discussions about realignment] to the extent resources are available, we would really like you to focus on people with the most serious needs, and we would really like you to have crisis services and some outpatient and some inpatient and things like that. But, that's how realignment mostly is written. It specified "to the extent resources are available" then provides guidance.

HP: I see, so the MHSA, the nonsuppantation clause said that realignment can go towards the parts of the overall system of care that the MHSA was funding. So, it had to be adjusted that way because there was overlap?

CH: This gets into a really complex area. If a County was already providing outpatient or already providing crisis services, and they needed more crisis services, if the previous crisis services were going to cost more each year from inflation, is that a type of supplantation or not? . And then how do you have an accounting system that can answer that question so that money can be tracked? And, that's what people worry about—how tightly are these things going be

defined, and what kind of a system, tracking system, will it require? Will it be so complex it really won't even be feasible?

HP: And, so the Counties were concerned that it would be too complex. How was it resolved then?

CH: There was more generic language that was included in it, and then the details were left to be figured out.

HP: Okay. And all of this detail, this was done before the election in 2004 before the vote?

CH: Before the language was finalized. Correct.

HP: And, how does the process work? The language was finalized before the proposition passed?

CH: Yes, because people have to know what they're voting on.

HP: Right.

CH: So, you have to give the specific language, and it has to go through the legislature and the legislative analyst, because the legislative analyst writes stuff that goes into the ballot, you know, the summary.

HP: That's the thing that you get in the booklet that most people probably read.

CH: Yes.

HP: I get it, okay.

CH: Yes, that's the nonpartisan [analysis]

HP: Okay, yeah, because I always wonder. There's so much technical stuff, I couldn't imagine people in the ballot box reading this in detail.

CH: Yes.

HP: OK. So in terms of crafting the language, were there other adjustments that were made during the course of finalizing the language that were significant in terms of the actual structure that the final MHSA had?

CH: The clients and family members, I think, feel that they had a lot of impact on making the language more client and family friendly. A lot of the language on the education and training money came from the planning council that had done a whole lot of work in that area. The language had always provided money for capital facilities but never for technological needs. And so, through the input from one of the County mental health directors, that was added. So some of the things were like that, everybody agreed. Other things were more controversial.

HP: What were some of the controversial things?

CH: A lot about the money and the role of the Counties.

HP: Yeah. So, in terms of the money what was controversial?

CH: The issues that we already talked about. If it was going to take away some of the flexibility Counties already had. So Counties could divert 10 percent of the realignment money out of mental health into social services or health, or the other way. They could divert it from social service or health accounts into mental health. And, it was originally proposed that Counties would get less or no Mental Health Services Act money if they did that. That was obviously unacceptable to Counties.

HP: Now, how was this process done, the refinement [of the MHSA]? Was this the big stakeholder process where there were meetings held locally?

CH: No.

HP: Was it just people up here [in Sacramento]?

CH: Rusty would convene people to get that consensus.

HP: Okay, and so it was you from the State kind of providing the "this is what this means, this is what that would mean" perspective. But then, it was client members, family members, and County people?

CH: Yeah, the meetings that I was in, and I'm sure Rusty was doing things that I wasn't a part of, but the ones I was in was mostly the State and the Counties.

HP: Okay, okay, so a lot of the particulars. My next question is going be a lot of how the MHSA was eventually structured. Maybe this was determined in the course of these discussions. How did the breakdown come up between the community services, the prevention/early intervention, the workforce education and training, and the innovation funds?

CH: I don't know.

HP: Okay.

CH: That was in there from the first time I saw it and it didn't change. I know some of the rationale was that there would be too much money to spend at the beginning. So it was to have some money available for infrastructure, because there would be too much to deliver that many services at the beginning. The thought was if you dedicate some of that to infrastructure then it would take large amounts of money and you can structure it over ten years. So, you build up the amount of money short term but then give them ten years to do it so that they've got sufficient facilities and sufficient technological capability to implement these new services.

HP: That makes a lot of sense actually because in the existing infrastructure you couldn't serve everybody that needed services.

CH: Right.

HP: One thing that I've wondered about was with the definitions. Were FSP's [Full Service Partnerships][16] written into the language specifically?

CH: No.

HP: And so, how did FSPs and Wellness Centers and things like that emerge? Were those things that emerged at the local levels, or were those things that came out of the State level?

CH: To me, the term Full Service Partnership came out of the State's stakeholder process. So through the input about the way people thought services should be provided. We toyed with a number of names, and that seemed to really capture people's imagination for—

HP: And, the stakeholder process took place after the proposition passed.

CH: Correct.

HP: So, that was then a huge undertaking of people coming together from all over the State, and the State DMH kind of administered that?

CH: Right.

HP: Okay.

CH: Yeah, we would do it in various areas of the State trying to get input and [figure out] what people believed, because it was such a grassroots proposition. People had expectations that they wanted to design it, and so it was really trying to figure

[16] Full Service Partnerships are programs similar to ISAs that were funded through the MHSA.

out, “okay, let’s make this a part of all of us rather than the State just coming out with rules or the Counties being left to their own.”

HP: So, it really was bottom up. I imagine you must’ve had quite a variety of suggestions—

CH: Yes.

HP: —on how things—what were some of them?

CH: Of how some of the things should work?

HP: Well, when it passed it just said that there was going to be a certain amount for community services, a certain amount for prevention, etc. So then, when you had the stakeholder process, what were some of the ideas that emerged from it that did come to fruition? What were some of the ideas that didn’t?

CH: I think mostly what happened in the stakeholder process helped to refine the concepts, but there was a lot of agreement on what the mental health system should be.

HP: What was that vision?

