

## **Catherine Camp shares her thoughts on the state of the public mental health system in California...**

I'm optimistic about the fact that during my time in mental health, the science has gotten progressively better. The drugs are better, the treatment methodologies are better, and the understanding of the complicated role that clients' own needs and wants play in a successful program has gotten consistently better. I think we take care of people better today than we did even twenty years ago. I know for certain we take better care than we did thirty, forty, fifty years ago. I'm optimistic about that.

I'm optimistic about public education. I think that increasingly people are willing to talk about mental illness, cop to the fact that there's always a mentally ill person in every family, and that more and more people are knowledgeable about the strengths and challenges and opportunities in mental health treatment.

I am pretty pessimistic about political decision-making at the California state government level. It is a disaster at the moment. It's completely dysfunctional. And I despair at the level of civil discourse. Neither one of those are unique to the mental health field, but they really hamper the ability to fund and deliver public services. There's one thing I think MHSA proved. It's that if you ask the simple question of most Californians, "are you willing to be taxed to provide better care for people who are sick through no fault of their own, or even maybe a little bit of fault of their own, but are really sick?" The answer is, "you bet. I'm willing to do that." I'm dismayed at the fact that we don't have a political system that can acknowledge that and react to it...

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**INTERVIEWEE: CATHERINE CAMP**

**INTERVIEWER: Howard Padwa**

**DATE: April 6, 2010**

**I. Early Career; State of Mental Health Funding in California in the 1970s and 1980s; Formation of the California Mental Health Directors Association**

HOWARD PADWA: For starters, tell me a little bit about your background, where you grew up, where you went to school, and then just kind of how you got into this field.

CATHERINE CAMP: I grew up in Pasadena. John Muir High School. Go Mustangs. I left, however, at the end of high school and went to college in Portland, at Reed College, and to the University of Chicago. I have a master's degree from the University of Chicago in Mark Twain.

I'm not a clinician and hope I've been straightforward throughout my career about the fact that I was a lobbyist and a policy analyst and a facilitator -- kind of community organizer. I was not a clinician. I used to say frequently that I didn't write my own material.

I worked early in my career in the poverty program and did Democratic Party organizing and campaign work. So in 1975, my husband and I moved to Sacramento from northern California, at the time of the Jerry Brown administration [Edmund Gerald Brown, California Governor 1975-1983]. I went to work for the Governor's Advisory Committee on Child Development Programs. As part of my poverty program work, I had managed a Head Start program [a program that provides services and assistance to low income children and their families], so the movement into childcare was clear. I went from there to the Assembly Office of Research, where I did [work] principally [on] children's programs.

HP: And this is not attached to any representative or party or anything.

CC: Well, my entrée was connected to political work. I don't believe that's the only qualification, but --

HP: But for many people it is, that's how they get into it.

CC: Yeah. It's often the entrée. I had done political work for Jerry Brown, so when he was looking for somebody to provide childcare policy for him at the start of his administration --

HP: There you were.

CC: I fit. I had also done work with Bill Lockyer [William Lockyer, California State Assemblyman and Senator, 1973-1988], who at the time was an Assemblyman. He also managed, as part of his Assembly duties, the Assembly Office of Research. So I went there for a couple of years. There isn't one these days, an Assembly Office of Research,

but it basically was a group of policy analysts and researchers who were available to the legislature, and my field of expertise at that point was children. Children's programs, foster care, childcare. I also did some work on school dropouts.

When Bill Lockyer moved into the chairmanship of the Assembly Human Services Committee I went to work for him as a consultant to the Assembly Policy Committee on Human Services. There were two of us, two policy consultants, and my part of it was welfare, foster care, and childcare. Bill was in that position for three years, I think. He went on to the [California] Senate at that point, and I stayed with the Human Services committee and worked for another three or four more years, while the committee was chaired by Assembly Member Tom Bates [California State Assemblyman, 1976-1996], from the Bay Area.

About 1986 or so, or 1987, I was feeling done, tired, ready for something new. I left the Assembly Human Services Committee and worked for two years, maybe even shy of two years, from I want to say 1987 to 1989, for the statewide Association of Community Action Agencies [organizations that work to empower the socially disadvantaged and encourage self-sufficiency]. I was their lobbyist and executive director, and a policy analyst for two years.

HP: Did this cover mental health as well as other --

CC: No. I'll talk about that in just one second. In 1989 the Conference of Local Mental Health Directors [directors of county departments of mental health], and specifically the county directors themselves, decided that they wanted to establish an association that was supported by dues from counties and staffed by folks that they selected, rather than relying totally -- especially for their advocacy -- on an employee of the [California State] Department of Mental Health.

They knew me for a couple of reasons. During my career in the Assembly Human Services Committee, I had worked on a couple of mental health bills for Tom Bates, who was someone who had a passionate interest in mental health and who carried legislation. So I had done some mental health work for Tom. And in addition -- and this was not necessarily considered a point in my favor by Mental Health Directors -- but I had helped assembly member Willie Brown [Willie Brown, Jr. California State Assemblyman, 1964-1995] put together AB [Assembly Bill] 3632, which was legislation that provided for treatment services for children in schools who needed special education because of their mental illness. He was Speaker of the Assembly at the time, and I wasn't the principal staff person on the bill, but I did bring in the mental health perspective and simply had more time than his chief of staff, Steve Thompson, who was the principal staff person on the bill.

HP: So you had some familiarity with the issues.

CC: So I had some familiarity. And the [county] mental health directors who were active in Sacramento knew me from that work. I had become interested in the public mental health system, especially around the AB 3632 [legislation].

At the time, the mental health directors wanted purely a lobbyist. They had a complex structure. Their regular meetings were managed by the [State] Department of Mental Health. There was a staff of at least three people at the State Department of Mental

Health who supported the Conference of Local Mental Health Directors, in a very complicated committee structure with regional meetings and statewide meetings.

The directors were anticipating at the time that they formed it that the Mental Health Directors Association would be a small lobbying unit. We got office space from the County Supervisors Association of California [CSAC]. In fact, at the beginning, the staff was me, and half of a secretary that I shared with another CSAC unit. In addition to the state-level lobbying, the directors also wanted to build stronger ties to the structure of county spokespeople.

HP: I'm curious. So this was for the county directors to lobby to [the] state DMH [Department of Mental Health]?

CC: Somewhat, although the bigger problem that they identified was that when they wanted to take a position on a bill, or more frequently even, a budget item, the staff at the [State] Department of Mental Health was barred from making any statement that ran contrary to the [state] administration position. So if the administration proposed a cut in mental health, the [state] mental health director's staff was barred from saying so.

HP: Could the mental health directors say something?

CC: They could. They could, but then, as now, they all had full-time jobs at home. And they didn't have a forum to put a position together, so it was difficult for them to be a sustained presence [in state politics]. They really wanted somebody who wore the team jersey, who was identified as county mental health, different from the state, and who could speak directly for counties.

HP: And what were some of the issues where the counties and the state were at odds?

CC: Well, the 1980s were extremely difficult times for county mental health. The state budget was deteriorating over that period. I don't know if you remember, but the passage of Prop. 13 [California Proposition 13, passed in 1978, which limited property taxes and the ability to raise them] completely restructured local funding and reduced the funding that was available to counties substantially. The state put some of that money back in, and as a result, had very little money for its own projects.

Mental health, unlike many of the other human service programs, had no mandate for comprehensive services, and still doesn't. There are some limited mandates, such as treatment for individuals dangerous to themselves or others. But for example, if you have a developmental disability and it manifests itself before you're eighteen, you have an entitlement to services [legally guaranteed access to benefits or services]. If the state takes a kid away from its parents, that child is entitled to services. And there are standards in both programs that determine whether the services you get following that entitlement are adequate. There was no similar entitlement program for mental health.

HP: So the state wasn't obligated to do anything.

CC: The state was not obligated. There are some very limited entitlements today - then and now. The long historic one is the entitlement under [California Welfare and Institutions Code Section] 5150, if a court finds that you are so seriously mentally ill that

you are a danger to yourself or others, the county, by law, is required to provide you with locked inpatient care sufficient to resolve that danger.

There are circumstances, and this relates to the federal education mandate, regarding the right of children for free and appropriate education. If you are eligible for special education, and if that eligibility is based on your mental illness, the school system ultimately is required to provide the services that enable you to benefit from an education. This is the issue that Willie Brown's AB 3632 addressed by requiring county mental health departments to provide services to such children. But in the normal course of events, if you're just really, really in trouble but you're not dangerous, there is no entitlement.

There was an effort in the 1960s when -- I think he was an assemblyman at that point -- Lanterman [Frank D. Lanterman, California State Assemblyman, 1950-1978] put forward a developmental disabilities mandate. There was an effort at that point to include mental health. It failed, and since that time it hasn't happened.

