

Dr. Stephen Mayberg discusses the importance of having a strong grass roots mental health community in California

I never thought I would stay at the Department very long. I mean the average stay as a state mental health director in the U.S. is two years. So I didn't think I'd stay very long both because of state history and national trends. One of the things that someone said to me was "if you're going to make changes don't leave footprints in the sand. Try and build something that will last, because when the tide comes in, the footprints are gone--whether it's legislation, whether it's regulations, whether it's some kind of infrastructure do something tangible." So my belief really was that if you can move the locus of control from one person at the State or one person at the County to the community, to the grass roots—to really build up grass roots support for system change—you can build an informal bureaucracy that ensures that the system goes forward no matter who's there. And so by building up an educated and an informed group of clients, family members, providers, Counties, advocates—you end up having a lot more people being able to speak articulately at all levels. This is not just testifying at the legislature, or the Board of Supervisors, or Mental Health Advisory Board meetings, this is anyplace where you start to have informed and vibrant discussions about the potential of the mental health system. California has brilliant people in it. There are a lot of brilliant ideas, and so giving people a forum to at least share some of those ideas or visions—even if it's before their time or it's a little out there—at least it's percolating, it stimulates some other kind of thought. And so the more people that were engaged, and understood, and bought into it, the more the likelihood of success of moving forward was.

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ORAL HISTORY INTERVIEW WITH DR. STEPHEN MAYBERG

INTERVIEWER: Howard Padwa

I. Early Career; Experience in Yolo County; Experiments with Alternatives to Hospitalization; The Need for Innovation; Early Involvement in State Mental Health Policy

HP: So this is Howard Padwa here with Dr. Stephen Mayberg from the California Department of Mental Health doing an oral history interview for the LADMH 50th anniversary project. So for starters Dr. Mayberg, can you just tell me a little bit about your background and how you got into mental health?

SM: Good question because I ended up not where I ever expected to be. So going back to the beginning I always wanted to be in mental health and educationally I went to Yale, then the University of Minnesota. I didn't want to do a traditional clinical practice and started looking for other types of opportunities for internships. I looked at programs where they were doing community work.

HP: What was it about the community work that—

SM: Well, even in my early 20's I didn't believe that an hour a week in a closed office would make as much difference without the involvement of the other significant factors in the individual's life. I worked with kids and families mostly. I was especially interested in adolescents so I definitely believed I wanted to look into community mental health. When I was at Yale, some of the professors there were doing community mental health and that's where I first got an interest.

HP: Who were the people you were working with?

SM: [Jerome] Kagan.¹ Way back when. And so I had no idea it would influence me the way it did. When I was finishing my graduate coursework, I knew I didn't want to stay in the Midwest because not only was cold (it was 20 below zero the day I left) but because the focus of treatment there was more on traditional practices. So I chose to do my internship at UC Davis. But because I was on a NIMH [National Institute of Mental Health] fellowship, I really couldn't afford to live in California on that stipend. So I had to have a part time job, and I got a one day a week job in community mental health, with the Yolo County mental health program.

HP: Okay.

SM: And so that one day a week placement evolved into working in Yolo County, while still working on my dissertation, commuting back and forth. I ended up

¹ Jerome Kagan was one of the pioneers of developmental psychology, and published groundbreaking work on childrens' cognitive and emotional development.

finishing my dissertation at University of Minnesota and being offered a job at Yolo County Mental Health doing children's services, which I liked doing.

HP: Okay, are you a psychiatrist?

SM: Psychologist. Psychologist by training, which fit in because I really liked working with probation, social services, education, part of understanding systems. Doing family therapy was really a good fit, and I enjoyed doing that. The unfortunate part about working in the mental health system is that promotions aren't based on clinical skills really—they are based on assuming more administrative responsibility. So I became the head of the children's service there, and then I became the Deputy Director there, and then eventually I became the Director of Mental Health for Yolo County. I thought that was where I wanted to stay, and it was a good job, and I was enjoying doing both clinical practice and administration..

SM: While in Yolo County I was involved in State issues, testifying because I was close [to Sacramento] and a lot of times when counties needed someone to be there [speaking before the legislature or committees in Sacramento], they would ask me "could you go?" It was half an hour across the river to testify, as opposed to flying up from LA, or taking a whole day [to travel]. So it was really through that process and experience that I began to understand State issues and County issues.

HP: Being involved at the local level and then also the State level.

SM: But most importantly working with other systems. I mean I still believe that mental health has always been too insular. Insular in the sense of therapy being in kind of that "black box"—people not even knowing what goes on in a session and how "it works". You go for a 50 minute session and trust that the mental health visit will resolve the problems entirely but that doesn't work as well with everyone as it could.. People are part of a community—they're not alone in dealing with and resolving their problems. So it was a great opportunity to have some sort of bully pulpit to push some of those issues of collaboration and cooperation.

HP: Doing these things in the State.

SM: And the County.

HP: I realize that every county is different, but in Yolo County what did mental health services look like at that time when you first came?

SM: It [Yolo County] was actually probably the primary provider. There were children's services, there were adult services, there were crisis services, there were hospital services, and medication services. [Back] then we called it "continuing care." It was really for the folks who would probably [be] members of the Full Service Partnerships [FSPs]² now.

² Full Service Partnerships (FSPs) are intensive community-based wraparound recovery-oriented services for severely and persistently mentally ill residents of California.

- HP: Okay, so it was a population that had more severe problems.
- SM: The population served had symptoms that were more severe, with priority being on more severe and difficult to serve [cases]. But being a small county you dealt with whoever you dealt with. And so the services were fairly wide ranging, and I think pretty innovative in the sense that some of the early community programs as alternatives to hospital programs were in Yolo County. The non-medical model alternatives had a start there.
- HP: Tell me a little bit about that. Because if we're talking the early 1980's this really ahead of the game.
- SM: Oh, it was, it was. It was way ahead of the game. One of the things we looked at was that people ended up kind of recycling through the hospital. Was that the best place? It was really expensive, but small Counties don't have a lot of money.
- HP: Is that how you came to the issue looking at this question? Looking at things financially?
- SM: Well, I think it started out as a humanitarian thing, but it was also a financial thing really, in the sense of hospital services were very expensive, and very medically oriented. There was really that disconnect in the 1980s between the medical model and the social model, and [we were] looking to see if there was a way to bridge some of that. So we started looking at non-hospital alternatives, and then started looking at things like mobile crisis—where we would have clinicians paired with the on call psychiatrist to see people before they were brought to the emergency room, or see them in the emergency rooms. That was pretty innovative for the time.
- HP: How did you come up with these ideas? Did you do a scan of what other people out there were doing? Or did you sit down and think about it?
- SM: I think partly that. There was a really active Mental Health Association³ there [in Yolo County]. Davis is a small town, and it's a university town, and so there's a lot of psychologists, psychiatrists there—a lot of mental health professionals who wanted to try and innovate. And it is always easier to innovate on a small scale than on a bigger scale, so you could take some of these risks as it were. And [we had] a Board of Supervisors that was pretty supportive of mental health issues. So it didn't work in the sense of saying that we invented any of this. I think innovation really tends to be much more of an extension of someone else's doing something.
- HP: Right.
- SM: So I think it was an extension of some of the other programs that were going on in other parts of the country. I think the mobile crisis issue was a good example—just looking at how many people ended up in the hospital that maybe didn't need to be there because it was 11:00 o'clock at night, 2:00 o'clock in the morning, and the doctor just said "put them in overnight we'll see them in the morning."

³ The Mental Health Association, currently known as Mental Health America, is a national organization that advocates to improve access to quality behavioral health services.

And with the cost of a hospitalization, if you could come up with an alternative that saves you a lot of bed days—

HP: Back then how much did a hospital stay cost versus a regular outpatient visit?

SM: Well, an outpatient visit was probably \$40, \$30 and a hospital bed was probably \$300—so ten times as much or something like that. And you're talking about an era when clinicians were \$25,000 [in salary per year]. So what you're talking about is if you can avoid \$3,000 hospital stays, reducing ten of those stays pays for a clinician.

HP: So you mentioned a lot about the more chronic and severe cases. How about for people of lower levels of acuity were they served in the public system as well?

SM: They were served, too. More often than not those were kids and it was through working with probation, working with the welfare department, social services, working with education that referrals were made and early identification and intervention occurred.

SM: And it [County Mental Health] actually was also one of the only places for mental health services in town, especially for people who were low or moderate or no income individuals. I mean you if couldn't afford to go to see a private practitioner [nothing was available], and so there was a lot of push for services for that population. The people who entered the system were usually coming in based on a crisis or some kind of emergency—an arrest, a suicide attempt, getting expelled from school or whatever it was—there was [usually] a precipitating incident. It usually wasn't someone calling up and saying "well I'm really worried about—I'm having trouble with my children and we're having some marital problems so could we get some marriage counseling and family counseling." It didn't work that way, it didn't reach that threshold. But the people who had an acute or precipitating incident ended up being able to get services in the County system to some degree even if they were not chronically ill or persons with serious mental illness..

HP: Now when you were doing these kind of innovative programs, what was the nature of the relationship between the State and Counties at that time? Was it difficult in terms of state oversight or funding?

SM: Well, the state would give grants, so their were grant programs available. And if you were willing to do the grants, that was a great opportunity for program growth. It was really in the era before there was such a heavy reliance on Medi-Cal, and so there was a lot more flexibility. There weren't as many rules and regulations that come along with federal participation, so depending on who you were working with at the State, there was interest and some support sometimes. What the State appeared to be looking at in a more global sense was [addressing question such as] do people have access to service, do you have emergency services, medication, at least some degree of the bare minimum. Are you doing the appropriate charting, are you doing utilization reviews?

HP: That's what the State was interested in.

- SM: Right, sort of the technical part, not the programmatic part. They weren't as concerned about program development.
- HP: And in your experience, was that a good thing that they weren't interested in the program development and kind of let it be at the local level? Or was leadership needed?
- SM: Both. I think it always continues to be a tension between Counties and State, the fine line between leadership and program development and monitoring and control. And so when you're a control agency you are looking at "did you fill out the charts right, is your paperwork perfect, do you have policies and procedures for everything and the right number of square feet"; which is very different from "is this an innovative program, are people getting better, are people being served." Those are harder things to measure, so I think the State has to play a role in terms of promoting innovation and change through leadership, but it also by statute [it] has to be the command and control and do reviews.
- HP: Yeah, they have to kind of fill that auditing role and things like that.
- SM: Right.
- HP: Now one thing just when I was doing a little reading up, I found mention that before you came to the State Department of Mental Health, you were somewhat critical of it.
- SM: That's very true. I wasn't somewhat critical—I was very critical.
- HP: Okay. Well tell me what were some of the issues at the State level?
- SM: Well one, there was a lack of continuity. Before I came there were 14 directors in 20 years, and so there was no real direction or policy or vision. Secondly,, I was critical that the focus had always been much more on the State hospital and less on community programs. The directors and staffing [at State DMH] came out of the State hospital and State system, and I believed that it was the wrong emphasis. If we were looking at alternatives to hospitalization locally, [I believed] we really should be looking at the State hospital as a dinosaur, and [we] should look for alternatives to the State hospital. Can we develop community programs as alternatives to State hospitals?
- HP: But the people who were working at the State were more products of that dinosaur.
- SM: Additionally, that was where the funding was. The majority of the funding and emphasis was in the State hospital system. There was really a laissez faire attitude towards the Counties in some instances, unless they [State DMH] came down and were sort of heavy handed being auditors. There really was not a passionate dialogue. And so the criticism was really not that the State was doing something wrong, it was that they could do something better.
- HP: They could do something more.
- SM: Right.

HP: When you say it was mostly—most of the state funding was going to the state hospitals, what was the proportion roughly was it 80%, 60%?

SM: Um, it's—well, let's figure it out. That the state hospitals even though the money came from the Counties had probably 4,000 people in them at that time at \$100,000 a year per bed. So you had the majority of—so I don't know I'd say 50% maybe something like that.

HP So half of the funds going to a very small portion of the population's need.

SM: Right.

HP: Now also this was pre-realignment⁴ we're talking about.

SM: I came in right after the realignment. I had been an advocate for realignment because the other thing that really was frustrating was in terms of advocating for money was that community local mental health programs were the largest non-entitled, non-mandated program on the general fund chopping block.

HP: Um hum.

SM: And so while Counties could advocate for that [community based programs] it didn't always mean that the State advocated for that. The State hospitals always got funded, but in the year before realignment there was a \$60 million cut in community mental health.

HP: \$60 million out of how much?

SM: It was probably 10%.

HP: Wow.

SM: A 10% cut. That was a big cut and it served as an impetus to consider realignment, because at least realignment stabilized the funding. In terms of history what's really fascinating to me is that insecurity—I wouldn't say insecurity, but to some degree the uncertainty of what the funding was going to be—stopped Counties from realistically taking risks to start new programs, because there was no guarantee of what funds would be available the next year. It's always hard to start a program and then say "oh, the funding's cut." And usually the last program that's been started is the first one to be cut. So there was a reluctance to innovate, because you just didn't know whether you were going to be consistently funded or not in subsequent years. So other than the categorical funding, if you didn't have a grant to do something, I think fiscal instability contributed partially to lack of program change and growth. Additionally, the other thing that was probably even more dramatic was the fact that as California was going through really rapid population growth, but the funding wasn't increasing. So those Counties that had big population growth had proportionately less money available for services per capita.

HP: When the State distributed funds pre-realignment was it set on a formula that was outdated?

⁴ Realignment refers to the 1991 Bronzan-Wright-McCorquodale realignment Act of 1991, which gave California counties more control over resources to fund their public mental health systems.

SM: Well yes, it was an outdated formula. And then with no new money there wasn't redistribution. You probably have heard the reference to "the equity wars."

HP: Umm, can you explain that?

SM: So some Counties had more money and were innovative and had rich programs, and some Counties had really hardly anything to work with—especially those counties that were rapidly growing or were underfunded to begin with. If you had been an early implementer of programs when there was money, or if you had had grant funds or something like that, you tended to have a higher per capita base than counties who had been more cautious.

HP: Um hum, right. How was the base determined?

SM: Well initially it was determined by population and poverty. That was the original mechanism for determining the base. That and County interest, really. There were times early on when there was a fair amount of mental health money, and whether Counties participated or not really had to do with whether the community was interested in mental health programs or not.

HP: If individual Counties were interested.

