

Susan Mandel talks about her early days as Director of Pacific Clinics...

So one of the first things I did was try to meet a lot of people and get a sense of what the needs were. And it didn't take a rocket science to identify two glaring needs. One was you ride down Valley Boulevard 30 years ago and you could see the ethnic Chinese signs were coming up all over the place; and there was not a single program for Asians [or] Pacific Islanders. So Allan Rawland, who is now the director in San Bernardino, was the district chief here at that time. So I went to Allan and I said, "Allan, I'm going to start something to try to get grassroots support to develop an Asian Pacific Center. Let's work together and do it, we'll both get credit." He said, "Sure." So I went about hiring somebody and the way we've developed our programs is [we have] hired people who have some experience. I find Terry Gock, who had some experience setting up a suicide prevention hotline and some other things. I said, "Terry, would you like to work three days a week as a psychologist and two days a week doing program development?" He said, "Sure." He's now the Director of the Asian Pacific Family Center and has been for many years.

Allan had gotten Gladys Lee working for him in Arcadia Mental Health. Gladys is now District Chief. So Terry and Gladys got together and formed an Asian Task Force where they worked with police and school officials and whatever, and in 1985 opened the Asian Pacific Family Center. And again everybody got credit for it, Allan, Areta Crowell, who then became the District Director, we all got involved and it met the community need. We worked together and it was a win-win and Allan was famous for that kind of collaboration; he really did that.

The second one was – that was the time of the little old lady in Pasadena. There was in Pasadena, it's true, we had a huge population of people over 65. There wasn't a geriatrician, much less a mental health program, so we decided we would try to start an older adult program. So we looked at what they were doing in Ventura, with their mobile team, recruited somebody from Virginia, paid his way to move out here and he worked in our adult program. We applied for a federal grant to do some adult work and we started our adult program that still exists here today. I had that kind of flexibility to identify a community need.

We developed a planning process with the help of Kenneth Chau, who was a professor of social work at USC, where we were guided by four C's in what we do and it still works today, thirty years later. If a program is Community-Based, Collaborative, Cost Effective and Culturally Competent, we do it. It's got to be all four of those things and if you think about it, you know, it really covers pretty much everything and that's how we evaluate every proposal, and every RFP.

READ THE FULL TRANSCRIPT BELOW.

INTERVIEWEE: SUSAN MANDEL

INTERVIEWERS: Marcia Meldrum, Howard Padwa

DATE: July 16, 2009

I. Education and Early Career in Oakland

MM: Good Morning.

SM: Good Morning.

MM: We are talking to Dr. Susan Mandel. The interviewers are Marcia Meldrum and Howard Padwa and it's July 16th (2009). It's about 9:30 in the morning. So for starters, I want to go into your background just a little bit; so can you tell us a little bit about where you grew up, where you went to school and particularly what factors led you into your particular career choice and eventually into mental health.

SM: I grew up and was born in the Bronx, right near Yankee Stadium, the old Yankee Stadium, and lived there until I was about five years old. Then I moved out to Long Island, in a town called Long Beach. My voice tends to drop sometimes.

MM: It's okay; this is a very good recorder.

SM: Okay; and that experience was I think, critical to me in many ways. The town of Long Beach was almost 100% Jewish, so during the Jewish holidays the schools closed, you know, everything stopped. My parents didn't seem to have any kind of friends, or connections that were not Jewish. All the Jews lived on one side of town, the non-Jews lived on another; and I was an overweight, sort of unhappy kind of kid. I got some counseling from a psychologist who helped me quite a bit and I made a choice to go to college at Madison, New Jersey. Drew University had a seminary there. I wanted to go to a place that was more like what I thought what the rest of the world was like; and I was really fortunate [that] that school had about 800 undergraduates at the time, maybe even a little less.

So the first night we got there, the professors invited us all to dinner. Each one of us was in a full professor's house for dinner the first night of college. It was just – it was a wonderful experience, so I sort of blossomed quite a bit. I was on the school newspaper and I was on the magazine, dating the star of the soccer team, and wanting to be a psychiatrist, though. And I hit organic chemistry, first "D" I've ever got in my life. I could not get organic chemistry! It was just impossible for me. So my chemistry professor, Dr. Scott, I remember him very clearly, said, "Well, Susan, you are going to have to take this over in the summer, and you are going to have to give up some of your activities so that you can really do this. You know, you need to think about it; maybe you want to go into psychology instead." So I thought about it, and I certainly didn't want to take it again, much less give up my summer working to do that.

Unbeknownst to, I guess, him *and* me, it was harder to get into a psychology program at the time then it was to get into medical school. This was 1962, and,

in 1962, first of all, there were not too many women at all in PhD programs. And in psychology, if you didn't have a 4.0, you couldn't go anywhere. So I then and went and got a terminal masters degree at the University of New Hampshire and from there got straight, "A's." There was nothing to do in New Hampshire, other than study, unless you drank or you ate. Most of the guys drank; several had to drop out of school. I'm serious; there was one restaurant in the whole town and it was in the motel and it was – So I got straight "A's," which led me to get scholarships to the University of Nebraska and the University of Cincinnati; and I was more comfortable with the University of Cincinnati. I liked the urban environment.

I got a wonderful psych training, I got trained at the county hospital, at the VA hospital, and at the counseling center at the university, for three years. I mean, in those days you did internships half time for three years. And I think, frankly that's a learning experience that should be replicated, because you know, an internship in one year, you don't grow as much as you do incrementally; you learn more over time. So I was then offered – one of my professors at the University of Cincinnati was doing a Sensitivity Group, which was very big then, in the Pendleton, Oregon, school system. So he said, "Would you like to go and help me, we are going to work with the superintendent and his staff?" I said, "Sure." So he paid my way –

MM: Do you remember the professor's name, by any chance?

SM: Professor Lansky. And, he paid my way, it was my first class and we had a wonderful time. I still have the Pendleton blanket that I got from the district. And he said, "You know, I'm going to stop in San Francisco on my way back to see my sister-in-law, would you like to do that with me?" So I said, "Sure I'll do that!" And like so many people, I visited San Francisco and thought, "Oh, this is the most wonderful place. I have to get a job here." So I came back on my spring break and interviewed and got a job with Alameda County, working half time on the inpatient service and halftime on outpatient, with a little bit in emergency.

MM: Now you were feeling, I mean, clinical psychology at this point felt like the right choice to you?

SM: Oh yeah, I loved what I was doing. And I actually thought that there was probably a reason I flunked in organic chemistry, in that – and I'm certainly not putting down medicine – but there is a lot of memorizing and stuff that you have to do in medicine, that you don't have to do in psychology. The only thing that I think was stupid that I had to do was reading Freud in German and having to take two years of German to do that. I mean, you know, certainly – and again it was sort of like the rite of passage, "I had to do it, so you have to do it." As if nothing was translated. I wonder if they still have people do that? So reading *The Interpretation of Dreams* in German was really onerous. But no, I loved it and I went to work for –

The guy who hired me is now deceased and he's infamous. He's Felix Polk, who was murdered several years ago by his wife. He was my first supervisor and he hired me. And I have to say it was, when I heard about it, it was a very, very, strange experience to realize that your first supervisor, and the guy that hired you

for work, was murdered and had allegedly abused his wife as a 16 year old. But it was Alameda County, I worked there for 13 years, it was wonderful. Working on the inpatient ward, I mean, it was an inpatient ward before LPS [the Lanterman-Petris-Short Act]. Mellaril [thioridazine], Stelazine [trifluoperazine], and Thorazine [chlorpromazine] were all there was. Nurses were still wearing little white hats and white uniforms. And doing groups there was just the most wonderful challenge. Everyday you had people coming in who were, you know, in flagrant psychoses and needing to try to integrate them into a group on a ward and make for a cohesive [situation].

MM: Can you just sort of talk about what your role was as a psychologist versus a psychiatrist?

SM: Sure, my role there was, I was a member of the team. We had a team of a psychiatrist, a social worker, and a psychologist. We basically all did the same thing, other than the psychiatrist prescribed medication. And we worked with the – actually, I worked with the nursing staff more than the psychiatrist did. And I moved up from being a line psychologist to a supervising psychologist. We didn't do much testing in those days; people were too ill, really, in the acute patient ward to do that. But I worked in groups more, and I guess some of my training in sensitivity facilitated being comfortable in groups. When I got promoted to senior psychologist, we actually worked with the nursing staff to take the uniforms off, to get into street clothes, to try to, you know, really sort of – nowadays, people would call it more recovery-oriented. In those days, we just said, "You know, this is not a medical model that we want to follow. We really want to be a little bit more – we want to model behavior a little bit more." So we did a lot of modeling and teaching.

And frankly the nursing staff probably saved my life, because when I first walked on that ward, nothing prepared me for it. And the University of Cincinnati was a wonderful clinical psychology [program]; but nothing prepared me for an acute County hospital in the city of Oakland. And I was terrified [she laughs] and I guess I looked terrified and I was 25 and I was trying to look old, so I had glasses and, you know, just the most severe suit I could find. And the nurses' aides and orderlies read me and I guess, but fortunately for me, they liked me. So they really taught me about behavioral interventions and how to work with people; and I in turn taught them how to do groups and how to participate in them.