So, the other thing that happened in the eighties, I think -- could have been late seventies, maybe eighties -- was a court decision relating to the other loose mandate that floats around in the health field, Welfare and Institutions Code 17000, which requires counties, when all else fails, to provide health care for their residents. The Code section itself is very old.

HP: That's in the California code.

CC: That's in the California code. And it underlies the requirement that counties provide a certain amount of public health, and indigent health services, at the local level. That's also the code section under which counties provide general assistance for people who have no other money and they get a little amount of money.

HP: Right. That's the GR [General Relief].

CC: The GR. There is a lot of flexibility about what constitutes an adequate response under 17000. But I think in the eighties, but it could have been the late seventies, Legal Aid sued -- I think actually this was a Los Angeles case -- sued under Welfare and Institutions Code 17000 and said, "the county has an obligation to provide this care."

HP: Was this *MHA v. Brown*? There was one case like that. [it was actually *Comber v. Board of Supervisors of Los Angeles County*]

CC: It could have been. Do I know the name of it? Probably could find it, but I don't remember. The court determined at that point -- kind of interesting to figure out whether they would still do so -- but at that point the court determined that the county's obligation would be met if it spent such funds as the state made available to it for mental health, on mental health. So as long as the county didn't take any mental health money and spend it for something else, they were meeting the obligation. In other words, it didn't create an obligation to dip into county general funds to pay for this.

HP: And that's what the county directors would have liked?

CC: That's what -- the reason for hesitation is that every county director depends for his job on three votes on the County Board of Supervisors. So throughout the history of the Mental Health Directors Association there is tension between advocacy for rights and funding for the mentally ill, and assurance that they're not jeopardizing the county financial or programmatic stability in their advocacy. It's why it has always been important that there was a coalition of lobbyists, including people representing consumers and family members, who can speak much more directly to --

HP: To the Supervisors involved.

CC: Yes, and to the needs of persons with mental illness. So in this kind of case the issue was, "are counties going to be on the hook the way they are for health services?" The mental health directors wouldn't take the lead on that. Some Supervisors wouldn't care. Others would consider that an --

HP: Act of --

CC: Yeah. Treason.

HP: Yeah, basically. So the solution would then be to try to get the state to fund this instead.

CC: Exactly. Especially since Proposition 13 sharply limited any ability to raise taxes locally. What happened during the 1970s, as the state budget got tighter and tighter, is that the funding that was available for mental health, which came directly out of the -- the money for mental health then was State General Fund plus federal match for eligible Medicaid expenditures, and some federal grant money, from SAMHSA's [SAMHSA is a federal agency, the Substance Abuse and Mental Health Services Administration] predecessor, but primarily out of the State General Fund.

HP: So State General Fund meaning that the governor would put together his budget every year and decide this much is going to mental health. That's all it was, really.

CC: That's right. And then counties were required to provide a match, generally 10 percent, in order to draw down the 90 percent from the state. And there were grants, and there were some modest, specific programs, but the basic funding was an annual state allocation. Through the 1970s there was never a cost of living adjustment [increases in order to keep up with rises in consumer prices], so the block of state funds got eaten away every year. Finally, at the end, 1978-1979, the state actually took money out of mental health, so there was a reduction even in the pathetic amount that they were giving counties already.

HP: Right. And then on top of that, that was right around Prop. 13, so the counties couldn't really raise the funds either.

CC: The counties couldn't raise the funds. In addition to that, the historic fight that occupied us all for way too long was the fact that the base amount that dated back to the 1960s and 1970s initially was an open-ended claiming. Starting in 1957, the Short-Doyle Act allowed counties to choose to participate in a community mental health program and get 50 percent funding if they were willing to put up the other 50 percent. By 1968, that sharing ratio was changed to 90 percent state, 10 percent local. By the

early seventies the amount available was capped. It was no longer an open-ended "you got the match, you get the money."

HP: Oh, I see. So there was a cap on how much the state would provide.

CC: Exactly. And one of the consequences of that is that counties that chose to be more proactive in the care for the mentally ill gathered up a lot of money in the sixties and seventies.

HP: Because there was incentive, the more you do, the more you get.

CC: That's right. Counties that had more conservative boards or boards that were less opulent, boards that weren't as supportive of mental health treatment services, boards that didn't have the money, didn't receive as much mental health funding. So there were huge variations in dollars per resident around the state.

The other problem over time was that areas of high growth couldn't get more money to adapt to their population growth. The term for this disparity of funding was "equity," and the counties that were under equity were Orange County, San Diego, San Bernardino, Riverside, most of the Valley counties, some of the high-growth foothill counties, like Placer. And to add to this whole sorry mess, San Diego County and I think Orange (I think it was a joint lawsuit), sued Marin, San Mateo, San Francisco, Contra Costa -- these were the high dollar counties [ones that spent a lot of money on mental health] -- for a readjustment of this fixed pot of money.

HP: To try to get it to be not based on --

CC: History, exactly. And not to be based on what was increasingly a twenty-year-old history.

HP: Because it was frozen at a certain point.

CC: It was because the total sum was frozen, even declining. Despite the inequities in funding, within the Mental Health Directors Association, there was an extreme reluctance to close a program down in one county in order to start up a new program in another.

HP: Well, yeah, because if you're the director in one county you can't say, "hey, we have to close up because San Diego needs a new clinic."

CC: "San Diego needs the money." And nobody had more money than they needed. Nobody was adequately serving the mentally ill.

HP: I'm curious, when you mentioned the more well-covered versus the less well-covered. Where did L.A. fall in the spectrum?

CC: Well, the trouble with L.A. is that it sets the mean.

HP: Just because it's so big?

CC: Because it's so big. It was about at the mean, although that may be more a factor of --

HP: -- it's size?

CC: -- it's size.

HP: And when you say "mean," like what percent of need was being met, roughly?

CC: You know, I used to have those numbers in my brain. You would push the button and out they would come. I would guess maybe 35 percent? And even after Realignment [the restructuring of how the mental health system was funded, which occurred in the early 1990's], which provided for an infusion, at least for a short time, the system really has never met more than 50 percent of need. There's never been enough money to adequately serve all adults and children with serious mental illness who require treatment from the public system.

HP: Even today.

CC: I don't actually know what MHSA [the Mental Health Services Act, an initiative that funded the mental health system, approved by California voters in 2004] did to the numbers. Unfortunately, when MHSA came in, mental health funding was on a downward trajectory, and so even though it was supposed to go for new services, new programs, new kinds of programs, it would surprise me if the net service reach still was over 50 percent of need. And need itself, of course, is difficult --

HP: It's impossible to really nail down.

CC: Yeah. Need is typically defined as 100 percent of the people whose mental illness is serious enough to require public services, and who have no other payer for their services. So they don't have insurance, or they're not independently wealthy. There still is some subset of that population who won't seek or receive services anyway, so it's a little bit difficult. But there's basically a line at the door, or a mediated service level in every county in the state. It was more dramatic by the end of the eighties because of the pressure of this lack of equity. And the fact that the state budget for mental health had just basically stopped dead, and then started to move backwards. The state was starting to take even some of the base funding, which had not had cost of living adjustments for several years.

The [County] Mental Health Directors, right about the time they hired me in 1989, issued a report that was basically a "state of the service delivery system" that had a skeleton in the cover. (chuckles) It was part of their dramatic statement of what was happening at the county level due to the lack of resources. So that was driving the formation of the Association as well. Directors said, "wait a minute, when the budgets get drawn, that's the very point at which we don't have clear identified advocacy on our behalf."

HP: And when you say "on their behalf" it's really on behalf of the mental health system at the local level.

CC: Yes. It was important then, and it's important now, what I said before, which is that I spoke for fifty-nine county mental health directors. Eighty percent of the time they were consistent with the views of other mental health stakeholders. The mental health directors worked very hard to see to it that their message was consistent with what

consumers wanted, consistent with what the provider-contractor community wanted, consistent with what family members wanted, and that we could go together to make those statements to the legislature, the state administration, even to the public. We were much likelier to be successful when we spoke together. But at the end of the day, I spoke for the public system at the county level.

## **II. Mental Health Advocacy at the State Level; AB 3777 and the System of Care**

CC: We formed, during that period, a group which may still meet, called the Mental Health Irregulars. All of the folks who were Sacramento based and speaking for mental health would get together at least monthly, and sometimes in the heat of the legislative session more frequently. It included all those people I just named, plus all of the guilds, the psychiatrists, psychologists, social workers, marriage and family therapists.

HP: So all of their representatives.

CC: All of their representatives. And we would get together and really do two things: identify those issues where we could speak with a single voice and, at our best, try to assign leadership to people with specific expertise. So at that point in time, for example, the psychiatrists in particular had someone who was skillful on the issue of guns, and there was a lot of legislation about barring people with mental illness ever from owning a gun. We saw it as pretty abusive legislation. On the other hand, it was also a dead loser to argue in front of the legislature, "so we have these mentally people and we want them armed." (both laugh)

So we tried to say, "alright, you take the lead. We're all pretty much in agreement on where we want to go with this legislation. You take the lead on this. I'll take the lead on the base funding because that's the bread and butter for mental health directors. And somebody else will take the lead on something else."