SM: Right. If they had the wherewithal to go for a grant or convince their Board [of Supervisors] to do something like this, or if they had the resources to. And by resources I don't mean just the money—I mean both the clinical resources and the intellectual resources to be able to figure out how to do something different.

II. Realignment; Creation of the California Mental Health Directors Association; Relationship between State and County Departments of Mental Health; Assembly Bill 3632; Assembly Bill 3777; Difference Between Directly Operated and Contracted Services; On Outcome Measurement

HP: So you mentioned that you were part of the movement towards realignment. Tell me a little bit, was that a campaign was it lobbying—how did it happen and what was your role?

SM: Well, it actually I think was a campaign. I think the idea came out of a variety of sources and certainly was shepherded through the legislature by a lot of meetings that brought all the constituents together. [There was] sort of an agreement to have everybody had to put aside their vested and provincial interests and to look at what would be better in terms of the big picture.

HP: Who were the players at the time and what were their interests?

SM: Well, I think there was the Mental Health Coalition was a big player in that. Sandra Goodwin⁵ was the point person in the legislature at that time and working through a lot of the issues and so—

HP: Mental Health Coalition being...

⁵ Sandra Naylor Goodwin the founder and executive director of the California Institute of Mental Health.

SM: The Counties, the providers, the trade organizations like NASW [National Association of Social Workers], CPA [California Psychiatric Association], advocates like NAMI [National Alliance on Mental Illness]—all of them. And the Coalition is still active.

HP: Okay.

SM: They were able to put aside their provincialism and moved to say “we’ve all got to agree do something” because that was one way that the legislature could not justify this lack of funding. [In the past] there was seldom any agreement about what to do; even Counties would fight with each other about who got how much money, contractors fought with Counties, the professional disciplines fought with each other. When there was that kind of partnership and coalition of coming together and saying “let’s look at what’s really good for the mental health system, not just good for me as an individual, me as a County, me as a provider,” the system really began taking off.

HP: That’s interesting. That must have been very difficult to pull together.

SM: I think it was to some degree but on the other hand most change really has a lot to do with the zeitgeist, the spirit of the times.. And then there were strong and charismatic leaders who could be passionate about saying “let’s try and do this together.”

SM: Interestingly enough, I was president of Conference of Local Mental Health Directors, then I became the first president of California Mental Health Directors Association. So I was the person who was on the transition from the old to the new, and was involved with some of that executive group that did a lot of that planning, negotiating, and shepherding the legislation though..

HP: Well, what was the transition? Before it was CMHDA [the California Mental Health Directors Association], it was a different—

SM: Right, it was in statute and it had originally been called the Conference of Local Mental Health Directors. They were supposed to comment on state policies and practices, but they didn’t have any sort of due structure or the economic structure that the CMHDA has. It was really a statutory organization. It was made up of all the directors from each of the counties much like CMHDA is now, but without any infrastructure—there really wasn’t much of an infrastructure there at all. Meetings were funded by and at the discretion of the State.

HP: I see. So what led to the decision to start CMHDA?

SM: Well it started when part of realignment eliminated the old Mental Health Directors organization, raising the question—what do we do now? How do we get to the place where we still can do something and have some sort of input, some sort of say, some sort of policy view? So there was an agreement of all the counties to contribute money and to hire an executive director to go ahead and to begin developing a new organization that would speak up for community mental health system.

- HP: And take that role, because I imagine that the County directors themselves were busy running their Counties.
- SM: Right. And I also think it is difficult for a peer to tell other Counties what to do. Counties are like a confederacy to some degree, in that they have to look out for their own County because that's part of their job, and they're really not expected to go and give away County resources to another County, or make decisions that would adversely impact their County. So many times, in terms of making decisions about where a County would vote on a particular policy they would always like to run the financial numbers and say "well, what does this mean for my County, what's the fiscal implication for my County?" Thus individual County positions weren't always mission driven as much as [they were] financially driven.
- HP: Right.
- SM: So just like in Yolo County making decisions about alternatives to hospitals and mobile crisis—while it sounds like a great mission-driven decision—it was also really heavily driven by finances. So a lot of the decisions that were made were financial decisions—getting an infrastructure that could do the analysis, getting some sort of professionalism, and getting someone who was in the Capitol [rather] than just pulling Steve Mayberg from Yolo County to testify and go back [home]. It was an important step forward in terms of the evolution of—
- HP: Now was that Catherine Camp?⁶
- SM: It was Catherine Camp.
- HP: Now you mentioned that you used to come over here to testify a lot. What would you testify about?
- SM: Most of my testimony was about children's issues. There's a lot of—I was sort of the children's expert and so whether or not it was true, that was the perception then.—and the joke in mental health was that my albatross, or punishment for that perception. was [Assembly Bill] 3632.⁷ This was my first big policy bill testimony, and I testified when the bill first came out about the fiscal risk and the cost, and [that] it wasn't a very good idea. Emphasizing how it was going to negatively impact the mental health system. The bill passed and the implications and problems in implementation followed me to the State, and continue to still be an issue 30 years later..
- HP: What did it [Assembly Bill 3632] do precisely?
- SM: 3632 was a bill that stated where if a child was found to need mental health services on their IEP [Individualized Educational Program, for children with special needs] in schools, that the mental health system had to provide those services. At inception education advocates stated "well there's not that many kids it's not that expensive, it'll cost maybe \$1 million." And there's something called the Mayberg-Usher formula—Ron Usher was the director of mental health in

⁶ Catherine Camp was the first director of the California Mental Health Directors Association.

⁷ Assembly Bill 3632 passed in 1984. It mandated that education and mental health providers needed to collaborate to provide mental health services to children with serious emotional disturbances.

Sacramento—we sat down and calculated what we thought the costs might be and we believed it would be about \$60 million, a very substantial sum in those days.

HP: Uh huh.

SM: And the decision makers were highly skeptical. They said “that’s impossible, \$60 million or \$1 million, we’ll take the easier [lower number.] Since it was a Willie Brown⁸ bill, it sailed through. There was a lot of advocacy for the fact that children needed services, but the Counties were really put at risk. Eventually that program ended up costing \$120-\$130 million.

HP: So it was a huge portion of the overall mental health budget.

SM: Well it eventually it grew to that. I mean Counties were slow in implementing it, and then it contributed to almost blowing up realignment because there was a poison pill provision that said if there were any new mandates on Counties, you have the option of getting out of realignment. The court decision about 3632 was that is was a mandate, but Counties were not being reimbursed by the State because of budget problems, even though they were entitled to the reimbursement.

HP: That came after realignment?

SM: No it came before realignment, but children’s services were impacted further by another entitlement lawsuit, EPSDT.

HP: Okay. So what was the relationship between the States and the Counties at that time? In terms of autonomy and money, pre-realignment and then post-realignment?

SM: I think that pre-realignment there was a disconnect that, when I got on board, it was really important for me to reconnect. I think there was a better relationship for a period of time between the Counties and the State—we worked on a lot of projects together, worked on consolidation—which was moving the fee for service Medi-Cal system into the Short Doyle Medi-Cal system⁹--worked on going from a clinic option to a rehab option, looked at closing down the State hospitals—which we really did. We went from 3,300 people in State hospitals to today, there are 600 LPS patients from the Counties. So we worked really well on those projects and so I think the relationship became more collaborative. There was still the issue that State was the auditor, and it always creates problems when someone comes in and said “Hi, I’m from the State, I’m here to help and audit you and then tell you how to do a better program.” There’s always going to be that kind schism—that tension that’s created there. But I think that

⁸ Willie Brown Jr. was a highly popular Assemblyman who served in the State Assembly from 1965-1995. After leaving the Assembly, he served as Mayor of Sacramento from 1996 to 2004.

⁹ This process occurred from 1995-1998. This required Medi-Cal beneficiaries to access mental health services through their county’s mental health plan.

that for a long period of time the relationship was really good, and then probably got more contentious after Prop 63.¹⁰

HP: Okay.

SM: I think it was just an issue of whose money is it, how do you control the programs, who sets the policies? Who are the leaders here, who gets to make the decisions here? I think the difference was at that time [after Proposition 63] there probably weren't the same cast of characters that were as collaborative as there had been at other times—and that's both on the State side and on the County side. So there was tension between CMHDA and the contractors, and tension between the client network and NAMI, about how the money should be spent. And overall tension with the State, who was saying "well we're going to interpret some decisions here, we're going to resolve that" and the Counties saying "but the money goes to us, we should get to do make those decisions." The way Proposition 63 was written there were strictures on how it could be implemented as well as differences of opinion about interpretation..

HP: And this is under the realignment we're talking about?

SM: No, this was under Mental Health Services Act—

HP: Oh.

SM: Realignment I don't think was much of an issue because what happened was the legislation took away the categorical funding, which took away a lot of the micromanagement of these little programs from the State and moved the State to a position of really looking at the bigger picture and providing leadership. There was a vision developed I think by everybody that the mental health system should concentrate more bringing in more revenue, especially third party payments. When I started at the Department of Mental Health, California was ranked 48th in terms of per capita Medi-Cal and Medicaid expenditures—they just didn't draw this federal resource down. I did an analysis of where the fee for service money was going and found that the majority—70% of the money—was going to inpatient stays for 8% of the population. Part of the problem was that at that time in the private sector you had two choices: you could have twice a month psychotherapy, or hospitalization. Well, if someone was in a crisis, twice a month isn't enough and hospital may be too much. So that was an impetus to move much more into a community setting that had a broader array of options. If you have wider array of services—which were permissible under the rehab option rather than the clinic option¹¹—and if you provide more case management, more support, more services in the field you are going to avoid hospitalizations. It made good financial sense and programmatic sense to change our Medi-Cal system to one of consolidation and the Rehab Option. At the same time, [by] redirecting to County programs the money from the State hospitals at \$100,000 a year per person, [if] you took ten people out of the State hospital, it gave you

¹⁰ Proposition 63 (2004) created the Mental Health Services Act.

¹¹ In 1993, California amended its State Medicaid plan to adopt the federal "rehab option," which allowed for more community based services based on a more long term community care model.

\$1,000,000 for program development. So it was now possible to really begin building the community mental health system up to what it could be and should be. If you have a robust community mental health system, you can avoid a lot of more restrictive environments, more expensive programs, freeing up more money for community based programs. Thus the combination of stability from realignment, increased community dollars from the State hospitals, consolidation of the Medi-Cal system, and expanded opportunities for Medi-Cal reimbursement through the Rehab option greatly enhanced the community system, and began the move to spend more dollars in the community than on 24 hour care.

HP: Is that what drove—you mentioned that there were 3,000 people in the hospitals and it decreased to 600, is that kind of what motivated that shift away from 24 hour care?

SM: Yep, that motivated it. And the belief that with better programs, with better medications, with wraparound services, that you could provide the services in the community rather than the state hospitals.

HP: And this was in the early 1990's we're talking here?

SM: Early 1990's, yeah.

HP: Okay, so—I have two questions. One is that there's always more people who need services than can be provided. So did it create an issue of lack of space in the hospitals then? Because even though it's wonderful to fund all these community based services that can prevent hospitalization, were the hospitals then flooded with much more need than they handle because they had less capacity?

SM: Well, no, actually. Fortunately there were enough beds, and in fact there was too many beds and staff. There was essentially a death spiral in the hospitals. You had to staff at a unit fully whether it was 50% occupied or 100% occupied. It cost twice as much for a patient if you had 50% occupancy, and so that's where you're going to price yourself out of the market. But what happened conversely is that there was a dramatic growth in the forensic population. So now there's 6,400 people in the state hospitals. All of the beds are filled with people that are coming out of the forensic system—not of the community mental health system.

HP: Right. So, okay, so that's nowadays?

SM: Nowadays.

HP: Uh huh, but back then did the decrease in the hospital availability lead to a shortage on that end?

SM: No, I don't think so—I mean there were always beds available. There were more beds available.

HP: There were empty beds then?

SM: There were empty beds.

HP: Okay. So you were taking money from the hospitals to create these wraparound services, but did those services really exist across the state at that point?

SM: They didn't. So the first step was moving to case management. That meant getting a waiver from the Federal government and getting Medi-Cal to pay for case management services. So no, there really wasn't on a widespread basis, those kind of wraparound services. Again, pilots and innovative programs helped shape direction. Assemblywoman Cathie Wright had two pieces of legislation, AB 377 and AB 3777, which really looked at this whole idea of coordinated or consolidating care wrapping around services.¹² It was a beginning from where we moved. It was really the first step in developing partnerships and looking at what those programs could do or what they would look like. And then I think they moved a little further forward when you started getting programs like the Village¹³ developing with those grants.

HP: Were you involved with the AB 3777 programs at all?

SM: Yes, but those were actually going on prior to realignment.

HP: Right. So what were the lessons learned from these pilots and what implications did they have for you?

SM: Well I think there's two—well I'll just be controversial about this.

HP: Um hum.

SM: I think the lessons learned were that certainly on the children's side, the collaboration made a huge difference. You could keep kids out of the State hospital, you could reduce hospitalizations, you could reduce out of home placements. The problem was that it was hard to continue to show savings, because after you'd reduced the hospitalizations to a certain degree, there was no one else left to take out. And so programs have to be revitalized to some degree—you can't continue to have the same measures, the same standards. So moving to standards of [staying] in school, out of trouble, being at home becoming the measure, that was really successful—really successful for the kids and the outcomes. It emphasized the power of collaborative approaches.

SM: But the other thing we learned in that was that when the programs became stultified when they didn't change they didn't work as well, or very well at all. And so even the beginning programs like Ventura¹⁴--where it was very innovative—because they were used to being the innovator, they stopped innovating, they stopped changing and the program stopped working as well.

HP: Um hum.

SM: So I think what we learned that about 3777 and 377 was that programs that keep paying attention to raising the bar can be pretty successful, and programs that remain the status quo, no matter what kind of programs they are, don't do as well. So it's a good learning experience, and the lesson is that continuous quality

¹² Cathie Wright was a State Assembly Member from Ventura County who served in the Assembly from 1980-1992. AB 377 (1984) created a pilot for the Children's System of Care, and AB 3777 (1987) created a pilot for the Adult System of Care.

¹³ The Village is an Integrated Service Agency in Long Beach that was created as one of the pilots under AB 3777.

¹⁴ Ventura County had one of the pilot programs under AB 3777. The other two pilots were at community-based agencies rather than county-run programs.

improvement isn't just a phrase--it's really an essential to be able to move your system forward, the whole mental health system forward.

