

## **Catherine Bond talks about her experience seeing an LADMH provider and what it taught her about recovery...**

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And the other thing she did was she empowered me. She said, "This is your choice." She gave me meaningful choices about the medicine – she didn't just say, [tapping the table with each point], "Take the lithium, that's what you need to take, you're going to be chronically ill for the rest of your life, lithium's the only thing that's going to help you, take the lithium." She said, "Look, [this] stuff doesn't always work for everybody. Here are some other options. What about this? What about that? Here's what you can do for yourself. Here's what you need to decide if you want to get treatment." And she gave me the choice. Now, I know doctors technically do that. But this woman genuinely means it. And people like me, or any patient – you, or anyone going to a doctor – can usually tell if the doctor is open to discussing the medication or open to discussing the treatment and answering your questions and allaying your concerns and giving you options and saying, "This is what I recommend, but here's what you could do." And even, maybe, recommending you get a second opinion, you know. Very seldom in my experience in the hospital did that ever happen...

And with all due respect, [a pause, and she exhales audibly] the mind-body connection – and the spirit – that makes a person a human being is all intertwined, and if you do something that radically affects the brain, you affect the person in a very meaningful way. If you give somebody pain medication because they have a broken limb, it's a very temporary disruption, and you usually warn them not to take too much. And you usually say, "You might feel a little fuzzy in your mind, but you'll be OK once you stop taking it," and so forth, and so on. But the psychotropic medication so often is recommended [she exhales audibly] without much – it's almost like – I'll give you an example. If I take as much medication as most psychiatrists I have met have recommended I take, I would not be sitting in this room talking to you right now. I would be sitting, probably in a board and care [a type of assisted living facility], staring at a wall... It's that strong. So I understand – and I won't get manic, and I won't get suicidal, but I won't have quality of life.

**READ THE FULL TRANSCRIPT BELOW.**

**INTERVIEWEE: CATHERINE BOND**

**INTERVIEWER: Howard Padwa**

**DATE: December 2, 2009**

## **I. Career as a Therapist; Personal Experience with Mental Illness**

HP: So, Catherine, for starters, why don't you just tell me a little bit about your background and how you came to be involved in mental health.

CB: I started as in mental health because I was interested – I was an English instructor, and I was very interested in my students and got interested in their stories and got interested in their families. And then I had a divorce, and so I was wanting to find out what that was about in terms of my own family. So I first started out working for a psychologist, and I was working as a paraprofessional lab leader in something called constructive aggression.

HP: Paraprofessional lab leader – what's that?

CB: Well, it means that I wasn't licensed or trained at the time, except by him. His name was George Bach [Dr. George R. Bach, clinical psychologist and early supporter of group psychotherapy], and he had written some interesting things on group dynamics, but he had also developed something he called constructive aggression. And we did fair fight training, and we did it at UCLA, and we did it all over the place. Basically, it's a forerunner to assertiveness training, but it's done where you ritualize angry stuff and then you formalize the negotiation of the rational stuff.

HP: Right.

CB: So we would help people – they used things like batacas, which were padded bats, and they would use ritualistically, you know – like a pillow fight.

HP: Oh, wow. And when was this?

CB: Oh, Lord, that was back in the early '70s – late '60s, early '70s.

HP: OK.

CB: So that's where I first got interested in psychology, and I went back to school with the encouragement of a professional from Dr. Bach's office. I got a license as a Marriage and Family Therapist – that was in '75. And then this lady, Yetta Bernhard, a psychologist, introduced me to Virginia Satir, and Virginia Satir was a well-known family therapist in family systems, and she developed something called the Avanta Network. This was a group of people interested in change – change agents.

HP: What kind of change?

CB: Mostly making the world a better place, but largely through interventions in family systems. And, of course, Virginia was internationally known, so she was bringing together people from all over the world, to talk about, basically, how to make the world a better place to live in. So that's

how I got interested. And then I was in practice for myself, I had a training business – *Action Seminars for Progress*. I trained people to pass the licensing test. And I was raising my son as a single parent. I was supposedly doing pretty well, although I had had an experience when I was 25, where I had a, quote, “bad trip” by taking LSD, and I ended up in a hospital. But the doctor described that as a toxic reaction to the drug, not as a mental illness.

HP: Right.

