

Alfredo Aquirre talks about the stakeholder process in San Diego County:

So we decided we wanted to make a break from that and we developed what we called a council structure, where we could have different stakeholders, from providers to family members, consumers to other interested advocates, and people from the schools, and bring them together as part of a council. They would provide feedback, input, criticism, perhaps advice with a very small “a,” and we would listen to what they felt the system needed. We would present the data analysis and help those communities understand the data but most importantly hear from them. And by [having a structure independent] from the Mental Health Board in terms of the stakeholder process, we were able to do that effectively. We went beyond the themes that were driven by MHSA, so those councils were really expected to look at the overall system, as opposed to just being an MHSA planning model.

We also wanted to recognize, kind of the importance, the prime role that the Mental Health Board played, so everything that comes out of our stakeholder process gets presented to the Mental Health Board. When we initiate a thirty-day planning process, we start at the Mental Health Board. We kick it off there. We go out to all the stakeholder groups, including the councils. We have something called the Mental Health Coalition here, and now at Behavioral Health, we have the alcohol and drug providers. We have the Mental Health Contractors Association. We go out to all these groups and get their input. We then develop what we feel is a plan that reflects the interests of the community, reflects the data, and reflects the understanding and knowledge of the system by our staff, and also keeping in touch with the broader County priorities. For example, there’s a strong focus on transforming our community called Live Well San Diego, which is a ten year transformation project to make our County healthier, safer, and more thriving. So everything we do has to align with that.

The other thing [is that] transparency was really key: always go back to those groups and say, “You gave us ten great ideas. We’re putting four of those in the plan, and these are the reasons why we’re not doing the other six.” Now, some of those other six are worthy to be put in the parking lot, so that’s another term that’s kind of a San Diego thing, “parking lot,” [so] that we always get reminded, whatever happened to that program we recommended? And you put it in the parking lot.

But again, by having this continuous process, we still clearly help the community to understand that we have obligations under MHSA. With MHSA, we do bring them up to date on changes, with each [program], whether it’s capital, facilities, technology, prevention, or intervention, we do have specific plans. It’s just that when they’re presented to the stakeholders, it’s presented within a context of a larger system. But we do remind them that we have these plans, and we actually have a big plan, the annual update now, that we do every year. We have to have a process for that, so we honor all of that.

Read the full transcript below.

ORAL HISTORY INTERVIEW WITH ALFREDO AGUIRRE**INTERVIEWER: Marcia Meldrum****DATE: February 1, 2013**

Q: OK, we're at the Department of Behavioral Health Services in San Diego. We're starting our interview with Mr. Alfredo Aguirre. Can you start out by just telling me how to correctly pronounce your name?

A: OK, first name is Alfredo; last name is Aguirre, but I'm OK with variations of that. I'm the Behavioral Health Director for the County of San Diego.

Q: And you've been in this position about five or six years?

A: Actually, as Behavioral Health Director, I've only been in this position since May of 2012. So I'm closing in on about eight months. Before that, I was Mental Health Director for a little over five years, and before that I was the interim Mental Health Director over both Adult and Children. So I was one of these weird types that was the Children's Mental Health Director, I think [San Diego was] the only County that had such [a position]. I was brought here in '99 from San Mateo County, which is in the Bay Area. I was recruited to be [the first] Children's Mental Health Director.

[Why a Children's Mental Health System?] Probably there was a ten-year – I'm not sure when Areta [Crowell] left,¹ but I think there was a period there where there were some politics and community and stakeholder engagement, and it was interesting that the Children's Mental Health System was formed with its own budget [and] its own programs, so there was a lot of interesting history around that. When I was in the position in '99, I was considered [by the State as] a Mental Health Director, so I'd go to all the [required] meetings [under the Association and State Department of Mental Health].

¹ Areta Crowell was Director of Mental Health for San Diego County 1986-1990, and Director of Mental Health for Los Angeles County 1990-98.

Interestingly, we [also] had an Adult Mental Health Director, Sherry Harrison, who then left within a year; they did a recruitment, and they brought in Mark Refowitz [as Adult Mental Health Director], and he had worked out [on the East Coast]. We got along great. We were really an amazing partnership because it wasn't competitive and we kind of backed each other up. So that was an unusual thing, and then Mark went on to Orange,² and that's when I became Interim [Director] for over three years. Then I became the official Mental Health Director, and then now I'm Behavioral Health. That means Mental Health, [including] inpatient healthcare, and Alcohol and Drug Services, and all the administration of course.

Q: Wow, so a pretty big job.

A: Yeah.

Q: OK, that was really interesting, and very helpful. Can you just start at the beginning, though, and sort of tell me how you got into this field. What sort of brought you into mental health at all?

A: Well, I've always been kind of a late bloomer. After graduating from San Mateo High School in 1971, I went into community college with no idea what I wanted to do career wise. Along the way, I worked as a volunteer at Juvenile Hall and began to think about working with people; that seemed to be an area that I felt pretty comfortable in, especially working with youth. I then, in 1973, was accepted into Cal State University Hayward – now it's called Cal State East Bay – and I got my degree in sociology. It took me a little over two years, and then I was fortunate to be accepted into the School of Social Welfare at UC Berkeley, interestingly as an Organization Planning and Administration student. While I was there, I again had somewhat of an amorphous view of what I really [wanted to do] – kind of understood the community mental health and [other] social services systems.

² An interview with Mark Refowitz is available in this collection.

At the time at UC Berkeley, there was a pretty strong community health track. I became interested in that and being at twenty-three, twenty-four, twenty-five years old, in the two years I was there, it's kind of odd to me that I would get a degree in Administration and Organizing, leading to a position of leadership, where I'd never been in the trenches doing work. So I decided on my own in the MSW program to do a minor in direct practice, specifically in community health.

I was born here. My parents are from Central America, El Salvador, and I had a real interest around my cultural roots and wanting to kind of recapture the Spanish that I had lost over the years and felt I wanted to [work] in a Spanish-speaking, Latino community. So I had the opportunity as an intern, in my second year of the MSW program, to work at La Clinica de La Raza³ in East Oakland, specifically the mental health center which was called El Centro De Salud Mental. I did both direct practice [which was to] do a basically direct counseling therapy with adolescents and their families. It was a pretty much a primary Spanish-speaking opportunity and internship. And then I did this kind of a community work track where I worked with a number of pre-clinical projects that all happened to do with developing mental health education projects, particularly for youth and families. So I got a little taste of community work and a little taste of direct practice. After graduating, I decided to travel to Central America with my brother who [had just] graduated from high school.

Q: What part of Central America?

A: El Salvador. So we decided – I was able with my stipend to get a van, and we cut our hair. We traveled all the way down the East Coast to Mexico and Belize and Guatemala; we took two weeks to get to El Salvador and spent a good chunk of time there. The whole trip was over two months, and we got to spend some time in Costa Rica [where

³ Opened in 1971 to provide free medical, dental and optometry services to Oakland residents, La Clinica de la Raza now has 31 sites across 3 Bay Area Counties.

we] had relatives. Then we had to drive all the way back. On getting back, I went to live with my parents who lived in San Mateo still, in the house I grew up in.