HP: Can you give me an example with the 3777 programs where there wasn't dynamic change where there should have been? And what did the lack of success look like?

SM: I think it—I think the examples were when that—take a County-run program where they just continued to do just case management and the traditional services and if you compare that say like the Village or Turning Point,¹⁵ where they were doing housing, where they were doing vocational training, where they were doing outreach, where they were dealing with really difficult folks in different ways with a culture that wasn't rigid, but with a culture that really embraced change. You could see the difference in outcomes if you compared the County-operated programs with the Village. I mean it was night and day and I think that had a lot to do with structure and values..

HP: So County programs they just really offered case management?

SM: No they offered more, but they didn't expand into doing the other things that you saw happening in some of the community based organizations. Part of that has to do with a rigidity that comes with working in a governmental system. The concept of 24/7 availability, flexibility, non-traditional programming is hard in governmental systems.

HP: Hmm.

SM: I mean people have 9-to-5 jobs, people have expectations and they have protections and job descriptions about what they can and can't do. So it's harder to make those changes in those settings.

HP: Could those changes be made in Counties just if contracts were rewritten, or if 24/7 jobs descriptions were written up?

SM: Sure. Sure they could, but that's always negotiated. And then it's [a question of] how do you get people to do that and what does it mean to have someone be on call? Even when I was in Yolo County, when we were starting mobile crisis [services] and [deciding] who would be the clinicians who would be responsible, it was easier and more effective with a contract agency. We knew we could get county staff to be available from 8:00 to 5:00, but after 5:00 it was much more difficult. So it was just easier to have a contract to say "we'll pay you this amount." There's something to be said about that sort of public/ private blending that makes programs work.

HP: Better go with the flexibility with the private it sounds like.

SM: Right. And kind of the ability to change more rapidly than Counties can.

HP: When you say rapidly is it a matter of day to day, month to month, week to week?

¹⁵ Turning Point is a community mental health agency in Northern California.

- SM: All of the above. I mean for Counties to make a program change is really complicated. For Counties to even do a contract takes months because you've got to write it up, it's got to be reviewed, it's got to go through a bidding process—which is fine, which is fair, you don't want people just to give money to their cronies or to something that won't work—but that whole process of making sure that it's transparent and that everybody can participate moves that months down the road.
- SM: I mean part of the problem in terms of starting Prop 63 was all the contracts between the State and the Counties took a long time. And then when the counties got the money, then they had to go through the same process of putting everything out to bid. And so people were saying “where are the programs, why aren't they starting?” We [would just] say “well government just takes a while.”
- HP: It takes three to six months to do anything.
- SM: Minimum.
- HP: Yeah, if you're lucky.
- SM: Yeah, if you know what it is you want to do. And when you're doing something innovative, it's hard to articulate or to write a contract for something that hasn't been done before. How do you measure, what are the guidelines, what are the achievements, what are the outcomes? How do you measure those things? Or is it reasonable to look at those things? There always should be a dynamic tension between change and our Madisonian bureaucracy that says “don't change too much, there's got to be some consistency. Just because you have a change in leadership the system should be able to go on and go forward.”
- HP: Right. So the need to preserve the system while also innovating.
- HP: Going back to 3777, you highlighted another tension. It seems that you're a publicly funded system with public money and you need to have some kind of accountability and structure. Was it difficult back then to reconcile that with the need for dynamism and say “hey, we're going to start a bake shop”¹⁶—things like that?
- SM: No, it had to make some sense but everybody knew what the outcomes were supposed to be. There was also a tension about [deciding] was this the gold standard of evaluation or is this just anecdotal? And it couldn't be anecdotal, [just] “I knew someone and they went to the bake shop and got better.”
- HP: Um hum.
- SM: But it also couldn't be like in a university, where we had a controlled study and we had everybody sign releases and had the human subjects committee review our [protocols], then we analyzed this to the nth degree. It couldn't be that either. There had to be something that had some statistical validity, a kind of generic statistical validity that there was change. but how do you measure change—

¹⁶ This is a reference to a client-run bake shop that started at the Village.

whether it was less hospital stays, less medication—quality of life interestingly enough didn't turn out to be a good measure.

HP: It wasn't a good measure, or it wasn't something where change was seen?

SM: It wasn't a good measure because judging what quality of life is, is really difficult.

HP: Yeah, it's very subjective.

SM: I mean am I happy, am I doing better or—I mean the classic example is when we were doing some of that I had my management staff review themselves, and we all had pretty poor quality of life scores.

HP: Hmmm.

SM: Because of the amount of time we were working and the impact it had on friends and family and on sleep and on eating. So all of the measures that you could look at and you say "is that a function of my mental health or is it a function of—[something else]. So there are so many other variables that are involved in that, that it was really difficult to look at that. You could look at levels of care and staying out of trouble, whether you're employed. For me the homeless programs, the measures for the Senator Steinberg¹⁷ bills are good examples of what you're really looking at—do you have less days homeless, less hospital admissions, less jail time, are you employed, are you involved in some other activity? Those are good measures. I mean if you do a discriminant function analysis you can't say what exactly it was that caused that [change], but from a global perspective it looks like there's change. It's difficult also in statistics that when you have so many people, everything kind of regresses to the mean. What I mean is that not all people change on the same measures, and while the majority of people have significant change, when you aggregate all the data, those changes may wash out.

HP: Um hum.

SM: So you get a lot of change for individuals, but if you just look at a global sense, it's really hard to see much deviation from the mean.

HP: In terms of recognizing that practically you can't do the perfect UCLA type of statistically powered study—was there pressure to produce that from the bean counters?

SM: Sometimes—sometimes there was. Certainly we had and did have contracts with [University of California] Berkeley, I did have contracts with UCLA, I did have contracts with [University of California] Davis. So we had a lot of contracts to have independent evaluators look at our systems, and it was helpful. But in terms of looking at the big picture, I think presenting to the legislature, to the public, you probably need things that are more sound bite oriented, more relevant. I mean people aren't interested in degrees of freedom.¹⁸ People aren't interested in

¹⁷ Assemblyman Darrell Steinberg's bills AB 34 (1999) and AB 2034 (2000), which expanded the pilot programs created by AB 3777. Steinberg is currently California State Senate pro Tem.

¹⁸ Degrees of freedom is a statistical term.

what—the minor differences and statistical significance are. They are interested in [answering] “are people off the street more.”

HP: They’re interested in significance, not statistical significance.

SM: Right, so social significance.

HP: And social issues become really much more important.

HP: It seems like such a tension in terms of the talk about accountability and outcomes. Was there discussion of that back then?

SM: Yeah, oh yes, definitely., For me that was always a discussion. How do we measure this? How do we know whether it’s working or not? How successful psychotherapy is...there hasn’t been any good measures of that really. I mean whether it’s the public system or the private system, it’s a real mishmash of results. So I think looking at social issues and social change became really a good way of analyzing what it was we were trying to do.

III. Peer and Family Involvement in the Mental Health System; Balancing Responsibilities as Director; Cultural Competence; Community Integration and Independence for People with Serious Mental Illness; The Challenge of Innovation

SM: And then I think patient satisfaction becomes an important issue, too. I believe people will come to get services if it makes sense to them, if they’re relevant. One of the things I did know about the research was that if people who are getting services believe in the services, or believe in the person providing [them], their compliance is much better and their outcome is much better.

HP: Um hum.

SM: And so if you have a system that’s developed that people buy into and have trust in or faith in, you’re going to get better outcomes. It’s not a placebo effect—it’s just that they’re going to follow through. I mean none of us follow through on everything the doctor tells us. I mean if I went and looked in most people’s medicine cabinets there would be boxes or jars of antibiotics that weren’t finished. And the reason is “well, I feel better I don’t need to do that, things are going okay now, I don’t need this.” And if the doctor said to me, “Steve, I’m really worried about this, you need to finish this, it’s really critical even though you feel better...” If I had that relationship with the doctor I’d be more apt to do that. But if I didn’t know the doctor I’d probably stop. And so I think that has a lot of relevance with mental health. That’s why I thought the family and the consumer movements were so important. I really pushed that because the peer support and the family actually spend more time with the clients than the mental health system.

HP: You anticipated my next question perfectly. What did client and family involvement in both clinical and policy things look like when you first came to the State and how did it evolve?

- SM: [At first] there was none. There was absolutely none. The director before me was upset that there would be clients in the audience wandering around, and he wanted them out of the room, saying that this was “a professional [event].”
- HP: Like during his hearings and things like that?
- SM: No, community meetings.
- HP: Oh. Well it was community—shouldn’t it be open to everyone?
- SM: Well, it should be but that wasn’t the belief. Clients really were the second tier. When I hired the first client representative to be on my executive team and there was a lot of pushback. Her name was Wendy Walker Davis. That was really difficult, first to get her hired because there was no job description for the client position and it was not civil service. Secondly, there were people saying “well, why would you have a client on your executive team? I mean that—essentially saying you’re having a crazy person that is going to help develop policy?”
- HP: What year was this?
- SM: 1993-1994.
- HP: And so what was your explanation?
- SM: I just said that I think that it’s really essential to listen to the voices and perspectives of recipients of service, and that unless we know the impact of what we do out in the field, we’re not going to be effective, we’re not going to have impact. [Even if] I think it’s a good program, it’s really what the recipients think that’s going to make a big difference. As soon as I was hired to be State Director I went out and met with NAMI and with the client network and really got an earful. They were angry.
- HP: What were they angry about?
- SM: Being disqualified, being unheard, not ever having a voice, having really good ideas and being diminished or demeaned.
- HP: Um hum.
- SM: And a lot of what they had to say made sense. I mean nowadays looking back at it, it’s well--of course, that’s obvious—but at that time, in that era there really wasn’t any real acceptance of having that kind of outside influence. There was a very distinct line between the therapist, the professionals and the client.
- HP: Um hum.
- SM: So [paraphrasing the approach at the time] “I’m the boss, you’re the patient. I’m going to tell you what to do, you follow the rules.” So it was difficult for staff, and the Department, to really understand why you would have someone who was a client and different, and what their role was—especially when they never had someone in that role before. I observed that many decision makers and policy folks never had had any experience at all dealing with the mental health community. I knew that you can develop mental health programs, but that

doesn't mean that you've ever touched anybody or known anybody or been friends with anybody who's been part of the [mental health] system.

HP: The folks who worked in the State Department of Mental Health, were they people that had worked in Counties before? Were they former service providers or were they just administrative?

SM: The whole mishmash. I mean you had a lot of people who were really just—and I don't mean this in a pejorative sense—they were bureaucrats. I mean they were analysts—they developed regulations, they did budgets, they did bill analysis.

HP: So they worked with paper, not with people really.

SM: Right, yeah. They pushed the system along.

HP: Right, which is necessary.

SM: And there were some clinicians—but not a lot of clinicians. And so among the people who had been part of the mental health system, there was still a ton of stigma. They weren't going to say “well, I have a diagnosis, too.” I mean so they were pretty underground. So it was really risky for someone like Wendy to be able to say “I'm here because I have had mental health issues, because I've been diagnosed, because I've been treated, because I've been hospitalized—but I have other skills too.”

HP: I'm curious how you wound up choosing the person you chose, because this sounds like it's very much ahead of time in terms of client representation in real decision-making. How did you come to her?

SM: Well, I knew her. She was in Yolo County and she also was getting a degree in psychology. She was going to graduate school so she could at least look at mental health issues from both sides. And she was articulate, she was intelligent, she had an ability to connect, people trusted her outside the system and she was courageous. Jay [Mahler]¹⁹ was involved in some of that selection process. He was helpful to me in terms of giving me feedback about what we needed to do. For me he was one of those early advocates who was in my office probably two days after I got there and said “you've got to do this, Steve, you've got to do that.”

HP: Um hum.

SM: And I think a lot of what that started to change was that people could come in and could talk about their issues. People who'd never had a seat at the table. So Jay could come in and advocate for a client representative, a voice or a seat at the table.

HP: Come in to see you, you mean?

SM: Yeah, just make an appointment.

¹⁹ Jay Mahler is one of the leaders of the client movement in California.

HP: So was that a conscious decision from your experience being at the County level that it was more important to be accessible when you were in the State chair?

SM: Well I think—that's a hard question. Was it conscious or is it probably just who I am? It's probably more a reflection of who I am.

HP: Is that how you managed at the County level as well?

SM: Yes, it was pretty much an open door. Respect and dignity for everybody. I mean everybody has a point of view, everybody has something to say. And my experience has been if you listened to people you don't have to do what they say, but at least it's not as demeaning as being disqualified and saying "you have nothing to add—you're worthless."

HP: That must have been difficult to in the same day have to go testify in front of the governor and then meet with client advocates. Was it a lot to manage?

SM: No, I liked it—I mean I actually liked it, I liked that dichotomy, I liked that tension, I liked the fact that it made me think I was really doing the job well because then you serve as a bridge to people who you can advocate for—people who never could advocate for themselves-- whether it's advocating for Counties, providers, for clients, for family members that. I mean it was like what you do as a family therapist. When I was a therapist and worked with the families [this is what I would do: explaining what kids had to say to their parents. Even though they're the parents they have to hear it. And you don't take away the power from the parents, but you say "are there better ways of dealing with it." Not to say that I was the family therapist for the State, but that process of being able to foster communication and keep communication going was really important to me. I found that there were people who were very supportive of that style.

HP: Yeah, that seems what good government should be really.

SM: Yes. That clearly was the idea. That's why dialogue and community process was built into Prop 63, that you should have community meetings and everybody should have a say and listen and good plans could arise from that interaction.. However, by building it in and by legislating it and by regulating it, it takes away something, because then it becomes something that's done by rote as opposed to from the heart.

HP: And once it's formalized it loses some of that—we'll get to Prop 63 in a minute.

SM: No, well there's plenty to go.

HP: Yeah, so one other question going back to Wendy, this original client advocate you added to your executive team. What did she do, what was her job?

SM: Commented on all our policies, sat in on all the team meetings, went out to meet with most of the client groups. She was the point of contact.

HP: So liaison.

SM: Liaison. And then when we started making these major changes about consolidation and moving to the rehab option I developed something called the Client Family Task Force. And so it was three clients and three family members

who served as sort of a kitchen cabinet to review all of our policies, all of the procedures, all of the decisions that we made. And that really was helpful because what ended up happening was that then we ran everything through their organizations]. It used to be we would just run what we did by the Counties, but we would run everything by the client network and by the families and say here's what we're trying to do, what do you think, how can we change this? Wendy and the Client Family Task Force would be the emissaries to NAMI and to the Client Network. Eventually we ended up having these huge meetings where everyone would come to talk about the process, to talk about what we were trying to do. It was open and welcoming, and I am thrilled that this continues to be the way the California public mental health system still conducts business. It really is a partnership.