CH: It should be driven by clients, family members. And it’s really the vision of the MHSA to be recovery-oriented, family friendly, culturally competent, client driven, you know, all of those kind of core values. There was a lot of agreement. Counties, providers, families, you know, just everybody agreed, and it was, like, “okay, how do you make that happen and what’s a structure that can move the system a major step forward in achieving what we already all believe?”

HP: And when you say recovery, this is one of my later questions, but in your view and in the view of of the stakeholders at the time, what was recovery? What was the recovery vision?

CH: I think initially it was not clearly defined. I remember one of my staff saying, "I just don't believe in it." And, I think we heard it, and it sounded nice, and we didn't really get what it was. We had an ongoing discussion with people to see if we could understand, but it was—really it was about hope. Can people participate and help direct their own progress? The core concept is that it's really the person's own life, and how do we support them in moving to where they want to be?

HP: So this is something that you as a member of the State DMH kind of got from being on the ground?

CH: Yes.

HP: Was this an idea that was also percolating at the hierarchy in the State as well?

CH: Not in my recollection.

HP: Was there concern or skepticism or hostility to this idea at the State level, or again was it kind of considered, "oh, that's nice, but it's not part of our day to day"?

CH: I would say probably more that, and it's, like, "okay, so they're using a new term. So what? You know, we still have to get plans approved by Counties. We still have to put out rules about what you can and can't use the money for. We still have to decide how much of this L.A. [County] gets." There were a lot of practical

things besides this philosophy. The ones really driving this philosophy were the clients.

HP: Did the philosophy impact the things that the State did in its more administrative functions? Were there ways that their philosophy kind of trickled up?

CH: Like, on how the money is given out? Probably not. In the language that we used, very much so, and in the whole community planning process—a process where clients and family members were really involved and it was not just tokenism. And trying to structure that so that that would happen in every County, I would say, yes, it had an impact.

HP: And how were you able to see that it wasn't just tokenism? Especially when you have such a large umbrella that you're overseeing?

CH: Yeah, I think that was one of the fundamental discussions in the stakeholder process. A lot of the clients and family members felt that you couldn't always trust what Counties were saying. And typically, they would tell us it was the next County over; it wasn't their County, but they were worried about these other Counties that they'd heard about that were bad.

HP: Oh. (laughs)

CH: And over and over you would hear that, but they wanted more and more proof that, more and more writing. Things like how many people by race/ethnicity did you have in each of these meetings? Where were the meetings? And so, more and more and more documentation of things that they thought would lead you to where you could make a judgment on whether or not the Counties were really following through on an authentic stakeholder process.

HP: Along with a client driven process.

CH: Right.

HP: And mentioned before that there seemed to be consensus during the stakeholder process. Do you think that the shape [of the MHSA] would have been any different were it not more client driven? Would the process have turned out similarly if not for the client involvement, or did the clients steer it in any specific direction?

CH: The clients definitely had a big impact. I think there was a clear mission but trying to operationalize that. What did that mean? And, putting that into specifics without having a gazillion rules, but trying to operationalize what that mission was, I think the clients really helped us get to. I think the whole issue of involuntary care and the Mental Health Services Act—

HP: What was that issue?

CH: Can you use the Mental Health Services Act funds for involuntary care?

HP: Because that inherently might not be recovery oriented?

CH: Correct.

HP: And, what were the debates like on that?

CH: The clients were adamantly opposed and felt like they were promised that it would never be used for involuntary [treatment], and that was the only reason they supported the MHSA. The families felt like there were a lot of people who did not access care who needed care, and so sometimes you had to provide involuntary care for a while. They felt like they were told that in the process and that they supported the MHSA was because involuntary care would be allowed.

HP: And what about the people who worked in the mental health system? What was their take on it?

CH: They wanted somebody else—like the Counties or the State—to answer the question. They wanted direction.

HP: Because they wanted it to be democratic, or they were just afraid to touch it?

CH: Yes, it's very volatile.

HP: Yeah, I mean it really touches on the limits of recovery very much, I think.

CH: Right.

HP: And so, it's an interesting question, so it was decided that it couldn't?

CH: No, that's not exactly true.

HP: Oh, so what was the final decision then?

CH: The final decision was that the programs had to be designed for voluntary participation, but you could not exclude people regardless of legal status. So, say for a Laura's Law, do you know Laura's Law?

HP: That's the—like Kendra's Law in New York.

CH: Yes, yes, involuntary outpatient treatment. So Nevada County was under court order to implement Laura's Law because that's where Laura Wilcox was killed.[17] And so, we worked with them to design a program, and they designed a program for people who were in the earliest stages of recovery. The clients really needed a lot of supports. Some of those were under Laura's Law, court supervision

[17] Laura's Law is a State Law that allows counties to provide court-ordered outpatient treatment for individuals with serious mental illness. It is named for Laura Wilcox, a young woman who was killed by a man with severe mental illness who did not receive treatment. To date, most California counties have either not implemented Laura's Law, or only implemented it on a limited basis.

through Laura's Law. But they didn't exclude others who had the same needs but weren't under the court order.

HP: I see.

CH: And so, we said that was okay.

HP: And then, what about people under conservatorship? I'm not sure if that's a different question altogether because that's more a matter of impairment.

CH: But, at the State we said was [involuntary] regardless because you could say that people under conservatorship are doing things involuntarily because they can't consent.

HP: So, it's a similar thing where it's under someone else's legal authority to enroll them.

CH: Right. And we said that they cannot be excluded [from MHSA programs] regardless of legal status. But, the issue, the discussion was never about conservatorship. So we threw that in to try to get more of a balanced discussion going.

HP: Now, what I'm really curious about is the CSS [community services and supports]. So, you came in with this general framework that 50 percent [of MHSA funds] were going to go to community services, something like that.

CH: Oh, it was about 80%.

HP: 80%, that's right. So you came in just with this idea 80% is going be community services and supports. How did it wind up turning out the way that it did, or did that vary completely by County in terms of this much goes to FSP, how much goes to Wellness [Centers], this is what an FSP looks like, that kind of thing?