My dad, who was basically retired at the time, said, "Hey, you know, at the Latino market on the corner, the woman that owns it also did community work for the County, and she says they're looking for a Spanish-speaking therapist, an MSW, to work with the Latino population in the central part of San Mateo County." I was interviewed, got the job, and started my career in community mental health, working with adolescents and families, and working in the community that I grew up in.

I worked in my middle school. I worked at my high school. I did a lot of work on the coast working with primarily Mexican and Portuguese migrant and nursery workers and their families. That was a great experience as well, to diversify, working with immigrants, and kind of bringing my own immigrant experience as a son of immigrants. That was a really great opportunity.

Q: It sounds wonderful.

A: Then after that, I moved into a supervising role, working with adolescents, and that was in '81. Then, in 1983, I was introduced to the adult mental health world. I was asked to become the program manager of the North County Mental Health Clinic which is in Daly City, California, which is just south of San Francisco County. That was a great experience, learning the adult system. At the time, the mental health system was just beginning to move away from kind of the traditional medical model, the treatment model, and starting to look at recovery models and beginning to work more in partnership with the communities and families. We started doing family support with Latino families and Filipino families.

Q: OK, so it was a largely Hispanic area then?

A: Daly City was primarily Latino and Filipino. I was [manager of the] North County area which was more than Daly City, but being specific, the south city was probably about 40

percent communities of color, and the other [60%] was very working class, strong Italian-Irish second or third generation communities that we served. So it was a rich experience, very catholic.

Q: Yes, really fascinating. That's great!

A: And then from there, I was asked to get more involved system-wide in the developing Children's Mental Health System. We applied for a federal grant. We got a System of Care Grant, and I basically began and became the program lead for San Mateo County for a federal grant, shared with four other Counties, Ventura, Riverside, Santa Cruz, [and Solano].

Q: OK, you'll have a chance to read the transcript over, so you can fix that if that's not right.

A: It was wonderful because we really took an inter-agency collaborative approach to working with children and youth. I was lucky to work under two outstanding leaders in mental health, under Beverly Abbott who was the Director, who really kind of took me under her wings as did her deputy Pat Jordan, whose real focus was children's mental health. She was one of my mentors in children's mental health. And I began to get involved in system development while still [overseeing] the North County Mental Health [Region].

It was a kind of a matrix model system, and, in those days as public mental health was growing, managers were expected to do more than just be over one siloed outpatient program. You were asked to do other things, and it was a great opportunity.

Q: It sounds exciting. Can you tell me, looking back, what was the thing you feel most proud of having done there?

A: In my San Mateo days, I think what I was most proud about was being a leader of a Children's System of Care that really went beyond working with the whole family in partnerships with child serving agencies in schools. When I got involved with the federal grant, we had already established good, working relationships with those agencies, but

we took it a step further, by involving parents and caregivers as partners and shifting our focus from blaming them. Even though we had an interagency-based system of care, we began to think [and] talk about parents as partners. I felt like I was – through my own style, I was able to not only model for my staff, but I had to go through some value stretching here on how we see the human condition and what we attribute problems to [and] to really begin to hear other voices.

And, in essence, as I assumed that leadership role to help staff move in that direction, I really relied on my own experiences; because actually, in working with Latino families, I did some things that were a little bit out of the box. I did a lot of home visits. I was able to share a little bit about my own immigrant experience. I think I did a pretty good job of partnering with fathers. In the Latino community, they often felt like they maybe didn't necessarily see themselves in a primary role as it related to the behavioral problems of their children. But I felt I was able to make strong connections with families and really value not only family, but extended family.

Also, all along the time – basically from the day I started working for San Mateo, I was involved in community organizing outside of my job. That kept me grounded with the community and helped me understand the role of things that determine bad outcomes or good outcomes in terms of the economics of the community, how well communities are bonded and how well connected they are to institutions like schools. So I think I was able to do some good work as a community organizer, in tandem with my County job. Back then, it was before I married and raised our children. I had a little bit more time to work evenings, but all of that was rich. And really I just see that whole experience as taking a System of Care that was pretty well grounded and really taking it to the next step of a stronger connection to communities and in working with families.

Q: One thing a lot of people have commented to me on is that it can be very, very hard often to get Hispanic families to accept the idea that someone in their family needs

mental health assistance. It sounds like with your background, you were really able to bridge that gap. I mean, do you see that gap as existing, or is it because the Anglos aren't asking them [laughs] the right questions or taking the right approach?

A: Well, I think that the issue of stigma is still with us. In fact, we have a huge Ending Stigma campaign in San Diego, [called "It's Up to Us."] It's probably the largest [anti-stigma campaign in the country]. So I can tell you that those issues are still there with our Latino community, years after the community mental health movement, if you see the community mental health movement with the federal legislation being in the mid-sixties, all the way –

Q: That's been fifty years.

A: I mean, I started my work in '79, and I did a lot of my work with Latino communities in that era of '79 to '99. I saw some real positive change, but we all have to remember that there is this ongoing immigration dynamic. So you continuously have families that are going through assimilation, acculturation, and may have their own views that are culturally based around how they view illness and problems and how to best address them. And their distrust of systems that don't seem to understand them well, and can appear quite foreign, so you know, that's a process that takes some time. I think what helped me back [then], at least in the central part of San Mateo, and also, I think, later in Daly City in the northern part, I think they were able to see me outside of my role as a mental health clinician or expert or a mental health administrator. They were seeing me someone like that who was involved, engaged, rolling up my sleeves around community issues and concerns.

So they saw kind of a hybrid kind of guy who could relate at different levels and not just as a traditional top down professional psychiatric social worker to a consumer. I mean, I really think we were able to see different sides, and so I think that helped.

Q: OK, so what brought you to San Diego? It's a big change.

A: On a personal level, I had lived in the Bay Area since my birth in '53 and was very grounded in the mid-peninsula area in San Mateo; that's where I grew up and went to school. I went through college in the Bay Area, in Hayward and Berkeley in the East Bay, and before I got married, had lived in Oakland and in San Francisco. Then, when we got married, we had our first child and lived a couple of years in San Francisco, and then we moved to Oakland to a nice, little neighborhood in the foothills, and we raised two children. My son came along about five and a half years after my daughter, and so I was very grounded in the Bay Area and very connected to my family.

My wife, however, came from LA, and her family was a little bit more [spread out over the country]. But we would always go to LA to visit her mother, and I had a brother-in-law there as well. So we would go to LA, and when we had children, we would always take them to San Diego. I said, "If we ever move to Southern California, I think I can handle San Diego. It's beautiful weather. It looks like a neat place to raise children;" and it was always in the back of my mind.

I knew that I wanted something [different, career-wise]. I wanted a challenge, not that I had hit a ceiling or anything in San Mateo, but I was encouraged by my mentor and the Director to keep my eyes open for opportunities. They were quite supportive. I had an opportunity to – I was recruited, actually, to take up the Children's System of Care in San Diego, which was just being born [during] a lot of controversy about issues that the community had with the Children's Mental Health System. I was recruited by Bob Ross who is now an executive directive or CEO, president, of the California Endowment.⁴ And he and I hit it off.

⁴ The California Endowment is a private statewide health foundation established in 1996 as the mandated non-profit subsidiary of Blue Cross California, with the goals of expanding access to quality health care for low-income families and improving the health of all state residents. Robert K. Ross, MD, has served as executive director since 2000.