- SM: Now, I can share that I never thought I would stay at the Department very long. I mean the average stay as a state mental health director in the U.S. is two years. So I didn't think I'd stay very long both because of state history and national trends. One of the things that someone said to me was "if you're going to make changes don't leave footprints in the sand. Try and build something that will last, because when the tide comes in, the footprints are gone--whether it's legislation, whether it's regulations, whether it's some kind of infrastructure do something tangible." So my belief really was that if you can move the locus of control from one person at the State or one person at the County to the community, to the grass roots—to really build up grass roots support for system change—you can build an informal bureaucracy that ensures that the system goes forward no matter who's there. And so by building up an educated and an informed group of clients, family members, providers, Counties, advocates—you end up having a lot more people being able to speak articulately at all levels. This is not just testifying at the legislature, or the Board of Supervisors, or Mental Health Advisory Board meetings, this is anyplace where you start to have informed and vibrant discussions about the potential of the mental health system. California has brilliant people in it. There are a lot of brilliant ideas, and so giving people a forum to at least share some of those ideas or visions—even if it's before their time or it's a little out there—at least it's percolating, it stimulates some other kind of thought. And so the more people that were engaged, and understood, and bought into it, the more the likelihood of success of moving forward was.
- HP: A couple of questions on this. One is that these things you're talking about—like the details of Medi-Cal consolidation. That strikes me as something you need at least a Bachelor's to understand. It's not easy. So was it difficult to educate? How did you educate families who didn't have the formal training? Or clients, particularly those with cognitive difficulties?
- SM: It took a little bit of time. The policy issues took a little bit of time. I had some staff that worked in the department who were just phenomenal in terms of doing that, explaining policies, decisions, implications and constraints in terms that were understandable. Carol Hood²⁰ was an example of someone who did a lot of that.

²⁰ Deputy Director of the State Department of Mental Health

HP: In terms of communication with the community?

SM: Working with everyone, working with the community, spending a lot of time, spending days sometimes going over the issues. This process helped us formulate how we wrote things—to move away from the kind of unmanageable, unintelligible bureaucratese into something that was more user friendly in terms of “what we mean is this and what we’re saying is this,” so it wasn’t couched in language that only attorneys can understand.

HP: Um hum.

SM: And learning how to present what we doing in ways people could accept. Using a psychological term, making what we did egosyntonic so people could say “yeah, this makes sense to me.”

HP: Yeah.

SM: And at the same time the other thing we did to was look at who else didn’t have a voice—and it was ethnic minorities. So we started a whole push for cultural competence, hiring someone full time on my staff to be on the management team who was going to represent cultural competence issues, ethnic issues. We began developing programs, and starting to put language in all of our bills that required cultural competency. It was a real push. I mean that did not make people happy.

HP: Why not?

SM: Well, because it was something new. It was forcing them to do something that we had done a terrible job doing. For me when I analyzed the mental health system in terms of who was receiving services and where they received it, it was really quite obvious that the system wasn’t equally accessible to certain ethnicities, and that depending on your color where you ended up was going to be different. So a person who was African American was more apt to end up in jail or in the state hospital than in the community programs. If you were in an education program, 3632 for example, if you were Caucasian you were more apt to end up in services as opposed to something else. So when you looked at our mental health system in the 1990s, most of the clinicians were Caucasian, trained in white middle-class therapy modes and that doesn’t work for everybody, in California especially. We know California very diverse and we needed to pay more attention to providing services to folks that made sense to them based on their upbringing, their families, their language. If you’re going to get family support and you can’t speak the language or you don’t understand the culture, it’s really hard to engage the family and work together..

HP: I say this as someone without a clinical background—other than the linguistic aspect, what are some of the ways that regular therapy, let’s say, would be different from culturally competent therapy?

SM: Well, I think just to give you an example. In some cultures mental illness can be seen as a reflection that you’ve done something wrong. Or that mental illness is a religious manifestation. There is the whole issues of guilt and denial and stigma and so family support is really critical to folks. So if the families either don’t see

the family member as having a mental illness or don't feel engaged, how can they provide support? To me that's the 50 minute hour dilemma again--I can see you and I can work on your issues, but you're going to go and live with your family and you're going to turn to them in time of crisis, and they're not going to know when things are going to start to slip for you. But if they're not engaged or they don't understand or they don't have the information, by the time it falls apart it's—it would have been much easier to intervene earlier. I think that families and peers provide an incredible safety net for our system. There's no doubt in my mind about that and we don't have enough clinicians or therapists to be able to do everything for everybody.

HP: And clinicians don't walk around in the world with you.

SM: No, that's right.

HP: That's where you live most of your life.

SM: I've never met a parent who doesn't have a good sense when their child starts to have something amiss. I mean they pick it up before the clinicians usually... and you see that not just in mental health. If you have a child and you go into the pediatrician, you know something's different about your kid right away. Sometimes it's not tangible, it's not a 102 degree fever, but there's something there. We have to start paying attention to those kinds of intuitions and those kinds of senses, and then working together. As our systems have been become more diffuse and less connected, and there's less of a sense of community, there's less people paying attention to that. It's easier for people to fall between the cracks.

HP: Um hum.

SM: So it's really a question of how do we build that up, so we can have supports? And it doesn't just have to be family supports. It can be religious supports or it can be vocational supports or whatever kind of supports. When I talked to the Client Network clients and ask "what did you find that was missing and made a big difference for you that we never talk about," and they'll answer "spirituality." They don't necessarily mean church, but it's that sense of having some kind of hope or some kind of faith or someplace to go or someone to talk to or some connection somehow. People are an amalgam of a whole bunch of issues, they're not just a symptom. and traditionally mental health used to just treat the symptoms. The mental health system used to say "we can give you medication. You're anxious, we'll give you a pill that'll reduce the anxiety. You know you're hearing voices, we'll give you a pill that may quiet the voices". But there are a number of other things that are going on that have to be addressed, too. So just dealing with the symptom isn't sufficient.

HP: Right. I'm going to jump ahead to the question I was going to ask you later about recovery because you mentioned this idea of community. Something that strikes me is that there's a lot of talk about the importance of involving the community and getting outside the mental health clinic, which is wonderful. But we don't live in a particularly embracing community these days.

SM: Right.

HP: We're all "bowling alone."²¹ So to what degree is it difficult to reconcile the recovery vision of the community being this warm, embracing place, with the fact that community is very harsh--particularly for people with socioeconomic challenges, many of whom are in the mental health system?

SM: I think that's a great question, and that's part of the stigma issue. Part of making this work is expanding the community. So it's not going to be your neighbors necessarily, but if you can get other social service agencies to be part of that supporting entity. I have experienced a time when if someone was mentally ill, no agency wanted to deal with the problems or the individual.. [They would say] "that's mental health's problem." Whether it's [with] education or social services or vocational rehab or law enforcement, their involvement and engagement has helped individuals really become a much better integrated as part of the community. That's where you start making some of those changes. But the community as a whole, probably not. I mean people are pretty insular. I think certainly the general population certainly wants things changed--they voted for Prop 63. But part of that is they don't want to necessarily have to deal with the mental health problems and clients. I can see that most people don't like walking downtown and being hit up for contributions from homeless folks.

HP: Um hum, yeah.

SM: We develop sort of a blind eye, it's amazing. We all do that. How you can walk and just not see people asleep on the sidewalk with their cardboard? We have some blinders on about that. And yet I don't--my personal opinion is I don't think the government should be responsible or can be responsible for fixing all of those problems. I believe the fostering of dependence on government programs doesn't always help people. It is important for us to learn how to give consumers resilience to really become part of the community. That's why I believe programs where people get housing, where they get jobs, where they get some kind of vocational activities--that's where you meet people and become part of a community. You meet people at work, you meet people at hobbies, you meet people in your apartment or in your neighborhood. But being in the mental health ghetto as it were, in a poor isolated [area] only talking to other people with mental health issues even in a community,--that's still a state hospital. That doesn't help. It doesn't allow you to transition very well into the community.

SM: Just because you don't have the requisite social skills and the community's not accepting--there's a huge stigma. If I moved into the neighborhood and said "Hi Howard, I'm Steve, I just moved here, I just got out of the State hospital and I'm doing really well and I'm going to get a job." Your response would not be "welcome to the neighborhood." It probably would be to walk through the neighborhood and say "be careful of this guy." That response still exists. Here we are in 2013 and stigma still exists. As an example--there's that fear

²¹ This is a reference to Robert D. Putnam's book *Bowling Alone* (Simon & Schuster, 2000), which discusses how individuals are increasingly disconnected from their communities in modern America.

expressed by two-thirds of U.S. citizens in a poll that they didn't want to be friends with or work with someone who has a diagnosis of schizophrenia.

HP: Still.

SM: Still—yes, because they're afraid of violence or unpredictability.

HP: Well yes. Look at the impact from the Sandy Hook shootings, the response being about mental health versus other things always comes up. I want to come back to something you mentioned in terms of that fostering dependence won't help people with mental illness. What's wrong with dependence, particularly if it's among people who maybe can't function well?

SM: Well, I think there's a difference between—there are levels of functioning and so fostering dependence really means what I'm in charge of. You depend on me, you rely on me, I'm going to run your life. I don't think people who foster that dependence are really willing to be available to run someone's life 24/7., Or they aren't willing. I see parents that can do that, families do that, but it doesn't help a person ever do anything other than look to other people to make their decisions and solve their problems. How do you learn not to repeat the same problems? How do you learn to accept the consequences of decisions? They aren't going to be able to get a job, they aren't going to be able to enjoy life if they're that dependent. There are degrees of independence. I'm not saying people should be totally independent, but if we set up systems that really require people to give up some of their independence to be part of the program, how do we ever get them out? How would you ever get someone out of the Full Service Partnership?

HP: Um hum. How would you inculcate independence?

SM: Well, I think it's how do you inculcate independence with a child? It's through a series of challenges and supports and reinforcements and rewards, setting up some reasonable goals and expectations. When people do that they can learn to handle some things. It's like learning to ride a bike, that you start with training wheels, then you graduate to someone running along side of you and then pretty soon you ride the bike alone. You may fall down, but you get back up and brush yourself off with support and encouragement. So it's really looking at giving people measurable goals and objectives and then reinforcements, rewarding them. Say "you've achieved this, look! You're really taking some control of your life." You begin then managing your illness, managing your mental health problems becomes your responsibility not someone else's responsibility. It could be a partnership.

That's why we changed the name from "System of Care" to "Full Service Partnership." Some people were upset about changing that name "System of Care," which was "we're going to take care of your independence" to "Full Service Partnership" saying "we're going to give you a lot, but it's a partnership. We want you to move on from that." So it was just a change in values and philosophy, from "we're going to take care of you" to "we're going to work together to get you where you want to go." And it may not be independence, and

for some people they may always end up being in a dependent living situation or in a board and care home.

HP: Um hum.

SM: But there are some things that they can have some control over, and let's figure what those things are.

HP: When you're in clinics and you ask providers "can everyone recover and get independence," often clinicians would say "most can but 10 to 20% can't" or something like that.

SM: Right, yeah, that's probably accurate—

HP: So for those people who are going to have to be in a board and care what does independence look like?

SM: Well, to me it is whether the client is being able to get involved in some kind of activity--you choose what it is, whether it's doing something to contribute to in the board and care. Whether you're doing some cooking or whether you're doing some cleaning or whether you get to choose your own clothes, those kind of things. I believe you encourage the client to figure out what those areas are, and graduating to more options. I would hope there are choices--so do you get free time, do you get to go to the store, do you get to go to town, do you need to be escorted? Those are all steps to independence. They aren't total independence but they're gradations. Some individuals because of their mental illness do not have the capacity to make adult decisions, and in some ways they are like children. Needing protection and guidance. Kids are never totally independent but you give them a few more privileges, a few more—the expectations go up a little bit so—

HP: Um hum. If we were to live in say a place where the mental health system could provide for people who are dependent, would independence still be a necessary end? Is it a matter that "the mental health system can't always take care of you so we need to encourage independence" or is independence good in and of itself?

SM: Well, that's an interesting question because I mean you go full circle because the state hospitals were developed over a hundred years ago with the idea of having a very self-contained, stress free environment. So they were developed in these really bucolic isolated areas. Napa Hospital, I have to say it's gorgeous out there. The hospitals had farms, they had dairies, they had everything they needed there. They had social activities and the expectation would be "we'll take care of everything when you're here." But did that help people? I am not sure, people and lived and died in the State hospitals. So was that good for them or was that good for the community to stay out of sight out of mind? So we did have the resources to do everything and I think it didn't work, we warehoused people and they were not part of society or the larger community. For example, we had 35,000 people in the State hospitals when Ronald Regan closed them down.

HP: And that was kind of the mental health ghetto that you're talking about—

SM: Yeah, right.

HP: Interesting, interesting.

HP: Okay, so we'll get back to some of these issues but I guess a good transition would to ask as the person in charge of running all of this, this vision of things being very individualized and tailored; if you have a caseload of ten people that's one thing, but you have a caseload of 200,000 whatever it is. How difficult is it to oversee this massive system, and kind of turn this into policy, when it's something that's supposed to be so individualized and so difficult to measure with objective outcomes?

SM: I think that's a great question. If you ever heard me speak, I always said "one size does not fit all," that we've got to have some flexibility, we've got to have some uniqueness, we've got to deal with individuals as individuals, and not just a cookie cutter approach. But the system doesn't really allow that. There's not enough people providing services, there's not enough services available so it is hard to tailor services for individuals. And so what you start at, and what you really look at is to say "okay, everybody, no matter where you are in California has to have access to a minimum level of services. Once a decision is made to pursue Medi-Cal, there are federal requirements stating you have to provide a certain array of services in a certain way.

HP: Um hum.

SM: Law trumps vision and so that's when the auditing part counts—this is going to be the minimum? So where the difference is, here's what the minimum is, here's what's available. How do you move from there to the issues of how you get programs that are more responsive, have different values? And how do you measure whether that works or not, or is that a good investment? I think the homeless programs showed that you could deal with difficult people and move them out of the system. The myth that people didn't want services with the "whatever it takes"²² mentality showed up, but those were just in really isolated instances.

HP: Um hum.