CB: So then after I was in practice for a while and working for a while – I was a happy workaholic, according to my own description – I did have a break. I became suicidal, and tried to tough it out for a year and a half, and because I was very proud and stubborn, I didn’t go to get help in time. So I did try to kill myself, and that was terribly hard – I’m sure you can imagine – on everybody around me, especially my son. And so he asked me to promise him not to do that again. So I said I wouldn’t, and I haven’t.

And so I had to then gather myself together after I got out of the hospital. I had had six weeks in a – in Kaiser – because that was what I had insurance for. And they decided that I was, in those days, manic-depressive, and they suggested I take lithium for the rest of my life. And since I didn’t do well on it – I got very sick, vomiting and all that stuff when it approached its therapeutic dose — I didn’t like the diagnosis. And I didn’t like the medication, so I left the hospital, went off the meds, and did what many people who are addicted do – I sought a geographic solution.

I had a cousin in Boston, and I went back and stayed with her and pulled myself together and got a job. And what happened for the next 17 years or so was that I would work for a while and do pretty well and not take medication and not get therapy and not have support groups and try to be the lone ranger. And I would eventually end up overworking, oversteering, becoming irrational, and finally, ending up in a hospital.

HP: So it kind of developed into a pattern.

CB: Yes. And that pattern is what got me back to Los Angeles after I had been teaching English as a foreign language in Daegu, South Korea and Lampang, Thailand.

HP: Oh, wow.

CB: And so I ended up on the street.

HP: In Thailand?

CB: No, in – well, I could have, but they very kindly said, “Why don’t you go home?” and I said, “Yeah, OK.” So I came back and ended up on the streets in Santa Monica, where I had once had a very lucrative private practice and training business.

HP: Oh, that’s where you had been before.

CB: Yes.

HP: Now, I’m curious. If we could just pause here for one second. As this was happening for you, how was it being a professional in the field? Did you recognize what you, yourself, were going through?

CB: Sometimes. I think for some of us, some people are quite aware. Some of us are aware some of the time. So yes, I thought for a long time, "Yes, there's something terribly wrong." The problem was there's a terrible stigma, and professionals are notoriously not tolerant of people with mental illness because we work closely with them and often see people like us, like me, in the worst possible light – when we're really, really sick. And so I, because of my training, I framed what happened to me as an illness. And because of my advocacy, I've come to see it as both an illness – which unfortunately, in my opinion, is not like any other because of the social status that's attached to it and because of the stigma and discrimination attached to it – and as a social status. [It represents] the Western [connotation] of "untouchable." So I was fighting my way out of that by saying, "I'm not going to be sick, I'm not going to be sick." And of course, sometimes that works and sometimes that doesn't. If I'm careful, and now that I understand how I can take better care of myself, I can. But I guess I'm an example, in my opinion, of what many people experience in this society when they're poor and chronically ill. They can't get help – we can't get help until we're totally flat. I didn't get any real help, at least from the public mental health system, until I was homeless.

HP: Why is that?

CB: Well, because if I were, today, to walk into an emergency hospital, an emergency room – that's the only place I would really have to go if I were homeless – they would probably keep me waiting, there would be no support system in that environment that would help me stay calm and grounded enough to be patient to wait for help. The only kind of help they could offer me would be hospitalization. Typically, if I didn't have resources in the system, the mental health system, they would hospitalize me until they could find some sort of shelter or some place that would take me, and then I would be turned loose, probably with a prescription, maybe with an appointment to a public clinic, maybe not. But there would be – there is no [she exhales audibly] safety net for people like – me. I was lucky in that because I came to this illness late in life, or at least in the middle of my life, I had had a lot of education, I had had a lot of training, I had had a lot of experience – life experience – that said that I was an okay person.

HP: Right.

CB: And so I would pick myself up and I would start over again – again and again and again. And that's very typical with the diagnosis I have because with bipolar disorder, of course, you have extreme swings in mood, and often accompanying that will come huge changes in lifestyle and ability to hold a job and support for yourself and all that good stuff.

HP: Right, yeah. OK, so you came back – so you were abroad teaching English, and this was part of your geographic experience.

CB: Right.

HP: And then, so you came back to L.A. And so what was is that happened then? You came back – how did you wind up on the street?