CH: Okay, so the statute specified how much would go to adult system of care and children's system of care, which we renamed community support. And then, the question was what was going to be an allowable expenditure? If you read the statute, it sounds like what was going to do was replicate AB 2034 and expand it, which would be FSP.

HP: Right.

CH: So the thought was initially that what the law was specifying was that you had to use all the money for FSPs.

HP: And, with the criteria of homelessness or incarceration or hospitalization? Or did that come in later? Do you know?

CH: That was—that came in later trying to recognize what was needed in the Counties. And yet there was so much focus on homelessness in the act [MHSA] that there had to be a priority for homelessness and getting more people in [for services], which became controversial later. Do you prioritize those who are not in the system, or do you prioritize those who are in the system? We were trying to make it consistent with what people who had voted on it were told, and they were told it was gonna reduce homelessness, you know, so that's—

HP: So, that meant the people who weren't in the system.

CH: --who weren't in the system, right. But that's very frustrating to people who have been in the system and underserved.

HP: And, what wound up happening for those folks then?

CH: We allowed both, but did say that there was a priority for the unserved.

HP: Not just the underserved.

CH: Right.

HP: Right, okay.

CH: So, we started out thinking that this is 100 percent for FSP, and then Counties started to say, “well, part of what you need is crisis [services].” You can’t have crisis just for a group of a hundred people. Crisis can happen anywhere in the County.

HP: And, this emerged from the stakeholder process or the County directors?

CH: Yes, stakeholder process, which included Counties.

HP: Right.

CH: Yeah, and then we realized there are some things that are kind of infrastructure-related that have to happen. So another example was that we wanted to have mobile crisis [teams] with the police, where you have a mental health worker go out with them. How do you do that for a group of FSPs? You don’t know who is going call the police. It’s more system wide, so we realized we can’t really have the whole thing be FSP because some of what its going to take to make FSP work is really a systemic thing.

HP: To provide services that people with FSP can access, but also that non FSP people could access.

CH: Right.

HP: Especially things that would involve collaborating outside the mental health system, because it would be difficult to tell 911 “only provide these services for these hundred people.” Interesting.

CH: Correct. I mean crisis [services] really [have] to happen through the whole County or for a large geographic region, even if it's not collaborating outside the [mental health] system. So, there are some things like that, or some of the housing options that wouldn't necessarily just be for a hundred people. So, it was like "100 percent [FSP] doesn't make sense, so then we started negotiating. Well, what does make sense then?" And we ended up at 50 percent, or the majority.

HP: Was there concern from some folks who envisioned the MHSA as being all an extension of AB 2034 that this was diluting the act?

CH: I don't really remember people advocating for that. It seemed like all the advocacy was "this can't *just* be for FSP" or the whole issue of "is it for the unserved or the people that are currently in the system?" But I don't remember. It felt more like we started at the State with thinking that it should be the 100 percent [FSP] and that people were negotiating us down. There weren't advocates to keep it at the 100 percent [FSP].

HP: I see, so there was no one on the other side, basically, so that's how it went. Interesting.

CH: Yeah.

HP: But was there a point at which people were trying to spread the umbrella too wide, in terms of too many things that were system wide things that were too far afield from the original AB 2034 vision?

CH: I don't think so; I don't really remember that.

HP: Okay, so you had the crisis resolution [services]. What were some of the other things? In particular what I'm curious about is the other things that emerged in the adult system—the Field Capable Clinical Services and the Wellness Centers. Were those then things that emerged in the course of this process of expanding the scope of what community services were?

CH: The Wellness Center is another great example. So, you have a hundred people, and as people progress in their recovery, maybe a drop-in center would be just the thing that they need. Well, how do you have a drop-in for one [person]. You know, you can't. You have to have a drop-in center, and so how do you do some of those things? So, a lot of support for Wellness Centers and things like that to strengthen the whole system and help all clients, not just the FSP's but to help the whole system.

HP: So correct me if I'm wrong, but it sounds like this was mitigating the issue that would come up from some critics later on, about the two-tiered system that was created by the MHSA. It sounds like the idea was to have something in it [the MHSA] for everybody.

CH: Yes, and I've always had a little trouble with the two-tiered system [criticism] because the two-tiered system was there with AB 2034, and the two-tiered system was what was envisioned if availability of FSPs was expanded. You know, then there would have been whatever number of people with FSPs, but there still was going to be a lot of people without FSPs. So, some are always going to get more, and some had always gotten more. So, with that whole argument [about the two-tiered system], it was difficult for me to understand what

they wanted. Did they want nobody to be in FSP? Priority for those in the system versus outside the system? I totally understand that argument, and that's just a tough one. There's not enough to go around. You can't do well when you're not going to meet some people's basic needs. You can't come to agreement. It's awful, and it happens at the State level or at the local level, but somebody has to decide when there's not enough to go around who gets first dibs. Some get more or better care than others. I don't understand what people were thinking was going to happen when they stated that we really screwed up by making this two-tiered system.

HP: Uh-huh. It was always there; they just didn't recognize it.

CH: Yeah.

HP: Why do you think the criticism came up after the MHSA when it had been there earlier?

CH: Because people were so hopeful and had worked so hard to get this. It looked like and it had been sold that it was going meet the needs of mental health. So, everybody's problems were going to get solved, and everybody's problems didn't get solved. Some did, and some didn't. So people were very disappointed and legitimately so.

HP: Um-hm. Now also just to be clear in terms of these questions of the Wellness Centers and crisis resolution services, were these things that were up to Counties individually to create or not create? Was there a stakeholder process that went back up to the State and then the State created these services?

CH: No, it was a County choice.

HP: So, these are all County things. So, a Wellness Center in L.A. County could be completely different from one in Marin County.