SM: I saw, in the first homeless program by Steinberg [AB 34] there were just three counties, \$10 million. We did program start ups on a handshake and hope, knowing we could figure it out, and we knew it would work, but we knew that we had to have evaluations to keep it going. So that isn't a lot [of money] but it starts to develop a belief that doing things differently can change people, and people that no one would ever want to pick as their clients. I have seen most clinicians wouldn't want to pick homeless [clients]-- they're really hard to work with. So it's a matter of changing the culture. And you can't measure culture change. So I'm really proud of the California Mental Health System because when you look at values and you look at where people are and their knowledge, they're really on the cutting edge. They're into recovery, they're into cultural competence, they're

²² "Whatever it takes" is the slogan of Full Service Partnerships, indicating that the programs will do "whatever it takes" to facilitate clients' recovery.

into housing programs, educational programs, job programs. They do believe in inclusiveness, they do have client and family members throughout the system participating in everything. So it really has become a given. So when you looked at me sort of askance and said “when you hired the first client, why was that so difficult?” It shows how far the system has come.

HP: Um hum.

SM: Now it's just a given. So part of changing a system is really making sure that you have that cultural change, and sort of the theoretical underpinnings and research that can support that the changes is in the right direction. We used research that can support the efficacy of client involvement, research that can support the importance of cultural competence, research that can show why recovery makes a difference. The research that shows the difference between outcomes in Full Service Partnerships and services as usual really becomes important. The research and the policy implications need a forum and a mechanism for dissemination, and so early on I funded that vehicle of dissemination—and that's how CIMH [the California Institute of Mental Health] started. The Department couldn't do that training, couldn't do that research. Even if we did, people wouldn't believe it anyway—some of the ideas and practices we were pushing were pretty controversial.

HP: Um hum.

SM: So giving money to a non-profit really made good sense. So now when you look at what CIMH does in terms of training, education, advocacy, you've got people that are really doing the cutting edge issues. When Counties hear the concepts enough, when providers hear the concepts enough, and all of the meetings everybody attends—they're not just for the providers or just for Counties, they're for everybody—then you end up changing the prevailing values and, practices and attitudes, the zeitgeist. So then there's room for innovation, room for change because it isn't a foreign idea. Being in government sometimes teaches you to be risk averse.

HP: Yeah, I mean inherently.

SM: Because when it doesn't work, then you're the headlines in the paper and everyone castigates you. But if everybody's saying it and everybody's doing it, there's cover. That especially applies to doing new types of programs you can say “well 30 other Counties are doing that” or “every County has this,” then it gives that impetus for people who are cautious to be able to move forward. There are always a series of Counties who are early implementers and will take some of the risks, and some Counties who will wait a little bit and some Counties who will never change. But educating, training, engaging--it's really about impacting the group in the middle, getting them to move a little more quickly into the adoption of a different set of values. But I think if you talk to anybody in Counties the values, the vision, the principles are pretty coherent. I give a lot of credit to a lot of people who made things get there.

HP: Um hum.

SM: I mean you've been to the [Proposition] 63 [stakeholder] meetings. People speak the same language. They argue about how to get there, but no one disagrees about where we're trying to get to. It's just which programs work and in what order.

IV. The Mental Health Services Act and its Implementation; On the Relationship Between Counties and Contractors; On Laura's Law

HP: So let's actually jump ahead to Prop 63. Tell me a little bit about your role in its development, leading up to the election in 2004.

SM: That was walking a tight wire, because by law an appointed official—and I was an appointed official—I cannot take a position on any initiative or any political—issue. And so I couldn't be an advocate or a critic of Prop 63's development, and I couldn't be actively involved in the development of the initiative or any of the politics that went along with it. So I really had to be hands off. The wiggle room for me was that [State] departments can provide technical assistance.

HP: Um hum.

SM: And so technical assistance is basically saying: "Here's some feedback about this—have you thought about this? "This may have this implication, this might work, this might not work" and so on. But in the sense of it, it was only technical assistance in that it got developed, as all initiatives do, with lots of input and lots of compromises. And it's brilliant and it has revitalized mental health in California and kept it going. But it has, as any initiative does, so many inconsistencies and some nightmares of implementation. But that you don't know at the time because you don't know.

HP: It's to be expected.

SM: Yeah.

HP: What were some of the compromises that came along during development?

SM: Well, originally it started out just to be really an extension of the homeless programs.

HP: AB 2034?

SM: Yes, AB 34 and AB 2034, and to do Full Service Partnerships. And that was going to be what the bill was. And then it was "well what about kids—this is our one chance so there should be children's programs" and then doing some polling, led to this whole thing about early intervention and prevention, there should be a part with that component.

HP: What was the polling?

SM: When the sponsors of the initiative were doing the politics and marketing of 63, they would run focus groups of voters and sample of issues, [asking people] "would you vote for this" and then seeing which issues and themes polled better. So when they're looking at how to attract more votes adding things to it, where

do you add? Some people said “oh, yeah, take care of homeless programs” and other people said “well, if it has something to do with kids then I’m really behind it.” “If there’s something about prevention, then that makes sense to me.” So pieces were added into it as it went along—that’s just an example.

HP: So the pieces beyond the Community Services and Support got added eventually?

SM: Well, yes and the Community Services and Supports part of it. I mean when you look at it and that’s some of the controversy that you’ll get some people— that said “no, this was all meant for people in the system, more money and all the money was supposed to go to counties to do things for existing folks.” And there was this whole issue of unserved versus underserved and the tension between the ethnic minority groups saying “we’ve always been underserved, now we have money, now you’re going to use it just on the people that are already in the system.” So it was sorting some of those issues out. So when it passed and when I talked to Darrell [Steinberg] and Rusty [Selix]²³ at the celebration [after Proposition 63 passed in 2004], I said “it’s really exciting but the devil’s going to be in the details. This is going to be a bear to change a whole system and a whole way of thinking.” When it passed the money was insignificant—not insignificant, it was a significant amount of money—but it was adding 10-12% to the mental health budget. So it was feasible that you could have sort of “boutique programs, you could start thinking about implementation as adding on different programs.. But as the economy tanked, the revenues went up from Prop 63 and core funding diminished funding for 63 became 20 to 25% of the Countys’ mental health budget. And so what was a boutique program became a mainstream or core program, and because there was a non-supplation cause in the—

HP: How did that— what was the thinking behind that?

SM: The thinking was really clear that if you just give Counties \$800,000 they might just put it into existing programs, they won’t keep doing what they’re doing [financially to support mental health]. They’ll pull out what existing funds they have, and the State could pull out any funding that they have [for mental health] and just use it [MHSA money] as a replacement in bad fiscal times so this needs to be a restriction on those practices. So it became really difficult. Here you have a program that’s pretty rich and vibrant that has rules about moving funds into other programs and those other core programs are eroding because their financing is contingent on the State budget and contingent on sales tax and that’s dried up. So that dichotomy contributed to the concept of the two tier system that people talked about. I think Los Angeles did a great job of that figuring out “well, geez, there’s nothing that says that you have to have separate programs. Merge the programs.” That was always the intent and it was something I strongly supported.. For example, Marv [Southard]²⁴ has merged a lot of the new

²³ Rusty Selix, the Executive Director of the Mental Health Association of California and the California Council of Community Mental Health Agencies.

²⁴ Marvin Southard, Director of the Los Angeles County Department of Mental Health.

programs with the old programs to build the support and services that make a difference to all recipients.

HP: There was nothing in the statute that said you couldn't do that? Because that was always the concern on the ground locally.

SM: It was always our encouragement. I always kept saying "do it, do it, merge them. Don't replace it expand it."

HP: I see, so that wouldn't be supplantation if you took the usual services you were providing them and just doubled them.

SM: Right or wrap something else around them.

HP: But does it then make it difficult through to follow a MHSA dollar versus a CGF [County General Fund] dollar?

SM: Yeah, sure it does. Sure it does, but it's once again [the question] should the system be driven by finances or by mission? I always thought it was by mission. If you can pass the reasonable person test and you're doing this type of merging and expansion and you're getting the outcomes and the services to grow that's fine. But you had "bean counters" and probably anxiety—more on the part of the Counties than on the part of the State—that there would be a problem in audits so, that you had to keep them separate. Blended and braided funding are really the only ways you can make this system work.

HP: To really do big things you need to take things is to take moderate pots of money and put them together.

SM: Right, yeah. And if you can't track it down to the [penny]—so what. If the program's working and it's got the right values and you're serving more people—I mean we said we do need to track the Full Service Partnership money, but that's only 50% of 80% so it's 40% of the total [MHSA] budget. So you got a lot of flexibility with all the other monies and programs.

HP: Um hum.

SM: So when you look at how many more people are served and how many of those people are served by MHSA dollars, that speaks to itself—that's the sound bite. "Look at this--we've gone from here to here with that money, and people are getting a new array of services."

SM: The beauty of Prop 63 was that California was becoming addicted to Medi-Cal. The only thing that people could get were Medi-Cal eligible services because they generated third party payment. So 50 cents on every dollar came from the Feds, but that is limited to the kind of services you get, the kind of provider who gives them, and whether you're eligible for Medi-Cal. But what about the 50% of the people who are indigent or underinsured in Los Angeles? Does that mean they don't get services?

HP: Um hum.

- SM: So there were no restrictions on [Proposition] 63 to say “put it all into Medi-Cal services.” [The Proposition said] “put it into whatever works. So if you can develop a program that’s going to save money in another place great, do it.”
- HP: But wasn’t—at some point a decision was made that MHSA money could be used to draw down Medi-Cal funds?
- SM: Oh, yeah and always was.
- HP: So even though there was the flexibility to not provide Medi-Cal services, it kind of provided incentive that you could double your MHSA money if you provided Medi-Cal services?
- SM: Well, you’re right. The tension was [telling Counties] “don’t just put it all into Medi-Cal services because then you’re eliminating a group of people who need the services.” Anybody who’s homeless probably isn’t going to have Medi-Cal, so [with Proposition 63] you could provide homeless services to someone who didn’t have a Medi-Cal card. And so to Counties that said “we’re just going to leverage all this and just do Medi-Cal services,” we said “no, that doesn’t meet the spirit of the law. The spirit of the law really is to provide Full Service Partnerships. Many of the services in Full Service Partnership are not Medi-Cal reimbursable. So you’ve got to do more than just Medi-Cal”.
- HP: So when Counties submitted their plans you sometimes actually said “no, this is a little too Medi-Cal heavy?”
- SM: Yes in some instances. That was the beginning of the creation of the tension [between the Counties and the State]. The Counties said “well, yeah, we need to do it” and we said “no, the law says you’ve got to do it this way. And so to some degree is it imposing a value system on Counties? Yeah. And to some degree did it create conflicts? Absolutely.
- HP: What was it in the statute that said MHSA funds could all be used to draw down the Medi-Cal match? Was it that a certain percentage had to spent on FSP’s or—
- SM: Well, yes. In the regulations we said that 50% of the Community Services and Supports [funding] needed to be spent on FSP’s, but we didn’t say that you couldn’t use that to leverage Medi-Cal. Any of the services in an FSP that were Medi-Cal eligible that was fine.
- HP: But you couldn’t discriminate who would be in an FSP based on Medi-Cal eligibility.
- SM: Right. And you had to show you had other services than Medi-Cal services in the FSP.
- HP: How did you guys come up with the 50% number?
- SM: Compromise. I mean some people said it [the MHSA funds] should have been all for FSP. But my read was that it [was to]—to expand services. So that was that whole idea of outreach and engagement—that if you wanted to get people

who weren't getting services, we wanted to expand services that gave you the option, because that language of outreach and engagement was in the bill.

HP: So the outreach and engagement outside of an FSP—what did that look like?

SM: Whatever you wanted it to be—to expand services to people who were underserved or unserved. So you didn't have to be homeless to be part of an outreach and engagement services.

HP: Uh huh.

SM: So certain counties used that to expand their outpatient services.

HP: I see, just to expand their regular outpatient. Were there any other stipulations? Or that 50% [of funds that went to FSPs] could have been whatever counties wanted it to be?

SM: Well, it had the outreach and engagement and Community Services and Supports. It just had to meet all those regulations, which essentially was [that MHSA funds needed to be used to serve] people who were seriously emotionally disturbed or seriously mentally ill. They had to be underserved and/or at risk of homelessness. So there had to be some criteria about who those people were.

HP: That was for the FSP's?

SM: Well, yes. But it's also for the whole CSS Community Services and Support. If you read the legislation, it wasn't intended for a population of people who were worried well.

HP: Or people who were in the [mental health] system.

SM: Right. Well, unless they were really underserved or at risk of being homeless. But you could have taken people like that and put them in a FSP—which some counties did. They said they needed more services.

HP: Now how does a Wellness Center fit within the definitions [laid out in the MHSA]? Or were Wellness Centers generally PEI [Prevention and Early Intervention]²⁵?

SM: They fit in CSS because that's just part of the Full Service Partnership. It's providing the support and the peer education and training, and some of the wraparound services. You see, a Wellness Center is not Medi-Cal reimbursable, but it's something we really encouraged. It made good sense to say "here's a place for people to go to get socialization, you get peer support, you get education, you don't have the restrictions of charting or medical supervision or you're not billing for it, but it gives folks one more option. To have something that's supportive of them as they move out of the depths in the mental health system into more independence." So anything like a wellness setting, some of the job programs, anything that could make sense. The advantage with Wellness Centers they weren't just limited to people who were in FSPs, because that was part of outreach and engagement.

²⁵ Part of MHSA funds were designated to go towards Prevention and Early Intervention Services.