I saw it as opportunity to work for a leader. I liked Bob, and I felt [that] not only would I get support, but I would learn a hell of a lot and-and also with the challenge – I always had aspired to be a mental health director, but I always felt I had one thing going against me a little bit was [that] I was kind of, I think, tagged as a children's person, even though I had had mental health clinic management responsibility. But it kind of worked against me a little bit, and very few mental health directors really came out of the children's mental health system. Probably in your history, researching, you've seen that.

Q: You're right, they move within the children's system.

A: And there's always been a little bit of a stepchild dynamic in mental health, between Adult and Children [systems]. I think that has changed with funding over the years, more focus on children's mental health, more recognition of the importance of mental health earlier on in one's life. But, anyway, that was kind of working against me. [Before my appointment in San Diego,] I had [over the years] dabbled with putting my name [forward], applying unsuccessfully [for Mental Health Director positions], although it was a good experience. Then, when I was sought after, I think partly because of the work I had done around developing a System of Care grant in San Mateo, I was able to make good connections statewide and nationally, and because we were seen as [being] on the cutting edge, in terms of children's mental health, in the five Counties that I spoke of earlier.

So in San Diego, they had just received a federal grant, the same federal grant to develop a [Children's] System of Care. So that was the other thing that they really wanted me to take on. So I was recruited to San Diego, and it was quite a challenge. I didn't know a whole lot of people here; I knew some people professionally.

It's been a great experience. I'll elaborate more, but I feel like it's just been a blessing to work in two Counties that are, I think, in the forefront of the community mental health

movement in the State. There are some great Counties, and I know that, but I just feel like I've had good experiences and, interestingly, in very different counties.

Q: I was just going to ask you to comment about that. I mean, obviously, they're different counties demographically, but [what were] sort of the differences in the mental health picture as you saw it?

A: Yeah, one of the things that – first I'll tell you what the difference is, and then I'll tell you some of my stereotypes that I came to San Diego with, and they were kind of shattered pretty quickly. What I think still holds, and I think this is more of a historical perspective is [that], if you look at California, look at Counties that received a lot of local support in terms of funding, [they're the ones that have] advanced in policies and programs. You have the Bay Area counties and the Greater Bay Area Counties, everything from Sonoma to Santa Cruz and Monterey. There's always been good support for mental health in terms of local dollars and match[ing funds].

Southern California is very different, except for LA. LA, I think, is kind of its own world, as you know. So I realized that and I think there is truth to that. I think there was an equity issue in funding, partly having to do with the fact that early on, some of those ratios that were developed in terms of future funding by the State really had something to do with local contributions to the overall revenues for the public mental health system. San Diego, like the rest of Southern California, didn't have that kind of investment. I mean, in fact – this is not with the current Board – but there were past Boards where they actually turned away federal money, because of the concern of either being saddled with liabilities down the road or mandates that would become problematic in terms of funding. I think that evolved when I got here. Certainly the Board supported the federal grant.

When I got here in '99, really some of the stereotypes [I held were that] I thought that San Diego was pretty underdeveloped, in terms of services and models, and resources.

What amazed me when I got here was number one, just the incredible expertise that was here, the fact that they had a very progressive dynamic [with] two academic institutions, UC San Diego and San Diego State, and very involved in research. There was a federal research grant that supported Children's as well as Adults' [Systems] and, in particular, there's one out of UCSD that supported developing models for Older Adults. So that was the other thing that struck me was just the models that were beginning to be thought about and [that] the intellectual bank here was much greater than I had ever imagined.

I think, in the Bay Area, to be honest, we can get a little bit arrogant and think we're ahead of everything, [that] we're kind of intellectually one step ahead. When I got here, I was kind of rudely awakened to, hey, there's another world here with just some outstanding thinkers and practitioners, all working very resourcefully. The other thing I had learned was that – and maybe Areta [Crowell] may have mentioned this – we have nonprofits here that are quite resourceful, that on their own, they've received grants. They've been very involved in developing care. They're very large. I mean, one of the differences between San Mateo and San Diego is [that] San Mateo is a very County-driven system, very strong union history.

Q: OK.

A: In San Diego, [the County is] very dependent on contractors, [on] more of a privatized [system], but through nonprofits, of course, but the reliance on large, nonprofit organizations. I think in LA, and probably Santa Clara, you see a kind of a mix of a strong County [system] as well as contract [providers]. But it was a stark difference, coming from San Mateo, with a large County hospital which included a County psychiatric hospital. In San Diego, [when] I got here in '99, [there was] no County hospital, although we do have a County psych hospital here, and so that was very different. In San Mateo, the one thing you had going was you had an organizational

direction that was one organization. They had very few contractors or nonprofits. In San Diego, you have this mix of a clearly developing leadership role at the County level but very strong leaders in the private sector.

The other thing that I also noticed was different here than San Mateo was [that] there were many more community stakeholders, a much more engaged community. Right away, [at] my first Mental Health Board meeting, I was amazed by the fact that it was packed. In San Mateo, we would have Mental Health Board meetings, and you might have ten people at the most in the audience. It was during the day. It was pretty much a consent agenda with some informational items. All of a sudden, there was clearly – what I picked up very quickly – a very engaged community [and] a Board that was quite responsive to the concerns in the community. It was a very active Mental Health Board. Both Boards were sophisticated; but in San Diego, I just felt it was much more grounded, a Board that was much more engaged with the community.

And also a fairly strong voice for children's mental health. That was the other thing that was quite different. In San Mateo, I was used to, again, a power structure that was pretty much institutional bound, interagency bound, including schools. What was here in San Diego was much more of a model of power and influence that was to some degree institutional and in schools, but to a large degree, was very community based, strong community advocates, people that worked in public interest law that were very interested in access to care for children. That was a big issue here in San Diego and again that was a huge difference between San Diego and San Mateo.

Q: Wow, that's really interesting.

A: So that was a kind of another eye-opener. The other thing that was amazing in San Mateo is we were very much as administrators, kind of sheltered in some ways – I guess it's a good word to say – sheltered from really knowing your budget, really presenting budgets [and] managing budgets. We were very operationally driven, but around the

money stuff, we were somewhat distant. I mean, we just kind of knew what we worked with, and we said, "Here's your allocation. Go at it." In San Diego, right away, [it was] very interesting, in terms of the budget planning process and the stakeholder process with budget, [we were] very engaged with the community, we were expected to know our budgets and what was pretty amazing, too, as I alluded to earlier, just to have a children's mental health budget was so unusual. It was kind of unheard of, and so that was another thing that was great to work with. I had a budget to work with.

I had programs that were uniquely children, adolescent, and I think that dynamic was created by the community. The community basically said the Children's Mental Health System is not working. Now, in really looking at the Children's Mental Health System, what I did find out was [that] there were some really great pockets of excellence, some good things happening with children's mental health. There was just not a system to pull it together. With the federal grant, we tried to pull it together.