CH: Right, or Marin might not even have one, or Marin might have already had one before the MHSA so—

HP: Okay, that's very good to know—

CH: Yeah, Counties had very different histories coming into this and then very different dynamics around how they're implementation of the MHSA happened. And so Counties are very different from each other.

HP: Just off the top of your head, are there certain types of Counties that have certain kind of types of histories or certain types of styles of implementation versus others?

CH: Some of the very large, urban Counties have some problems and challenges and strengths beyond others. They probably have more evaluation, expertise, more administrative structures, more kind of urban problems.

HP: In terms of related to poverty, things like that?

CH: Poverty, homelessness, some of those kinds of things, difficulty in getting housing. You know that's a very different issue in L.A. than it is in Shasta [County]

HP: What are the strengths and weaknesses, the strengths and challenges in Shasta compared to L.A.?

CH: I think it's a smaller County, so its people know each other. You have less of a bureaucracy to organize, and you just go over to somebody's house, or you see them in the grocery store, and you get things organized. But, the other [side of it

in small Counties] is that you have less infrastructure, so pulling off things is really difficult. There's fewer other resources, so other than County mental health, there's probably not much else going on in mental health in Shasta.

HP: In medium-sized Counties was the picture different, kind of a mix of the two issues?

CH: Yeah, I've always thought medium-sized Counties were probably the more ideal size. They've got sufficient infrastructure where people have the chance to think and really design things. And there's enough variability, enough money so that they can have choices for people. There's not just one, say, drop-in center or something, but you might have a couple of types of drop-in centers, more chances to have interpreters or some of those kinds of things. And yet, it's not so big so that you're dealing with kind of a state—you still know each other, know the other managers and stuff like that.

HP: Yeah. Thinking about just L.A. which is one I know, it's not just a matter of having urban problems, but that it could be its own state. It could be its own country.

CH: Right.

HP: So, from the perspective of the State, did it seem different dealing with stakeholders, or dealing with anything, in a huge County? Was it different in trying to make the stakeholder process be truly bottom up and truly participatory while also meeting the aims of all the constituents?

CH: I'm trying to think of the big Counties, Santa Clara, Orange, San Diego, L.A., all of them I would say had outstanding stakeholder processes.

HP: I know in L.A. it was enormous.

CH: It was enormous, but thoughtful and inclusive. I think most people would say that.

HP: With a stakeholder process being so inclusive could it become *too* inclusive? Was there risk that the stakeholder pool would expand to people maybe going for the money rather than people who were truly invested in mental health?

CH: I think people were worried about that, but at the local level. It was not an issue at the State because we weren't contracting. We didn't have money to give away to contractors, so it was—

HP: It was all about just looking at the County plans.

CH: Yeah, and the Counties had to deal with that, and so it wasn't really an issue for us I don't think. It seemed like the bigger issue with the clients and family members. They felt excluded because they were not making all of the decisions about the County mental health program, like, who got contracts and what the budget was going to be. You know, where does stakeholder input end and management begin? Or where is that line when [you say] "thank you for your input. Now I have a job to do." Initially it was so inclusive and people felt such ownership. I think that line got blurred as the stakeholders [started] feeling excluded for things that I don't think they had any business in.

HP: Such as deciding these things that required a degree of expertise.

CH: [Like] who was going to get a contract? Right.

HP: Yeah.

CH: It's a function. That's what somebody's job is to do, and they're to be held accountable for negotiating a contract with, say, an individual provider or something.

HP: It's the limit of direct democracy.

CH: Yes, yeah.

HP: That's interesting. So, I guess another question is about the County-State relationship. How did the MHSA shape that? Was there tension between the State and Counties? Or did they work together? I mean I'm sure it was probably a mix but overall how did that work?.

CH: And, I would say it evolved. At the beginning, the Counties were asking for direction. They were supposed to put on this huge, community planning process, and they said "get us a template or something." You know, "help us out." And so, we did. Then later they felt that was too directive. Well, it was never meant to be directive. It was meant to be assistive. So, over time some of the things that we were doing, we thought were at their request to help—like clarify what are the services and general system development, what are Wellness Centers, what makes it a Wellness Center, how do you know if you've got recovery or not, defining terms and some of those kinds of things. How do you know if you've got cultural competence? Some of those guidance things that I think were initially helpful to many people, over time many felt restricted by them.

CH: In terms of approving the plans, we tried to transform our administrative processes just as the Counties were having to transform their systems. So we said, "there's no due date. You can submit whenever you're ready. We will keep your money here; we aren't gonna give it away. So, submit when you're ready." There was reversion, so if they waited too long, it would go away. But, it wasn't a rule created by the State Department of Mental Health. That was the statute.

When Counties would submit, they would bring a team up to explain what it was that they were asking for, and there would be a dialogue with the State staff asking questions. "Is this what you mean? Is this what you're trying to achieve or something like that?" And, initially people felt that was a very good process, very supportive on both sides, very informative. Over time, we became more bureaucratic in asking for more and more detail in order to satisfy our administration, which wanted to be able to answer every question.

HP: What question? Questions about what?

CH: How they were using their money. I remember one of the early ones that got people so angry was that we provided some money up front just for Counties to get going. Because how do they hire staff to even write RFP's? I mean, they were way down on staff the same as what we were. So, we put a bunch of money out there. And so how do you spend a lot of money? Well, you buy things. You know, it's not just for staff, but you buy things.

HP: They need printers. They need—

CH: And what they wanted was cars. So a lot of requests for a lot of cars were submitted, because there were supposed to be a lot more mobile services and stuff like that. Well, the concern was that if it became known that all this Mental Health Services Act money was to buy 200, 500 cars, whatever, what would be the public perception of that? And, would that end up closing down the MHSA? So we would ask the County "why are you using this number one car? What is your plan for the number two car?" And then, they'd come back, and we'd say "we've got some follow-up questions for you now about that number one car…"

HP: I see. Now when you say administration, who is the administration, like, the governor?