- HP: So it's part of outreach and engagement, because if you view it as a continuum-- FSP over here, wellness over there, wellness could take people from this side or from this side?
- SM: Right. And so people in the community who might not want to come in to mental health [clinics], or maybe who only have an appointment every six weeks, can go there [to a Wellness Center] and get more services. They're still seriously disturbed but they can go to the Wellness Center.
- HP: So wellness was considered outreach and engagement, okay.
- SM: Or part of FSP, it's sort of both—it's a hybrid.
- HP: And they could also be part of PEI if you think of it that way.
- SM: Right. And so if you were creative and you really thought about it the way it was structured you could do pretty much anything you wanted. So this whole issue [of people complaining] that it [the MHSA] was very prescriptive, and that the rules were too tight—if you read the regulations, that's not the case.
- HP: Where did that perception come from then?
- SM: Well, I think it's fear of audits, fear of change. People saying "oh, you've got to do it this way." You know the whole idea that it had to be a new program. I sent out letters saying "no, it doesn't have to be a new program." The whole issue is that the upside of community involvement is that it's great; the bad side is that if misinformation's out [there], it's hard to change perceptions if they're inaccurate.
- HP: Right. So going back you were talking about how when the initiative first passed, you were meeting with Rusty [Selix] and [Darrell] Steinberg, and said "the devil's were going to be in the details." What were the devils that you envisioned creeping around?
- SM: Well, coming up with the regulations. How do you get 58 counties to change how they do business? Some know how to do it, some don't know how to do it. You have issues of sorting out what are Full Service Partnerships, what is CSS [Community Services and Supports]—what percentages, how do you get the money out, what's the allocation formula, how do you do it, how much does each County get. I mean—
- HP: How did you decide how much each County would get?
- SM: We met for a long time with Counties and did a formula that was 50% population and poverty--the old formula--with new money. And then we looked at issues of the Medi-Cal population in the County, the number of homeless people they had in the County, equity [of mental health services available] in a County, the cost of doing business in a County. We had five other factors. So we came up with a formula for each County to get a percentage of that—driven 50% by population. But then we figured Counties who had less money and more of an indigent population and were poorer and [had] more Medi-Cal [eligible residents] would have more unserved populations than counties that had a lot of money.

HP: So was this in a way to address some of the inequity that existed before between Counties?

SM: Right, right.

HP: Okay. And how did the stakeholder process inform the writing of the regulations?

SM: It surprised us and shocked us in ways that I don't think we were prepared for. We had our first meeting to talk about what we were going to do with Prop 63, and 600 people showed up. You can't do regulations--you can't do reasonable discussions with 600 people. So we hired consultants and we had meetings throughout the State. We did the same thing at the State level that people did at the County level; get information to inform us on how to develop regulations, [information] to develop programs to try and make it work. And people were very passionate--incredibly passionate--about what they wanted. The confusion about a stakeholder process [was] that some people really believe[d] that because it was a stakeholder process—because what they said was said and that had [it] to be done, not realizing there were 600 other people who had maybe similar opinions or not similar opinions. And so the development of regulations was really much more difficult than usual. Usually in regulation development there are not as many people involved, and there's a lot more County involvement because they're the ones who have to implement programs. [With the MHSA] it got diluted to some degree [since] there were so many players that participated.

HP: And the players, what was it that they wanted to see that was different from what you had envisioned?

SM: Well, I don't know that they wanted to see things any different than anyone envisioned. But I think it was [question of] how you get there, what the emphasis should be, who gets to make the decisions. And there were a lot of militants from client groups in [meetings] saying "we finally have a place at the table and we get to tell you what to do." And that wasn't really what it said in the [MHSA]. And they're just one group. So in the community meetings, some people are better advocates than others and some people really mobilize better. Some people were politically sophisticated, and some people weren't. So you would have people who would bus in large groups of people to promulgate a certain point of view or approach.

HP: What groups were those?

SM: Well, clients for example. But some of the providers did that, too. [They would] get all their people there and say "let's push for this. This is what you want. You want to have more programs like you're getting here. You come and talk about that." So you'd have a whole bus full of people all saying the same thing.

HP: So suddenly it was like—the stakeholder process became a hearing almost.

SM: It was, absolutely.

HP: So in what way did that shape the regulations that came out of it?

SM: Well, I think we listened. But all told, when you look at both the stakeholder process at the State level and at the local level, there were 125,000 people that

participated. I could go to any County and sit down with a group of people and they would know as much about Prop 63 as I did almost. I mean I lived it—but they knew the ins and outs, and of course as we said the initiative was always subject to interpretation. Stakeholders all had their interpretation of what the initiative was to do, and their own ways of reading it. I mean, from a sociological and anthropological point of view, it was fascinating from just trying to manage that much input and involvement. [But it was] probably was not the best way to do traditional government programs and rules. When you look at how the legislature works, they write the bill and then they have hearings and then they make the amendments and then they vote on it. But it's not continually open all the time, not dynamic and constantly changing, which it [the MHSA stakeholder process] had been.

HP: Earlier you were talking about it how wonderful it is to have client involvement and family involvement, and not have it just be people who are professional government workers making policy. Did this swing too far in the other direction?

SM: Yeah, it may have.. Because the reality is that what people want and expect and what a system can actually do are often times discordant.

HP: What did they want?

SM: Well, they wanted everything. They wanted to be able to have these kind of programs and those kind of programs. However, the bureaucracies didn't have the capacity to do that, or couldn't do it the way some people had wanted to.. They [bureaucracies] have to live within their existing rules and regulations and their other resources. But people [were] asking and people [would] say "well, why can't you just write us a contract for that?" Well not really, because that's not how government works or should work.

HP: What were some of the kind of programs or contracts they wanted?

SM: Take for example, some peer run programs. [Stakeholders asked] "why do we have to go through the Counties? Why can't you just give us money to go ahead and start the program right away?" And we [would] say "well, because one, the law says Counties run the programs; two, Counties have the mechanism for doing proposals, RFP's, and letting money out. And thirdly State's not going to make decisions [about] what a County can do or can't do."

HP: Um hum.

SM: So you need to really work within the system. And then the argument was "well, this is supposed to change the system, this isn't supposed to be business as usual." In some ways it was supposed to be different--there was a different vision, different values, new money and new involvement. But in other ways it wasn't going to totally change the whole mental health infrastructure, especially when it was only—at the time—10% of the budget.

HP: 10%?

SM: Yeah. But people expected that it would change everything. And some people are still upset about that. [They still ask] “why didn’t you put all that money into beefing up programs for people already in the system?”

HP: Why are those expectations there do you think?

SM: People have hopes and fantasies, and saw this as a panacea. And they can be impatient, they feel they have been waiting 20 years or 30 years for the system to change, and now they had their opportunity and they wanted it to happen right away. When change doesn’t move quickly, they get frustrated and angry, and I don’t begrudge them that anger. So how do you keep them having hope, but know that it’s going to take some time? I kept saying to people “it’s going take five years for this to really take off,” and people didn’t want to hear that. They wanted to think it was going to be like AB 34, where it took five months to get it up and running. Well, that’s three counties with \$10 million with three \$3 million programs.

HP: Whereas this is 58 Counties.

SM: With \$750 million. With five different programs that we’ve never done before.

HP: Exactly. And all the infrastructure it takes to build it up. One thing you mentioned is that it went through the Counties instead of being directly from the State. What was the thinking behind that?

SM: Well, Counties have to run the program.

HP: How come?

SM: Because I can’t tell you who’s a good provider, what the needs are in L.A. or in Alpine [County] or in San Bernardino [County]. I think that the uniqueness of each County needs to be respected, and they know what their most pressing issues are. The community has to come up with some solutions how to solve them. I mean there are 35 million people in California—it’s huge--and so there’s no way that the State could order or should order how Counties should do business. Part of realignment was moving those responsibilities to the Counties. That’s part one. Then I think part two is that realistically the manpower, the human resources, women power, wasn’t there at the State. So the bill passed in November [2004], took effect in January [2005]. People right away started asking “what are you going to do, what are you doing to do.” I had zero staff to do anything with implementation, because you couldn’t ask for staff ahead of time, because that would be taking a position on a bill. And our budget goes July to July so—

HP: Oh, so you didn’t have staff that you could put on this until seven months later?

SM: Right. So we had to pull people off other assignments to try and bring in some consultants and contractors to try and develop a huge, system changing totally new program. We had no infrastructure to develop a program, and no mechanism to hire people to be State employees to do that. So I think that’s a classic example why the State is not well suited to be able to be responsible for

total program implementation because it is--just that lack of being able to be responsive and reflexive to significant change.

HP: Um hum.

SM: And so people would say well, "why didn't you anticipate that?" Well, you can't anticipate if you can't—

HP: Yeah, you can't hire people. And what if it doesn't pass?

SM: Yeah, right. And you can't put it in the budget because then you're taking a position about it [the bill]. So people don't realize that, but I had to deal with that—that was how it was.

HP: So you mentioned a few minutes back about some of the tensions that came up with Prop 63. One you mentioned was contractors versus Counties. Tell me a little bit about that.

SM: Well, I mean contractors really thought it [the MHSA] was their bill.

HP: Why?

SM: Because they put all the money in to do the funding of the initiative,—Rusty [Selix] wrote it. That they put a lot of money in to do the advocacy and to do the marketing of it and to do a lot of the stumping for votes. So they really believed that since they put a lot of energy and effort into it, contributed, that they should be identified as prime recipients of some of the resources. I don't think it was necessarily the issues of providing services, because that worked out. I mean they knew they were going to get those opportunities. But for monies that were available for education and training for example, [they thought] "why should all that money go to the Counties to get educated and trained about new ways of doing business?"

HP: Oh, that they wanted just their staff to receive the education and training instead of the entire County.

SM: Right.

HP: Oh, so that's what the sticking point was.

SM: That's was one, yeah.

HP: Okay. But was there a back history in terms of statewide the relationship between the contractors and the Counties, was there—

SM: There's always tension—a ton of tension.

HP: Tell me a little bit about that.

SM: Well, it's tension in the sense I mean it's like tension between the State and the locals. I mean it's who gets to make the decisions, how are the contracts allotted, how much are in the contracts, what are the expectations in the contract, who's going to audit the contract, what do you have to do. Especially on the children's service side--if you were a provider that worked with juveniles and you had multiple Counties involved, every County had a different contract and different requirements. So the paperwork was difficult or burdensome. I am

trying to say it's sort of a mini State-County relationship between Counties and contractors.

HP: Uh huh.

SM: And some Counties are really very experienced contractors they do a lot of contracting and others didn't want to use any contractors. Some counties wanted to spend all their money on County employees, and that had a lot to do with history. In some Counties there was the politics of it. It could be union politics versus non-union politics.

HP: Because the unions were generally the Counties and all contractors are non-union?

SM: Many of them are, yes. That can be a big political issue. That's not a policy issue, that's not a program issue. When you have elected officials involved they pay attention to those issues, too.

HP: You have to pay attention to the politics. Something I wonder about—I know that in some Counties at least if you work for the County you make significantly more than if you work for a contract agency. One would imagine that that would mean that you attract better staff if you pay them more, if they get better benefits within the County—

SM: Not necessarily.

HP: Not necessarily? I mean because I'm curious does that come into the equation when thinking about this? Is there this question of quality in the contractors versus the County?

SM: No—I mean quality of staff is variable at all levels. I think most people would say that. For example, you could realistically say that the quality of the staff at the State Department of Mental Health ranged from phenomenal to marginal, and that the quality of County programs ranges from phenomenal to marginal and the quality of contractors programs ranges from phenomenal to marginal.

HP: So it's hard to really—

SM: Yes, I mean it's a bell curve for all levels of government, contractors and services.. And so I don't think you'd say County programs are better inherently than contract programs. Some are, some aren't. And some contract programs are better than County programs. And it also depends on where you are.

SM: And so an example of some of where the tension was--some Counties told contractors they couldn't participate in the stakeholder process because they had to recuse themselves because they were voting for things that they would have an economic benefit for them. And [then contractors would] say "well, how do I get my point across then? You've excluded me from talking about programs that I helped develop, and writing that I've worked on [for] this initiative [Proposition 63]." And then they would say "well Counties you're voting on it and you economically benefit from it so this isn't [fair]." So there was that kind of tension.

- HP: Right. And then was there an issue with what you talked about before with flexibility? I know that some Counties started providing the FSP services directly. Did that create difficulties in terms in of just what you were talking about before? How difficult it is for Counties to provide these kinds of services?
- SM: Well, some Counties had already had that experience. If you had an AB 2034 program—those really were very similar to FSP's--you could have expanded that type of program.
- HP: Um hum.
- SM: This example was a classic source of tension. One of the criticisms from a group of folks who were a part of NAMI was that we should have put all the money into FSPs and it should have gone to Counties. The problem I had with that was not all counties had FSP's. So how would you do that? I couldn't give them money to develop something they didn't have or expand something they didn't have, especially if a contractor and Counties didn't all run any of those programs. So it became this whole issue of getting people to figure out how to develop them [FSPs] and what it meant--what was the right balance. Some Counties have a combination of both County run FSP's and contract run FSP's and that seems to work well for them.
- HP: I'm curious, why would NAMI want it to go only to the County FSP's?
- SM: Well, it's not NAMI, it was just members of NAMI. That was not a NAMI position at all, the organization was actually supportive of the broader interpretation of programs.
- HP: Okay, yeah.
- SM: But some of the vocal critics said it wasn't implemented right because their family members were in County programs.
- HP: I see, so they felt that it was excluding—
- SM: So if you expanded County programs to have FSPs, their family member who was already in service would get services.
- HP: Uh huh. So again it comes back sectional interest--versus the system's interest--that started to creep back in.
- SM: Right.
- HP: Is that because there was a bigger cookie jar so everybody wanted to stick their hand in?
- SM: Well, right. I think whenever you have money, people forget it's finite. And they get into fighting about "well, me first. I've been starving, and so I need that" and "I've been in line for a long time, where is mine?" And it's hard for them to hear "well, someone else is starving more than you although you're really hungry." And it's hard for people to hear "these programs work better than those programs."
- HP: Yeah.

SM: I believe in evidence—evidence based practice or practice based evidenced. It shouldn't run programs but it should help inform choices. But to give you an example, if you look at the research that programs that are like extended day treatment programs--I mean rehabilitative day treatment programs that go on forever. Their outcomes aren't very good at all—they really aren't. I saw that people think these programs don't create dependence, and people don't move from these day treatment programs, as opposed to employment programs, which have significantly better outcomes. The difference is [that] rehabilitative day treatment is paid for by Medi-Cal. Supported employment programs, or employment programs, aren't. So how do you get people to give up this program that's not working and say "here's the evidence that it's not working compared to this program" and invest in a program that does [work]? Well, people who are running the day treatment programs don't want to give up the program and they'll say "well, why?" And it's hard to see why you would give up some third party participation to invest in a new program where you're not going to get third party participation, but you get better outcomes. What you could argue is [that] you're going to get cost savings in the long run because those folks are not going to be in your system in the emergency room or in jail or whatnot.

HP: Um hum.

SM: But that kind of shift is hard because people tend to look at things—and I'm not saying it in a critical way--but we all look at things from our point of view. If you run a program, you tend to think that's a good program. Or if you're not getting the services you want, you tend to think about what you need, not what someone else needs. It's hard for you to say "well I know I'm not getting enough, but someone else needs it more." Most people aren't that gracious. Some are but—

HP: Yeah.