So I think, you know, I can't say it was just unique as a psychologist. I think I did have a little more group training than other people did and on a ward like that, I mean, you are not doing individual intensive psychotherapy or cognitive therapy on people who were acutely psychotic. So the idea of helping people identify what was the thing that triggered – these days, as I look back, we'd call it a "WRAP plan." You know, we focused in the group on what got you here, and how can you avoid that happening again? And we did that, we didn't call it a "Wellness Recovery Action Plan;" but that's what we were doing, because that's the only thing you could do.

MM: Were these people recovering to the point where they could leave the hospital?

SM: Oh, you bet, oh yeah, and then we followed them in outpatient. There are a couple of significant things about that time. I also worked in the emergency room and that was before LPS. And you could come in and look at me and say, "My husband is looking at me funny, I'm afraid of him, and I think he's crazy;" and we would write up a petition. And the sheriff would go out and that person would be given a paper and have to appear at 9:00 the next morning. If you didn't appear, the sheriff picked you up and off you went to Napa State Hospital. And if you were not fortunate enough to have a resident or somebody take a liking to you, you could have been there "forever," and there were lots of people who [had that happen]. So I have a unique sense, and I think a lot of us who worked in County hospitals and in emergency rooms before LPS think patients' rights are very important. Due process is very important. And I'm, you know, when people say, "We've gone too far, it should be a lot easier to do some of this," I think, "Wow, I remember when it was way too easy and I'm not sure I'd agree with that. It was horrible." So I appreciated LPS when it came.

HP: What did LPS do exactly, what changes did it make?

SM: Well it [mandated] due process. So you had to have a 72 hour hold and a 14 day hold, and if you were gravely disabled, you have to be able to prove that you couldn't take care of yourself. Or if you were imminently dangerous, there was a standard of what was dangerousness; and if you, I guess it was after 14 days, if you were still considered dangerous and you could prove it to the court, a health expert, and argue with a public defender, you could go away for as long as 6 months, before you had another court hearing. But before LPS, there was no court hearing, there was nothing; you just went away and that was it and nobody got anything out of it. So I think that the change to LPS occurred during that time; it was really important.

The other thing that I think is a part of mental health is that I got promoted from the senior psychologist to become chief of the inpatient service, so I was a psychologist in charge of a medical unit in a County hospital. So the only person who talked to me was the oral surgeon, because neither one of us were real doctors. It was a very uncomfortable situation.

MM: Can you tell me about what year – this started about –

SM: We're probably talking about 1974 by now. So I started in Alameda at 1967, and [in] 1974 I was the chief of the inpatient service. And we had a very – We were in a County Hospital where the administrator was not very fond of mental health services; and when we would have a budget cut, he wanted to cut psychiatry. And I don't know what came over my body; but I can remember to this day, we were meeting in the cafeteria. I literally got up on the table and started – that's how I felt about myself [gestures something pulling her upward], that I got up on the table and said to people, "we're not going to do this; you know, we are going to fight this; we are not going to let this happen." And we didn't.

HP: How did you fight it?

SM: Well, we organized; we went to the Board of Supervisors; we did the kinds of things we do today. But sort of, at that time it was really not, there weren't too

many mental health advocates, we weren't into mental health advocacy. But that event led to my identifying that maybe I did have some really leadership [skills]. You know, up to then I was doing leadership work, but I didn't feel like a leader. And that led to my applying for the Director of Mental Health position in Alameda County, when it became open, very shortly after that. And I competed against a psychiatrist from Berkeley, a very nice guy, and the person who was selecting the Director was a hospital administrator type for the health care agency and he chose me. So I was the first woman, first psychologist, Director in the State.

MM: Can we just stop here and go back a little bit? So this is probably not a bright question; but you spoke of having read Freud when you were in school. Wasn't this a period when psychology was sort of shifting from psychoanalysis into a more transactional analysis and is that what you saw yourself as doing, or were you not really working a theory-based –

SM: No, I wasn't working [with] theory-based. I mean, I guess to some degree, I was using some sensitivity training and that kind of stuff, without trying to get people to – No, I mean working on an acute inpatient hospital with very little kind of medication that was successful, you know, you had to do very basic survival kinds of things. And it was much more behaviorally oriented, I don't mean conditioning, but I mean talking to people about their behaviors, how that behavior gets you in trouble; and as I say, I think more as I talk about it, it was much more like [a] wellness recovery action plan. What triggered this, how are you going to avoid that trigger again? Oh, very practical. You just had to, and I think I didn't learn until I came here how destructive insight-oriented psychotherapy was for people who were psychotic, because we didn't do it in a County Hospital.

MM: And the psychiatrists didn't come – were they not doing it in other sessions with these patients or was this –

SM: No, no. It was much more medication management, much more focused on the here and now. I mean, these were not people who could – by the time somebody was in control enough of their behaviors to be discharged, any opportunity to really talk – That moved on to an outpatient setting and then to some place else.

So when we worked together as a team around management of client behaviors and issues, [it] was much more, you know, trying to make an assessment about whether it was safe for this person himself or herself to go back into the community, whether they'd hurt themselves or somebody else. And the important lesson I learned there is you can never stop someone from committing suicide. If you could do it on a locked inpatient ward, you can do it anyplace. And of course it's also very hard to predict violent behavior, both as a clinician and then as a spouse or family member. Everybody agrees it's okay and boom, look what happened. So it makes you humble and –

MM: I can see that. You said that the medications didn't really work very well?

SM: No, I mean Stelazine and Mellaril; Stelazine produced stelazine jitters in a lot of people. It didn't control a lot of thinking. Thorazine sort of knocked people out. I

don't think, I guess we had Haldol [haloperidol] towards the end, but in the beginning, it was just those three. And of course people used Librium [chlordiazepoxide, a benzodiazepine like Valium] and other kinds of things. It may be that a lot of the people who were admitted in those days, their problems were severe enough and the level of schizophrenia or bipolar disorder. I guess lithium was in use at the time. But the majority of the people we had were really schizophrenic; and as is true today, it's an art as to what medication will really work or not and when you're dealing with people who are there for less than 10 days, I mean the art – you don't have time to adjust anybody's medication. I mean, you know, it either works in the beginning or it doesn't. So it didn't allow a lot of time for – it was crisis treatment more than anything else.

MM: How much time – were you able to stay in touch with these people after they left the hospital?

Well, sure, because at that time we had an inpatient-outpatient split, so you saw them in outpatient afterwards. I don't think we were quite as aware of substance abuse issues then, although I had one man who taught me a real lesson; [he] became psychotic all the time after one beer. But it took a long time to figure out that that's what it was. You know, married guy, couple of kids, functioned really well in between these bouts; and just one beer whipped this guy out, he just became flagrantly schizophrenic. But again, we didn't pay as much attention to substance abuse issues. I'm not sure whether they weren't quite as prominent then as they are now, or if we were just ignorant. Again, I'm not sure.

MM: Yeah, it would seem in San Francisco at that time, it was sort of an approach – it would probably be evident.

SM: Well, no, this was Oakland. But still, it didn't seem to be as much of an issue. I don't know.

MM: So as you were keeping in touch with patients, with people who have left the hospital, were there specific problems that you identified – I mean we hear a lot about stigma now as being a main problem attached to those living in the community. Or was it a matter of behavioral control? Or what would you identify as their major problems?

SM: Well, definitely stigma. But again, the Bay Area was so different from when I came down here. There were halfway houses, there were three-quarter-way houses, apartments, you know, supported living situations. I mean we had a lot more resources in the Bay Area than [they did] here. Medication was readily available [there]; here we're giving out samples, I mean. So there were more supportive situations available, not for children, because again, at that time, the services were all driven by adults. There were a little children's clinic and a couple of residential treatment programs that had existed for a long time, that started as orphanages and changed. There were no older adult services.

But, in that part of the time in the Bay Area, there were also a lot of ethnic and cultural services for adults who had problems, first generation, second generation, third generation, even; and clinics that identify themselves as, "I'm the first generation API [Asian Pacific Islander] Clinic," "I'm the second

generation,” and they fought with each other for resources. But there were those kinds of resources in the community. But, sure, there was stigma. That’s why the lack of patients’ rights existed, because, you know – “Gee, you look a little funny, they got to get you locked up;” and I tell you, it was almost that easy, it really was. It was horrible, it was just horrible. It was really horrible.

II. Director of Mental Health for Alameda County; County v. Contract Clinics

HP: Tell us a little bit about your time as the Director at Alameda, some of the challenges you faced.

SM: Well, I do have to say one thing, when I was the inpatient Director, the psychiatrists were not very nice to me. They didn’t like it, and so they would frequently disappear. And if you have ever been on an inpatient ward where somebody was about to have a manic episode in catatonia, you know, if you need anything, you need a psychiatrist to help you get some orders done. And they would disappear. That was okay, we dealt with it.

It was directly opposite when I became Mental Health Director. Everybody else in the State was a psychiatrist and they were all men. And they were wonderful, they accepted me right on, they did not discriminate. I went through the ranks; I did everything, so I thought that was really quite unusual.