HP: So, organizing the organizations, basically.

CC: Right. Informal. We didn't ever have officers, but it was a functional way for the mental health community to speak when they could with a single voice. It tended to fall apart around involuntary treatment. It tended to fall apart around guild issues. So when the psychologists wanted the right to prescribe, and the psychiatrists said, "over our dead body."

HP: You let those fights be solo.

CC: Yeah. The Irregulars would back out of those fights. I was going to say the Mental Health Directors struggled mightily with the involuntary treatment issue over time, and it never went away. We also tended to struggle over some of the issues with regard to drugs.

HP: What kind of issues would you struggle with?

CC: Well, many consumers were very suspicious of movement to make drugs easier to get, cheaper to get, more commonly on the Medi-Cal formulary --

HP: By drugs you mean meds --

CC: Yeah, meds, yeah. Mental health directors tended to view effort to make them more available, and hence cheaper, as ultimately a budget issue.

CC: The other way we got into trouble from time to time, was over subsidies. Those were the days, in the nineties, when the drug companies were wallowing in cash. They probably still are. But they would say, "let us pay for your entire meeting, including opulent food and an open bar."

HP: (laughs) And then we'll talk to you.

CC: And then -- yeah. And, [the drug companies would say] "oh, we wouldn't want to influence you about our own particular medication, but we just want to make certain that you guys are comfortable and happy." That kind of offer went broader, of course, than pharmaceutical companies. Nursing homes and hospitals also tended to want to provide support. And I'm embarrassed to say that it took me a little while to learn that the price to be paid for accepting that money was higher than directors were willing to pay.

I do have a very vivid memory of having agreed to let an owner of a nonprofit rehab facility sponsor -- I can't remember now whether it was a meal or hors d'oeuvres or something -- but something at one of our quarterly meetings. One of the mental health directors grabbed me by the shirt front at the meeting and said, "let me just tell you that I am meeting with them the day I get back to my county to negotiate a contract, and I am completely uncomfortable walking into that negotiation having eaten their food and drunk their wine. Don't set me up like this again."

HP: I could see that. That's interesting.

CC: So shall I go back to the nineties?

HP: Yeah. Let's --

CC: So I got hired in 1989.

HP: So you got hired in '89. Now, a couple of things were happening around then. One would be AB 3777 [1988's Assembly Bill 3777, which authorized the creation of pilot projects for Integrated Service Agencies] and the other would be obviously Realignment.

CC: 3777, and for that matter, [1988 Assembly Bill] 377, were -- the children's part of that, the 377 --

HP: [Assembly Bill 377]. Was that the Children's System of Care?

CC: That was the Children's System of Care -- it was fundamentally county drafted, county sponsored, and the Mental Health Directors were always profoundly supportive. It came out of a county mental health director, Randy Feltman in Ventura. The initial three test counties were all county-based. And it was the way people believed services ought to be targeted and services ought to be delivered. The notion of evaluation being a clear and public part of it was also important.

What became difficult in terms of advocacy at the state level was that, in its purest form, counties were looking at expenditures for some troubled children that included foster care, probation, drug and alcohol, and mental health treatment. For the most part, an increase in mental health expenditures meant savings in the other expenditures. And there was no way to sort that out budgetarily at the state level in a rational way. Mental health directors argued, and probably argue today, that it's the right thing to do, and it's the right way to serve kids, and the outcomes for kids are better. But financing is always difficult.

3777, the Adult System of Care, it is fair to say didn't come from counties. The leadership on that came out of the Mental Health Association in Los Angeles and a state-level commission, not really out of the counties, although the counties were completely supportive. There was, from the beginning, a fair amount of frustration that the funding to make the switch over to that way of delivering care was never available, from the Mental Health Directors' point of view. [The directors' line of thinking was that with this program] there was an expectation that counties should redirect base funding to a contractor for 5150 calls? [The directors initially thought] "I don't think so."

HP: How come?

CC: Because that director would stay employed for about a week and a half after the first time some 5150 client went off the rails, and caused a public problem.

HP: Oh, I see. Because it would mean actually decreasing 5150 [funds], so a 5150 that needed to happen maybe wouldn't.

CC: Yes.

HP: I see. It seems that people agreed this was a good idea in terms of how to go about it. What was it hoped or believed that this model would accomplish?

CC: That it would make good, basically, on the deinstitutionalization promise [from the late 1960's when state hospitals released individuals into the community]. If we provide you with whatever it takes, your hospitalization will be reduced, your law enforcement interactions will be reduced, your family difficulties will be ameliorated.

HP: You'll get a roof over your head.

CC: You'll get a roof over your head, and things will stabilize. It was clear to see in the case of the pilot programs. The pilot programs had specific money, they could measure it. In the larger community system it was more difficult to see, but at the heart of the later Medi-Cal fight over reform, for example, was the switch from the clinic model of Medicaid financing to the rehabilitation model of Medicaid financing, which allowed counties to use those funds outside the walls of the clinic, in somebody's house, in a community center, in a homeless shelter. Medicaid does not provide "whatever it takes," but in a rehabilitation model it could provide key services.

HP: In regular outpatient programs you could?

CC: Under the rehabilitation model, you could provide outpatient services someplace other than inside the walls of a clinic, and use a more diverse set of providers

HP: When did this change happen?

CC: 1993 I believe. And the impetus for reforming Medicaid/Medi-Cal was a part of the System of Care philosophy. [The idea was that] we need to take what has been a constrained medical model service system and expand the kinds of people who can provide the service, the places where they can provide the service, institute client-specific plans that coordinate all of those services around a set of goals. Those were all contained in the rehab option effort in the early nineties. And the learning for that came out of the [AB] 377, [AB] 3777 effort.

HP: So seeing how that could work and that it would work.

CC: Right. So there was broad support. I think it was sometimes harder for the broader constituency for mental health services to see that those big system changes would in fact drive the delivery system. It's easier to say with the pilot program, "you've got it, you can go look at it, you can prove it."

HP: "You've a hundred people, look at how much better they are." So when you say that they didn't see it, what did they think of these changes?

CC: I think, for the most part, everyone realized that the pot for those pilot programs simply wasn't getting bigger. [People were also thinking] "what's the matter with this system? Why isn't it completely turned over [towards the Integrated Service Agency model]?" It is like moving a battleship. I know that if you look at the typical county mental health service today compared to the typical county mental health service in 1990, it would be a dramatic change, and it would be a dramatic change in favor of a System of Care.

HP: A System of Care, meaning?

CC: Meaning individual plans, documented outcomes, coordinated services. The other issue for this system, like every system, is that there's a lot of people who work for county mental health, and some of them took longer to convince than others. And in any big system, sometimes you just have to turn somebody's desk to the wall. (both laugh)

HP: And put them in the naughty corner.

CC: That's right. [jokingly] "Go to your room. You're not getting this." It took a while. I think, as a system, the benefits of coordinated care and single case planning and targeted outcomes were recognized earlier than the goal of really aggressive involvement by the consumers in identifying their own goals. It just took longer for that to be integrated into the system. I wouldn't describe the Mental Health Directors as being resistant necessarily, but some elements of the System of Care took longer to institutionalize than others. And some of that's just personal. At the time that I was hired in 1989 it wasn't too many years before that when the majority of mental health directors were psychiatrists. Integrating that switch took a while, too, as the benefits of social work and --

HP: So when you're talking about this change toward the System of Care, you're speaking specifically about case management, about helping people find a job, helping people find a house, not just giving them meds and therapy?

CC: That's right.

HP: And I guess it's at the same time moving away from the psychiatrists. That would lean more toward the social work profession in terms of the directors themselves.

CC: Yes. At least integrating that social work perspective.

HP: I see.

CC: I don't think there's a mental health director who would dismiss the need for really good diagnosis, really good physical exam and assessment, and medication when appropriate. And all of those tend to be the prerogative of the psychiatrist. Nobody would dismiss that. It was adding the other elements and integrating fully that took time. Probably our consumers would say it's not fully integrated today. The task was to make certain that everybody in the unit, including the psychiatrist and the nurse and the administrator and the bus driver, all are comfortable with this shared decision making. It took probably longer than it should have to integrate that into daily operating procedure.

HP: So sharing with each other, not even necessarily with the consumer. The psychiatrist and the social worker working together.

CC: And valuing each of the perspectives fairly. I feel like that struggle went on during the nineties, that kind of learning curve. And above all just the implementation of change. It's also true that when money's tight, you don't hire a bunch of new staff who are just out of graduate school and really get the new technology. You're stuck with the guys that have been there for twenty-five years. They're still wearing Birkenstocks. That was tough. I feel like the change however happened, by and large.