SM: And so I think that's what created a lot of tension, a lot of difficulties. And the State had problems, but not as much as Counties, because all of that dialogue and tension really became much more polarized at the local level, at the stakeholder hearings, with all the demands for services, and what the programs could be or couldn't be. Sometimes people can interpret the regulations however they want. So it's always easier to say "I can't do that because the regulations don't let me do that."

HP: And it's hard to say "sorry, we're not going to give this to you."

SM: Right, even if the regulations would let you do it.

HP: I see, so misinterpreting the regulations would serve a political purpose there.

SM: Well, or taking a conservative interpretation of the regulations.

HP: Yes, um hum, it makes sense.

SM: And it makes it someone else's fault.

HP: Good way to pass the buck.

SM: Right. But we all do that.

HP: Yeah, exactly. Then another tension you mentioned is with clients and family members. What were the issues that emerged with those groups?

SM: Well, it was an issue that was underlying a lot of the tensions was the issue of voluntary versus involuntary treatment.

HP: Um hum.

SM: And how much reliance should you have on traditional treatments, medication, hospitalization and whatnot, as opposed to the push for peer run programs or the ability to kind of craft your own programs. Those were the two extremes. Laura's Law²⁶ was a big controversy. The regulations were written in a way that counties could implement Laura's Law.

HP: Why did you decide to do that?

SM: Because it was the right thing to do. I personally believe that voluntary treatment is the best. But I also believe that involuntary treatment is essential and necessary—that there are times when people really need to be involuntarily treated. The more options you give people, the less you have to do involuntary services, but there are always are times when people do [need] it [involuntary treatment]. So they shouldn't be eliminated from services because they need involuntary care.

HP: And involuntary [treatment] can still be recovery oriented?

SM: Sure. It's just a step. I mean three days in the hospital is involuntary, but if it gets you back on the right track, it's helpful. But if your treatment plan is that whenever you act up we're going to put you in a board and care or we're going to put you in involuntary treatment or we're going to give you involuntary medication, that's not creating independence or trust in the system. So I believe that when involuntary treatment is not the dominant value system of what services are available, but is an integral part of it, I think that is appropriate.. I think that involuntary has to be a part of the system so the exclusion of any involuntary treatment from options doesn't make sense in [the] whatever it takes [philosophy].

HP: And have the client groups come around on that or—

SM: No really, but unfortunately the client groups have recently imploded and have less voice anyway. NAMI's appears to be fine with it. But for some of the clients, no they haven't. The two mantras [for the client organizations] are "nothing about us without us," which is reasonable and "no involuntary treatment," but that just is not realistic.

²⁶ Laura's Law is a State Law that allows counties to provide assisted outpatient treatment—involuntary if necessary—for individuals with serious mental illness. It is named for Laura Wilcox, a young woman who was killed by a man with severe mental illness who did not receive treatment. To date, most California counties have either not implemented Laura's Law, or only implemented it on a limited basis.

- HP: So now looking back on that initial [MHSA] implementation and how it unrolled--tell me two things that you think have been great about it and two things that you wish maybe had gone differently.
- SM: Well, I think where 63 is now--the kind of programs that are starting to come out, the value changes--it's really exciting. There are some phenomenal things that are happening. I think it kept the mental health system afloat--if MHSA had not been there with these really bad budget times, the system would have just shriveled and regressed back into a hospital and medication and emergency service-based program. So do I think it's a great initiative--yes. Do I think the values are right? Do I think it's been taking off? Absolutely. As I said to people when we were starting to do this, I thought it was the State's responsibility to get the boat out of the harbor, and that's complicated. But once it's out of the harbor people can take it wherever they want, and people are taking it to really great places so—
- HP: And that's really happened now with the Counties approving plans instead of the State?²⁷
- SM: Yes. And I think that would have happened anyway. I mean we were even talking about doing that before that financing strategy became legislation and saying "why are we reviewing this stuff?" I mean we were just nibbling around the edges--once people have the right kind of concept and figuring out how to do that, that would be fine. I think in retrospect the miscommunications about what can and can't be done [with MHSA funding] could have been handled better--this whole issue of new programs versus expanded programs, I wish that had been clearer. The focus on regulations and fear of audits and sort of this tension that comes with that--it would have been a lot better to have probably different kind of dialogue. There were too many players involved, but to get to a way where you can have more flexibility in the implementation [would have been good]. I mean you can't have total flexibility, because you've got to make it work, but to be able to have had clarity about regulations and less regulations but more adherence to important ones—
- HP: What were the important regulations do you think?
- SM: Well, I think the important ones are the intent, which was really to change the way of doing business in mental health. This whole idea of Community Services and Supports and Full Service Partnerships and reaching out to unserved populations, getting people in the system that haven't been in the system and offering them a wide array of services. That's the critical part. It shouldn't be either/or, and it shouldn't be at the expense of the existing system. The existing system has a lot of value to it, and it's working, and it is a safety net. It [the MHSA] shouldn't be a boutique, and it can influence how the system works. So whether it's recovery or whether it's evidence based practice or whether it's new ways of doing business. I think that would be one of the things that I would hope would have been different.

²⁷ Since 2011, the State Department of Mental Health has no longer needed to approve Counties' annual MHSA plans.

SM: The other is just that you learn a lot in retrospect. Trying to invent a program that's never been done before at this magnitude is--looking back at it, no one would ever take that on. I mean it's too much. Really redesigning an entire mental health system, from values to way of delivering services to financing on the fly—people expected it would go right away. I see that people are complaining about the Affordable Care Act, where they've had three years [to prepare] and they still aren't ready to have it up and going. They don't have all the kinks out. I mean we started just rolling 63 out within six months.

HP: Yeah, you had to because of—

SM: The pressures—people wanted that, and you needed to do that. So it wasn't something that was as contemplative as it could have been. It wasn't because it was reactive sometimes. We made some mistakes or did things we didn't necessarily have to do. Those missteps complicated things. People are at different places all the time, so getting everybody at the same place at the same time is always hard. We were able to do that with realignment, we were able to do that with the consolidation of the fee for service and Medical, we were able to do that with the rehab option. However, we were able to do that with other things because it was more orderly and thoughtful and there was adequate time for planning and implementation. There just wasn't the time to do that [with the MHSA]. The expectations were incredibly high, the desire was incredibly high, and the amount that had to be changed was huge.

HP: Was it just the size of the change, or was it also the democracy of it? I'd imagine that if there wasn't going to be a stakeholder process, you could have had a plan written up in your drawer ready for implementation on January 1st.

SM: Yeah, maybe. But I think it never should have been the Steve Mayberg Plan or the Rusty Selix Plan or the Darrell Steinberg Plan or the CMHDA Plan. It never could have or should have been that. It should be the California plan. Changing the whole system and the values in a system is really hard. I mean it just is really hard work and a long and at times painful process..

HP: It's hard to do in a short time period.

SM: I think it is complicated because it's getting many people to deal with the issue of stigma and misinformation. There are people who are still critical of new or different mental health programs. There are articles in the papers about why are you doing education about stigma and why are you doing programs about bullying when you should spend money only on treatment—and this is within the last year. Perceptions and understanding of the mental health system are not always informed or accurate.

HP: Um hum.

SM: What I mean is that some people just may have their clear cut sense of “this is the way to do it and so we should change everybody to get to a certain point.” and all these pieces will eventually fit together, but you just have to trust a little bit. However, trust is really hard when you've had a system that hasn't had the

resources to give everybody what they need or what they deserve or what they expect.

HP: Yeah, yeah. So more time to really plan it out and maybe you perhaps let it evolve rather than having it have to be as revolutionary as it was.

SM: Um hum. But like in physics, it was a quantum jump. You build up a sense of energy and you go to a new orbit. The problem is we didn't know we got to a new orbit, we just—and we didn't know where it was going to take us. And it took us to a great place. I mean if you go around the State and you look at some of the programs and some of the things that are going on, fabulous, fabulous stuff. Some of the programs and results that have come out of this initiative have made huge differences both in the provision of services and certainly in the lives of clients and people that are recipients of services. I know and believe it just really made a big difference and people are engaged. And once you build those successes in, it's easier to add new things and people will give you a little bit latitude to try new things. For example, Los Angeles County and Orange County can try some different things now because they've had some core successes. There weren't any core successes when we first started. It was just hard enough to get the money out.

HP: Yeah.

SM: As we talked about, with the bureaucracy from the state, getting money out, and then Counties having to go through RFP and the planning program process—the pent up energy gets really, really high. And we didn't choose the low hanging fruit. Dealing with homeless, dealing with the most at risk people, dealing with people who—

HP: Shot for the stars.

SM: Yeah, you're picking the hard ones, not the easy ones. And that's the way it should be. That was, I think, the other fear—that people would just take easy way out with programs and people served and while Counties may have bitched and complained, they took the tough challenges—difficult ones—and they're doing the tough interventions. Not to say that there's not a lot of problems out there—there is and that there's not enough money in the system.

HP: Um hum.

SM: When you look at the evolution of the system sort of tying this all together, the decision in 1991 to move to realignment and transfer authority and responsibility to the Counties began this system change. To start closing state hospitals contributed to this. To consolidate the private and public Medi-Cal dollars consolidated the care, expanding the array of services through moving to the rehab option, by looking at programs like AB 377, AB 3777, AB 34, AB2034—all are progression towards system change that is a little bit more incremental, by expanding the amount of services, adding the more community oriented [care], developing a recovery model, starting to look at people as individuals [who are unique]. Listening to the clients, listening to family members, listening to ethnic groups all were evolutions that contributed to this transformation in our mental

health system. So the history was there, and is probably why the coalition and the community supported it [the MHSA]--because they did believe that it would work. It's just that that pent up excitement and enthusiasm is hard to manage.

HP: Yeah—a little too much.

SM: You don't want to put anybody down and you don't want to slow them down. You want them [stakeholders] to be enthusiastic and you want them to participate. But it's also the reality of politics and bureaucracy and RFP's and just the limited expertise that it takes a while to develop those changes. Realistically, there weren't enough people at the State who really understood [Proposition] 63 to be able to provide good mentoring for it.

HP: If you had more manpower do you think that would have helped?

SM: No, no I don't. In some of the technical parts [yes,] but in terms of mentoring, envisioning and being able to figure out how to do the programs and design , no—. It[was a question of having visionaries and how to develop thought leaders. How do you have people who can envision and conceptualize a concept into a program, and who understand how Counties work and what consumers and families need and how contractors work? There just aren't a lot of people around who can do that.

HP: Especially since it's very different in Shasta and L.A.

SM: Yeah. I mean even Counties had trouble having people envision how to make the system work. There was not a book you can read or there's not a program you can look at or a place that you can go visit where this is happening. So it was truly trailblazing. The State of California did some amazing trailblazing but you don't always go in a straight line. You run into some mountains and some floods—we didn't have any Donner parties but—

V. Experience on the President's New Freedom Commission; Defining "Recovery"; The Affordable Care Act and the Future of the California Mental Health System

HP: Okay, there are two other things I wanted to ask you about. Tell me a little bit about your experience on the New Freedom Commission.²⁸

SM: Great experience, because we got to look at the whole mental health system in the United States and see all of the problems and come up with some recommendations of what should or shouldn't be done. The findings were consistent that the system was fragmented and too reliant on federal funding, whether it was Social Security or Medicare or Medicaid. But if you look at the recommendations, and if you look at the road map [laid out in the Commission Report], and then you look at where California is and you look at what

²⁸ Dr. Mayberg was part of a national expert panel convened for George W. Bush's New Freedom Commission on Mental Health in 2002.

happened—where we'd been even before [Proposition] 63, and [also] with [Proposition] 63, we fulfilled everything that was addressed in the New Freedom Commission. Every one of those recommendations we developed a response to and moved forward.

HP: Hmm.

SM: [In the Commission] we talked about integrating services, we talked about being client centered, we talked about services for children and through the life span, we talked about research, we talked about using the 21st century technology, all those things. And so if you read the New Freedom Commission report, you will I was able to get a lot of California values and programs incorporated in that document.

HP: And how about the definition of recovery that kind of came out of that document? What were the discussions like around that? Was there controversy? What were the sticking points?

SM: Well, the controversy, of course, was around some of the beliefs by some of the critics that people never recover. That mental illness is a chronic illness and that you're given a diagnosis and [that after being diagnosed] you're life is going to be difficult no matter what, for a long period of time.

HP: Um hum.

SM: That was part of it. And I think that there was the other sort of extreme viewpoint on the recovery part— sometimes advocated by a more militant part of the client network--[saying] “we can do it ourselves, we don't need treatment, let us make the choices” and some of [the belief that] “mental illness is manufactured by Pharma²⁹ and by society.” So there was some of that tension.

HP: Sounds like you had a pretty big tent there.

SM: Yes, and it was tense. I think the leading advocate for the client movement, Dan Fisher, a psychiatrist³⁰, was sure that he was just going to get the stuffings beat out of him, and was [on the] offensive to begin with. I think [he] was surprised that people were willing to listen, and [were] fairly moderate. Some of the more outspoken critics did not think the moderate approach was enough, but many believed it struck a fair balance [of Fisher's perspective]. The issue about spirituality and faith based services certainly got toned down, and there were a lot of pressures when we talked about minorities and what that term were presented; people wanted to include sexual minorities, gay, lesbian, transgender issues.. That broader definition of minority groups kind of got toned down [with some people] saying “let's not add red herring to this, let's really focus in on the issues.” However, the clear take away is that the color you are and where you live is going to impact the quality of care you get. People can relate to that fact. That's the sound bite of that finding, and it doesn't have to get into the details

²⁹ The pharmaceutical industry

³⁰ Daniel Fisher M.D., Ph.D. is a psychiatrist who is also living with schizophrenia. He is the Executive Director of the National Empowerment Center.

whether they say they support special programs for gays or any particular sexual orientation—well, no, that's not what it's about. So I think the issues of recovery were there to some degree in all the recommendations, but with an infrastructure problem and lack of services, it is hard to talk about recovery without any access. I think that the children's part [of the report] about referencing certain models of systems of care was there and supported the idea of coordination and collaboration to avoid fragmentation and to get better care..

HP: What was it that turned the skeptics? You mentioned that there were people who believed that people with mental illness are going to have their illness forever, but then they kind of came around. What did that process look like?