But it was a very, very, activated stakeholder community. I think they wanted the system to be – there was a movement here in this community for children's mental health to kind of wrestle away the center of gravity from the County and make it purely community-based. There was a strong community organization here called Heartbeat,⁵ which I think their vision, their goals, including outcomes for children, will always be lauded. But along the way, some of the realities of actually being able to make sure [that] the system came together and provided and did all the tangibles, making sure there was access and people weren't waiting for services, and really pulling it together and making sure that the Board supported it – I think, by bringing me into San Diego, it kind of grounded it back with the County, without disengaging from the community. In my opinion, without Heartbeat, we wouldn't have had that kind of community engagement.

⁵ The San Diego Heartbeat Family Partnership is a non-profit family-run organization that provides resources and information, advocacy, and support services for families and providers on topics surrounding children's mental health, special education, and other children's services.

So my job was to demonstrate to the Board that we were achieving better outcomes for children. To this day, we have – every year – we now are at fourteen years of transformation – we have a [yearly] report that talks about how our children’s model has changed over fourteen years. That was the key, was to demonstrate better outcomes, to understand there was accountability in the money that was being spent, especially with this federal grant.

All this was pre-MHSA.⁶ So all this stakeholder stuff that happened before that was required by MHSA, we had already been doing it in this County; so it wasn’t like all of a sudden, we were asked to do, a new community engagement process. We had already been doing it; it had even started before I got here. So again, looking back, in looking back at the differences between those systems, by that degree of community engagement and also partnership with families and clients, I will say [that] by the time I got here in ’99, the consumer movement started shifting into gear in the late nineties, into the early 2000s. So we saw the same thing here in San Diego.

So that was an emerging partner and in the Children’s System, not only was it family caregivers, but it was youth partners. And we were one of the first Counties to really have a strong youth voice, youth development, and that really helped guide our efforts when MHSA said, “You’d better do something about the young adult population.” By having a lot of these engaged young adults, it helped us pave a way in thinking about what should our Transitional Age Youth System⁷ look like?

⁶ MHSA, the California Mental Health Services Act, was passed as a ballot initiative in 2004 and signed into law in 2005. It created a new funding stream for mental health services, a 1% tax on incomes over 1 million dollars, and mandated transformation to a new recovery-oriented system at the County level.

⁷ Transitional age youth, between the ages of 16-18 and 25, are moving away from school, family, and foster care support systems, and are not yet engaged in adult systems of care. If they lack education and job skills, they are often at high risk for homelessness, poverty, physical and mental health problems, substance abuse, and criminal activity.

Q: Wow, that's exciting. So talk to me a little bit – I've looked at the Children's System in LA a little bit, and their needs are really varied. On the one hand, there are kids who are having problems in school. On the other hand, there's a whole group of kids in foster care who have *multiple* problems and you need to work with – there's a whole group that works continually with Children and Family Services on that basis alone. And then there are the Transitional Age Youth as well, so do you want to talk about what you think is – Well, I could ask you what you think is the thing you did best, or I can ask what was your biggest headache?

A: OK. One of the things – and this is not just the kids, but the Adult System – one of the outcomes that we showed right away, in moving, in implementing the System of Care was we went from – at any given time – probably close to twenty youngsters in the state hospital. By the time we got to about 2001, we were down to one or two and then as we moved into the mid-2000s, we actually have nobody in the state hospital. Now most Counties have made that shift, and even LA has gone from a huge number, as you know, to just a small number. So that was really important.

We began to see a significant reduction in wait time down to – basically since '99, we've taken it from over two weeks that was pretty common, even three weeks in the nineties, as we moved into the 2000s, it's been right around three to five days wait time. Our youths have – we have what we call our Emergency Screening Unit, and our numbers [there] have decreased, although we are starting to see a little bit of a spike up, because overall inpatient beds have gone down.

When I was [first] here, we were only in seven schools doing kind of more traditional day treatment programs as a part of Special Ed. We then went from about seven or nine; in

a span of six years, [to] over three hundred schools, thanks to EPSDT for the Medi-Cal⁸ beneficiaries. And one of the models was, we wanted to do more to impact budding mental health issues in schools, so we began to look at the maps of where our largest low-income populations were, because we knew they'd have high clusters of Medi-Cal eligibles. So we started mapping out a strategy throughout the County, where the clusters of low-income areas [were], and we began to connect mental health services to schools [in those areas]. So we went from again very few schools to over three hundred.

All of our measures in terms of satisfaction [and] opinions about did services make a difference – all those have been really steady and good. We did look at school functioning and that seemed to be doing well in terms of academic achievements. But one of the things that frustrated me in San Diego – it's because I was so used to it in my prior County. Now, mind you, San Mateo is a medium-sized County. The Ventura model⁹ was built a lot on investing what you would spend in residential care in community-based services, so even before Wraparound and all this, we were looking at models that would work closely with probation, child welfare, and Special Ed to reduce the use of residential [care for children]. What we would do is, we would look at a baseline of residential costs and, in essence, begin to redirect those past expenditures and begin to budget for community based services. They were able to reduce and keep very low [levels of] out-of-home placement [in San Mateo].

We didn't have that kind of system here in San Diego, because we're so large, and I would venture to say most Counties – not Riverside, because Riverside was part of the

⁸ Medi-Cal is California's Medicaid program. EPSDT (the Early Periodic Screening, Diagnosis, and Treatment Program) is the child health component of Medicaid, offering comprehensive primary, dental, and mental health care services to eligible children.

⁹ The Ventura Model for mental health care reform, which grew out of a Children's Demonstration Project originally created in 1984, stressed interagency planning and collaboration to deliver comprehensive community-based services.

Ventura model – but I think the other Counties that are large, LA [and] San Bernardino, really probably had struggled with tracking that as well. We do a lot of certainly Wraparound, as you know. Within the Mental Health Services Act, we developed certainly community-based models that are comprehensive, whatever it takes. However, we're not tracking outcomes in terms of the foster care budget, like we did in my prior County. And that's been a bit of a frustration.

But some of the models – actually, one of the models we have in reducing out-of-home placement, without having the broader aggregate outcome data, was looking at our foster family agencies. LA County had them all over. They took from EPSDT dollars, and they funded some foster family agencies. We took that model, did a very similar model in San Diego, and I think for a while we were one of only two Counties investing EPSDT. It's funny now with the lawsuit of *Katie A.*,¹⁰ as you're aware, [and] the whole focus on transforming services for foster youth, that this has been a process that's been going on a long time.

So again, even in the early 2000s, we were looking at therapeutic behavioral services. How could we serve foster youth in a different way? How could we make sure that foster youth were getting appropriately screened and assessed and referred to the appropriate level of care? How do we work most effectively with Juvenile Court? So we developed these models over time. It's the aggregate data tracking that I struggle with.

Q: I bet. That's always very challenging. And then just trying to get people to report seems to always be very difficult.

A: I also was going to say the other thing that was very different about coming from San Mateo to here, when I talked about being sheltered from the budget process, we were

¹⁰ *Katie A. v. Bontá* is a class action lawsuit filed in federal district court in July 2002 against Los Angeles County, the Department of Children and Family Services (DCFS), and county and state officials by the Western Center on Law and Poverty for force the state and county to provide individualized mental health, behavioral support and case management services to children in foster care. LA County reached a settlement with the plaintiffs in March, 2003. The State of California reached a settlement agreement with the plaintiffs in December 2011.

also very sheltered from the media. What I noticed in San Mateo was it was really managed very effectively by our Director of Health Services and at times our Director of Mental Health. In San Diego, all of a sudden, this idea of communicating effectively with the media and being transparent and having a presence with the community through the media hit me in the face right away. And it was something I had to get used to, not that I wasn't comfortable necessarily with a mike. It was just this role and always having been sheltered by a higher level executive, and now all of a sudden, I'm in and making sure that I'm addressing, at the time, issues having to do with children's mental health. That was a unique experience, but very rewarding in terms of my development professionally. I'm so glad I've had that experience.