CH: No, within DMH. So Steve [Mayberg] would be the ultimate authority, yes.

HP: So it wasn't really increasing bureaucracy but increasing stringency because of—

CH: Stringency. But before we said if you submit this plan, then it'll get approved. Then it was, like, "OK, now I'm gonna ask you fifty questions from this plan, and you have to submit all of these answers to these fifty questions. And then, I will have another twenty-five, and then I will have another—" and so it got discouraging. So initially, I think there was real positive feeling, but over time it got discouraging to Counties.

HP: And the increasing scrutiny, this was because of political pressure?

CH: A judgment call as to what's the right thing to do?

HP: Was it out of fear of a headline in the *San Francisco Chronicle* saying "MHSA Dollars Going to Buy County Cars?"

CH: Yes.

HP: Did things like that come up?

CH: They did not. The press was all over that stem cell institute which passed at the same time.

HP: Oh, what was that?

CH: It was another initiative, but it was on use of stem cells.[18] So people were focused on deciding should they get the money [for that research]. And so, the

[18] California Proposition 71 (2004) established that conducting stem cell research was a constitutional right, and authorized the sale of public bonds to raise $3 billion in funding for stem cell research.

newspapers were all over that initiative that happened at the same time, and we were under the radar.

HP: So, that must have been—was that a blessing or a curse do you think?

CH: Oh, a blessing. Early on, you know, you're struggling to get through every day, and—

HP: Uh-huh, the last thing you need to worry about is the wrong kind of front page headlines.

CH: Right. Then you'll be fighting fires instead of still trying to get the thing implemented.

HP: Over time there have been some stories here and there. I remember there was a hip-hop car wash, and it made a headline that MHSA money is going towards this.

CH: Oh, is that right?

HP: Yeah.

CH: And the Hmong Gardens [that were being supported with MHSA funding]--

HP: Yeah, things like that.

CH: —there was an equestrian program. A lot of the prevention programs, especially those that are engaging underserved communities, have been questioned.[19] The two-tier issue from Rose King, you know, did we screw up the entire MHSA and

[19] Some have questioned the use of MHSA Prevention and Early Intervention dollars for programs that are designed to provide community-based services outside of mental health settings for individuals who do not meet diagnostic criteria for severe mental illness. Among the MHSA-funded initiatives across the state that have been criticized have been the use of MHSA funds to support a hip hop car wash, Hmong gardens, and an equestrian program.

not really do it consistent with the statute..[20] But mostly, it's been under the radar.

HP: Do you feel like there's been enough positive PR for the MHSA?

CH: There's been quite a bit, and people have worked on that. I think commission [Mental Health Services Accountability and Oversight Commission][21] has really tried to make sure that there's positive PR. And, I think Counties do a lot locally.

HP: You mentioned intervention—that was one thing I wanted to get back to. How did the shape and form of PEI [Prevention and Early Intervention] evolve?

CH: It was a less direct path than the community services and supports. Community services and supports was our bread and butter. I mean that was what the public mental health system did every day. There was agreement. People knew what mental health should be doing, just didn't have the money to do it. So, it was kind of more discussions on the fringe I would say—huge discussions, but the core [of the mental health system] we knew [what community services and supports would do].

CH: Prevention and early intervention was brand new. There were some that thought that the [purpose of this part of the] Act was just to prevent early psychosis, and others that thought we should be at the way early end of prevention—screening and doing some of those kinds of things for people who have no identified problems at all. The commission was very involved. The commission had a unique role with the prevention and the innovation [components of the MHSA],

[20] Rose King, a leading advocate who was instrumental in the creation of the MHSA, has been critical of MHSA dollars being used to support programs that do not directly address the needs of Californians with the most serious and persistent mental illnesses.

[21] The Mental Health Services Accountability and Oversight Commission (MHSAOC) is a statewide commission that was established as part of the Mental Health Services Act.

and so as the commission got more kind of rolling, they took a very strong interest in the direction for prevention. They made clear early on that they wanted the bulk of the money going to kids and that they wanted it to be for the full breadth of prevention and early intervention.

HP: So that meaning the people who did not meet diagnostic criteria for severe mental illness, but the people who were in the primary care settings? That kind of thing.

CH: Or even before primary care, you know, where there's no identified mental health problems. So from primary prevention to secondary, tertiary prevention, the whole range of things.

HP: Now what the relationship between the State and the Oversight and Accountability Commission?

CH: The Oversight and Accountability Commission was established to oversee—and there are still arguments about this, but to me the statute is clear—the MHSA and systems of care. Well, I don't know what County mental health does other than systems of care and the MHSA, so to me it's the whole system.

HP: Yeah.

CH: But, some people believe it's only MHSA funded stuff. That debate continues to this day. But they [the Oversight and Accountability Commission] clearly have some authority over the prevention and innovation components of the MHSA to approve the money. The commission is outside of the administration, so the State Department of Mental Health reports to the Health and Human Services Agency which reports to the governor. The Oversight and Accountability

Commission sits outside [of this hierarchy] and gets funding from finance, but doesn't really report to the governor. But the governor has twelve appointees out of sixteen, so they coordinate with the governor and try to not get on the wrong side. But, they also have legislative and constitutional officer appointees as well.

HP: So, the community services and supports is operated by the State whereas the PEI innovation is operated by the Oversight and Accountability Commission?

CH: I wouldn't even say operated, and it's changed over time what the commission's role is, so the commission now approves use of innovation money. But nobody approves any of the money anymore other than the County Mental Health Board. So, there's no State approval at all anymore of the rest of the MHSA funds.

HP: When did that change?