MM: Yeah, that must have been hard.

SM: And we had one Supervisor, rest his soul, Fred Cooper [Supervisor 1971-86], who was a great mental health advocate. He was really, he and Joe Bort [Joseph Bort, Supervisor 1967-84] were the two people who were very interested in mental health and supported me. I enjoyed the – I had very interesting conflicts with community-based agencies when I was the Director, which is really interesting now –

HP: Yeah, being on the other side.

SM: Thirty years later, I’m working with some of those same people and you know, we can smile about it; because I think as Director, I wanted to have some standards in place and wanted to have residential programs that were doing X – that had these kinds of goals and whatever and some of them didn’t want to do that. And I think I could have accomplished the same thing by having sort of an overarching set of goals and then identifying the uniqueness of each program and letting them spell it out; and I’m not sure that we did that.

HP: And was it a split, like directly operated and contract, the way it is here?

SM: Oh, yeah. And I had a Contractor’s Association, which led me to form one when I came down here. I had a Contractor’s Association which was very active. It made my life miserable, because you know, they were constantly challenging what degree of services went to the private sector, what to the public, what was the planning process, how open was that, how closed was that. I had a Mental Health Advisory Board that was very active. I had a contracts committee and regularly reviewed what was going on, and contract and agency programs.

It was my impression that Mental Health Commissions, at least that one, functioned at a different level. They were much more engaged and involved, without being intrusive. I mean, I thought they had a much higher level of understanding. When you asked them to review a plan, of course they didn't know every element of the plan, but they had an overarching view of what was going on in the County and could give feedback that was sort of reasonable. Although some people would say, "Oh, it's a rubber stamp," it wasn't a rubber stamp; it was a -- so yeah, there was a very effective Contractors Association and a Mental Health Commission.

I think one of the challenges that I noticed at the time that goes through until today, that bothered me about whether I was going to be a member of the Mental Health Association was the Mental Health Association was delivering services and it was a service delivery organization; it was a contractor. And, in my mind, it was supposed to be an advocacy organization and you lose that ability when you become [a service provider]; and I think that's carried on down here. So you know, why would I want to give to an agency now, that's competing with me for contracts, I mean, I'd rather give to Jim Preis's organization, Mental Health Advocacy Services, or a non-mental health organization, or my own, rather than somebody else's. So the role of the Mental Health Association in Alameda County, was again conflicted, because it was a contractor at the same time it was trying to be an advocacy group.

HP: What sort of advocacy work was it doing back then?

SM: I think it was doing a lot of work again about getting better quality services for adults. Everything was adult-oriented and I think that's why you have to appreciate Leona Egeland [California State Assemblywoman 1975-80] coming along with her Egeland language about reserving 25% of funds [for children], because adults sucked everything up. I mean, the resources were so scarce and again, if you think about it in the crudest way to think about it: if you are faced with a 25 year old man, who is in flagrant psychosis and maybe will hit you, as opposed to a 7 year old kid. You know, the theory was, well, you can grab the 7 year old kid and protect him from himself or from others and you can't really tackle [the adult]. I mean, that was really the level of thinking. So you had to put your resources into -- For me, it's the reason why I'm not still there, because the people who I hired and worked with are still there [she laughs]; and one of the -- Actually, the Director of Health Care just retired and I had hired him as a social worker, from Napa State Hospital, to do -- we were doing a lot of work then in two areas. One was placement of people: how we could get people out of Napa State Hospital and into the community, so we did lots of studies.

MM: Was that something you saw as a desirable goal, or was it something that was being imposed?

SM: No, we wanted to get people out of the hospital and into the community. We had residential programs, we had half-way houses, [and] we had resources for people. So we just sent a group, a combined group of County staff and contractor staff, under this guy Dave Kears [later Director of Health Services for Alameda County], up to Napa to do that. We had an organized sort of study that

we wanted to profile and we did that and we began to pull people out of the hospital, one by one, in terms of – It was very expensive; and you know, we had to pay for it out of our County resources and we placed people in the community, so that was a big effort.

The other effort was constantly trying to balance the needs of the multicultural – Oakland was very multicultural then and there were lots of pressures between the African American Community, the Hispanic community, [and] the Asian Pacific community then. So I experienced those in 1976 and '77, when people were just starting to deal with those struggles down here, 10, 15 years ago. But I would still be there if it wasn't for Prop. 13. And again, during that period of time, as I said, I was very involved in the Director's Association. I had moved up, I was on the executive committee, I was their legislative person, their President-Elect, and when I left, I was their President. So they were not very happy.

But, as President-Elect, one of the things we did was try to – Jerry Brown was Governor [1975-83], Gray Davis was the Chief of Staff and he could not control Jerry Brown. And we did have a plan; it was called the California Model. It was historic. We developed the California Model, because there was nothing that existed in the country at the time. And there's still nothing I could find, in doing my human resources work with the Planning Council, to say, how many of this should you have per hundred thousand [population]? I don't care whether you want the model to include people in recovery, or family advocates, or whatever. I mean you have to have a basic number of psychiatrists, or nurse practitioners to base it on; there's nothing that says per hundred thousand, you should have this. So the California Model was designed to do that. And we were trying to get Jerry Brown to fund it; we got a commitment from him for a hundred million dollars and [that] those commitments would occur.

MM: Wow.

SM: Yeah, we had a big meeting with him at the Capital and we had poster boards, we showed him everything we needed and we had people; and he really had a difficult time paying attention. We actually had one guy, who still exists in the system, Dave Favor, who would say, "Governor, pay attention!" But this guy would do budgets on the telephone. We would have conference calls; I kid you not, on Friday nights at 12 o'clock-midnight. This guy was doing budget conference calls on the state budget and you know, you always wonder why Gray Davis could not put some order in that, but he couldn't. But we got the commitment and as always happens in mental health, Prop. 13 passed right after that and destroyed everything; that was 1978. And it was horrible; this time these budget reductions in terms of what's happening with realignment, what probably will happen with MHSA in 2011, can't compare to just precipitously one day you have the money and the next day you don't, and trying to do a planning process. As I said, do you for your own staff, do you fire the African American social worker, the Spanish speaking one, the Asian Pacific [worker] – or the one child specialist that you have, or the one older adult specialist; and in the community, what goes, the first generation [clinic], the second generation, API? And I was popping Maalox, I mean, like it was going out of stock.

MM: It was stressful.

SM: Oh, it was horrible, just horrible, and I was only 33 years old. And serendipity. My boss was sick; the mail came through and there was an advertisement for the Director of Pasadena Child Guidance Clinic, and I felt so awful. I knew it, I knew of the place, because the Director was a psychiatrist at the time and he participated in the Director's Association. So I knew about the clinic and it had a very good reputation. I applied and, after four interviews, being flown back and forth, because they never could understand, why would somebody who has a 22 million dollar budget and 700 people want to come to an agency with \$800,000 thousand dollars? I said, "That's why!" [she laughs]

So that is really what pushed me; because I loved working in Alameda County and I wouldn't trade the experiences I had there for anything. It gave me my commitment to [the belief] that money needed to be spent on people who really need services and an appreciation for how little money there is, so it really has to be spread effectively across all the people who need it. And, as I say, I still have more friends there than not and made more friends from the people who were contractors who fought with me all the time, who are now working with me down here. And the public sector governance hasn't gotten any better.

I think there's a real difference in Alameda County as opposed to Los Angeles. One of the differences was, since it only had only a little under 2 million people, when I was there, and it is still about that size, you had a relationship with the members of the Board of Supervisors, that was more personal. Also, their districts are smaller, and they tended to look at the County – it was easier to look at the County as a whole and make decisions about the whole. Not that there were not people who were proprietary about "my district and I got", there was some of that, no doubt; but the people who influenced policy there were the County Administrator's staff, so each Department had a County Administrative Officer.

One of the advantages of being an executive in a non-profit setting is when you have to do something, or if you make a mistake, you get the credit, you get the blame and it's your decision, blessed or not by your Board. But you don't have to go out and do something you think is wrong when somebody else tells you to do it. Here, it tends to be that health deputies have more influence like that, although I can't say, I don't know that they tell people [what to do], because I am not in that position. But I think they have a lot of influence and they are not elected people, and in this case the same is true. So that plus the horrors of going through Prop. 13. Now people, when I moved down here, everybody up there looked at me like I was going to a place where I might as well be dead, because there's no place to eat, there's no culture.

HP: In Pasadena?

SM: Well, there wasn't. When I came to Pasadena, there was nothing. We did have to drive 45 minutes to get a decent meal, that was true. Not true now, people from the west side come over here now; but 30 years ago, that was not true. But people in Northern California were very snobbish about Southern California. But when I came down here, I was horrified at the lack of resources and services. I guess just a brief history of funding in California, because one of the things that I think is very significant about the times we face today is that, when we started to

do the deinstitutionalization under [Governor] Ronald Reagan, we all, as Mental Health Directors, we all agreed with it, because he would have had to put maybe 3 billion dollars into state hospitals to restore them. That was just stupid; but of course, the money didn't follow.