Q: OK, good. So do you want to talk then a little bit – and you can put it in [the context of] the way your own career is developing at the same time – about what was the MHSA impact on San Diego?

A: Well, I'd like to say that our transformation started before MHSA, that it wasn't kind of the big bang theory, but more of kind of an evolutionary process. It's kind of my mantra [that] our system wasn't born [in] November, 2004 when the voters voted for Prop 63. What it did, though, was – I think it crystallized for us in this County a more strategic planning process, as opposed to – even though we had engaged stakeholders [previously], I think it was more driven by people feeling deficits or people feeling they weren't getting the resources and making their voice clear and trying to work responsibly to meet a myriad of unmet needs in the community. With the Mental Health Services Act, it did provide a structure of stakeholder engagement and we had to figure out how to do it most effectively. We wanted to honor those structures for community input that had been there, but [also figure out] how to make it more consistent – not only consistent in terms of staff's process responsiveness and consistency in [the] data we were

presenting to the community – but also consistency among the different stakeholder groups.

When I said we had to do it twice, it's that whole stakeholder process [that] we originally had developed [versus] what was recommended by the State, where you needed to have an MHSA community planning structure. So, as you probably know in talking to different Counties, the stakeholder process really has – there are really in my opinion kind of two models. Some Counties developed a whole new MHSA planning structure. We kind of went down that road, and we ran into some problems because of issues around conflict of interest by involving providers. Mind you, 80% of our system is contracted out, so we recognized that we were missing a wealth of information and input from our contractors. So at the time, a lot of those groups were tied to our Mental Health Board, almost like subcommittees to the Mental Health Board.

So we decided we wanted to make a break from that and we developed what we called a council structure, where we could have different stakeholders, from providers to family members, consumers to other interested advocates, and people from the schools, and bring them together as part of a council. And they would provide feedback, input, criticism, perhaps advice with a very small “a,” and we would listen to what they felt the system needed. We would present the data analysis, the gap analysis that each County was supposed to develop and we would present that and help those communities understand the data but most importantly hear from them. And by [having a structure independent] from the Mental Health Board in terms of the stakeholder process, we were able to do that effectively.

And again we broke away from – what we said was, “We’re going to have a model that doesn’t just address MHSA, but we’re going to have the council. We have a Children’s [System]; we have an Adult [System], older adults, housing. Those just don’t deal with MHSA. They deal with issues around best practices, issues having to do with Medi-Cal

expansion, integration with alcohol and drug [treatment], whatever the issues are. We went beyond the themes that were driven by MHSA, so those councils were really expected to look at the overall system, as opposed to just being an MHSA planning model.

We also wanted to recognize, kind of the importance, the prime role that the Mental Health Board played, so everything that comes out of our stakeholder process gets presented to the Mental Health Board. When we initiate a thirty-day planning process, we start at the Mental Health Board. We kick it off there. We go out to all the stakeholder groups, including the councils. We have something called the Mental Health Coalition here, and now at Behavioral Health, we have the alcohol and drug providers. We have the Mental Health Contractors Association. We go out to all these groups and get their input. We then develop what we feel is a plan that reflects the interests of the community, reflects the data, and reflects the understanding and knowledge of the system by our staff, and also keeping in touch with the broader County priorities. For example, there's a strong focus on transforming our community called Live Well San Diego, which is a ten year transformation project to make our County healthier, safer, and more thriving. So everything we do has to align with that.

So to go back to the Mental Health Board, we would initiate processes, and we ultimately would come back and recommend to the Mental Health Board what the input was. The other thing [is that] transparency was really key: always go back to those groups and say, "You gave us ten great ideas. We're putting four of those in the plan, and these are the reasons why we're not doing the other six." Now, some of those other six are worthy to be put in the parking lot, so that's another term that's kind of a San Diego thing, "parking lot," [so] that we always get reminded, whatever happened to that program we recommended? And you put it in the parking lot.

But again, by having this continuous process, we still clearly help the community to understand that we have obligations under MHSA. Now that everything has been localized, I think what we're seeing now is – I'll talk about the service transformation, but I'll just talk more about the stakeholder process right now. With MHSA, we do bring them up to date on changes, with each [program], whether it's capital, facilities, technology, prevention, or intervention, we do have specific plans. It's just that when they're presented to the stakeholders, it's presented within a context of a larger system. But we do remind them that we have these plans, and we actually have a big plan, the annual update now, that we do every year. We have to have a process for that, so we honor all of that. It's not to say that we kind of homogenized everything and MHSA is lost. It's still recognized that there are some requirements in MHSA that we have to follow and we're subject to audit by our local auditor's office. So we are all very clear about that, but we wanted to make sure that we did not have a siloed planning process for MHSA.

So, when you look at Counties, typically you'll have Counties that really have stuck with their MHSA planning structure and other Counties that have kind of more integrated MHSA into their broader planning structure. And you could make arguments for both. I mean, this is how we did it in San Diego.

So, in terms of services again, a lot of things have been happening. I think, in terms of older adults for example, one of the things that we recognized with older adults was the prevalence information speaks to a population of older adults that may ultimately have their behavioral health needs met through the private sector, [given] the role of Medicare. So we recognized and helped the community understand that, even though the [older adult] population is 13 percent, when we look at the public mental health system and really who has pressing needs that are underserved or unserved, we'll make adjustments.

But, with older adults, we relied a lot on a very unique program, and obviously the Full-Service Partnership¹¹ for older adults. We also have a strength-based case management which is focused on the strengths and working with older adults. That's an action evidence-based practice, so those are kind of things for older adults. For adults, what we did, aside from the Full Service Partnerships and programs to enhance services like co-occurring disorders,¹² there were a couple of areas where we wanted to make an impact. We kind of knew about healthcare reform even as early as 2005, and we really began planning –

Q: Well, it was coming anyway.

A: And we were, I think, probably one of the few Counties that invested a lot of MHSA in the primary care system, specifically in FQHCs.¹³ So what we learned, though, was you can build up behavioral health capacity in FQHCs, but just because you invest money doesn't mean there is true integration. And we're really looking at addressing the whole needs of the individual and what we found initially was, even though we were increasing access to mental health, particularly for groups like the Latino population, addressing some of those disparities, what we weren't seeing was the integration. And so we work with a Council of Community Clinics here [to make integration work]. They're a consortium of all the FQHCs, and we decided to begin to look at how do we build a more integrative continuum of everything from collaboration, providing the consultation necessary, to ultimately the primary care providers being able to treat mental health issues for those individuals that are stable and can benefit. The other

¹¹ Full-Service Partnerships or FSPs are MHSA-mandated programs to provide intensive client-centered services to the seriously mentally ill.