CB: I lived on the street – oh, I lost everything. I lost my luggage – I basically walked away from it because I was so completely into my delusional state, and found myself on the street in Santa Monica. And so I was convinced that it was meant to be, it was all very symbolic, full-circle. But I was back on the bottom instead of on the top. And so I was very fortunate in that I met a couple who were street people. And they were very knowledgeable, very street-wise, and

I may have reminded them of their mother or grandmother or somebody. They took me in, they took me under their wing. And they had appropriated a fire escape off of an alley in Santa Monica. And so they assigned me a landing, and they helped me get a comforter from the Salvation Army and told me where I could get showers and food and clothing, and helped me survive. And so I stayed on the streets for six months.

HP: OK. And how was it?

CB: For me, because I was convinced it was all very significant and meaningful and wonderful, it was not scary. And it probably should have been. This is why people sometimes get nervous about allowing people like me to make choices.

HP: What do you mean?

CB: Well, there are people who say that people with a diagnosis of bipolar disorder or schizophrenia or schizoaffective disorder or even major depression ought to be locked up, whether they want to be or not because they don't know enough to get in out of the rain. They don't know enough to take care of themselves. So I survived on the street for six months. I'm glad that I went to the street rather than a hospital.

HP: How come?

CB: Because in the natural course of events, without medication, as I came out of my high, my manic episode, I looked around and I said, "Boy, this is kind of dangerous out here" [they both chuckle]. And the people I was with said, "Yeah, it is," and they said, "You really need to have street smarts to survive." And they very kindly said, "Catherine, you really aren't very good at that." [They both laugh] So they actually encouraged me to go to a shelter. They knew about these shelters and they encouraged me. And when I went to the shelter, the people said, "Well, you have a choice. You can stay on the street, or you can get treatment." I thought they meant I had to go to a hospital, and they said, "Oh, no, no, no, no. You can go right over here to Edelman Westside Mental Health Center" [a county-run mental health clinic in West Los Angeles].

## **II. Experience with the Mental Health System; Recovery and Peer-Support**

HP: Now, about how long ago was this?

CB: This was in 1989, '90. I'm sorry, '99. OK. So it was about 10, 11 years ago. So I went to Edelman. In those days, interestingly enough – unlike today, because of the economy – I was able to walk into this public mental health center without an I.D., without any proof of insurance, without any insurance, without any money, and be seen by a psychiatrist.

HP: Wow.

CB: I went to the window, she took my name, she said, "Please sit over there," and about 15 minutes later, the psychiatrist came out. And I'm going to mention her name – she's very- I'm sure it's ok.

HP: Uh-huh.

CB: Dr. Nancy Finch. And Dr. Finch was very gracious, she shook my hand, she invited me back to her office. We spent five or six minutes talking about how I am in general. I commented on a picture behind her desk, which was painted by her grandfather, and her pictures of her family on the desk. She found out I had a son, and, you know, we talked. So then, after we had connected, she asked me why I was there. And I said, "Well, this shelter says that I have to have treatment, and I figure that means medication." And she said, "Well, you made a little face there. What do you feel about [medication]?" I said, "They keep trying to give me lithium." And I said, "It makes me sick." And she said, "Well, you know, not everybody can tolerate that." So we talked some more, she laid out some possibilities, she made some recommendations, we talked about the side effects and the pros and cons, and I agreed to take a mood stabilizer. And I went back with my own little bottle of pills and presented myself at the shelter – "Here I am. I am now in treatment" [HP chuckles], and so they said, "Come on in."

HP: Great.

CB: So for the first time in my life – but I really want to emphasize this – only because I'd hit rock-bottom –

HP: And that's what brought you in.

CB: – was I able to get help from the system. And what happened was, that shelter, which is funded by the system, enabled me – referred me to a wonderful self-help group called BACUP [Project BACUP — Benefits Assistance Clients Urban Projects]. And that helped me to get benefits where I had tried in the past and couldn't get benefits.

HP: So this was while you were also a client at-

CB: In the shelter.

HP: Oh, so in the shelter, attending Edelman.