They tried to encourage the development, in the Short-Doyle system, of community clinics by doing – I'll give you 50 cents if your County puts up 50 cents [under the Short-Doyle Act of 1957]. Didn't work; Northern California did it. And then they went up to 75 and 25 [cents] and eventually it was up to 90 and 10 [cents]. But there was no plan. OK, you had to do inpatient and outpatient and emergency, that was it. So there was nothing that said, "Gee, if you're going to take this money, we expect a comprehensive array of services, whatever." So Northern California, San Francisco, Marin, Santa Clara, a lot of those Counties took a lot of money. Down here – well, there's no mental illness in Southern California; it was very slow. Then the money ran out and –

HP: When did that happen?

SM: Oh, gee, not long ago. I mean, the money was gone pretty much before I got here. So, I'd say by the time of Prop. 13, it was gone.

MM: In the 70's.

SM: Yeah, in the 70's. So you had what's called –

MM: During the merger.

SM: What's called the equity issue. So there's no equity and funding is historically based in California and it's never been reallocated. So we have a place like Riverside now, that's had a 40% population growth; they've had no change in their allocation to reflect that. You have the growth of older adults, nothing. [For] children, [we have] the EPSDT and Healthy Families. But for older adults, for ethnic communities, [and] you know, the Hispanic community is now the majority community in California, there has been no growth in services. So San Francisco [and] the Northern counties have significantly more money because their Boards put it in and there was no plan. So when I tell my Board, well, funding is historically based and there's no way of re-allocating resources, they look at me like I'm absolutely psychotic myself, because it does not make any sense, but it's true. And that's really, that's a fundamental structural problem in the mental health system. So when I came down here, it was like I did come to a third world country. I mean, I was just, we were giving samples for medication; I mean, there was no medication budget.

MM: Okay, let me just go back a little bit, because you have talked about the horrendous things that have happened in Alameda. And you have talked about what you learned from there. Was there one thing that you would look back on as your time as Director there, that sort of stands out as an achievement that you would be very significant, or that you would be very proud of?

SM: Oh God, one thing? [pause]

MM: Or even two things.

SM: Well I think the growth of multicultural services. I think we were ahead of our time. Although we didn't know it in having community-based programs, but we were at least smart enough to encourage them and develop them, because I think that's – and I think we tried really hard to develop children's services. A very energetic psychiatrist, Stan Seifried, directed that; and the director of one of the children's clinics, Gwen Foster, who's now [senior program officer for mental health] with the California Endowment. So I think those are the two things that, if I look in retrospect, were good. You know, when I was on the inpatient services, I think getting nurses out of uniform, working in groups, so there were lots of little baby step kinds of things that I think made progress. Also I would say multicultural services, some sensitivity for the need of children's services. The thing that most embarrasses me is my lack of appreciation for community-based agencies; that's very embarrassing.

HP: What was it that community-based agencies were able to contribute that the directly operated system wasn't able to at that time up there?

SM: Remind me to tell you about the Mental Health Director's Disease. Well, I think one of those is flexibility. I mean it's the same thing now. I mean, you see an idea, you go to your Board, and, if you can fund it and it's consistent with the mission you could do it, you know. You don't have to wade through sixteen levels of civil service to hire the people; you can generally try to get a bank loan together to deal with whatever resources you need. It's hard to get a facility built, you have NIMBYism, but it's just flexibility. I mean, you can just get programs started.

What happens to you though when you are a Mental Health Director – I call it the Mental Health Director's Disease – is you tend to – and maybe it happens when you're, I don't mean, this sounds egomaniacal, [but] when you're President of the United States, you know, the same thing happens. You get surrounded by a group of people who give you advice and you sort of trust them. They are the only people who sort of appreciate you, I mean they're not throwing darts at you, at least to your face, and most of the time they are supporting you, and encouraging you and giving you comfort; so you listen to them and it's easier, so then you wind up trying to protect your own, and protect County [programs]. So it's very hard to maintain that view of, you are, as a Director, responsible for the system as a whole, not just County operated programs; you've got to be concerned about everything. But when you don't have [input], so that's why and we did try, we had community-based agencies in meetings and we tried to get equal participation; but it's not a level playing field. It isn't here and it wasn't there. There are certain benefits that accrue, because you are listening to people and getting support and you do need support. I mean, it was a horrible job then; now, I don't know why anybody does it. It's thankless.

MM: Was there any sense at that time that the community-based agencies and clinics were trying to sort of cream the better patients and push the more difficult [elsewhere]?

SM: No, you know, I always hear that and same thing, are they willing to take on insured people or whatever? I think the difference between – I can't tell you what it was like to come here and the first time I had problems meeting the payroll. It was very shortly after I got here, because the County check was late. And I fortunately had a relationship with United Way, because we got United Way money. And I called Eleanor Hawkins, our liaison, and said, "Eleanor," I was crying. I said, "I can't meet my payroll because the County check is late, can you lend me the money for two days and I will pay you back in two days?" She said, "Sure." She lent it. United Way did support its agencies, you could have your roof collapsing and they would give you [help].

That was, I've never forgotten that and I think, and I've told this to Marv [Southard] and other people. I think every County employee who's in a senior management position should have to work in a non-profit for a month and have to meet a payroll. Because you don't know what it is like to have to – You have all these people counting on you to feed their kids and pay their mortgages and it is a horrendous responsibility. And you know, you've got a Board of Directors, but when push comes to shove, you are the person sitting in the chair that has to make sure it happens. And I think when you are in the County, and the same is true for every County, you get your check. Things may be going badly, and I'm not saying the Counties don't have financial troubles now, and they've got cash flow issues, and the State owes them half a billion dollars for 3632 [special education funds], sure, all those things are – Are they worried about whether their employees are going to get a check next week? Am I worried about that? Damn straight I am.

HP: Well, because they can run in the red.

SM: And they have County General Fund resources, they have reserves. Things happen like these things that all of a sudden pop up like, "Oh, you're denied access to the med system to verify MediCal and eligibility." Send out a note [to say] that's cancelled as of today. Well, gee, that could mean up to three or four million dollars of loss to an agency like mine. You just, you don't understand what it's like, unless you are doing it.

HP: And the community based organizations back in Alameda, were they the ones focused on the ethnic communities and –

SM: Yes, and we had a lot of CASRA organizations so that my buddy Rick Crispino, who runs Bonita House [in Berkeley, was part of CASRA, California Association of Social Rehabilitation Agencies]. CASRA started in the Bay Area, so we had a lot of half way houses and three-quarter-way houses and crisis residential alternatives and those kinds of programs for adults, as well as West Oakland and East Oakland Services for African-Americans and several Asian Pacific Islander services, primarily ethnic Chinese, and then one Latino Program also in East Oakland, so yeah. And those were all very grassroots community-based services, but they served really sick people. I really don't know where that "cream of the crop" thing came from. Here the myth is: we don't serve the indigent, only the County does. Well, you know, if you don't give us any money for the indigent, then we are not going to serve the indigent, because then we will

be out of business and what is our responsibility? Our responsibility is to try to stay in business and you work with the funding that you've got.

III. CEO of Pacific Clinics; Meeting the Needs; Working with LAC-DMH; Merger with Portals

MM: Right. Okay, so you come down here and you described it as kind of a wasteland.

SM: Oh, it was. So one of the first things I did was try to do a -- you know, meet a lot of people and get a sense of what the needs were. And it didn't take a rocket science to identify two glaring needs. One was you ride down Valley Boulevard 30 years ago and you could see the ethnic Chinese signs were coming up all over the place; and there was not a single program for Asians [or] Pacific Islanders. So Allan Rawland, who is now the director in San Bernardino, was the district chief here at that time. So I went to Allan and I said, "Allan, I'm going to start something to try to get grassroots support to develop an Asian Pacific Center. Let's work together and do it, we'll both get credit." He said, "Sure." So I went about hiring somebody and the way we've developed our programs is [we have] hired people who have some experience. I find Terry Gock, who had some experience setting up a suicide prevention hotline and some other things. I said, "Terry, would you like to work three days a week as a psychologist and two days a week doing program development?" He said, "Sure." He's now the Director of the Asian Pacific Family Center and has been for many years.

Allan had gotten Gladys Lee working for him in Arcadia Mental Health. Gladys is now District Chief. So Terry and Gladys got together and formed an Asian Task Force where they worked with police and school officials and whatever, and in 1985 opened the Asian Pacific Family Center. Now that has -- and again everybody got credit for it, Allan, Areta Crowell, who then became the District Director, we all got involved and it met the community need. We worked together and it was a win-win and Allan was famous for that kind of collaboration; he really did that.

The second one was -- that was the time of the little old lady in Pasadena. There was in Pasadena, it's true, we had a huge population of people over 65. There wasn't a geriatrician, much less a mental health program, so we decided we would try to start an older adult program. So we looked at what they were doing in Ventura, with their mobile team, recruited somebody from Virginia, paid his way to move out here and he worked in our adult program. We applied for a federal grant to do some adult work and we started our adult program that still exists here today. So those were -- I had that kind of flexibility to identify a community need.

We developed a planning process with the help of Kenneth Chau, who was a professor of social work at USC, where we were guided by four C's in what we do and it still works today, thirty years later. If a program is Community-Based, Collaborative, Cost Effective and Culturally Competent, we do it. It's got to be all four of those things and if you think about it, you know, it really covers pretty much everything and that's how we evaluate every proposal, and every RFP.