HP: And when did it happen, do you think? When was the tipping point?

CC: I'd like to think by the end of the nineties. Other consumers could probably make a better estimate than I. The other thing I would say about being director of the County Mental Health Directors Association is that I saw mental health directors when they were with their peers, with their party clothes on, meaning I didn't see them behaving badly. When they came to Sacramento to talk to each other they tended to be on message. Certainly nobody was going to say, "System of Care, what, are you kidding?" But, in fact, they marshaled significant resources and advocacy to implement System of Care at home and to pursue it --

HP: To advocate for the funds.

CC: Yeah, to advocate for the funds at every level.

### **III. California's State Budget and Mental Health Funding; Realignment**

HP: We were talking about the way the county versus state funding worked. Tell me about how Realignment came about and how it got through and what it did.

CC: Well, the state budget was in a catastrophic meltdown only matched by the state of the state budget today. I want to say that the size of the deficit was at least -- well, fourteen billion.

HP: Fourteen. That's chump change today. (laughs)

CC: (laughs) This is 1991 though.

HP: Okay. That was real money back then.

CC: Yeah. And it got a little worse after that. Pete Wilson [California Governor, 1991-1999], to his eternal credit, proposed, when he introduced his budget in January of 1991, that the state impose a tax. I can't remember at this point what he initially proposed, whether it was sales tax or vehicle license fee tax, but he proposed a tax that would go directly to counties. And in return for that, instead of the state-county sharing ratio with the mental health budget controlled annually by the state, the new Realignment money would replace most of the State General Fund.

HP: So it was the VLF [vehicle licensing fees] and the sales tax money [to go to mental health]. And this was after the nickel-a-drink attempt [an early 1990's campaign to add a five cent tax to alcoholic beverages and use that money for public mental health]?

CC: Isn't that funny? I don't remember whether the nickel-a-drink was before that or after that. I have a vivid and visceral memory of sitting in front of ironing boards in every shopping center in Sacramento with those petitions [for the nickel-a-drink campaign]. But I don't remember when -- I want to say maybe it was after.

So anyway, Wilson proposed it, and I should say I was no great fan of Pete Wilson's, but it was a statesman's move, and it was the end of his presidential aspirations because he was in fact proposing a new tax. And he paid for that in the Republican Party thereafter.

HP: But it would still be good for the state budget in the long term in that it didn't siphon money away for these social services.

CC: At the end of the day, he proposed to realign parts of the Social Service Budget, parts of the Health Budget, and parts of the Mental Health Budget. One other player in this who was really key was Assembly Member Bruce Bronzan from Fresno [served in the California Assembly, 1982-1993]. He had been chair of the Assembly Health Committee and had held a series of hearings on mental health, and knew the mental health field inside and out. He had a staff person -- Sandra Goodwin, who had been a mental health director in Placer County and had been head of the Conference of Local Mental Health Directors for at least one term, and so [she] knew her colleagues and the mental health field well. And he was charismatic and an enthusiast. You would today, "if you talked to Bruce Bronzan, find that [he would say] this is the best day for best service, in a world that is full of opportunities." He was lovely. He was joined by State Senator Dan McCorquodale [served in California State Senate, 1982-1994], another experienced legislator with a strong background in mental health legislation.

The other piece of serendipity was that the California Mental Health Planning Council had been working for at least a couple of years on a programmatic framework, specifically that it was going to put into a Master Plan for California, the System of Care. This is how to do it, how to implement it. So unlike other health and social service fields, we as a field had just spent a couple of years thrashing out what we wanted as a System of Care.

HP: All you needed was the money.

CC: All we needed was the money. And, unlike Health and Social Services, both of which had entitlements of various kinds, we had no entitlement, had lost steadily for the previous decade, and had nothing to lose. In addition to that, by that time Sandra Goodwin in Bronzan's office and myself at the Mental Health Directors both kind of had our feet underneath us, and we said, "we can do this. We can take this partial Realignment that the governor is proposing and, using the master plan, take fifty years of mental health law and rewrite it so that it is clear, focused around System of Care, identifies target population, and is a unified whole."

HP: How did the funding relate to these specifics of the law and how the system would look though in the legislation?

CC: There's the proposal and then there were the compromises that got made along the way. Wilson's intention was to provide in '91-'92 the dollar amount that had been provided in '90-'91. So his intention was, "you won't lose by this but you won't gain by this." The draw for mental health directors and the rest of the mental health field is most of the categoricals and bits and pieces of plans and requirements were eliminated. There would be a single pot of money to be spent. The law previously had been pretty open-ended about who the money was to serve. Realignment identified a very specific target population of seriously mentally ill adults, seriously emotionally disturbed children.

HP: Seriously mentally ill meaning Axis I according to the DSM [The American Psychiatric Association's Diagnostic Statistical Manual of Mental Disorders]?

CC: Yes, with functional impairments. This was particularly important for family members, I have to say, who believed that there were too many lightweights in the public mental health system.

HP: The worried well instead of the seriously mentally ill.

CC: Exactly. They were happy with the target population. The other benefit is that it was going to be dedicated money, meaning it would be mental health money. One of the little twists of state law at the time, still a twist of state law, is that if Wilson had simply raised taxes and put it into the State General Fund, 40-something percent of it would have gone to schools. It would have been dedicated to education. If it was put in a separate fund for these Realignment purposes, there was no education carve-out of the money.

HP: But there was still the possibility that it could go to health services or to --

CC: There were a couple of threats, one of them minor and one of them turned out to be major. Unfortunately for the mental health world, In-Home Supportive Services was

part of the mix. A non-negotiable demand by the state is that the state never be on the hook for an entitlement program that it couldn't meet. So the fact that social services in particular, more than health, had entitlement programs in there was a potential threat. If their costs shot through the ceiling, they would have first claim on any growth.

HP: And since this pot of money was available to them, they would have first claim.

CC: They would have first claim on growth. Even in the worst years, the benefit to the county is, "you got a hundred million dollars last year, you're going to get a hundred million dollars next year." The amount of growth is going to be dependent on what is happening in these other programs.

HP: I see. So you're guaranteed the hundred million, but the budget could go three hundred million and we could just give you a hundred million. Right?

CC: Correct. And there were other policy events that affected the Realignment growth and distribution. But the biggest problem, frankly, was In-Home Supportive Services. The legislature said, "we're going to require that In-Home Supportive Services providers become county employees or county contract employees, and that their salary levels be set by negotiated contracts." We [the mental health community] said, "we think that's probably a great idea, but you're doing it with our money. Don't do it with our money." And we were never able to go up against the labor unions who were the advocates for the In-Home Supportive Services change. We basically lost that fight, and it has nibbled away at growth, even in years when there was growth. So we had decent growth for the first -- maybe until about the time I left, which was 2001, I think, or 2002. We had pretty decent growth up until then, but then IHSS [In Home Supportive Services] just cut into it. We also had some bad years because of foster care. All it takes is one bad foster care case in a county and all of a sudden placements in the foster care world go through the overhead, and that pulls up costs.

HP: And the In-Home Supportive Services went up because more people started doing it, because there were more people needing it, or --

CC: Some of that, but also, thanks to legislative action, the pay for In-Home Supportive Services workers went up significantly. They became either contractor employees or county employees. In most cases I think the county --

HP: So it raised the cost of the service.

CC: It raised the cost of the service substantially. The other requirement -- and you'll see if you ever look at the code for Community Mental Health Services, we even had a little shorthand for this. There are some very limited entitlements left in the law. Medi-Cal, the 3632 program, which is for special education kids, and 5150, involuntary treatment. Beyond that, it was made clear that no entitlements were created. The counties were required to provide services in a System of Care "to the extent resources are available." [phrase in the law meaning that it was not an entitlement] And that, frankly --

HP: And that was part of Realignment.

CC: That was part of Realignment. And the drive to be sure that expectations were limited to “to the extent resources are available” had two foundations. The State Department of Finance required that we not set up any circumstance under which the state could be found to have mandated a service that they didn't pay for. And County Boards of Supervisors basically asked the same guarantee, that the law was not describing a perfect world of services with inadequate resources to provide them.

There was some effort in the early years to address the inequitable allocations we talked about earlier. So there was no takeaway from specific counties, but there was a distribution of growth that was tilted toward the counties with greater need. The “under equity” counties would tell you, if you talk to San Diego or Riverside, that there was never enough growth to really make up for their losses, but there was some effort to address equity.

The Mental Health Directors want a robust, adequately funded mental health system based on the System of Care, as do most of their lobbying constituents, their constituents, and their lobbying partners. Boards of Supervisors want ultimately to be sure that this is not a wild raid on their own bottom line, on their County General Fund. The state wanted to be completely protected against any raid on the State General Fund. And it turned out that some elements of Realignment were more complicated than others. For example, counties took over, for the very first time, decision-making about civil commitments in the state hospital [counties also assumed the costs of civil commitments in state hospitals]. And what that required was figuring out for every person under civil commitment in the state hospitals, what county they belonged to.