SM: Well, I don't think some of them ever came around. I think that they could see that with good treatment, the research showed that they [clients] didn't have to be in treatment forever. There was some research out of New England, I think maybe it was Vermont—

HP: The Harding Studies?³¹

SM: Yes, that people do get better.

HP: Right.

SM: So—and when Dr. Harding came and testified, she didn't say everyone gets better, but she said a third need minimal care and a third need continuing care. So that's still two-thirds of the people that don't have to be in the [mental health] system all the time. Taking a strengths-based approach, that at least by focusing on the positive rather than on the one-third that always [needs] to be in the mental health system, we could learn some valuable lessons. Let's give people some hope.

HP: Was there a concern that by focusing on the two-thirds who can graduate from system that the one-third who need to stay in the system would kind of be encouraged to leave [prematurely] or forced out?

SM: Well, I think people worried about that to some degree. But I think the value system of the report was built on hope and transformation—I mean it was hopeful. President Bush was seen as being oriented towards independence and moving on and encouraging non-restrictive interventions and responsibility.. I mean whatever you want to say about the President, that clearly is a value of his - a belief that people can change. The fact that he went through his own recovery with substance use, and you didn't forget about that journey [once you experience it], so—

HP: Was he personally involved in this Commission?

SM: Well, he picked the people. The White House did have influence. So, for example, Charlie Curie, the SAMSHA Administrator and Bush appointee— Charlie was a person who got an award for stopping seclusion and restraint in

³¹ Longitudinal studies conducted by Dr. Courtenay Harding following the life trajectories of individuals diagnosed with schizophrenia showed that between one-half and two-thirds of them achieved considerable improvement over time.

the state hospitals in Pennsylvania, was really a believer in less restrictive care.³² He frequently met with the White House and communicated what the Commission and the White House were thinking, informing better debate. In addition then you had Mike Hogan³³, and I, on the NFC [New Freedom Commission], who really came out of the same [kinds of] state experiences, and we frequently had the same perceptions about recovery and independence and advocated very strongly the same way. So you had an administration and the people who ran programs being able to really push for the belief in that [recovery] and with good credibility. I think with Mike's years and my years of experience,—we were the senior mental health Commissioners and leaders in the National arena, I think that people listened to us, which is nice. They were respectful of us.

HP: So that helped animate what the commission did?

SM: Right.

HP: Good. So I'm going to wrap up now with just two questions about the future. One is about the Affordable Care Act. With that, the increasing focus on integration, and the consolidation of the department into the Department of Health Care Services³⁴, how do you see things unfolding in the future?

SM: I think the greatest opportunity that mental health has had in decades is within the Affordable Care Act, within the exchanges, and with the implementation of parity.³⁵ So there's opportunity—the great opportunity's there.

HP: What are the opportunities?

SM: Well, the opportunities are one, that there's funding—a ton of funding available. That you're expanding—Medi-Cal is expanding, [so] that people who were indigent now can get coverage to pay for services. Mental health services can be reimbursed that weren't reimbursed before, so it [will bring] more money into the system. And parity insures that it has to happen, which is really positive. I think that the fact that you have that [increase in funding means that] you can start doing more prevention and early intervention. The programs and strategies that counties are starting to do with [Proposition 63] so that people can get services earlier, so that they don't have to languish or explode into the system with a 5150.³⁶

HP: Um hum.

³² Charles Curie was a member of the New Freedom Commission who had previously served as Deputy Secretary for Mental Health and Substance Abuse Services in Pennsylvania before becoming an administrator with the Federal Substance Abuse and Mental Health Services Administration (SAMHSA). Curie played a key role in organizing the New Freedom Commission and developing an action plan for its recommendations.

³³ Michael F. Hogan was the director of the Ohio Department of Mental Health, and the Chair of the New Freedom Commission. During his time in Ohio, Hogan oversaw the closure of several state hospitals.

³⁴ The State Department of Mental Health was consolidated into the State Department of Health Care Services in 2011.

³⁵ Parity refers to legislation mandating that insurance benefits for behavioral health conditions be as comprehensive as those for physical health conditions.

³⁶ A "5150" is an involuntary psychiatric hold in an inpatient setting.

SM: So I think those opportunities are great. And the [Proposition] 63 money can be leveraged, or should be leveraged, to be the [Medi-Cal] match for all of those programs. So I believe you could—I mean when you talk about leveraging Medi-Cal, you really can leverage a lot more now, bring down new dollars. That is because it's an approach that funds services for the unserved population. They were unserved often because they were indigent and there was not money to pay for resources, but now there can be..

HP: Now that they're [going to be insured]—

SM: --you can bill all those eligible services and so bring a lot of money into system. That part's really positive, so that's really exciting. The critical issue is about the [insurance] exchange requirements. Is Medi-Cal going to be responsive to the needs of the mental health population? Are we going to have a small benefit package, or are we going to have a robust benefit package? There are groups who would like to propose a minimum package of benefits, which is really good since it means there are now some benefits, but we just need to make sure that the minimum isn't the maximum. That's going to require a lot of advocacy, and it's going to require a lot of behind the scenes work to make sure that the rules and the regulations about how ACA and the exchange are implemented in California are appropriate for the mental health needs of California's population.

HP: Wouldn't parity assure that to a degree?

SM: No.

HP: How come?

SM: Well, when you look at it, it [parity] just says it [mental illness] has to be treated the same way [as other conditions.] But you can define who gets services. The threshold is fungible, and so what's considered medical necessity can be subtly changed. So you can say "yeah, we offer medication and a doctor's visit if you have a physical health problem. [So if you have a mental health problem], we'll offer you medication and one psychiatrist visit." It doesn't mean you get weekly visits, it doesn't mean that you get therapy and—

HP: Case management and community support.

SM: All of those things, yeah. So then you would have to argue "yeah, but if I broke my leg, I could physical therapy and I would get rehabilitation. That should be included for mental health conditions. Or if I had breast cancer, I would get screening and I would get reconstructive surgery." So how that's interpreted for the mental health conditions is critical. So they [the insurance companies, can say] "yes, I'll give you meds or I'll give you a doctor visit "or they could say "I will give you the whole panoply of services." Mental health has always made the mistake of assuming all the services [it offers] are medical services, and we need to remember that insurance is only medical. So housing and jobs, a lot of services that mental health does, aren't covered by insurance. Even with the rehab option a lot of those services aren't within the purview of Medi-Cal. Those types of services are rarely covered by most insurance companies.

HP: Right.

- SM: School visits, home visits—most of those things would rarely ever be covered by insurance. So you have to ensure that relevant and necessary services in mental health are covered. I was the person who cleaved mental health out of the physical health system and it had to be—and for good reasons—
- HP: What do you mean out of the system?
- SM: It was part of the health system and then I argued that we [mental health] needed to be carved out.³⁷ So it's got to be carved back in [now]. We had carved it out because there weren't services available for mental health—people were being excluded from care, they were denied service because they had a “chronic condition,” there wasn't parity and there was no legal reason to have to provide equivalent service. . Any managed care organization--or even Medi-Cal--didn't necessarily pay attention to the needs of the mentally ill. There was a lot of research about that redirection of dollars from mental health care to physical health, and that was when the financing was even worse.
- HP: And “chronic'd” out meaning there were limitations, you could have only some many visits a year?
- SM: Well, no, if you had a chronic condition you weren't eligible for anything.
- HP: Oh, saying “that's not a medical concern because of pre-existing chronic conditions?”
- SM: Right. That was a concern, and that's why we carved that out. And then no one knew what the array of mental health services should look like. Now we know what it [should] look like, and now we have to integrate back with health and coordinate care. I think the integration of behavioral health and physical health is the number one priority for our system. We can't have the mind separate from the body.
- H: Right.
- SM: And so primary care and primary care providers are going to have to be the people who are going to be the case finders, they're going to have to be doing some of the treatment. There have got to be resources available at the front door--not at the back door--for people when they come in to get mental health services. And it's going to be a lot better if someone comes in and gets treated for depression, anxiety, first [psychotic] breaks, schizophrenia, early on. The [typical] duration of untreated psychosis is three to five years and [the] duration of untreated neurosis is five to eight years. Those are lost years, never regained. [We should] cut that way back to be months, not years. So that's the key issue.
- SM: So to the he second question, does it make sense to dissolve the Department of Mental Health? Well, probably from a theoretical point of view--modeling the integration of mental health with physical health--that's absolutely the right thing to do. Having the tie-in with Medi-Cal and health care exchanges is really

³⁷ “Carve out” refers to having behavioral health services managed by completely different insurance plans, separate from those covering physical health care. California's specialty mental health carve-out took place under Mayberg in the 1990s.

important. That's really essential. But having a voice, making sure it happens, having a presence—the way it's structured right now it's hard to know whether that will happen or not. [As head of the State Department of Mental Health] I was a peer of the [head of the Department of] Health Care Services. So I would meet as a peer with Department Directors and Agency Secretaries. I would argue that “now you've got to include this, no you can't do that, the bridge to exchange isn't inclusive enough.” So I could argue that [then], but now it is more difficult to argue two levels up [the chain of command]. With your boss, it's harder to argue.

HP: Yeah.

SM: So it puts more of the issue of advocacy out in the community. But still, you've got to have an administration that's responsive to [mental health]. The mental health community has got to get consolidated to be able to [advocate effectively]. [It's important] to have that focus, [but] people want different things. What the Counties want may be different than what contractors want and what families want. [What mental health needs is] a coalition again, to be able to advocate to get back to where they were philosophically in 1990 and 1993, all wanting the same things for the good of the entire system and giving up some of their individual fiefdoms to make the system work. If they do that, then mental health will continue to flourish.

HP: But it's difficult to do that [coordination and advocacy] if you don't have a department head who will then bring the message and push it along.

SM: Right--then you can support whoever it is, you can all have the same message.

HP: Right. Another thing that comes up with this question you mentioned primary care integration—how do you see the holistic recovery oriented world of mental health working as it becomes integrated with primary care, which is [more oriented towards having visits that are] ten minutes in and out?

SM: Well, that's part of where education goes. That's a flaw that we've created by carving out this ten minutes [of a primary care visit] for your mental health, but we don't know whether you make it [to that visit] or not, or you may have to wait six weeks. How do we build some of that recovery holistic view back in? How do we move mental health into the clinic? For example, at Kaiser in pediatrics, they were having the psychologist two or three afternoons a week stationed in the primary care clinic. So when the primary care provider would see a child with behavior problems, with ADHD, with whatever—Asperger's--they would just bring the psychologist who was there at the clinic into the office right away and begin developing a plan. So they worked collaboratively--still working through the pediatrician but using the mental health [clinician], so it was a team that was doing the holistic approach. It was not the usual saying okay, “I'm going to refer you to Steve over in mental health, call him up.”

HP: So it was true integration.

SM: Right. So mental health needs to move into some of those systems, and be available for consultation, for support, for services there. When you start doing that it minimizes some of the stigma [around mental health]. [It will just be] “I

went to my doctor, he had referred me to someone there and I saw the nurse and I saw the psychologist and I got a plan.” I think with the advent now of technology we can follow up better, we can give people opportunities to get a variety of coordinated services and to start getting care.

HP: Okay, so the final question. Let’s say you were going to be in charge for the next ten years, how would you steer the system? How would you make it work?

SM: Well, for one thing, when I went to work at the State I never wanted to be the mental health director, that wasn’t in my game plan. You soon have to realize you’re never really totally in charge. For any Director part of it is then figuring out what do you have authority for, what do you have responsibility for, and how much do you just manage? And a lot of it is just managing but more importantly it is leadership by collaboratively developing a vision, a plan, a strategy to get there that is inclusive, proactive and measurable..

SM: That being said, in the next ten years where would I focus energy? I really would focus it in on making sure that the opportunities for the Affordable Care Act and the Health Exchange are really maximized for mental health. I really would push, too, for much more integration with primary care. In retrospect, I think mental health has become too insular, and to some degree having lots of money allows you to be insular. Mental health doesn’t have lots of money but they have more money than other people. The new programs allow them to be insular. But mental health has to be a part of the larger health programs [now], they have to be a partner. They can’t say “it’s my money and we’ve going to do it my way.” If you’re a good partner, you bring your value system and your way of doing services to people, so that they can see the value in it. [So the question is] how do you move that forward into the next level? Integration is really hard, and so that’s what I would push for. There are still a lot of people, who just in the mental health system, are really frustrated and angry about not getting services. If you go to FQHC’s³⁸, if you go to primary care clinics, if you go to rural health clinics they’re furious about not getting access to mental health services. And you’re going to have to listen to that and you’re going to have to deal with that. We’re all in this together, and as I said before, [we need to] make this mission driven rather than financially driven. What’s best for our system is not what’s necessarily best financially, but it’s [what’s best] for the individuals, for the community, for the family—for where we live as a whole. How do we make that happen? That’s really hard. I mean it’s system changing and that system change is exciting and challenging and fun.

HP: Yeah. I mean with what you were talking about how hard it was to make the MSHA a reality, when you do something revolutionary it’s going to be hard. I wonder with the ACA, because when it fully rolls there are going to be people politically targeting it.

SM: I mean it’s already targeted.

³⁸ FQHCs—Federally Qualified Health Centers are primary care centers that serve poor, underserved, and uninsured populations.

HP: Yeah.

SM: And that was actually one of the other things that happened with MSHA. You're never under the radar anymore. You've got the money and then it brought a lot of entirely new people who were never involved wanting to have a say about the money and programs. [Then critics say] "well, there's money, we want to take the money for something else" I was always constantly at the legislature saying "no, you can't think of trying that. Of course there's money here, but we haven't had a chance to get it out yet but we're accumulating it first." An interesting difference with the MHSA and most other State programs was that we didn't have any money to give out until the cash came in. So we had to wait for the taxes to come in before we could let it out. So we never tried to spend money that we didn't have, which is good budgeting. That's why I think it [the MHSA] survived some many ups and downs.

SM: So, yeah, the ACA is going to have a lot of challenges. Would I want to get involved in doing some of that? There's a part of it that's a challenge and another part of it that's a ten-year commitment. It's going to take ten years to fix it. Just like it took five years to make the Mental Health Services Act become to be functional. So you're in for the long haul, there are no quick fixes here.

HP: Yeah, it's going to be interesting times.

SM: And while it may be that some trains have left the station, a lot of decisions have already been made that maybe needed to be fixed, but the opportunities are still great..

HP: So we'll see on that.

SM: Yeah.

HP: Well this has been wonderful. Thanks so much for your time.

END OF INTERVIEW