CB: And a client at Edelman. The other thing that the shelter and Edelman suggested were self-help groups. And so I went over to a place called Step Up on Second [an agency in Santa Monica], and I joined a group called Ups and Downs, to which I said, "Oh, I can relate to that" [Howard laughs]. And so I learned about some of the dimensions of bipolar disorder, but in a group of my peers where people were saying, "Look, this is what I needed to do to get well and stay well. I'm not saying you should do this, but it worked for me." And giving each other resources and giving each other support. And I was very leery of doctors because I was very afraid of being put in another hospital. I had been in and out of hospitals in New York, Massachusetts, I think once in New Jersey – that's kind of hazy – Arizona, and California. Five states.

HP: And in each of them, they tried to give you lithium?

CB: Uh-huh, and gave me absolutely no help, other than to say, "Take your lithium." And [they] gave me absolutely no referral when I got out – [they] just dumped me out.

HP: Well, it sounds like one other thing that was different when you went to Edelman was [that] this psychiatrist you saw there laid out choices.

CB: Absolutely.

HP: Could you tell me how she was a little different from the people you had seen before?

CB: Yes. Dr. Finch did two things that were absolutely essential – to my way of thinking – for people to get better. She offered me hope, because after 17-some years of bouncing around like this, I didn't have much hope that I could get better. She offered me hope that I could get better.

HP: How did she do that?

CB: She said, "I think you can get better." She said, "Look at what you've accomplished." You know, "You've done this and you've done that," and she even reminded me of my role as an English teacher. She said, "I'm starting a –" she likes to read – she said, "I'm starting a reading club, and we've got a little pot of money that were able to buy some paperback books, and I've noticed that a number of my clients – patients – like to read." And I said, "Oh, yeah, I love to read," and she said, "Oh, why don't you join us?" So there was a sense of holding the hope for me until I could then feel hopeful again.

And the other thing she did was she empowered me. She said, "This is your choice." She gave me meaningful choices about the medicine – she didn't just say, [tapping the table with each point], "Take the lithium, that's what you need to take, you're going to be chronically ill for the rest of your life, lithium's the only thing that's going to help you, take the lithium." She said, "Look, [this] stuff doesn't always work for everybody. Here are some other options. What about this? What about that? Here's what you can do for yourself. Here's what you need to decide if you want to get treatment." And she gave me the choice. Now, I know doctors technically do that. But this woman genuinely means it. And people like me, or any patient – you, or anyone going to a doctor – can usually tell if the doctor is open to discussing the medication or open to discussing the treatment and answering your questions and allaying your concerns and giving you options and saying, "This is what I recommend, but here's what you could do." And even, maybe, recommending you get a second opinion, you know. Very seldom in my experience in the hospital did that ever happen.

HP: And especially when it comes to things like medication, where it really is – that's the doctor's reign, you know?

CB: And with all due respect, [a pause, and she exhales audibly] the mind-body connection – and the spirit – that makes a person a human being is all intertwined, and if you do something that radically affects the brain, you affect the person in a very meaningful way. If you give somebody pain medication because they have a broken limb, it's a very temporary disruption, and you usually warn them not to take too much. And you usually say, "You might feel a little fuzzy in your mind, but you'll be OK once you stop taking it," and so forth, and so on. But the psychotropic medication so often is recommended [she exhales audibly] without much – it's almost like – I'll give you an example. If I take as much medication as most psychiatrists I have met have recommended I take, I would not be sitting in this room talking to you right now. I would be sitting, probably in a board and care [a type of assisted living facility], staring at a wall.

HP: 'Cause they affect you that strongly?

CB: It's that strong. So I understand – and I won't get manic, and I won't get suicidal, but I won't have quality of life.

HP: Right, right.

CB: So some of us – and I’m one of ‘em – make the decision that we take as little medication as possible. Or sometimes we clue people in around us that what we need to take in case of an emergency, a crisis, would be, probably an anti-psychotic like [taps her hand with each name] Abilify or Zyprexa, or one of those, [tapping hand] something quick and intense, but short-term. [Abilify and Zyprexa are antipsychotic medications used to treat schizophrenia, bipolar, and depression.]

HP: Right.

CB: The tendency of the doctors even now – and I’m not faulting them – is to say, “To be on the safe side, you ought to take X, Y, and Z forever. You ought to take it without stopping ever, without attempting to go off it, without, you know –”

HP: So erring on the side of over-medication.