We had big problems. When I talked to the Police Department, the youth officer said, "Referring people to Pasadena Child Guidance Clinic is like throwing a rat down a dark hole." I was horrified, horrified and what was happening was that, at that time, the clinic was very psychoanalytically oriented. It was not taking the cream of the crop, it was taking first come first serve; and when you came, you had to have an automatic psychological assessment which took six weeks or eight weeks. By the end of that time if you still wanted treatment, if you still needed treatment, you got assigned to a therapist and if there was more than one kid in the family, you got a therapist, [each child] got a therapist, and your mother got another therapist, so you know, we may have been serving about 50 people.

So at that time Don Lomas came to work for me [in 1981, as Director of Child and Adolescent Programs] and Don and I put together a position paper. I was the Chief of the Clinic and we put together a position paper about this is where we wanted to go, this was our vision. The Board approved it, gave it to the staff and we talked to the staff. We worked through it for a couple of months and were able to successfully have two or three people decide that they didn't want to do what we wanted to do. We wanted to – we abolished, you know, mandatory psych testing for everybody. That may have been good for an APA internship program, but it wasn't good for the clients. So that was our first effort at re-shaping what we did as a Child Guidance Clinic, to really say this is where we want to go, this is what we want to do.

And the other problem we had is that we had a very small clinic on the grounds of Huntington Hospital, where Della Martin [Mental Health Center] is right now. Remember, [with] historic funding, we had almost nothing. So we had a half-time director and we had a lot of volunteers and I think maybe we had one part-time psychiatrist.

So slowly but surely, we tried to sort of – and I think that's when my public sector work helped me. First of all, I knew something about schizophrenia and what treatments might be more effective. And the other is that I had a real commitment; that, if we are going to take public money, we are going to do what we are supposed to do with the money; so this first come first serve, that was not what Los Angeles [DMH] was paying for. They wanted us to do some triaging, whatever. And I think that's made a difference in terms of, certainly in our philosophy, because you know, you bring baggage with you; and so very slowly but surely we [made progress].

The other thing that I think helped me a lot, that sort of surprised me more than anything was, [that] when I moved down here, I didn't have to reestablish relationships. My reputation followed me and Dick [J.R.] Elpers was the Director; he wasn't the first Director, I can't think of that man's name [Harry Brickman]; but Dick was, shortly after I got here, the Director, and he and his staff, I sort of felt like I'd walked into a meeting and had never left. You know, usually you have to reestablish your credibility and who you are –

MM: People already knew who you were.

SM: People knew who I was and they showed me a degree of respect that really sort of surprised me. I didn't expect that I would be able to just move into the leadership structure as much as I did. And both he and Areta [Crowell] wanted help and they wanted people. I think she was the district person at the time. One of the problems I – I don't know where you want to go – but I think one of the fundamental issues in managing Los Angeles is that the eight Service Areas are all managed differently; and it doesn't matter whether the psychiatrists are doing it, or this thing or that thing. So one of the recommendations that we made in the CCC [Comprehensive Community Care] plan that I was really involved in, and I want to talk about it a little bit, was that there would be one person assigned for every area who was the fundamental decision maker, who can really do it, because it was horrible.

MM: Pacific Clinics is sort of spread out around several Service Areas, is that right?

SM: Really we started just in Service Area 3 and then when Pete Schabarum wanted to contract out, [change one of] the public facilities to private, we bid on El Camino which is down in Santa Fe Springs, and so we have that program, so that's 3 and 7. Since we merged with Portals, we're also in 4 and 6 and we have our Armenian Program in 2, in Glendale.

MM: Was the sort of, I mean, you talked how when you came down here, you began developing programs for Asian Americans and for older adults. Were you seeing this at the time as part of your job to sort of grow this program?

SM: Oh, yes. Oh, sure it was, of course it was; in non-profit, you can't survive unless you grow. When Elpers and Areta were here, we did get – when she was Director and when he was Director – if they got a cost of living, we got a cost of living. Now, that doesn't happen and it hasn't happened in many years. So the only way you could do that is you start a new program, you get your 15% overhead; and that 15% helps you do these other kinds of things. Oh yeah. So we've grown from 800,000 to, you know, right now around 90 million dollars.

MM: And how would you characterize the situation that you found? Was it a situation in which there were many people who needed services, but weren't getting it? Or was it simply a matter of programs that were in place but they needed more building up and more direction?

SM: Well, I think the right people weren't getting services. Okay? I mean, we weren't really doing a lot of triage, so that we were trying to serve people who – you know, my philosophy is, we shouldn't be providing a service that somebody else could buy in the private sector. So we always admitted anybody regardless of the ability to pay to our day treatment programs for kids, because there weren't any other day treatment programs for kids. But for our adult programs or for child outpatient programs, there were child psychiatrists, so if you could pay, you should go there. We don't need to – we don't take your money. So that's how we became so heavily dependent on the MediCal system, because we don't take private paying clients unless you can't buy it any place else; and to some degree, and again most of the people who come to our Asian Pacific Clinic, Armenian Clinic, they are basically poor than not. But we would take somebody who could pay if we had the only Vietnamese speaking person they could find.

So it was more not the right people and there was some degree of it wasn't quite the right service. If you don't have the right people, then you certainly are not necessarily doing the right service. So you know, and I'm not meaning that people were not doing, I mean, some of the people in the Child Guidance Clinic were doing insight-oriented long term psychotherapy. But, since they were doing first come first serve clients, that was okay and some of those people needed that; but I didn't think that was what the County was paying for.

The other thing, and again when I got here, the County had complained that our charts weren't in order. There were lots of loose papers and we weren't doing financial eligibility right and all that kind of things; so there was a lot of busy work to sort of do as well. But largely, it was getting a sense of what's needed here. I've always felt one of the biggest failures I think I've had is that I have not been able to convince the County that we should be able to divide up the work. You do what you do well, we do what we do well and let's divide up the territory; because for the first 15 or so years that I was here, maybe even 20, Arcadia [Mental Health Center] and we fought for who was going to survive.

HP: You and the County clinic?

SM: It was horrible. That's the only County clinic in Service Area 3 and for a period of time, for many years, the District Director of Arcadia was responsible for the [Service] Area. I would say, "Come on guys, that doesn't make sense. We're fighting for survival." And again, I think the overall system would be more effective if we had done that. To say, let's divide up the duties and work together. You know, you do this, I'll do this. It makes sense if there's certain things we can do that the County can't do and vice versa. But it didn't happen.

MM: So tell us about the merger with Portals and about the circumstances that led to that.

SM: Sure, and now I do want to talk about the CCC project.

MM: We want you to talk about whatever you want to talk about.

SM: Okay, because I'm really proud of that work and I think it did a lot of precursor stuff to MHSA. The merger with Portals; I'd never thought about merging. I'm also not a very social person; I don't go out a lot with other mental health providers. Jim Balla [Director of Portals] called me and said, "Would you like to have a drink with me and talk about [work]?" I said, "Yes," but don't ask me why I said yes, because I never do that kind of thing. I usually say, "No I'm busy," you know. So we met and he said, "You know, I was sort of wondering about whether there are ways we can work together. You're child and adolescent experts, we're expert in [the] psychosocial rehab model, we're in different service areas. What do you think?" So I was sort of intrigued, because I wanted to do a better job in housing [and] the vocational services. I mean the two most important things to our clients are housing and work and they have an extraordinary person in work and employment, Laura Pancake. And I thought gee, if we could get access to that, that would be terrific.

So we began a due diligence effort that took probably 18 months, maybe a little longer, in which it really became clear that it wouldn't be a merger where we were laying off staff and closing facilities, because we were in different places. It might really lead to the ability to retain staff; and retaining staff is hard, because we don't pay much. The prisons are just trying to suck up everybody and the County offers better wages than we do. But it would allow people who wanted to live in Rancho Cucamonga, maybe they could work in Rancho, they could work at our San Bernardino facility, [or] if they wanted to move to Ventura or back and forth. So we eventually, with lots of Board work and Board committee meetings, agreed on a merger. It started in July of 2007, where our Boards joined and where we had 12 members from Pacific Clinics and 8 from Portals, for the first year. And then after that, from the second year it was just Board members, we don't distinguish. And it's gone amazingly well [knocks on desk]. I mean, it's just really surprising how few glitches we've had.

We've had people move back and forth; the Boards are getting along well. Jim has just filled the void here as the executive vice president/COO [Chief Operating Officer]. My COO had gone out on disability more than two years before the merger and I couldn't find anybody. So it's just sort of been a win-win. Our employment program is just taking off. We've had more successful placements than we've ever had, we have more employment specialists working; and our housing program, our housing director is working with Portals as well and placing people in the community and developing alternatives for transitional age youth [and] adults, so it's just been great.

MM: So it's a matter of both of you having strengths and being able to share them?