CH: A couple of years ago.

HP: What led to that?

CH: Frustration that it was too bureaucratic and—

HP: So the process you were talking about before.

CH: Right.

HP: Was—so was that a decision by the State DMH?

CH: It was a decision by the legislature and affirmed by the governor.

HP: Has that changed then how the act has been functioning on the ground?

CH: I doubt it's changed how it's functioning on the ground because it just takes one step out of [the process]. Before, the Counties would design their program and write it up so that people understood it. And now, they do the same thing, but they're writing for a different audience. They're writing for their own local—

HP: Boards instead of for you.

CH: —and for their Board of Supervisors instead of for us.

HP: So, if the Board sees a County car that raises an eyebrow, they're the ones that have to worry about it not the State.

CH: Correct.

HP: Okay. So with all the complaining about the State bureaucracy, the State never actually really said no [to Counties]? It wouldn't actually affect the structure of what services were delivered, it was more just approving the plans?

CH: There may have been once when we said no to a program, and I can't even think now what it was. Usually, we'd say, well, "we're a little worried about this." Like in Nevada County when they wanted to implement Laura's Law. First they said it's gonna be only for involuntary treatment, and we said "no, that doesn't meet the regulations. But, talk to us. What are you trying to achieve?" And so, we helped them come up with something that was fully approvable.

HP: Right.

CH: And, that's typically the process that would happen.

HP: Yeah, so the State wasn't really in a role of auditor. It was more of auditor/assistant to make sure that everything was kosher.

CH: Correct, yes.

HP: Okay, that makes sense. Do you have other thoughts that stick out for you in terms of how the MHSA evolved, from approval at the ballot box to implementation?

CH: It was just so confusing, you know, early on. Like "what did this part of the statute mean?" And, parts of it were inconsistent. And so [we were trying to figure out] "what do you think they were trying to get" [done with the legislation.] So we really were working on the spirit of the discussions and what people brought to the stakeholder process. We tried to do that as much as follow the statute. Now there was a real feeling that unless the actual words were in the statute that it had no value, so you go and you parse each of the words, and you have attorneys look at it. And then the conversation has just really changed. So, when you're looking at, like, the integrated plan—that word is in there [the MHSA statute] once. And so, do you really have to have an integrated plan when it's just the title, and that term is used nowhere else? And, what is being integrated? So to me it really changed the flavor pretty dramatically of the discussions, of what was going on. I think the philosophy of what people were trying to achieve—having more client and family member input, having peers as staff, having recovery and resilience be the basis for how you approach clinical care—I think those have changed the system. But, what goes in a plan, and what's the timing and that kind of thing, has changed over time.

HP: I realize that you're not on the ground in the Counties providing services, but can you think of some specific ways that the services provided in clinics now are different from how they were pre MHSA? Like obviously, there were FSP's, but in terms of just the regular course of business, how has this recovery vision changed things? Beyond the generalities about services being more "client driven" and whatnot, what does that actually look like on the ground?

CH: When I first came to California, I worked with a gal named Faith Ritchie who was the financial person at San Mateo County, which was a very innovative County, very cutting edge. She left the State about ten years ago and moved to Washington. She has just come back. I just talked to her in the last couple of weeks, and she is trying to figure out how things got from when she left to where they are now. And, I said, "Well, what are the changes that you see?" Which to me is kind of what you are asking, except I'm in the thick of it, so it's hard to see the changes over time. She said, "It's so different, the role of clients in the Counties, clients and families. Now everybody has clients and family members who are employees." And, when she left ten years ago, before the MHSA, there were a few, and people were struggling with it, and it was more the exception than the rule. A lot of what she was talking about was not specific services but how clients and family members are involved throughout the mental health system in the delivery of care and design.

HP: And, what does that—how does that change it? If you have recovery-oriented social workers or recovery-oriented psychiatrists, what do clients and families bring to the equation that recovery-oriented professionals wouldn't necessarily be able to offer?

CH: And, this is beyond my area of expertise because I'm not clinical at all, but to me it's if I had somebody…I got rheumatoid arthritis many years ago, and when I got it, it was really scary, and I didn't know what was going on. So, the doctor would tell me some things, and he was nice. He was very nice. He was very accessible. But, I felt very alone, very confused, didn't know what was going to

go on. I got into a group where there were other people, and you could chat about the things that you cared about, or that were concerning or something. So, to me, it's just you're talking to one of your own rather than a professional, someone who really gets where you are. So, you know, they've walked in your shoes, but the doctor hasn't.

HP: Um-hm, so that adds something to the quality, to the—

CH: Tremendous! The same thing, like, for cultural competence. If I go into a group of all Latinos, they might rather chat with one of their own rather than me, who has no background [in Latino culture]. I might care about them as individuals or something, but I just don't have the same cultural background or frame that they bring to it.

HP: Great, OK. So now looking back at the MHSA, name two things that you think have gone particularly well and two things that you wish had gone differently.

CH: I think we really got the spirit of involving clients and family members in a way that they could fully participate and help the Counties understand how to do that, because you don't just send out an invitation--which is what I did on a previous project that. Just sent out an invitation, and if they didn't come, "oh well." They were invited, and I thought that was enough. And, I was educated that, no, that's not enough.

HP: There's a difference between invitation and engagement.

CH: Yeah. And giving the background so that they understand what the discussion is about. Making sure that they're prepared so that they can understand the questions that you're asking them to give input on. And, how you prepare them

for that discussion is different than how you prepare others. We used to have a meeting in the evening, the night before meetings, to go over what we were going to discuss the next day. They could ask questions kind of in a safe setting before they got into a public setting. So I think different ways of really doing client and family engagement

I think what we did with the involuntary care was—kept the MHSA together. I think that would have split the MHSA.

HP: How come?