¹² Co-occurring substance abuse with mental health disorders.

¹³ FQHCs (Federally Qualified Health Centers) are approved by Medicare/Medicaid to provide comprehensive primary care and preventive care services to persons of all ages, regardless of their ability to pay or health insurance status.

thing, of course, was just making sure we begin to establish medical homes¹⁴ for our adult patients and our older adult patients.

But it's more of an issue for adults to address the disparity in life expectancy for people with serious mental illness, so that was one thing. The other thing we did was we felt like we were starting to see issues around access to care and wait times. We decided we were relying a lot on our psych hospital, our emergency psych unit, and there were a lot of walk-ins, more urgent care requests for services or people showing up for services. We wanted it to be a true emergency psychiatric unit, and we wanted to get more of the walk-in urgent care people that are trying to follow up on medications that have been prescribed when they get out of hospitals. We wanted to build an urgent care model with all of our outpatient clinics, so that's another thing we've done with the adult system. We actually reduced the wait time. We're down to a couple of days a week now for a basic outpatient visit, because every clinic must have an urgent care component. They all vary. So we actually have clinics that all they do is urgent care, and they do short-term, and then they refer out. So that was the other thing.

The third thing we did in the Adult System was we recognized that people needed – in LA, they did something similar – You had people that were getting very concrete Full Service Partnerships. You had other individuals – a large population that were meds only – but you had a population kind of in between that needed more recovery enhancements. So we started doing kind of “a Full Service Partnership Lite” [which] is what they call it in many Counties, including LA. We began to enhance those individuals that really need more than just a medication only regimen and began to add more in terms of – whether it was case management, cognitive behavioral groups, living skills groups, vocational-oriented activities, but all kind of within the broad spectrum of

¹⁴ A medical home is a team-based model to provide comprehensive and continuous health care through coordination of services.

recovery. So we wanted to usher that into our outpatient clinics, and so we began to transform a lot of our more traditional outpatient clinics with MHSA funds. So that was another thing we did.

Then finally, what we did on – and this was more recent – I'm not sure if this has come up in your research on the history of MHSA, but one of the things I think, one of the shortcomings of MHSA, in terms of its original conceptualization by the authors, was they really didn't focus on the co-occurring population. There was very little on that, so we kind of took it upon ourselves. We already had a dual diagnosis initiative here called CCISC, basically a comprehensive integrated service system for people with co-occurring disorders.¹⁵ We had already actually just started that before MHSA. We were able to keep the training going. We would train clinicians in the Adult, Children's, and Alcohol and Drug Systems to learn how to work with co-occurring.

So what we did with MHSA down the road is [that] we began to recognize that on the Adult side, we felt like we needed to look at having Alcohol and Drug specialists in County clinics and vice versa, mental health specialists in Alcohol and Drug clinics. We did the same thing on the Children's side, although the Children's side was more of a Prevention and Early Intervention [focus]. So, for example, you have an adolescent recovery center [and] you embed a mental health worker through Prevention and Early Intervention, [then] you're able to kind of address some of the secondary mental health issues behind the substance use issues.

So that again was something we did on both the Adult and Children's sides. On the Children's side, we decided this was an opportunity to really talk about early childhood, preschool activities, really invest more in MHSA or earlier on, upriver, so to speak, and

¹⁵ CCISC stands for Comprehensive Continuous Integrated System of Care, a strengths-based protocol for co-occurring disorders treatment developed by Drs. Kenneth Minkoff and Christie Clare of Harvard. It was implemented in San Diego County in 2003.

we've seen our penetration rate for Medi-Cal eligible children under five just skyrocket with this effort.

Q: Wow. That's amazing.

A: So that was a major effort; by using MHSA to –

Q: So do those come under PEI?¹⁶

A: Actually both. We actually have both PEI programs as well. We have a Triple P program, positive parenting program, that we do, which is evidence based. We actually work with young children of military families. They're dealing with the issues of returning servicemen and women, so that's been a great experience. So we invested more in early childhood activities and then what we also did is, as I mentioned earlier in the children's system as part of the transformation, we expanded school-based mental health.

Then what we decided to do was we realized that there were indigent children who weren't benefiting because they weren't Medi-Cal eligible. So we used MHSA to provide kind of a companion funding, so any child that had a mental health issue, regardless of being covered by health insurance or not, would be able to benefit from services. So we used MHSA to build up our school-based services. So that was good.

Then I will say one of the things I think we're all very proud of, as I mentioned earlier, we have a major stigma campaign also, "It's Up to Us." We invested a lot of money, and we looked at Prevention and Early Intervention and all the different strategies. We have our early intervention, our First Break stuff. We have a program that deals with people that hit the hospital with alcohol and drug problems, and then historically they wouldn't connect with Alcohol and Drug Programs, because they have basically some complex

¹⁶ Prevention and Early Intervention programs were also mandated under MHSA. Counties were to select and implement evidence-based protocols to prevent the development of serious mental health disorders in children and youth at risk, as well as in older adults, people exposed to traumatic events, and other at-risk groups. Triple P, the Positive Parenting Program, is one such protocol, designed to provide parenting support for families with children from birth to age 12.

alcohol and drug [and] mental health issues. We have something called Bridge to Recovery where we follow people to make sure they connect effectively to recovery programs out of our emergency psychiatric unit and our County psych hospital. So those are things we do more; when you look at prevention and early intervention, they're more early intervention.

We have programs that address at risk populations, like we work with the younger siblings of youth that have been involved in gangs. That program is in one of our lower income area pockets in Central San Diego [where] we've trying to address the gang issue. But again, we see these younger siblings as at risk, and then we decide if it's up to us to do a more universal primary prevention [in] the messaging that goes to the community about helping to reduce the stigma and discrimination that keeps people from getting the care they need. So that was a huge campaign. We're continuing it.

Not only did we do that, but we did two other very interesting kind of universal prevention efforts. One was actually designed, even though it's primary prevention because you're working with building community awareness about mental health, but we did a housing discrimination initiative. It was called Housing Matters, where we worked with communities to be more receptive to people with serious mental illness.

Q: Yes, how do you convince people about that? I think it's one of the hardest issues sometimes.

A: Well, what we did is there's kind of three pieces to it. One is just dealing with the issues of perceptions about people with mental illness and how do you address the "not in my back yard",¹⁷ so Housing Matters deals with that. We also work with the Corporation on Supportive Housing, and they've helped us develop our housing stock of permanent supported housing. Part of that effort really is to work effectively with developers, but in

¹⁷ "Not in my back yard," or NIMBY, is the label frequently applied to community and neighborhood protests against housing for the mentally ill, ex-offenders, developmentally disabled, and other stigmatized individuals in residential areas.

that process, there is a community vetting process to any project, so in doing that, that's where kind of the attitude-influencing work takes place in Housing Matters. So that's been great.

Then third is, of course, we work with people that have been homeless [or] who are at risk of homelessness. Part of the strategy is to work again with whether it's landlords or what have you to build supports. We have a lot of people living in independent living facilities, which is not board and care.¹⁸ And there are a lot of just poor conditions. There's some degree of exploitation. What we said is we were going to develop an association, and for those independent living facility operators that are interested, we will provide support and education. We will basically certify them as ILA certified, as having independent living facilities that meet certain standards in terms of the appropriateness of the facility [and] their responsiveness to the tenants that live there.