SM: And being in different areas, so you know – most mergers, when people think about the banks. And that was the big thing we had to convince our staff about. This is not like the Bank of America, where we are going to close branches. We're not there. We have a training institute, so that was now available to the Portals staff. So we have lots – it's a larger organization with lots of resources to bring to the table. But we also wanted to maintain the Portals brand because it's fifty years old and it's got a well [known] name, just like Asian Pacific Family Center. I was talking to one of the senior deputies for Supervisor yesterday who said, "Well, maybe, I could contract with Asian Pacific Family Center to do something." And I said, "Well, they are really a division of Pacific Clinics," and she didn't know that. I didn't really care! That was one of the things we try to do is we want the identity - we want the community and the clients to feel comfortable about the place. So you can brand something so well that it becomes a part of the community.

IV. Comprehensive Community Care; the CCMHA; Working with Consumers and Family Members

MM: [Reading the Comprehensive Community Care booklet] Is this a recent development, 2001?

SM: Don't tell me you don't know about this.

MM: Well, I've heard about it.

SM: Why don't I give you a copy of that? I have two. Marv [Southard] wanted to improve the system and Yvette Townsend and I facilitated what today would have been called a Stakeholders Group.

MM: When did you start work on this?

SM: '99, I believe; and we had a consultant who worked with us. But if you look on page 7, that was the vision we tried to create. I'll make you a copy of this page. It lists some of the objectives. [Reading] The objective: to implement a single administrative structure in a defined geographic area to serve clients across [the] age and service continuum. That was the way of getting, let's stop this nonsense of who's in charge. [Reading] To utilize the family-focused client-centered team model to provide comprehensive integrated services in a focused geographic area. To identify factors that need to be taken into consideration in transitioning clients, [and] providing integrated services. To evaluate the effectiveness of a single administrative structure, in improving accessibility and quality. Those were the objectives and then we had outcomes. For me, to some degree, that was really what the Mental Health Services Act was all about.

So we [did this at] Pacific Clinics and it was a wonderful effort. Robin and I co-chaired some groups. Yvette and I co-chaired some others and people came together and we really had consensus on including family members and consumers. And we took all of our adult and child clinics, which were separate in Pasadena, we had four and we integrated them. We had to play around with case loads and whatever, so it's now called Pasadena Family Services, Monrovia Family Services. To me, it had a lot to do with cultural competence, because if you don't want – a family, I don't care whether it's Armenian or Hispanic, Asian, African American, they do not want to come in five different doors. They don't want to bring Grandma one place, they want to come in [together].

I felt like it was sort of like going to a Kaiser, where you've got a general practitioner who sees you; if you need kidney work, you get referred to a kidney specialist, but otherwise there's certain basic kinds of stuff that everybody does. So that's what we try to do, we try to have everybody do basic stuff and we still have specialized children's services and older adult services and transitional age youth services; but everybody tries to work with everybody. And I think – it's just so interesting to me that the – Not too many people really, I mean, I'm real proud of this plan. I was proud of the input, proud of the objectives. I'm not sure how many people actually tried to do it. I know we did.

HP: So this was something you as an agency did, but [not] the County as a whole?

SM: Yeah, not the County as a whole, and I don't know why they didn't do it, because it's Marv's plan. You know, and I suspect union issues probably had something to do with it. It's not so easy to change things in the County; but even some of the overarching principles, you read these principles –

MM: They look very familiar to me.

SM: Right? I mean –

HP: Well, especially, the idea of integration.

MM: And I have heard this referred to as a model in some senses, but –

SM: We talked about the important of substance abuse, everybody is using. If the client isn't using, somebody in the family is using. But almost all of our clients are using, and then our kids, 7 or 8 years old, are sniffing Magic Markers in the restrooms at school. It's ridiculous. So that was something that was really an important effort on Marv's part, that I feel proud of participating in and that we, I mean, if nothing else happens, the largest agency in Los Angeles implemented some of those principles and are still practicing those principles.

MM: So have you found that with the MHSA and the new talk about transformation, have you found that your work on CCC sort of feeds into that? Or no?

SM: No, because the – I believe, and for the record – and I've said this in the Mental Health Services Act Plan and everything else – it is culturally incompetent to talk about these age groups and target groups and separate the money. I just think it's so artificial. I think there are ways of – people say, how do you protect money for kids? You could protect it, that's what you have evaluation for and contracting for. So I've got a TAY [transitional age youth] program over here and an older adult program. You know, it's just stupid. I just think it's stupid. Particularly given the way the demographics are going in LA. I mean, the majority of the population is Latino and Latinos didn't want to go to little silos ["silo" refers to the fragmentation of health services for institutional, political or funding reasons]; I mean they want to bring Grandma and Daddy and everybody else.

MM: And they are very family-based.

SM: Everything is family-based and I think the same thing – in the Armenian Family, it's the same way. If we don't talk to the patriarch, we're not going to get anywhere. So how do you – for years, I've fought for, you know, can't we try to get MediCal to have a family billing? No. I mean that's another stupid, stupid thing. You ought to be able to bill for the family; you are working with the family. No, you have to bill for the identifying patient and it's just not – And the other [thing is] billing by the minute these days. And the Mental Health Services Act, we bill by a minute, do whatever it takes.

The other thing Los Angeles did is that, which I don't mind going on the record on, is in order to try to spread the resources, heavily leveraged all the Mental Health Services Act programs with MediCal and our children's program is 90, 10. 90% MediCal. Pretty hard to do whatever it takes and not risk an audit, with this allowance. So you know, other Counties did not do that and when we talked to Marv about it, his response was, "Well, I would have had to do less."

HP: What are some of the things that you can't do because of the leveraging with MediCal?

SM: Everything has to be based on medical necessity, so you know, say you have some flex funds that could help pay for the ballet lessons or whatever, but flex funds are sort of limited. "Do whatever it takes," might mean that you want to spend 4 hours or 6 hours taking the kid on an outing to experience nature. Try to

get that through MediCal. That's not a treatment plan. It's not going to happen. So it just kind of limits your flexibility to be spontaneous.

You can't be spontaneous. It's very hard to be spontaneous when MediCal is involved, because everything has to be on a treatment plan. And again, what I'm handing you is a chart. It starts in, and I forget what year it is [1999-2000], but if you flip through it to the current year, what you can see is that California now is dependent totally on FFP – Federal Financial Participation. It is the major funding source in California and that's a problem. I'm not sure how much of a problem it is for community agencies, but it's a significant risk.

HP: How come?

SM: Because we get audited. We had 18 audits last year.

MM: 18?

SM: 18 and that's not – I mean, we're supposed to be a good agency.

MM: That's probably time-consuming as well.

SM: Horribly time-consuming. We've tried to work with our lobbyist, Rusty Selix at CCMHA, to say, you know, we're probably spending a quarter more time – We just prepared for the Moss Levy audit that's done every few years in the County to make sure – [Moss, Levy, and Hartsheim are a CPA firm conduct many city and County audits in California.] We had three months of preparation time, they reviewed 1300 charts in our agency, 6,000 claims. We had a conference room about this size, loaded with charts from floor to ceiling, all the way around. And the result was 15,000 dollars of questionable billing; there were some notes missing. So it probably cost us maybe fifty or a hundred thousand dollars to prepare for that.

HP: So it's a drain on resources?

SM: Yeah and it certainly didn't pay for the four or five staff from that firm to do that.

MM: Yeah when you think about it, talk about not cost effective. So talk a little bit about then your involvement with the CMHA? Is that right?

SM: CCMHA?

HP: Yeah, the CCMHA.

MM: The ACMHA, the Association-

SM: Oh, okay. When I came down here, remember I had this Contractors Association that was making my life miserable, but also was effective. I came down and there were a few Community Mental Health Centers that would meet on their own and we were a Community Mental Health Center, our Pasadena facility. [Our] construction grant required that. And I met with them. But at that time [President] Reagan decided he didn't want the Community Mental Health Center Act and he dumped it. So I said to these people, "Why do we want to have a

name that he's dumped? I mean it's like it being an Edsel. I mean we don't want to do that. You know, let's form a Contractors Association." So we hassled a lot because they had some money left in their dues and they thought we were after them for their money. But we basically worked it through and finally formed a Contractors Association that was – And that's what we called it at the time, a Mental Health Contractors Association. I was the first president.

And the only other person who agreed to be on it was Marv Weinstein, God rest his soul, from Portals, because everybody else was afraid. They were afraid of retaliation that – you know, what would happen if we organized and if we did that, whatever. We got through it and I think, over time, depending on who the Director is at the time and who the Deputy Director is, we've made greater or lesser use of it. I mean Robin Kay [Deputy Director of DMH] makes tremendous use of it, calling together groups from ACMHA. It's now merged with probation and child welfare, which I think has not helped the mental health agencies, and in retrospect, I would have not voted to support that.

But she makes great use of people, saying, "This is what we want to do; what do you think about this?" She uses the agencies to work through what exactly should DMD do; she's very clear [that] it's not a decision making group, but it helps her. And frequently the County Executive is there and some other people, so they get to then learn what some of the ins and outs are. She's probably the most positive extreme; and she had worked at a community agency, so she has a sense to know that she doesn't know everything and she might have to understand the impact. Others have been less inclusive, where you basically had to, you know, beat on the door.