HP: Wow. So you could have someone in a hospital up north who was from L.A.

CC: That's right. The same issue was true for nursing home level of care, for Institutes for Mental Disease [inpatient facilities for the severely mentally ill]. And a really specific case -- we finally, with respect to the Institutes for Mental Disease, had to have a little mediation team of mental health directors to sort out the last dozen or two clients.

I had a favorite story about one woman who had been in the state hospital in Napa for a long time. She had been living in San Francisco at the point at which she was 5150'd and ultimately placed in Napa. Her family, and hence her conservator, lived in Contra Costa, I think. When we had the mediation about her to try to figure out where her case was going to be assigned, we had her come to the meeting. She had been in a kind of day release program. They had been preparing her to be released from the state hospital, and she had some sort of job outside the hospital and then would go back and sleep there at night. So San Francisco County made their case, and Contra Costa County made their case, and then we said to her, “where do you think you live? Where do you think you belong?” And she stood up from her chair and said, “I'm a registered voter in Napa County.” Well, alrighty, then.

And for mental health directors on the crassest level, the issue was, “okay, for everyone who's released from the state hospital, your base Realignment funding goes up by something like a hundred and twenty-five thousand dollars because that's a full year placement in the state hospital.”

HP: And that's money that's not being spent anymore, so now they can --

CC: Well, it depends. Some of the people in state hospitals stayed in state hospitals, and some of them didn't. And some of them were eighty and some of them were nineteen. So all of that is sort of a calculation. Do I want my base amount to go up by a hundred and twenty-five thousand dollars, but I am going to be responsible for this person's care forever? So it was an interesting process.

HP: And these people are so expensive to provide services for.

CC: Yes. These are the sickest individuals.

HP: So these are huge stakes involved here.

CC: Yes. One of the consequences of Realignment was that -- the number of people in state hospitals had been going down dramatically since the 1950s, by design and by the happenstance of better drugs and better therapies and better treatment modalities. There were about 2,700 people who were in state hospitals through a civil commitment at the time of Realignment, and by no more than -- I'd be surprised if it was even five years, it was down to less than 500. Counties acted aggressively to review the clients and see if there wasn't a better community placement with a System of Care that would meet the needs of a client better.

HP: So it inadvertently created this move towards community care.

CC: Right.

HP: Even though that certainly wasn't the intention.

CC: I have to say it was the intention of the Mental Health Directors. It was the intention of the Mental Health Directors to move this system toward a System of Care.

HP: So this idea that a Village-type program [the Village is an Integrated Service Agency/System of Care provider in Long Beach] is better than a hospital.

CC: Right.

HP: And the idea was to get that funding and be able to provide these services for these folks.

CC: And we think we can, if we have control of that money. One very nice story. A mental health director in San Benito County, which is Hollister --

HP: That's the middle of the state?

CC: Right behind Monterey, inland of Monterey. Had a client that they believed could be adequately treated in the community. The family wanted them in the community, a woman. Napa State Hospital said, "oh no, uh-uh. You're going to be sorry. This person is completely out of control. You don't want to do this." San Benito sent their clinical people up, they did an assessment, they said, "we're movin' her." Napa State Hospital said, "you're going to have to do that against medical advice," and the county ultimately said, "we're doin' it." So they sent a clinician up to pick up this volatile, against-medical-

advice client, and put her in the back of a county cage car. You have to believe that wasn't any fun.

HP: It's like a paddy wagon.

CC: Right. Drive her back from Napa to Hollister and got about half way back and the car stopped by the side of the road. The driver of the car just freaked. "Now what am I going to do? I've got this person in the back of the car, and the car won't work." From the back of the car this woman says, "Well, you know, I've been listening to "Car Talk" [a call-in radio show about automobiles] for four years and I'll tell you what it sounds like to me. I think maybe if you do this maybe the car will start." The guy did whatever she requested, and the car started, and he drove her home. (laughs)

So there were programmatic benefits. There were financial benefits. The other thing that happened is that the funding for mental health programs before then had been subject to action by the legislature every June, or July, or August. So the exact amount of funding was never available.

So for example, one of the things that Alameda County did with their Realignment funding was take a bunch of their state hospital money and over two or three years, established a special inpatient unit for people with organic brain disorders and dementia who could be treated better closer to home. Had a specific program that was targeted around this much narrower set of conditions, because they knew, no matter what, they were going to get that money every year. So they could do long-term planning. They could say, "okay, if it takes us two years to set this up and to move these people in a thoughtful way into the program, we can do it because we've got the money."

The other issue is that instead of eleven categorical programs, the county was responsible for planning for what the public mental health system was going to be in that county.

HP: Right. Because Realignment made it so that when they got the money, they decided what to do with it.

CC: They decided what to do. What part's going for state hospitals, what part is going for Institutes for Mental Disease [institutions], what part is going for community mental health, and where, and in what configuration.

HP: And what that would look like.

CC: Yeah, what that would look like. It always comes down to money, doesn't it?

HP: Was there variation of what they decided to do with it? Did some counties decide, "we're putting a lot of people in the hospital," and then some said, "we're going to go more community based." Were there variations like that?

CC: Well, there probably were, although I would more describe -- now, keep in mind, my job is to be their advocate. My job was for so long to be their advocate that I'm not sure I could do any county bashing, even if I tried. Some counties were slower to implement a comprehensive System of Care, and not all counties chose a System of Care that depended on a contractor like the Village. Some counties did System of Care

programs that were county managed. Some of them were excellent, and some of them stumbled more.

So I would describe it as a matter of speed, rather than if they implemented Systems of Care or not. There's all sorts of factors. Since I retired, I have done much more work with the smaller rural counties than I have with the bigger urban counties. It is more difficult in medium to smaller counties for the mental health director to say, "I'm not taking care of the worried well." One small county that I know of has a higher percentage of clients who are stable, they come in once a month for a med check, but still consume resources and really aren't moving. These are people who may not, in a very tight fiscal climate, be your first choice for the most immediate need. On the other hand, the political consequences in a county where you are going to see your Supervisors at the Safeway over the weekend, to simply say, "okay, this group of people? not serving them anymore," is much more difficult. So it has taken longer. I think, honestly, every county has moved, and some of them have moved significantly.

#### **IV. Medi-Cal Consolidation**

HP: Right. The other thing is the Medi-Cal change that happened in the early nineties. So tell me a little bit about what was it like before, and what was it that happened. What was the change, exactly?

CC: Before the early nineties, there were basically two Medi-Cal programs in California, a fact that the feds [federal government] were never really comfortable with. All Medi-Cal beneficiaries were entitled to receive medically necessary mental health inpatient treatment and a very limited scope of benefits for outpatient mental health treatment if they could find a provider in the larger health world, or if they could find a provider who would accept a modest rate of payment for outpatient care.

In addition to that, I'm not sure I know when, I want to say 1970s maybe, the state received permission that when a county provided a Medi-Cal eligible service to a Medi-Cal eligible beneficiary, they could get the federal match funding. So when that same county got that hundred million dollars, to the extent that they spent thirty million of it on Medi-Cal eligible services, they could get the 50 percent federal match. So their hundred million would change into a hundred and thirty.

In the early nineties, not driven by the mental health world, the state, once again under Pete Wilson, was moving pell-mell to managed care [a type of health plan that focuses on cutting costs more than the public system]. If Wilson had had his way, the entire Medi-Cal program would have been handed over to private health insurers, like Blue Cross, who would run a managed care program for Medi-Cal beneficiaries. The threat was that mental health would be included. Counties were concerned they would lose their capacity to draw down federal dollars.

Some of the impetus for what came to be called Medi-Cal Consolidation also came from consumers and family members who said, basically, "the only people who really get how to deliver services to seriously mentally people are the public system. Blue Cross doesn't get it. They limit benefits. They charge higher co-pays."

HP: And there wasn't real parity [coverage for mental health services on par with those provided for physical health services] then.

CC: And there wasn't real parity then. Most private health plans did a poor job of providing the depth of service that the seriously mentally ill needed. They tended to have "you can come see a clinician once a week. You can come see our MFT [marriage and family therapist] once a week as long as you don't use more than twelve visits in a quarter." And there weren't case managers and there weren't --

HP: None of the System of Care.

CC: None of the System of Care. In addition to that, if you go back to the other example, if the county, on top of everything else, had to take that thirty million dollar match that they were getting out of their budget, it would severely limit services. What the public mental health system was afraid of was that this pell-mell movement toward managed care was going to take our money and our services along with it, to the extent that we were serving Medi-Cal [clients].

HP: And then you'd be subject to the rules of the Blue Cross.