So we developed a training model. That started a few months ago. We actually used MHSA Innovation funding¹⁹ for that, because people felt that because ILFs are not licensed they kind of go untouched, unmonitored. So we didn't want to approach it from developing a community licensing kind of model where we're going to be hovering over them and driving 'em crazy, because we really have no authority to do that anyway. [Furthermore,] we didn't want to have our approach be tainted with a notion of monitoring. We wanted to see this [program provide] support and education for the ILF operators. So we actually have, I believe, close to thirty operators that have signed up that have gone through the training and are going to be certified and be part of our association.

¹⁸ Board and care homes are licensed facilities that provide housing and services for persons, including mentally ill, physically disabled, developmentally disabled, or elderly, who are unable to live independently.

¹⁹ One stream of MHSA funds is designated for Innovation Programs for novel and creative approaches to increase access to underserved groups; increase the quality of services, including better outcomes; promote interagency collaboration and increase access to services.

So then, of course you're probably familiar with the Statewide Suicide Prevention plan.²⁰ I was on the task force, along with Bill Arroyo²¹ from LA. Both Bill and I said, "Man, it would be great to do something like this in our Counties, and so, when I went back to San Diego, when we were looking at MHSA PEI, we wanted to make sure we had a strategic suicide prevention strategic plan for this County like the State has. So we used the State as a model, and we developed the suicide prevention plan. We've shared that with other Counties, and so that's been great. Then we also have a specific suicide prevention effort with the largest school district in our County, the second-largest in the state to LA, that's the San Diego Unified School District.

It's pretty exhaustive. We have [this information] online – I could certainly give you our annual update if you'd like to look at it. Whatever you want, I'll give to you.

Q: OK, I can email you for those things later. But it is quite interesting. It's interesting the different emphases that the Counties have.

OK. So I just wanted to follow up on a couple of specific things. The issue of integration – it seems like you've really been sort of ahead of the curve on this one; but particularly the problem of mental health clients who really aren't getting their primary healthcare needs met. Do you find that they're reluctant to go – [that] sometimes they feel stigmatized going outside their nice, comfy mental health clinic where they're already being seen? Or how do you sort of encourage them to get their primary healthcare needs met?

A: I actually think we learned a lesson. I think all of us were a little bit naïve when we first embarked on this whole integration effort. I admit in San Mateo we were – San Mateo was one of the flagship counties to do what was called a primary care mental health

²⁰ A Statewide MHSA program.

²¹ Dr. William Arroyo, Assistant Medical Director of the Los Angeles County Department of Mental Health.

interface. This is way back, again way before MHSA, and so this isn't like something that was new to San Diego.

Q: It's been around but not very well implemented most of the time.

A: Right. Usually what happens is you co-locate, and the people don't talk to each other. So we began the process here, as we wanted to bring better access to mental health for individuals that were going to health clinics, but we knew the job wouldn't stop there. We had in our mind then our clients, people with serious mental illness and children with serious emotional behavioral disorders, really as they make successful gains as part of the recovery, or as they build resilience if they're younger, that their mental health needs could be addressed by the primary care system.

I think we got a lot of push-back and reaction because I think it was scary, certainly, for some individuals who had built relationships with the mental health provider or the mental health clinic or a social worker or just the ambiance, the support that they felt where they were getting their mental health services. And we said, "Well, listen, you know, if you're part of a client-run clubhouse or you enjoy some of the recovery activities, it doesn't mean you have to give that up, but in terms of your kind of bread and butter medications, that could be handled, we believe, by primary care. We're going to ensure that you get your healthcare you need." But, putting aside the healthcare, they were just concerned. So I think we learned from that.

I think [it was important to stay on the topic of] the disparity in life expectancy, concerning other health conditions [that impact our clients and represent factors in shortening] one's life span rather than their mental illness. We need to begin to look at what does it mean to establish a medical home and be very open to different ways of approaching that. You don't have to have everything done by primary care to make sure that they have a medical home.

So one of the things we really started doing is some point in time studies on the percentage of our adult mental health clients that actually knew their primary care physician or [the location of] their medical home. Forget the term “medical home”; just who is your medical doctor? Many of them didn’t know. Those that did know, OK, that’s one step. You know who your primary [doctor is] – you know where you can go to get medical care. Does your medical care provider talk to your psychiatrist? More often than not, no. So how do we then build strategies to look at building the capacity of our mental health system to access important physical healthcare information and vice versa to improve the overall healthcare of the individuals?

So we actually developed something called Integration Institute. We have a two pager that describes it. What we did in that Institute is to build a consultative model that goes both ways where psychiatrists can access primary care consultants, and we’re paying them for this, of course. Everything costs. We’re using MHSA to develop this Institute, and in the cross-threading of that, of course, is again primary care to be able to talk to someone in terms of psychiatric mental health issues. It doesn’t have to be a psychiatrist. It could be a mental health professional, nurse, social worker, psychologist. But if it’s about psychotropic medications, then you may need someone who’s versed medically, an RN nurse practitioner or a psychiatrist.

So we have been building on that model. Every year we have an Integration summit; we’ve had three of them now, very successful as they’ve gotten bigger. I think we’re kind of breaking down those barriers around how to build incentives. We need still to work around payment structures as we get into healthcare, and that’s very complicated, complex, as you know. But we want to at least get to the point where people know who to call, and the importance of that. And the medical society and the psych society, they’re all supportive; but it took time because I think what we were doing initially was very idealistic. We had a certain ideal of what we think the care should look like, and we

were somewhat imposing it on our provider network, and we backed off and are trying to learn from them.

Also we're fortunate enough to have two SAMHSA²² funded projects here that are really focused on models of integration within – and these are nonprofits that partner or pair up with a federally qualified health clinic. One of the things we also did was we said, "Let's build more of a collective support interest in the whole concept of integration." So we're getting away from trying to deal with the isolated tandem of mental health professional and a primary care provider, but look at what we call paired clinics. So every outpatient clinic is paired up with a federally qualified health clinic. And they're about building relationships at a management level, at a clinical level, and doing their own consultation. A lot of that, frankly, because, if there's some level of acuity going on, you know, people do try to call each other, but it's very crisis driven. We wanted to set up something that's a little more structured but let the providers, let the clinics do it, figure out a way to work best with their peer clinic. So that also has been not a top down model, but what we say is, we challenge them. We say, "You believe in this. You want to do this, but you don't want to do it the way we're saying you need to do it." What we say is, "At least start with the paired clinic;" and so that's come a long way, too.

Q: That's the first step; that's great. Okay, so recovery. I mean, San Diego had actually been turned in this direction before MHSA came along. Can you talk to me a little bit about, though, what recovery actually means from your perspective? I've heard multi-definitions from everybody, a different one from everybody I talk to. There's a vision: hope, wellness, recovery. But there's also the reality. Some people are never really going to make it to wellness; at least, I have that impression.

²² The Federal Substance Abuse and Mental Health Services Administration, or SAMHSA, was established in 1992 as part of the Department of Health and Human Services.