I think as an association, just of mental health agencies, we have been very effective lobbying the Board of Supervisors. We had good working relationships with Harry Hufford, the CAO [1974-85], and with David Janssen [CAO 1996-2007]. And that makes a big difference, when David Janssen knows who you are – There were times when we would all be sitting in the first row, when Hufford and Janssen were here, and they would come over and talk. There were Supervisors, you know, and you would hear Supervisor Gloria Molina say, "Oh, there she is sitting in the first row again," and even if you didn't say anything, you were watching. Your presence made the vote a little bit different. So those were times when there were options and there was money and ACMHA was very effective. They knew who the leaders were and it made a difference.

I think these days the merger has really diluted – child welfare issues are really not the same as mental health issues, probation issues are not the same, and to have one association try to deal with all three things at the same time has not been useful. But I do think, overall, as agencies, we've benefited from being organized and I think the County has benefited. There were times when you know, there were times when a County Director, who will remain nameless, can't speak to something, but can provide you with information and make sure you go before the Board and you get it out there, and the smart Directors do that, and that's a win-win for everybody. We are there to advocate for the public. We have taken down busloads of clients, had clients testify, family members testify, and for a County-operated facility, it is hard for them to do that.

MM: So how would you characterize that, working with the directors and DMH itself, I mean, it sounds as if you tried to play a role where you offer them support and advice.

SM: Always, I think; and again, some of that may come from having been a Director myself. I think you need to be able to hear something. With several Directors that I knew fairly well, I would feel comfortable saying, "Let's talk," and I would just say, "I just need you to hear this. You just need to know." And I think they knew that I was speaking for at least a portion of the mental health community and speaking what was true, that somebody else might not tell them, and they appreciated it and I think – That's why I said, I think you get that Mental Health Director's Disease, you are in this little cocoon and people don't tell you what you don't want to hear; so sometimes you need to hear it from somebody else. As I said, I came down here with a reputation that, even if you didn't like me, you respected me; and most often people felt [when] I spoke, I didn't make things up, I was truthful and I didn't try to hurt anybody. I was doing it just for the good of the system, because I really did care. So people take it that way and you need to do that, because otherwise – Some directors hear better than others and you know, some don't want to hear. I could think of one that absolutely didn't want to hear anything. He wasn't here long.

HP: How would you describe the kind of relationships you have had with family members and other advocacy groups?

SM: We were the first in Los Angeles to give NAMI an office in our building; and I certainly recognized that one of the biggest changes that was occurring in Washington – if it wasn't for Stella March, we wouldn't have case management billing. This little lady, five foot tall, she changed it. And I wanted NAMI on my side when something went wrong and I wanted them to say, "Don't hurt Pacific Clinics." It was a very selfish motive. We were serving lots of their relatives and we needed to have a good relationship. So we gave them an office. To this day they have an office, and right now it's at Foothill, that we pay for. They just pay for their telephone.

And the other thing we did develop was a – Chris Amenson developed a lecture series that is now in its 19th or 20th year, called "Surviving and Thriving with the Mentally Ill" and it has about four weeks on schizophrenia, a couple weeks on bi-polar disorder. He has now taught Michael DePaolo how to give that, we just finished it. And we do that and it's a major attraction for NAMI members, because it really does give you very basic information, as well as focus on how to respond to your relative, talking about how not to criticize and how to praise and all that kind of stuff. So I think we have a relatively good relationship with NAMI. We handle our own [board training] – our QAB [Quality Assurance Board].

HP: Yeah, if you could talk about that a little bit.

SM: We just had our installations in here last night. Orange County was there. One of the things that I recognized from my work on the Planning Council, was how effective many of the clients in recovery were in influencing public policy at the Planning Council. And I thought, "Gee, we don't have enough of these people." Part of our job should be to train people on how to be on Boards and what it is

like to be a Board member, what your responsibility is, how to do that, and some people to train people on how to do RFP reviews, stuff like that. My feeling was that if you really want to be an influence, you have to be on a governing board; and in order to get more clients on governing boards, they need to know how to behave and what's expected and what you do. So, as you could see from some of your brief experience, we went through agonizing efforts. Our first effort, I asked the social worker who worked for us, who was very nurturing, to lead the effort. She turns it more into a therapy group. She meant well. So it took us a while to get somebody who really could have that right balance of providing a little guidance and a little direction when necessary, but not take it over.

For example, the last effort we had at reviewing bylaws was that they had something about, I don't know. So I raised my hand, was recognized, and I said, "You might want to put that in policies and procedures, not in bylaws." Oh, it has something to do with the date of the meeting, every third [week of the month]. I said, "You don't want to have to redo your bylaws every time, so some organizations would do this." So you don't tell them [what to do]; so then we developed, in addition to bylaws, they have this extensive policies and procedures kind of book. So that's the dance. I try faithfully – the Executive Committee meets every second Wednesday at 2 o'clock in the afternoon.

The problem we are having right now is that it's getting a little cliquish in terms of – We got three new people on the Executive Board, who were just installed last night. But still people who know how to manipulate a group can get nominated to run for an office and whatever. So I think one of the things that Ann Marie and I have talked about is I'm going to bring up at the next meeting just an observation that sometimes groups get a little cliquey and they need to be sensitive to expanding and opening up. So I did bring up a little bit of that, so this year they have an executive apprentice for the Board. And the other thing that horrified me is the Board started to talk about high functioning clients and low functioning clients. Stigma, that's what I'm saying, we talked about that. You start stigmatizing amongst yourselves, I mean that's – really imagine how horrible that is.

But it's been good. We have lots of people who started as QAB officers and they also took our consumer training course and they are working. We traded off with the Mental Health Association Board members, for a while. I don't know how many people who have been involved are now currently on boards any place, but certainly some of them were ready, some of them were not. Orange County QAB just started up again. They were there last night. We had two people from Portals; I mean, we filled the room. I was really – It was amazing. They organize it, the installation, themselves and do the whole thing, recognize each other for their achievements. It really is a client governance and it gives me good feedback.

They make site visits. One of the things I wanted from them was to tell me what's going well and what's not going well, so they do site visits. Three or four of them go to a site and they do it the way – we trained them to do it the way you would do it if you were really doing one for the State, where you have an entrance conference; you show people what you are going to be looking at; you do it; you have an exit conference; and then you write up a report. And they get

paid; they get a certificate – a gift certificate of their choice, either to Wal-Mart or Target or to Ralphs, and so it's a job; but it also teaches – and it also gives us feedback. They interview clients, they interview staff, and they make observations about the physical facility. Each division has mini-QABs; they feed into it and we learn from it. [From] our Asian Pacific Group mini-QAB, we learned that the doctors were coming late and were keeping clients waiting. And that's not acceptable so we were able to – So you get information that really is important to them, but also [to] us in terms of enhancing services.

We send them to conferences. In addition to preparing their budget for the year, they prepare a conference budget, so they have to choose which conferences they want to go to, which local ones. And we focus on two national ones; they usually try to go to the Alternatives Conference and then the Health Association [Clifford] Beers Conference. And we require them to get a medical clearance since they can't get insurance, because we had problems with somebody having medical needs.

And they have to go to a couple of day conferences and then they go to a one day overnight conference; and then they graduate to going to Washington DC, or Buffalo was the alternative [last year] – It wasn't in the winter. That's where again you need to train enough people to do that, so the same people are not always going to these out of town trips. We give them the same per diem that we have, or that the State has, and they have to bring receipts and they have to be accountable for the money; they can't buy gifts, they can't use it for alcohol, and they have to give a report when they come back, whether it is a day conference or an overnight conference. And they love that, because it gives them a sense of what's going on, and we hear that and it gives us some sense of what's going on in the rest of the world as well.

HP: And you mentioned also that you also noticed the effectiveness of consumer advocacy on the Planning Council earlier. Tell us a little about that – just going back to your experience with consumer advocacy.

SM: Well, you know, I was as prejudiced as anybody else. The idea that somebody who had serious and persistent mental illness could be an effective chairman of a forty person Council. I mean, it wasn't that I thought it was impossible. I never really thought about it. And then I saw this person who was functioning, taking medication, but functioning every day and running this thing, and I thought, "Oh my God!" You just reshape your view of the world, how did this person get there to be able to do this? So that led to my commitment to say, okay, we can show that if people can do this – and it's strange.

Most recently, we have been having this discussion that the State Department of Mental Health has changed. Communication is not the same; there is a whole new cast of characters and the clients and family members on the Council were talking about a fear of retaliation if they went through an issue resolution process and I said, "We have a fear of retaliation." I just went through something, where I gave some feedback that somebody didn't like and I heard about it. So everybody is afraid that if they speak the truth – So people look at me and one person said to me afterwards, "I felt so much better when you said that, because it didn't make me feel so out of it or so paranoid."