CH: People don't even think about it now because the families were adamant that you had to have involuntary care and that they were promised that the MHSA would fund it. And, the clients were adamant, no involuntary care and felt that they were promised it would not be a part of the MHSA. And, I think we found a way to walk the line.

HP: That's often not a part of the story that you hear, so I'm glad you shared that.

CH: It isn't, and I think there's very few people in the system now who even know we struggled with that. I would say the bulk of people like you would say "you just can't fund involuntary." No, that's not what the rule is, and it's more nuanced. And, there are some who still don't believe it, so it's being litigated, I think.

HP: Um-hm, when these things are litigated, who—I mean how can a judge decide because, if the State wrote the regulations, that's the regulations, right?

CH: Somebody would have to decide if they were inconsistent with the statute.

HP: Ah, so if they were inconsistent with Proposition 63.

CH: Correct.

HP: It's unbelievable ten years later this could still be going on.

CH: I know. And the two things that I feel bad about: one is that we still don't have outcomes and data that we're using to monitor.

HP: And, why is this again, same thing?

CH: The same thing, same struggle for twenty years.

HP: Who are the people now involved in determining what the outcome should be?

CH: By statute who approves the outcomes is the planning council [California Mental Health Planning Council]. The commission also approved the same indicators or outcomes as the planning council. The commission agreed with the planning council. The commission has worked with a branch of UCLA to calculate these priority indicators. But I see the same thing happening: it's going to go under. The new people that are coming in want to focus on a different set of indicators than those that have been approved that we've been working on. I continued working as a retired person to just try to finish that part, and I feel it falling apart again.

HP: What were the indicators you had agreed on?

CH: There were a number of priority indicators—client satisfaction with services—there's a whole matrix of them.

HP: And then, what do the other folks want to bring in or think don't belong?

CH: They don't like the data, and there's always a problem with data. You could always argue a different indicator. They just want to start the discussion about what indicators to measure again, and you can always do that.

HP: This is when you've got to keep academics out of the real world, I tell you. (laughs)

CH: Yeah, and it's not UCLA that's doing it; it's the State again.

HP: Oh, interesting.

CH: But, you just get that close, and then something is gonna divert it, so it's happening again. The other thing that I feel badly about is I feel that we had a really good start on the MHSA, and we never changed over time. We just did the same thing that we did at the beginning three years later, five years later, so the plans didn't get streamlined enough.

HP: Streamlined in terms of making the approval process quicker?

CH: L.A.'s initially was, like, three inches thick or something, you know, four hundred pages or something. Does L.A.'s really need to be four hundred pages, the second, the third, the fourth, the fifth time that they submit it? Probably not. So, not enough ongoing management to keep updated with the changes. And then you get the legislature coming in and saying "OK, nobody is going to approve [anything anymore] now."

HP: Wait, what was that?

CH: Because the legislature changed it, so the MHSA--nobody approves [the plans] except for innovations. So, 5 percent of the money has oversight of the plans but the 95 percent doesn't?

HP: And, did they decide to do it because it was too cumbersome?

CH: Yes, Counties were frustrated with the State department [of mental health].

HP: What was the reason that it didn't evolve, do you think?

CH: I think there wasn't sufficient staff at the State that were dedicated to the MHSA to really focus on managing it over time.

HP: So not having people who could sit back and manage as well as people who were doing the actual approval of all the plans. Someone to actually oversee that.

CH: Right.

HP: And, that actually leads to another question I had about the merger last year of the State DMH into Department of Healthcare Services.[22] What implications do you think that's going have for the mental health system, and for mental health in California in general?

CH: And, I can speak freely now because I no longer work there, but—

HP: There you go.

CH: —I think there is a lack of any leadership now at the State level on mental health issues, so I think that'll decrease the visibility of mental health. And as we go into the Affordable Care Act, I think it's a very dangerous time to not have knowledgeable and powerful people at the State advocating for mental health.

HP: Yeah, I thought so.

CH: But, in general terms, there are many services that mental health [clients need]. The ACA is not going to worry about people's housing. It's not going to worry if they get a job.

HP: I see.

CH: It's going to get them medication and therapy.

[22] The State Department of Mental Health merged with the State Department of Health Care Services in 2012.

HP: And, with the talk of the Patient Centered Medical Home[23], you don't think that will cover these needs in the same way that mental health has?

CH: They will worry about a broad view of the person's medical conditions, whereas mental health has had a more holistic [approach of] looking at the person. [Mental health providers ask] "do you have friends? Do you have a home? Do you feel safe?"

HP: So it forebodes potentially bringing things back to where there could be more medicalization, as opposed to the recovery orientation that's developed?

CH: Yes.

HP: What can help address this do you think? What could be done to help make sure that mental health and the recovery orientation is preserved in the future?

CH: I'm not sure without a—you know, in terms of State action, like, right now we have [Darrell] Steinberg who is a terrific supporter and [State Senator] Jim Beall, who is another one that's a terrific supporter of mental health. But, if you don't have a champion in the legislature, and you don't have one in the administration, I don't know what you do. I mean then it's all the locals, but they've got a lot of issues to deal with, and I don't know what you do. It's a very sad thing for me.

HP: It's difficult because there's a lot of promise in integration, but in terms of the people who are the most pressing, high need that there's potential problems there.

CH: Now, combining alcohol and drug and mental health I think has tremendous promise.[24]

[23] Patient Centered Medical Homes are clinics that will be providing care for many individuals with multiple chronic conditions—including mental health disorders—under the Affordable Care Act.

HP: Tell me about that.

CH: Because most of our clients have alcohol and drug use disorders, and we ignore them and substance abuse providers ignore the mental health. I mean, something has to happen. We have too many clients in common and too many providers in common, and I think to put those organizations together, and to make the State figure out how to make those work I think is great!

HP: And, is that what's happening? Is it being combined—

CH: Yes.