A: Let me start first with sharing a testimony that came from a consumer, when we started the campaign around helping people understand what it's like being in the shoes of someone with a major mental illness. So the story, as this individual talks about it, is recovery, and we have a pretty robust program in helping people with lived experience learn skills in being peer support counselors – peer support specialists is what we call them – and I go to their graduation.

One person's story [or] metaphor was with his first schizophrenic break. He was nineteen. He was driving a car, and he knows where he wants to go professionally, what he wants to do, places he wants to be, a family he wants to raise, and somewhere along the road with his illness, he looks in the mirror, and he begins to see his reflection fade away. It was so powerful the way he described it, and he said, "What recovery is about is getting back in the car and looking in the mirror and seeing that image come back," and [having] that direction be clear in terms of where he wants to be.

So I think it comes down to basically a process where, like for anyone else, resources are brought to bear and supports are brought to bear, so people can achieve their dreams. It may be a different dream than they had when they were sixteen; but allow them to have a dream and to determine where they see their lives. How will they find contentment, find a sense of purpose in life, a sense of connectivity to their community, their family, the world, how to make sense of their life, so it's purposeful and meaningful to them?

So I think that is what recovery is about is being able to provide those supports. With that comes the acknowledgment, in understanding who you are, what you're made of, understanding your personality, understanding your physical condition, your illness, managing it, that's part of your recovery. That is part of getting to your dream, whatever that is, is to manage that and not let that derail you and find your image blurring again in that mirror. So how do you manage that? It's not to neglect the fact that people are

contending with an illness, but it's also a lot of other things. It's not just the physical illness, but also recovery involves being comfortable with your notion of a greater good beyond yourself, a sense of spirituality, whatever that may be – that's part of it. And really also, as I alluded to earlier, the physical health care side of it – how important that is in understanding your body and treasuring your body and taking care of it, whether it's through diet, exercise...You know, it's what we've got. And we can't get anybody else's [body]. And loving yourself is a part [also].

Q: Right, not giving up on yourself.

A: So that's kind of a long description of recovery.

Q: Yes. I've met a lot of clients who really are doing great. They're engaged in a lot of wellness activities. They're working as peer advocates or consumer workers of different kinds. Do you think it's reasonable [and] possible to start moving many more of these people into the community, getting them jobs on the outside, outside the County system or outside the mental health system? This is a problem a lot of them seem to be coming up against. They come up against what we might call a glass ceiling.

A: Right.

Q: It's really hard to move out of that, and without that, then they'll always be, essentially, mental health clients. That will always be their primary identity.

A: Yeah, I think we still get stuck in some of those old constructs about our own biases about people with illness and what they're capable or not capable of doing. Just two examples. The first client I ever had was a teenage boy who was – talk about tough to really help – he had his first break of schizophrenia, actually, as a fifteen-year-old, and his psychiatrist actually was not in the County system, was outside somehow, but I was his therapist. [The psychiatrist] was making every effort to get him to complete his SSI, and, trained as a social worker and understanding as much as I understood in terms of

public benefits, I knew what SSI meant. To me it meant a lifetime of dependency, and I was seeing this boy who had a lot of talent, smart, very interesting, but very isolated. I remember I went to the medical director, and I said, "You know, this guy's doc is recommending and he wants me to start paperwork for his SSI application. I'm not comfortable with that. Why are we writing him off so early? What does this mean?" "Well, you have to reapply, and he can come off [SSI later]." I said, "I just don't like it. I just think it's too early." I didn't. I wouldn't buy into it. I worked with this kid for months, and I – and at that time, there was nothing about family partnership or strength-based, but I was just kind of looking at this kid saying, "He's got a lot of talent." At the time did I say, "Wow, this is" – did I talk recovery? No, I just realized I didn't want this kid railroaded, and this is the first client I saw.

Years later, I noticed, as we started to look at the hiring of family partners and consumers, there was this notion that you can only work them half-time because they'll get too stressed and they'll blow out and blah-blah-blah. And I think that's just another perception. It's a barrier we throw at people to say, "We're going to corral or limit your dream of being fully employed." If you want to work full time, why should anything hold you back if this is what you want? Let's try to get there. So I do think that the system still has that [attitude], and I think it's changing. I do think people are kind of breaking out of that and I do believe that there are still those restrictions.

I'm the Public Conservator²³ until next week. I'm designating someone else next week. But that's a tough job, and basically we're just saying [that] someone for a period of time cannot make decisions for themselves. And you do want to look out for their health, their wellbeing. You want to do what's right; you don't want to put them at risk. But that's a pretty big deal. So I understand the realities of limitations in people's

²³ The Public Conservator is court-appointed to oversee the medical care and finances of an individual who is mentally disabled and cannot do so for himself, or herself, in the absence of an eligible family member.

[capabilities] at a given point, but how do we make sure the system is driven not by laying out limitations and restrictions on people, but paving the way or helping them pave their own way for what's possible? So it's a struggle. It's still is.

Q: What are you seeing as your biggest challenge right now?

A: I think the biggest challenge for me is we're at a crossroads. What will be the future of the behavioral health system? How will we ensure that our community is true to the intent of [Health Care Reform], making sure people have access to whatever substance use disorder services or mental health services they need as part of their health plan. And, having said that, what will be the role and public charge of the County mental health system? We have developed a very robust recovery system and a very robust system of care for children. How do we ensure that we sustain those systems when you're going to have a lot more people covered, and the crossroads is – how will we work with health plans to ensure that people have access to the practices they need to support their recovery? How do we not be tempted to structuring a system in terms of what a basic mental health plan is, the lowest common denominator, which is basic mental health services, whatever, twenty visits and that's it? And we're going to try to move everyone into that system.

But how do we develop an effective tiered system where, as part of recovery, people can have their care integrated if that's appropriate, have additional supports as needed, or if they need more comprehensive services for their complex condition, still be able to benefit from the programs we've developed, much of which has been certainly enhanced with MHSA. So to me the challenge, again, is that. Right now, it's funny. You look at the Adult system, and we were talking about this today as we begin to look at strategies to carve in and integrate care – How do we make sure that there's a part of the system, and I don't care what you call it, carve in or carve out, that we'll still have those recovery oriented services? And my goal, my challenge, is to make sure we don't take any steps

back because, as the world becomes Medi-Cal for example [laughs], you're still going to have individuals that have complex, serious, mental health conditions.

You're still going to have a nineteen year old, two years from now in 2015, that's going to have a first break. I mean, as much as we do [for children], I'm not naïve to know that we're going to have a first break [in late adolescence]. We're going to have someone coming out of jail or out of state prison that has complex issues and needs. How do we make sure that we have a system that can meet their needs? And, if we try to again homogenize and go to the lowest common denominator for the type of health services, we're going to start to see that outcome, start to see people in spikes [of critical care], potentially, and in the correctional system, potentially in homelessness, and hospital days going up. So the bottom line is, we have our work cut out. I think there has to be a way to sustain the systems we've developed in partnership with [Health Reform]. That's to me the largest challenge.

Q: OK, well, that's a good way to end this. Thanks for very much for your time. This was very, very educational.

A: Yeah, well, I hope I didn't ramble too much. I know part of this is a lot of people rambling. [laughs]

Q: That's the idea. You answered most of my questions without my [laughs] having to ask them.

END OF INTERVIEW