CC: Right. So we proposed -- and this came explicitly out of the Mental Health Directors. This really was our project. First, that the Medi-Cal system for the mentally ill adopt the rehabilitation option rather than the clinic option, which I've already talked about. And that we take the Short-Doyle Medi-Cal System, which was that the counties could use their existing money and draw down a federal match, plus the fee-for-service mental health system, and manage it as a single consolidated mental health system for seriously mentally ill adults and children.

HP: It wasn't consolidated?

CC: It wasn't consolidated before that. There was the fee for service over here, and the county-based Short-Doyle system over there. One clear example of the problem-- once again, I don't remember the numbers anymore, but there was four or five times more inpatient money in fee for service than there was outpatient money. The outpatient benefits were lame, and the number of providers who were willing to provide them almost as lame. So there wasn't very much outpatient treatment in the fee-for-service system. And the other benefit, we believed, from Consolidation, was going to be to make the service much more available and much more community based and outpatient oriented.

It was a stretch for the feds. In 1993 they approved the rehabilitation option. And I've said, the two biggest consequences of that was that it created a much wider range of licensed practitioners and a much wider variety of places where the service could be delivered. We received approval and started to consolidate in 1995, and that required a waiver from the federal government because what it meant for the consumer was that if they needed mental health care that was sufficiently serious that it required a specialist to deliver, they would have to go to the county. So that was a big deal for the feds to move away from any willing provider to "you have to go through the county."

HP: It was a lot more work for the county.

CC: And there was potentially a huge increase in population. It was complicated to define the new program as well, because most mental health care broadly defined is

probably delivered by GPs [general practitioners]. You're depressed because your mother died and you get a tranquilizer from your GP. That's a mental health treatment, but there was no way the county could take that in. The reason it's called specialty mental health is, when the medical necessity is sufficient to require the treatment of a specialist, it would come under the purview of the consolidated mental health treatment plan.

The other thing that was complicated was that counties took a huge risk. And what counties said was, number one, it's county choice. The county can choose to participate or not. What the county would be given was a dollar amount that was based on what the state was spending for the fee for specialty mental health services. And the county was betting that it could manage the entitlement to Medicaid services within that dollar amount plus federal matching funds.

HP: If it couldn't, what would have happened?

CC: If it couldn't, and it couldn't in some cases, although nobody has ever done an audit that documented this and it's probably not anyone's interest especially to do that audit. If it didn't, it was going to have to dip into its Realignment money. There was an open-ended federal authority, so a county could claim 50 percent on anything they spent on eligible services. And initially it was a great deal because under fee for service, hospital services were way more accessible than outpatient [services were]. And the number of Medi-Cal beneficiaries who received care in the years following consolidation shot up, and the amount of outpatient care substantially increased. So the feds were actually happy. Their concern was, "is access constrained by having to go through the county?" And the state and counties were able to show that, in fact, access was improved, and did reports to the feds right along.

Once again, every time you do something with the state it's always about mandates, it's always about entitlements, and we accepted what turned out to be -- who knows whether it was a bad deal or not a bad deal. But the original legislation said it's all at county choice, and the state will continue to give counties the dollar amount that was being spent in their area in '94-'95, adjusted for caseload and medical consumer price index increases at the option of the state.

HP: What did that mean?

CC: Well, what it meant was the minute we got to 2001-2002, the state quit giving -- every time the state got into a fiscal crunch, they said, "you don't need that cost of living increase."

HP: Right. So then that fell on the counties to fund them [the cost of living increases] with their own Realignment dollars.

CC: Yeah. So I would venture to guess that for every county -- the ones I know have seen greater and greater encroachment on their Realignment spending by the Medi-Cal entitlement. And who that's a problem for are the non-Medi-Cal eligible, indigent, seriously mentally ill folks.

HP: For those people Realignment was the only [funding] source.

CC: Right. It's a little more complicated for children. Shortly after consolidation, the state lost a lawsuit that said it was not providing a federally mandated early periodic screening, diagnosis, and treatment service, EPSDT for Medi-Cal eligible children. The state, at the end of the day, signed a consent agreement saying, "you're right. We're not providing EPSDT services." Which basically says a Medi-Cal eligible child is entitled to any reasonable medically necessary service, including services that aren't in the state's plan. And the state was not doing that.

Counties argued successfully, although the state made them do it through the mandate claim process, which took forever and payment took even longer, argued that the EPSDT mandate was not part of the deal at the point of Medi-Cal Consolidation, so any increases in non-federal funds required by EPSDT needed to be funded by the state.

When the state got into trouble in the early 2000s, not only did they quit funding cost of living increases for the base state Medi-Cal contribution, but they also slapped a sharing amount, which I think is 10 percent, on the counties for increases in EPSDT above a certain level. The state's argument was, if all of the costs for EPSDT are shared between the state and the feds, and all the decision-making about who's eligible and what they're eligible for is made by the county, there's no incentive to be cost efficient.

HP: Right. Exactly. Because it's so easy to spend other people's money.

CC: So counties are on the hook for the non-federal share of entitlement costs above what the base funding pays for for adults and a 10 percent match on some of the EPSDT expenditures, program growth above a certain level. One of the things to watch over the future is that notion that this is a county option to participate. Will some counties be forced to withdraw from the program?

HP: When it's actually a mandate?

CC: Well, no, but the costs to consumers and the risk to counties -- there have been counties that have seriously considered handing it back. The problem with handing it back is, the legislation also says if you're Smith County [a hypothetical county] and you say, "you're not funding this adequately, I'm losing my shirt on this, it's yours, you figure out how to deliver services here," that the state will take your base state Medi-Cal funding. They also will take a portion of Realignment that is basically the match for the old Short-Doyle program -- the non-federal share that was associated with it. At the beginning of this, the fee for service part of Medi-Cal Consolidation resulted in a dollar amount of what used to be State General Fund that had been used to draw down a federal match.

In addition to that, counties had the right to claim federal match for dollars that before Realignment they got from the state that was State General Fund, and then after Realignment was Realignment money. But it was used to pull down [federal funds]. So if the county now said, "okay, we're not going to operate this Consolidated program anymore," the state will take the check it's writing out of its own general fund that's associated with the old fee for service, but it also will take some part of Realignment money that's associated with that --

HP: So it's a double whammy then.

CC: It's a double whammy. The couple of times that counties have looked like they were going to get serious about turning it back, the state has said basically, "we're going to take the Realignment money that you're spending today, drawing down federal funds." The counties said, "well, that's not fair. You ought to take a Realignment share that goes back to '94-'95 when you handed the program over and make do with that." The conversation has gotten ugly quickly both times, and none of the counties so far that have considered it have actually done it.

HP: Right. It's a big risk.

CC: It's a big risk. And the other risk is that if you're sitting on the Board of Supervisors, you're responsible for public health and safety, and now you're turning over the management of the sickest mentally ill patients to Blue Cross, or whoever. Or to some distant bureaucrat in Sacramento if they decide to run it directly. I can't believe they would.

So from the Mental Health Directors' point of view, even if you set aside the money, and even if the money came out even, it would really bend and maybe break the capacity to deliver public mental health services.

HP: Right. And to have control over how you deliver them.

CC: Right. So it has been complicated. Now, unfortunately, as the state gets broker and broker and less functional, the threat is that a county will decide that it really just can't meet that Medicaid mandate which is medically necessary in specialty care, that they can't meet it even if they threw all their Realignment money into the hopper. And that they have to give it back because they can't manage, and they're going bankrupt anyway on the side because they're not getting enough tax money.

HP: The Realignment money is going down anyway.

CC: The Realignment money is going down. I thought the collision was coming sooner. MHSA [the 2004 Mental Health Services Act, which provided a new revenue stream for public mental health] has frankly given a new base to county mental health, and it doesn't seem like there are threats from any board today.

HP: You never know.

CC: You never know.

## **V. AB 34; The Mental Health Services Act**

HP: Okay. I'd like to talk about AB 34 [1999 California Assembly Bill 34, which expanded integrated service agency programs], MHSA, and then a couple of general wrap-up questions. The AB 34 and the AB 2034 programs [2000 Assembly Bill 2034 expanded the AB 34 programs], how did you see those when they came about?

CC: You know they were variations on the System of Care [the idea of providing integrated services for consumers] theme, it seemed like, targeted to the homeless. What they did that we seemed collectively unable to do up until then is develop a simple

understandable reporting system so that politicians and community members said, "I get it! I put this money in and here's what I got."

HP: They actually came up with concrete data.

CC: Yeah.

HP: Showing this is a good investment.

CC: And [not producing] understandable data is, frankly, probably one of the bigger failures of the public mental health system. I felt like we worked on evaluation and accountability my whole period of time, and each product was less clear and less self-evident than the one before, until AB 34. That may be my own particular take on it. I thought there were two real two significances [to the AB 34 program]. The target population, of homeless mentally ill persons, was one that every community in the state finds annoying or troublesome, and the program is reported in a way that every newspaper editor in the state could say, "okay, I get that. Worth the money." So here, here! It was a good model, and a part of the good model was the capacity to deliver a public statement.