CB: Right – [erring on the side] of caution. Now, I had a boss – wonderful man, unfortunately deceased – Bill Compton, whose diagnosis was schizophrenia. [Bill Compton was a prominent mental health advocate in Los Angeles beginning in the 1990’s.] He had a horrible experience on the street for nine months, and he was desperately trying to get services, and nobody would see him. So once he got on something that helped him, he said to me, “I’m scared of going off it, Catherine ‘cause I’m scared the voices will come back.” Now, if my experiences in mania – or whatever you want to label it – were such that I was terrified, I would probably do the same thing. I would say, “Give me whatever you can give me. I don’t want to have that experience.” The problem is we’re very different, all of us, and we have different experiences. Some people will take almost anything in order not to have the voices, or some people, like the man in the film, “A Beautiful Mind,” [Dr. John Forbes Nash Jr., Nobel-prize winning mathematician and economist who had schizophrenia] who will train himself, with help and love and support from his wife and everybody else, to identify and recognize the hallucinations – if you want to call them that – that he’s experiencing, and say, “Oh, you’re not real. I know you’re not real. I’m not listening to you,” because he so desperately want to do the mathematics, and he couldn’t do it on the meds.

See, those are choices people make. I’m not saying they’re right for everybody – I’m saying they’re right for me, or they’re right for him, or they’re right for her. That’s the piece where people get a lot of concern – because I’m alone, my family’s dead, so I don’t have family saying, “We’ve got to take care of her. We’ve got to be sure she’s in a safe place. If it means locking her up, it’s OK. If it means medicating her, it’s OK. Do it, do it, do it [taps her hand as she says this],” and get me on guardianship, or whatever. I’m here because I’m a survivor and because I think the key to us, often, is what they talk about with the children — resilience – [it] is when you get knocked down, are you able to get back up again? And are you willing to do it over and over and over again? And that’s how come, you know, I was helpful, sometimes to people, even after my initial break, in Flagstaff, Arizona, because I went back into my field, and I could say to them, “This was my experience,” and they’d say, [emphatically], “Really?” “Well, you know, this is what happened to me.” And they open up, and we’d talk about it.” And I could say, “You know, I found medication helpful, but I had to be very clear with the doctor, blah, blah, blah, blah, and here’s how you advocate,” and [they would respond] “Oh, yeah, I can do that.” And people found it helpful, so I was even able after the fact to work somewhat, although I wouldn’t, right now, want to reactivate my license. Because I’m doing what I like doing in advocating for people like me, and [for] myself, and I like what I’m doing in consulting. And I

also recognize that if I were to get sick – which, God knows, psychologists, psychiatrists, marriage and family therapists, social workers, everybody can get sick – but if I were to get sick and it were mental, I would feel I were terribly letting my clients down.

HP: I see, yeah.

CB: But that's, you know – how can I guarantee that I'm not going to have a stroke? And am I not going to go into private practice because, you know, God forbid, I should [have a stroke]- it's very interesting. I do know a couple of women who have the same diagnosis I do who are in private practice and doing very well, and they're specializing in people – working with people...

HP: With their own diagnosis.

CB: Yes. Right.

HP: Interesting. Interesting.

CB: So it's a funny world. You define who you are in the process of making the choices – very existential – and then you figure out what that meant in terms of the consequences, and then, hopefully, you're willing to pay the price of the consequences and move forward.

HP: Right, right. So for you – you talked about how the medication was laid out – choices for you – what were some of the other things that helped you on the road to recovery?

CB: Definitely the peer support. I had never- I didn't really have much experiences with drugs so I didn't really have much experience with 12-Step [programs], but self-help is the basis of all of the peer support, is sort of where it came from – you know, with AA (Alcoholics Anonymous) and all of the different modalities. Then people figured out, boy, with we can do this for cancer, we can do this for, you know, mental illness – it's a format, it's voluntary, you know, people clearly choose to be there, they, quote, "work their program." I found that helpful. And I have, over the past, I'd say, nine years, now, I've found therapy helpful. Now, I didn't in the past because I wasn't willing to trust, and that's been my issue from childhood. That's one of my family of origin issues – my mother died when I was born. And the person I bonded with – my aunt, by marriage – was not the person who eventually raised me. So I had this loss of my mother, followed by the loss of the first person who was there. It kind of tends to make it tough.

HP: Growing up a little bit...