HP: —into a behavioral health program?

CH: Yeah, the mental health happened last July and—

HP: Alcohol and Drug Programs is just happening I know.

CH: Yes, July, 2013. It's a part of healthcare services. And the problem to me for healthcare services is their main job is to run the Medi-Cal program. And, it's gigantic. It's forty, fifty billion dollars, whatever it is, and they ought to be focused on it. And, everything else will be second or third or fourth priority behind Medi-Cal, so the discussion will always be Medi-Cal.

HP: And, the MHSA will effectively be run by the Counties then.

CH: Or it'll just blend to where there is nothing distinctive [about them] anymore.

HP: Right. And that's actually one other thing I wanted to get at. With MHSA, funds being eligible for a Medi-Cal match, did that influence the implementation at all, or shape the services that Counties decided to provide with it? Or who they were decided to serve with that?

---

[24] The California Department of Alcohol and Drug Programs was also consolidated into the State Department of Health Care Services in 2013.

CH: I doubt it is—I mean it does somewhat, but I don't think it was a major driver. I think over time it'll become a bigger and bigger driver, but at the beginning I think the Counties had all the money that they could spend and I don't think trying to squeeze every last matching dollar out of it was their initial focus. I think the initial focus was on what are they were going to do, and how to keep people out of the hospital, because what a waste of money that is, excess hospitalization anyway.

HP: Yeah.

CH: I don't—some people are really opposed to Medi-Cal, and say it's really horrible. I'm not one of those. I think Medi-Cal does a lot of really good things.

HP: Does Medi-Cal cover recovery-oriented services that the MHSA would cover?

CH: Sure, it depends on where they're delivered, if they're part of the covered services, but you can do any therapy anywhere. You could even do it by a peer so long as they're supervised and bill for it. You can do housing.

HP: Oh, you can do housing with Medi-Cal?

CH: Yeah, because you can do rehab. You can't pay for the house; you can do supported employment. You can't teach them to flip a burger, but you can talk about it.

HP: So, it can do 90 percent of what a recovery-=oriented wraparound service would be basically.

CH: Right.

HP: Interesting, OK. So one final, double barreled question: 1) What's your vision of where mental healthcare in California is going; and 2) is if you were in charge, what would you do?

CH: So, where is mental healthcare going? I think I'm not really sure. I think a lot of things are going come out of the ACA and we probably haven't even figured out what some of the questions are yet. I don't see how you could still have the money going directly to County mental health under a full implementation of the ACA. I think Counties will be providers of care to managed care organizations. But then I think "where is the additional money to really focus on the recovery things and not just the medical?" I think that will get lost, and—

HP: The MHSA wouldn't be able to fill that gap maybe?

CH: I think that it will be refocused, because what's going to be the County's role? It'll be the managed care company's responsibility after a while. That's what it seems like to me. You know, maybe you'll start out where the Counties will have an agreement with the managed care firms, but we tried that with Healthy Families[25], and it doesn't work out very well. You need to have somebody in charge.

HP: What happens if the managed care companies take control, it just becomes increasingly medicalized?

CH: It becomes medicalized, and they provide less and less care to people with serious mental illness. Our clientele is not one that shows up for care, and

[25] Healthy Families is a state-sponsored form of insurance for children and teens who do not qualify for Medi-Cal.

healthcare providers are not ones that usually go out and find people to serve. They have them come in to get care.

HP: The efficiency that's implicit in the managed care model doesn't necessarily lend itself to the SMI population.

CH: Correct, yes.

HP: So that's a potential vision. If you became health czar of California, what would you do?

CH: Health czar or mental health?

HP: Yeah, mental health czar including control over health let's say. I'll give you a magic wand.

CH: (laughs) Well, on the mental health side I'd try to do something about the data systems. I think until we can describe in with data what we do and why it's important, and I think that's possible, and I think what we do is important and can be demonstrated to save money, but we don't have systems to do that now or we don't do it. I think we're just going to lose this argument with the managed care firms, and I think mental health will lose unless we can provide the data to show how important we are for this population.

HP: Where is the bottleneck with the data? Is it the County level? Is it the providers not entering things when they provide the services?

CH: The State level system, the core system, was built in the 1980s, I believe, and it's just on the verge of implosion. It's very difficult to do any kind of new data systems at the state level, so other than Medi-Cal, it's pretty hard.

HP: And, particularly if you're trying to show things about the MHSA.

CH: And, there is an FSP database, but it's under-resourced at the State.

HP: So, the State hasn't invested in that centralized infrastructure?

CH: The State didn't get infrastructure funds; State got some generic funds. But, the State has had a number of real debacles with information technology, and so it's controlled so tightly it's pretty hard to implement any kind of IT solutions.

HP: Okay, other things that you would do?

CH: Try to bring back the voice of clients and family members. I think they're not within the State system anymore. And then I would want to resolve some of the core issues with the Counties. The Counties are where the services are. That ought to be the primary place, and the State needs to figure out how to support the Counties. And those [Counties] that are awful—[the State needs] to do something about those few outliers. There's always going be 5 percent or something. How do you identify the 5 percent without harming the 95 percent?

HP: That seems like it's difficult because if you have across the board regulations, that could hurt the high achievers.

CH: Right. And then I think my focus would be the ACA. I think that's where it's at.

HP: Yeah.

CH: I think that's the future; that's what's going to decide the future of mental health.

HP: And it really is about showing that these kind of new services work for people with SMI.

CH: Right, and I think Counties have got to find a way so that they can effectively work with managed care plans.

HP: Great. Well this has been wonderful. Is there anything else you'd like to add that we didn't cover?

CH: I don't think so.

HP: I've kept you for quite a while. (laughs)

CH: Very comprehensive.

HP: All right, well, thank you so much; it's been great.

END OF INTERVIEW