HP: To show that it's a good model.

CC: Yes.

HP: I guess that kind of moves naturally into the Mental Health Services Act.

CC: Mm-hmm.

HP: You were no longer with the Mental Health Directors Association at that point, but you still remained involved in the field?

CC: When I left the Mental Health Directors, I went back to the legislature for two years, frankly for retirement plan purposes. I worked for Senate Budget [the California State Senate Budget Committee], but I didn't do mental health. Somebody with a long history in mental health who works for Senate Budget continued to cover mental health, number one. And number two, they felt like it was potentially a conflict [of interest] anyway, for me to go directly from representing counties to doing mental health. So I did other stuff -- welfare, other human services stuff.

I then left after two years and retired, and it was about the time that MHSA passed. I have done some work for the California Institute for Mental Health and a handful of rural counties, helping them write their MHSA plans and do their community outreach. So I have a narrower slice of the picture, and mostly rural. I've done principally small counties. And that's coming to an end too, frankly. I don't keep in touch enough now, which means I'm probably dangerous, as I drift away. I don't go to the meetings, I don't read the bills, I don't follow the regs [regulations]. I'm about done. I still have a couple of contracts that I'm really winding down. So I know a little bit about MHSA.

HP: What are your impressions of it, in terms of (a) what it was like, the build-up towards it, and then (b) also what's been good about it and what hasn't been so good about it.

CC: It has turned out to be a surprisingly robust and enduring pot of money, and isn't that good news!

HP: Thank goodness.

CC: It came in at what was probably the right time. Counties really were able, for the first time, to build new programs. Realignment, after all, didn't add new money. In fact, the first year of Realignment, because of the difference between the estimate on which Realignment was based and what had happened to revenues by July 1<sup>st</sup>, counties got handed seven hundred and fifty million dollars worth of programs and got [only] about six hundred and seventy five million dollars worth of cash [to operate those programs]. And it took like two or three years to catch up, with Realignment revenues to the base.

And, as I said, while counties have been able to draw down more federal funds, Medi-Cal generally, in the last four or five years, seven years, hasn't kept pace with inflation. So even though there was a drive to do System of Care, a drive to implement programs that were modeled on AB 34, the new resources to do that were missing. And MHSA, because of when it happened, provided money that counties could and did use to implement new services, and meet unfilled needs that they had identified. It has been particularly powerful I think in terms of integrating consumers and family members in the planning and operation of public mental health programs. So it's been great. It's made a huge difference all sorts of places.

HP: What are some of the differences it's made in terms of the budgets, and also the services offered?

CC: The counties that I know tend to be counties that, for example, don't have contractors or private nonprofits who are able to do AB 377, AB 3777, AB 34 kinds of services, so it's often county staff that form these treatment teams. But they have been able to set up small caseload treatment teams for the sickest clients. Most counties have made major strides toward taking people out of Institutes for Mental Disease far away and moving them into intensive treatment programs back home. In some cases where they do use contractors, for example, they've taken board and care homes and beefed them up with a more comprehensive program and case managers.

They've been able to establish new services in ethnic or geographic communities that were unserved before. So Modoc County, for example, has hired a Spanish-speaking young woman who's a social worker who now goes up once a week to Tulelake, which is the back of beyond [very rural], and it's an agricultural area. [She] provides treatment every week to a Hispanic community that had never seen treatment before.

HP: And that's amazing that there were no services like that there before.

CC: It's little, it's far away from anyplace, it's right on the border between two counties, and under MHSA the two counties pooled their money and are doing intensive treatment services in that part of the world.

HP: So really geographic expansion.

CC: Geographic expansion and ethnic expansion. The number of consumer-run Wellness Centers has just blossomed. I'm assuming that's true in urban areas, too. I know for certain that it has in rural areas, that they've set up consumer-run, peer support, and Wellness Centers that have made a remarkable difference, and a remarkable difference in the management of the program as well. The consumers have a place to kind of consolidate their influence on the design and management of the treatment system.

HP: So it's kind of an incubator for advocacy.

CC: Right.

HP: From a clinical perspective -- I know you mentioned you're not a clinician, but what is the importance of consumer input and peer-to-peer and consumer-run services?

CC: Across the board in healthcare it's become clear that people don't benefit from services where they don't buy into the goals. And because of the nature of mental illness, the consumers had been the last people to be consulted about how to design services so they well and truly meet their needs. It's also true that consumers and family members both have been very aggressive for the last fifteen years about saying, "we want to be a part of figuring out how to do this." The alcohol and drug field, for example, has for a much longer period of time understood that peers can talk to peers often much more effectively than --

HP: Than a professional.

CC: Than a professional.

HP: So like the AA model versus going to a professional counselor who went to graduate school.

CC: And, ideally, what you get with a peer support center is both. What you get from a peer support center is good clinical assessment, good case management, and peer support. And peer support is, at its simplest level, as in Wellness Centers, cheaper, often more effective, often more comprehensive. So you'll call a peer and say, "I'm really in trouble today. This is the anniversary of my last hospitalization," or whatever, whatever the reason. "I'm in trouble today, I really need a little help," at nine-thirty on a Friday is a whole different issue than getting your doctor.

HP: Getting an appointment to see your therapist.

CC: Yeah. I don't know if that's the most comprehensive, but it's been a really effective way to broaden the scope of services, particularly for the non-medical parts of treatment. It's much easier for peer centers to identify and manage access to housing and employment services, too, than clinical centers. And usually more effective, and probably cheaper.

I guess the other big area of MHSA-driven change is the collaborative area. In the counties that I know, for example, the prevention [Prevention and Early Intervention] money in particular provided a real impetus to get together the schools, the public health departments, alcohol and drug programs, and say, "huh, here's what we want to do as a

community. We'll put in MHSA money, what about you? Maybe you can put in some of your Safe Schools money--"

HP: -- on our side.

CC: Yeah.

HP: So really making it a societal thing as much as departmental thing.

CC: Exactly. That's been effective and remarkable.

A quick answer to what didn't work so well. The state, at the beginning -- you know, you do just want to move toward the word "blockhead" at some point. I think there was a certain kind of institutional resentment of the extent to which Realignment, and [Medi-Cal] Consolidation for that matter, had moved planning, management, and delivery of services to the county level.

HP: Resentment on the part of State DMH?

CC: State DMH. Their initial out-of-the-box planning processes [for the MHSA] were incredibly complicated, time-consuming, unnecessary, non-trusting. So counties wrote hundreds of pages of planning, and then they handed it over to somebody who was hired at the State Department [of Mental Health] the week before last, who waded their way through it and sent it back and sent it back. Once again, my lens on this has been primarily small counties, but there was Modoc County, which is where Tulelake is -- Tulelake actually is right on the border with Siskiyou [County] -- but Modoc County has six clinical staff, including the director.

HP: In the entire county?

CC: In the entire county.

HP: Wow.

CC: And about ten thousand people. So asking them to answer the same questions that L.A. answered? Give me a break. Give me a break. It was complicated. Their review process was complicated.

HP: Was it necessary in order to make sure the money was spent the way it was intended, though? Or not really?

CC: Well, from my point of view, how would they know?

HP: What do you mean?

CC: From my point of view, do you think those program analysts in Sacramento reading those plans know how it's going to be spent? Do I think there ought to be some review and some accountability? Absolutely. [But] it was way overdone, in my judgment. It was way too paper dependent. The state provided very little in the way of technical assistance or help. They simply threw out requirements for these huge complicated plans.

To a certain extent, it's still going on. I just wrote for Modoc County, because they only have six staff, their plan update for next year, the rules for which came out in February maybe, with the statement that if you really want your money to start July 1st, you have to get it in by about mid-April. Most of the way through March, after we had already written the plan update and already taken it to the stakeholders for review. And then the state said "oh, you know, we made some mistakes in format and questions in our plan update. Here are the new rules for the plan update."

HP: Redo it. And it becomes so much more difficult that with everything you do you have to run it by stakeholders. It just adds so many layers and delays.

CC: And I'm sure it translates elsewhere as well. I'm sure it translates into big counties, too. But the last time I went to the Modoc County stakeholders, they basically grabbed me by the shirt front and said, "how many times are you going to ask us the same question anyway? Weren't you here last year asking us the same question? Stop it! We don't want to come! We can't come to a meeting! We see each other every day anyway! The alcohol and drug program director's office is next to the mental health director's office, the school folks drop in there three times a day. They're just right across the street. And you want us to have a meeting so we can tell you that we agree with this? Get a grip!"

HP: So the stakeholder process has been a little too onerous.

CC: I don't want to back away from the fact that the collaborative requirements have been important. The documentation for it has been onerous. And I have to believe that there was a better, smarter way to be sure that it [MHSA money] was being spent on stuff you wanted it spent on, without requiring that people write *War and Peace* annually in order to prove it.