CB: Yeah – developmentally. At least that's how I explain it. You know, we all write our own story. We all try to make meaning, right? So that's how I make meaning – in terms of that trust was an issue for me, and because I've been in the field and, you know, was trying to maintain that I was able to figure things out. You know, I was not so humble. I wasn't willing to say, "I really need help." But in the past eight years, I've been able to develop a good therapeutic relationship. And that's been great because I have not chosen to go to the hospital, and I have gone through some crises. So I've survived – not particularly well – but I've survived in my own way.

HP: It's equipped you to make it through.

CB: Yes, right.

HP: Now when you about these self-help groups and these peer support groups – you mentioned BACUP, Step Up on Second – tell me what these were like when you first went to them. What were the things you learned?

CB: When I first went, the fellow in charge – I'm going to give him credit by name – Fred Lee – lovely man. He still works-

HP: This was at Step Up?

CB: Yeah. He still works – and it was a Project Return group – he still works for Project Return. [Project Return is a consumer-run mental health support group with the organization Mental Health America of Los Angeles.] He had been trained by a social worker, bless his heart. And he had the same diagnosis – that was the requirement. And he was someone who loves facts, and loves to learn about things. So he had a *DSM (Diagnostic and Statistical Manual of Mental Disorders)*- whatever it was at that time – [DSM] III, or whatever – he had the physician's desk references, and he had all this, articles, and he would come in and he would essentially, part of it would be essentially educational. But what kept me coming back was not because he told me about the side effects of the medications, but because he was such a warm, caring human being. He wasn't in it for glory, he certainly wasn't making much money – it was a stipend kind of thing where you- you know, to cover snacks and transportation and stuff. And he clearly cared. And that's what kept me coming back, plus the fact that the people who came to the group – some of them were very interesting people. And we would have these wide-ranging conversations about current events, or whatever somebody wanted to bring up. And because so many of us – and I'm including myself – are alone. And so to go to a group where it's not therapy, it's not, "We're the experts. We're going to help you get well," but it's more like, "We're all in this together. Let's figure out what we want to do here."

HP: And with people who have common problems.

CB: Right. And you'll hear that from cancer survivors and all- it's wonderful to talk to someone who's been there and knows – really knows – what you've gone through.

HP: Even better than someone who's gone to school, studying it.

CB: Well, it's a lot more comforting, and unless the person who's gone to school, like Dr. Finch, is an extremely kind and caring human being who's very respectful, people like me tend to be a bit prickly because there is a social stigma. Crazy people are looked down on.

### **III. On Stigma; Working in Self-Help and Peer-Support; Alternatives to Hospitalization**

HP: Yeah, tell me a little bit about the stigma, and how you've experienced it, have you seen it change recently?

CB: Well, I wish to say that I could tell you that I- well, I'm a little obtuse where it comes to this because I expect to be respected. I grew up in an environment where I was well-educated, I was given all kinds of opportunities, I was an English instructor, I was a Marriage and Family Therapist. I got respect, whereas many of us, it's like teens or early 20's and your education's interrupted and people talk to you like you're two years old and so you have either a- you can call it a chip on your shoulder, but you're thin-skinned, you're very sensitive. So I tend to be a little obtuse when it comes to people looking down on me. But I have experienced it. The more I've come out, and the more I've been public about, not just that I have these professional skills,

but that I have this diagnosis and I have crises occasionally, the more I've noticed people in the field of mental health – some – have a hard time with me, and they get offended if I speak as if I'm an equal. They expect me to say, [she speaks timidly] “Oh, yes. Oh, isn't it wonderful? Thank you so much.” And if I say, [confidently] “Well, you know, let's talk about that. I don't know if I agree.” [she laughs].

HP: And that's very interesting because in addition to the life experience, you have the training, as well, that would put you on an equal footing.

CB: Yes, yes, and what I have to remember is that there are some people who will look down on anybody [she laughs, HP chuckles]. And there are some people, who, if they have a Ph.D look down on people with M.A.s – I don't know – there are people that will - but I do know that it is a social status. I do know that. I'll give you a recent example. There was a wonderful book, and it was written by a fellow by the name of Steve Lopez – the Los Angeles Times journalist – [Steve Lopez is a prominent columnist for the Los Angeles Times]—

HP: Right.