But I think that's an issue that gets dealt with not well and that, if you want to really encourage consumer and family participation, there has to be some ability to convey that you can say something and *not* be retaliated against. I mean, I worked in Counties, I work with a County now where they just don't like us, because we speak up and it's not acceptable and it shouldn't be that way. I mean, if you don't do your work, if you have poor outcomes, if you are ripping people off, that's one thing; but if you speak and disagree, to have contract issues come up as a result of that, that's pretty –

So I know it happens; and I just can't imagine what it must be like to be suffering from schizophrenia or bipolar disorder, taking this heavy duty medication, coming to these meetings, and trying – you know, the meetings are long, they start at 8:30 in the morning and go to 6:00 at night. I mean, I'm exhausted; I'm not on meds and I'm not struggling with trying to manage symptoms of mental illness. And *then* to have to be retaliated against because you try to give honest feedback, I mean that must be –

But I have really seen there are lots of people who have chaired the council who have done a really good job. One of my best buddies, Jay Mahler, he was on the council [Mahler is Program Director of Mental Health for Contra Costa County]. He and I knew each other from our Alameda County days. We weren't always good buddies in those days, either. But now we are and he frequently runs into me. He's involved in some spirituality work; we were involved in the spirituality conference several years ago and thirty years later we are still working together. And he is still doing fine and is now in charge of consumer affairs for Alameda County.

V. Closing Comments

MM: So thinking back over these past almost thirty years –

SM: Well, if you count Alameda County, forty –

MM: You have talked about some of the things that you have done, some of the things where your viewpoint has changed. Is there any particular thing that you have learned either from working with people in mental health or working with clients that has changed the way you think about the problems of the mentally ill?

SM: Oh God, everything. I mean, I just think – you know, my textbooks say mothers make people schizophrenic [she laughs]. You pick up nine or ten [such references] easy. When we did our first spirituality conference - I don't know what year that is [2001] – it was our 75th anniversary, so go back. That was my apology to family members and clients; for – when somebody said, “Jesus spoke to them or they saw God” – it was my apology for saying, “That's delusional , a religious delusion.” Because one of the things that I have learned that for almost everyone who is in recovery, there was some kind of something that they identified as a strength or a higher power or you know – nobody gives it the same name – that assisted them in their recovery. So when we used to look at that and say, “You're religiously delusional here.” So I learned mothers do not make people schizophrenic. I learned that there is a need for spirituality in recovery

and self-help; and I've learned that people who have mental illness have far more strength than we have ever realized.

I've learned that I do not have all the answers. I mean we used to do – I'm the doctor, you are the client; close the door, don't ask me what I do in there; it's like I lay on hands. You know, a lot of that, the distrust of the professions, really comes from a lot of us in my generation, who didn't focus more on what are our outcomes, what's happening; we just did this kind of stuff. And so I've learned that I could learn just as much from my clients and their families, maybe *more*, than just trying to say, "I'm the expert, let me tell you."

I've learned about the influence of substance abuse, which is just a horrific component. I've learned about the actual brain damage that occurs – If you're treating somebody who is dually diagnosed and you look at some of their scans; sure, you've got two different parts of the brain that are impacted now. Of course, it's hard to treat these folks. With kids and families, I've learned about the horrible impact of these video games on their brains. We have done several things on why children kill; and there's very definite brain damage influence, that is reversible if you take, what are those auto games?

MM: *Grand Theft Auto?*

SM: *Grand Theft Auto.* Those are probably the most destructive to young people's brains than anything you can imagine and really lead to a desensitization to violence. If you take it away from ten days to two weeks, it's reversible; but that's horrible. I've learned to be more appreciative of different cultures, including geographic culture differences. People from Appalachia are different from people from New York and you've got to really remember that. I had a patient from Appalachia that I was probably cruel to, when I was an intern, because I had to do some psych testing on her and paid more attention to getting my psych testing done than I did to her. I remember that when we ask students to do things.

I think I am more sensitive to how much there is to be done and how little energy there is to make change – that there is more resistance to change. You know, within my own organization as well as outside, people would rather stand still than change, even though you have best practice and all that evidence. I mean, from the time that I started training in 1960 to now, I mean, it's like, there is just no comparison.

MM: Do you think at all it has been easier for you to change coming, from a psych background and a background in group work, than for the psychiatrists? You have spoken about them as showing you a lot of respect.

SM: My impression these days is that there are not enough psychiatrists really involved in the public sector anymore, because they don't just like giving medication. They do not want to push pills. So, if you look at the Director's Association, oh God, I don't know; I mean, it will be far and far between to find a psychiatrist; I don't know exactly. And in our own organization, we have two medical directors in the whole place.

So I think the absence, which I don't know if it's good or bad, you know, we've moved away from the medical model. So having a lot of psychiatrists is not – On the other hand, we have hired a consultant, a person who used to teach at USC, Dr. Ragnoff, and she has been very helpful; she works about 10 hours a month. Because we have some questions about best practice. We look at the person's records and we do peer review, but what do you think about this? I just did a survey, what was the frequency with med visits and I was really pleased to see it's about once a month and I thought it would be much higher than that. But I don't think there's enough psychiatrists in the system to implement something like that.

And we do face a real crisis in history and leadership, in that most of us, a lot of us, are aging out; and there are not too many people who are coming up in the ranks who have – I don't know how many people know about historical funding and why it's such a mess and why it will never be any better, unless we do huge infusions of money in some of these under-equity Counties.

MM: If you had – do you want to have a question before I go? I'm about ready to start my terminal set of questions.

HP: Well, I just wanted to ask, since you mentioned it, how would you define the Recovery Model?

SM: Sort of the same way I did the work I was doing [she laughs] on the inpatient service. What got you here, what could help you not get here again, what do you want to do and how can I help you do it?

HP: Find the problem and try to fix it.

SM: And what do you want to do? You don't focus only on the problem, you focus on what you want to do and how I can help you do it. But if you don't have a WRAP Plan available to you, then it's pretty hard and we try to encourage our staff to have WRAP Plans, because again, if you don't understand when the symptoms are coming back and what you can do to try to manage that, then it doesn't matter if – you know, you've got to have some of that ability to manage it.

HP: I guess the extension of that would be, for the public mental health system, what would a recovery-oriented system look like?

SM: Well, I guess, to me, it would start with being family-oriented, because you need to build on where people are and the strengths within that group and for lots of people – not true of me I mean, I make decisions all the time and I don't consult my family. I have hundreds of people who work for me from different ethnic groups, who would never make the simplest decision without going home and discussing it, not just with a spouse, but with everybody in the family. I mean it's foreign; I respect it, I just can't imagine it. So I think partly we non-ethnic family, we need to really be more appreciative of the family model and what that means to people; so I think that's one thing.

I'd have a lot more money in employment services and in housing, because those are the two major, major kinds of things. If I didn't do anything, if I had a

family-oriented system that had a lot of money for housing and a lot of money for employment services, I think people would get better, because if you assume people can work, you know, they can. Everybody is not going to work 40 hours a week, but lots of people work part-time. Some people can really work full time.

And I had a woman who worked for me, very high level in the organization, and it took her maybe three years to tell me that she was on medication for depression, because she didn't want to come out. And she eventually did, and of course, it was a wonderful role model for our clients. But I don't know how many people we have who are in recovery, because, you know, a lot of people still don't feel comfortable disclosing it, which is a sad commentary, particularly given that we are supposed to be in this recovery-oriented system. So if you're really in it, wouldn't you expect people who are at the highest levels would come forward and say, "Here I am;" because it is so motivating to other people, who are going to think, "If she can do that, I can do that."

MM: Looking back now, I'd like to ask you first what you think your most important contribution has been to mental health services in LA, and then sort of a side – is there something that you wished you could have done that you just have never been able to do, that you've tried to do, but couldn't?

SM: I think my most important contribution to L.A has been identifying talent within my own organization that could develop programs that are needed within the community and particularly in our multi-ethnic services. I think we have made a major contribution in showing that you can provide services to ethnic communities, but I couldn't have done that without having a person who – So if I am anything, I am a good talent scout.

I think what I regret is that I haven't been able to help the County define what we should – how we divide up the work so that we are not [competing] – I think it would have been more of an effective system and a more efficient system if we had some [division of labor]. And, you know, we made stabs at it over time, "you do this, we'll do this." But we just didn't get there and I think that's too bad, because we are still competing with doing an FSP over there, and Arcadia is two blocks away from here, and an FSP in El Monte. I mean, do we really need to do that? I think we should be doing things a little bit differently. There is not a fundamental difference between them; if one was for Vietnamese and one was for English, I would say, "Oh sure, that makes sense;" but it's not. We're all doing the same thing.

MM: Is there anything you'd like to add?

SM: No, I think you know, Jerry Brown [Governor of California 1975-83], who I criticized earlier, said once that he feels sorriest for the toll booth taker at the Bay Bridge, because he or she just has the most boring job in the world. And I have the greatest job in the world and if you would have told me that I would still be working at 67, I would tell you, "You are out of your mind!" But I still enjoy what I do. I think it's a privilege to be able to do work where people say to you, "You have saved my life, or you have saved my family's life." In private practice, once in a while that happens. I have been privileged to participate in an organization where we've saved thousands of people and you just can't, you know – that's a

privilege and it makes you feel that your life is worth something, that you have left a mark. I feel that if I were to die tomorrow, I made a contribution that will be remembered and some of it will be long lasting and not a lot of people could say that.

MM: Good, thanks, excellent. Thanks very much for your time.

HP: Thank you.

END OF INTERVIEW