So it's been frustrating. I think that the governance -- the Oversight and Accountability Commission [the Mental Health Services Oversight and Accountability Commission, established under the MHSA] has taken a really long time to get organized and efficient. And the fact that there was complete separation between the Planning Council, which was the consumer-family-stakeholder body, has been separated from the Oversight and Accountability Commission. There had to be a way that was less onerous, and less painful to watch, to put the governance together.

I don't think the people who wrote the initiative were particularly focused on governance, they were focused on the political issue -- which was writing something in the initiative that said to the public, "you're going to know whether you got what you're paying for." That's important, but boy, it's been painful and time consuming, and more money on moving paper back and forth.

HP: That could be going to services.

CC: That could be going to services. All the money that Modoc County -- which I hasten to add is not huge sums, but all the money they've spent on me [to assist in the writing of MHSA plans] --

HP: Uh-huh. That could be going to [services] --

CC: Why are we doing it?

HP: Right. That's interesting.

CC: Why are we doing it?

HP: Yeah. In a place like L.A. it would be a little different, but I can see in the smaller counties that definitely --

CC: But I also have to believe that there is a simpler way to tell where the money's being spent in L.A. for that matter, than these huge plans. I couldn't lift the first MHSA plan from L.A. Have you ever seen it? It's like a doorstop. There has to be a simpler way. And I think, for that matter, L.A. County's current leadership is top of the line. It's hard for me to believe that the plan reviewers in Sacramento are smarter about what L.A. wants and needs than the people in L.A. There has to be some way to take the AB 34 experience of simple, credible numbers and use that as your checkpoint. When it goes awry, if you find that Modoc County isn't serving any Hispanic folks, then you're in trouble. Somebody needs to fix something. But if they are --

HP: But until it's broke, don't fix it.

CC: Yeah. It would be smarter to butt out. And I think the same thing is true in L.A., that there's ways to figure out.

I also think there's always an interesting pressure, and I have a local bias and it's not the only point of view, but I think that often those requirements for plans are constructed by Sacramento-based lobbyists whose power and interest group comes from a state level review. That's quite a different thing from an honest stakeholder effort at the local level.

We organized at the end of the eighties, as we were losing our shirt, these huge rallies at which hundreds of people would ring the capitol. Those are enormously expensive to organize, and you don't, at the end of the day, get locally targeted input. But there's a whole cadre of people, probably me included, at the Sacramento level who think they're smarter than the locals and want to know. We need to know what kind of housing programs those counties are planning. [But] why?

HP: As long as they're getting people housed. It's interesting hearing it from this point of view, with the story you told about Realignment, and then adding this, viewing it as a tug of war between county and state.

CC: Absolutely. Absolutely. I think it was — and still is.

HP: Even if it wasn't originally written to do that, that's been the result.

CC: That's been the result.

HP: Right. Interesting.

CC: The state is coming some way back, although they're still not very good. There's been some drawing back of this huge plan writing system that went into place. And I

would be the last person to say anything mean about the money. It's made a huge difference and it's made a difference at the absolute community level on the ground.

HP: Particularly with what's been happening to Realignment money lately [due to the economic downturn, Realignment funds had decreased dramatically].

CC: That's actually probably the challenge, and thankfully there's some young whipper-snapper who's going to help figure this out. It won't be me, but –

The other weakness in MHSA at the beginning was this effort to draw a line that says “this is not for existing programs. This is for new programs.” That's nonsense. All the programs ought to be run in a responsible way, especially given the other cutbacks. It doesn't make any sense at all to say, “huh, you got here on a Thursday, so you get the gold-plated program, and you were here month-before-last, before we got the MHSA money, so you get the really crappy program.” The mantra of the small counties are one plan, one audit.

HP: So the idea of the integrated plan --

CC: It needs to be integrated --

HP: And integration of MHSA in non-MHSA, or integration within MHSA programs themselves?

CC: Integrated between MHSA and non-MHSA. Although I don't think this is intellectually consistent, I don't think it's a bad idea to keep, for example, the prevention money separate, to just permit that. It's so hard to maintain prevention when your base services are going down the tubes, but having the state be the cop in that regard is helpful. So I'm not sure I would collapse all the boundaries within MHSA, but I certainly would say if you can make a credible case that you can run your entire program like an MHSA program, do it. Quit fooling around. Do it. Don't keep this separate. And don't create a system at the local level where you've got the golden programs and the ones that are dying on the vine. That's not healthy for anyone, least of all the mentally ill.

## **VI. Contracted and Directly-Operated Services; Concluding Thoughts on the State of California's Public Mental Health System**

HP: Okay. I know we need to wrap up, so I'm going to ask two more questions, even though I would love to ask some more. One is, your thoughts, as someone who's worked with a lot of directors everywhere, on contract service providers versus directly operated county-run service providers. What are the advantages of each in terms of service delivery? Is one better than the other, or is a balanced system healthier? What are your views on that?

CC: Oh, interesting. At the end of the day, there are really good directly county operated services and really good contract operated services. I'm not sure I think a statewide rule is helpful. And I have a personal political response to it that I'm not sure has anything to do with quality -- every publicly operated program that I know about also has a union base for its employees, which means the people who are actually working in the program have negotiating authority, salary, and benefits. And I wish that were true

of every contract agency. It isn't, and I think better services are delivered by people whose workers are solidly based, and typically that means unionized.

I feel like often, not always but often, the move to contract services is, "well shoot, we can get that little nonprofit over there that pays twelve dollars an hour as opposed to twenty, and no benefits, and boy, won't that be cheap." I think that we've watched a world where decent working jobs are disappearing. I hate that.

If that issue were set aside, if contract agencies were fair to their workers and supported their workers, there's a kind of flexibility in contract work that is often helpful, often allows you to be more adaptive. When I talked earlier about the fact that it took a long time for some counties to implement new treatment methodologies, and you can use a contract system to do that by changing your contractor, if nothing else. Or making it a part of your contract demand.

I think there is a line of thinking by some mental health directors, which I have some respect for, which says public agencies ought to only do those things that the private agencies can't do. Some of the linking with other agencies, some of the collaborating with other agencies, some of the contract management have to be kept within the public sphere.

I do have one really firm belief. I think when it comes to the planning and managing, evaluating, and auditing, I'm much more comfortable with a public entity doing that. I think it's a little harder to see this from L.A., but in every other county in the state it's a lot easier to get down to the Board of Supervisors. They're there every Tuesday, they're accessible, and they're incredibly responsive. If County A is not taking care of their 5150 responsibilities, the first people to know it are going to be the Supervisors. It is going to take forever and a day for some state bureaucrat to know that, or even a state legislator. And the private nonprofit which may not have an accessible open board — some do, some don't -- they never know. I really think there's a level of activity that has to take place at the local level.

[As for] service delivery? I'm probably agnostic, except I do have a preference for paying people decently, giving them negotiating rights and good benefits.

HP: And belief that that will also lead to better service as well.

CC: Absolutely.

HP: Finally, looking at the public mental health system now, what are you optimistic about, what are you worried about?

CC: I'm optimistic about the fact that during my time in mental health, the science has gotten progressively better. The drugs are better, the treatment methodologies are better, and the understanding of the complicated role that clients' own needs and wants play in a successful program has gotten consistently better. I think we take care of people better today than we did even twenty years ago. I know for certain we take better care than we did thirty, forty, fifty years ago. I'm optimistic about that.

I'm optimistic about public education. I think that increasingly people are willing to talk about mental illness, cop to the fact that there's always a mentally ill person in every

family, and that more and more people are knowledgeable about the strengths and challenges and opportunities in mental health treatment.

I am pretty pessimistic about political decision-making at the California state government level. It is a disaster at the moment. It's completely dysfunctional. And I despair at the level of civil discourse. Neither one of those are unique to the mental health field, but they really hamper the ability to fund and deliver public services. There's one thing I think MHSA proved. It's that if you ask the simple question of most Californians, "are you willing to be taxed to provide better care for people who are sick through no fault of their own, or even maybe a little bit of fault of their own, but are really sick?" The answer is, "you bet. I'm willing to do that." I'm dismayed at the fact that we don't have a political system that can acknowledge that and react to it, and I feel like the level of political discourse, especially in the recent past with the [national] healthcare debate. It has been driven by this notion of "my generation has its Social Security, the hell with your generation. Not one tax dollar, I don't trust government, and I'm not even going to be civil about the discussion." I'm pretty despairing about the state of discourse.

HP: And the implications that it would have for mental health and for governance in general?

CC: Yes. How will we ever sort out a decent level of funding if we can't talk honestly about being communally responsible for taxes for a public good? Why can't we do this? If it's controversial to cover the uninsured, we're doomed. Or at least in danger.

HP: Right. Okay. Well, anything else you'd like to add?

CC: I don't think so, except I enjoyed it.

HP: Me too. Thank you so much.