CB: —called “The Soloist,” and it was about Nathaniel Ayers. And, you know, Nathaniel's story, and it's very well known. [Nathaniel Ayers had attended Juillard School and later met Steve Lopez when Ayers was homeless and had schizophrenia.] And I read the book – very beautifully done, very sensitive – about the development of this unlikely friendship. A real friendship. Steve doesn't look down on Nathaniel, Nathaniel didn't resent Steve, you know. They had a- it was prickly, and Nathaniel's not an easy person to get along with from what I hear, but it was – and neither is Steve, apparently [HP chuckles] – but what they did with it was they made a Hollywood movie.

HP: With Robert Downey, Jr.

CB: Yes – Robert Downey, Jr. and a wonderful African-American actor –

HP: Jamie Foxx.

CB: Jamie Foxx. And they – the actors were wonderful, but they changed the story.

HP: How'd they change it?

CB: Well, for one thing, they couldn't quite figure out how to allow as how Nathaniel was welcome in Steve's home around his little daughter, and so they did away with the family piece, and they had Steve divorced or something. And then the other piece was they couldn't resist including a scene where Nathaniel became violent. They said, “Nobody will believe it otherwise.” That's stereotyping, that's discrimination because people with mental illness are often more likely to be victims of violence.

HP: Right.

CB: And I think Nathaniel probably has been. And it's sad because those are the assumptions that people make.

HP: And for the stigma to be there even in a piece like that that you think would work towards humanizing people with mental illness instead of sort of dealing with the stereotypes.

CB: Yeah, exactly. And it was a bravura performance, but they were stuck with that script and that was the portrayal. Now, I went with a friend who hadn't read the book. She thought it was a wonderful movie, she thought it was great, she thought it was very realistic. I thought, yeah, I'm sure you do. [a pause] It's like if someone who's African-American says to me, "Are you racist?" My honest answer is I don't think you can grow up in this country and not be. It's a terrible, endemic thing, and until we get at that, I don't think it's – I don't think the system is going to be able to change as much as it would like to, maybe.

HP: Yeah. Well, I guess that's my question regarding stigma – is how can we change it? What can we do to improve the situation?

CB: Well, you know, you read the research, and people say you got to get one-on-one – you got to get down and get real and talk about life and then, you know, say, "Well, by the way, I have this diagnosis." And then people go, "Really?" And sure enough, that's what happened to me with some ladies that I used to play a board game with. And after a couple of years, I finally said to them, "You know, I've got to tell you something. I've got this diagnosis." [They responded] "You can't. Oh, it's impossible. Oh, my dear, you're the sanest person I [know]." And they [said] all of this stuff, and I thought, well, maybe it does help to get to know somebody. And they didn't treat me differently afterwards, although they became somewhat – maybe they did [treat me differently] – they became, "Are you OK?" You know, "are you doing ok?" You know, they would do that.

HP: Like concern.

CB: Yeah, concern. But concern- if I said to them, "I have diabetes, it's under control," somebody might say to me, "Are you OK with your diabetes? Are you feeling OK?" I didn't feel that they were stigmatizing me. But I think if I had started out two years in advance, I don't think they would have invited me to their little club much.

HP: That's interesting.

CB: It took a while until they were firmly convinced who I was before I felt safe, and then they felt safe.

HP: Right. So it has to be one heart and mind at a time.

CB: It seems like that's the best way. But I'll tell you something – I'm going to send you an ad. I'm going to send you an ad I've developed that I'm promoting, I'm advocating for at the time. They say one in four Americans have diagnoses of mental illness at some point in their lives, so the ad is an ad for an employer – "Are you an employer?" And it says, "Well, if one in four – that means about 20 percent or more of the people who work for you have either a mental illness or had had one, and they're good workers and they're productive and they're working for you well, and how 'bout you give us a chance? And we want to work, and we want a chance to improve our lives." Because another discriminatory remark is "Everybody wants to be on benefits and sit around and let the government pay for them for the rest of their lives."

HP: You mean a stereotype about the mentally ill.

CB: Yes, yes, it's not true. Most folks want to work, and not necessarily in the mental health system because they've experienced discrimination in the mental health system, and that's what they tell me. They want a job – a job job.

HP: Yeah. We'll get back to that 'cause I do want to ask about that. OK, so can you tell me the story about – so you were attending these support groups back at Step Up on Second. How did you go from there as a participant to starting to work with self-help groups?

CB: Fred Lee said to me, "Gee, you've got an interesting background." I said, "Hmm," and he said, "My boss would probably like to meet you." So Bill Compton interviewed me and I ended up doing a group for him at Step Up called the Friendship Club. And we did a little- activities in the community and then we, occasionally we'd go over and listen to the City Council and, you know, stuff. And so that was the beginning, and then when he got my resume, he said, "Oh, I could use a training coordinator. You've done a lot of training."

HP: And this was because of your work experience and teaching.

CB: Yes, right, right. And so I became a training coordinator for Project Return. And interestingly, I was only on benefits for two years, but when I went back to work for Bill, I said to him, "I'm afraid of losing my benefits." I had a Section 8 [Rental Voucher Program] apartment in Santa Monica, I had a, what they call SSDI – Social Security Disability Insurance – because I'd worked, and I was afraid – after two years. I could only imagine how people who had been on that for years and years and years would feel if confronted tomorrow with, "OK, now you go back to work."

HP: So you were afraid to make that jump because when you do that, you'd lose the benefits, and then it's ...

CB: That's right, and then – and it is a phased out thing, and they try to address that and so forth, but there's a real fear that people have, because if you've been on the street and absolutely rock-bottom-

HP: You don't want to go back.

CB: You think, "Well, you know, that's pretty scary and maybe I'd better try to hold on to what I've got. So it took a leap of faith – but that's – see? Again, the resilience – but I had had what I had had in my background that made it possible for me to do that and to take the risk. And taking risks is something else that people don't like to do with people like me.

HP: How come?

CB: They like- they want to play it safe. "Well, you might get sick again." "Well, you might get violent." "Well, you might kill yourself." "Well –" you know – and yeah, sure, I could walk out in front of a bus, too, but-

HP: Well, I mean, anyone could.

CB: [sarcastically] So should I stay at home all the time? [They both laugh]

HP: Right.

CB: Yeah. See, that's the problem. So Bill took a chance on me and I ended up being an associate director eventually. And then the – Project Return is a program of something called Mental Health America of Los Angeles [a nonprofit organization that offers mental health and social services] – and so I went for a year from being Bill's associate director to being director of training for Mental Health America.

HP: Which is the – under- Project Return is under Mental Health America.

CB: Yeah, right. They wouldn't like the word "under," but it's a program of.

HP: Oh, OK. A program of. Now could you tell me a little – also, just what Project Return does, just so we're –

CB: OK. Project Return does a number of things in order to help people that are peers. In other words, I have a certain diagnosis, you [a peer] have a certain diagnosis, we have a program, can we be of use to you? Can we offer you a support group? There are over a hundred around the county. Can we be there for you in the evenings and on weekends – when you're alone at home – by phone? We have a Warm Line, a Friendship Line. If you're locked up, can we come see you if you're in an IMD [Institution for Mental Disease] or in the jail or in the hospital can we run a group there that you can join and then we can hook you up with some of our support groups when you come out.

HP: And they had been doing all of this before you had joined them?

CB: Oh, yeah. Well – yeah, and then I helped when I came back – I went to Sacramento to work with the California Network of Mental Health Clients [a statewide consumer-run advocacy organization] for about a year, and Bill got sick, and he asked me to come back and pinch hit. And so that's how I got back to L.A. and also how I got to be director. And we enlarged and expanded the roles of some of those particular programs. We also opened a very nice Latino – Latina? – Latino Center called El Centrito de Apoyo [The Little Help Center], and that one in Huntington Park is good because we have so many people who speak Spanish and need to know that they're welcome.

HP: Right, right.

CB: And, of course, the whole point of a peer support program is that it's inclusive. Bill was proudly gay, and so we were one of the very few places, I guess, that people knew that people who had a diagnosis who were gay would be welcome and would not have a double issue. The current director [of Project Return, Keris Myrick] is an African-American woman and we have all of the different groups that are in Los Angeles County welcome and represented in some way in the different parts of Project Return.

HP: Right. And what are some of the other expansions that it's done?

CB: Well, there's a growth called Community Outreach that went into the IMD's – Institutes for Mental Disease – they're kind of a step down from the hospital, often for people who are conserved and often for people maybe – sometimes – who are forensic, and we're doing more groups in there. We also expanded to do more training and consulting. We do training, or did training – I think they still do – for people who are wanting to get hired – it's called an Introduction to Peer Support. It's a three-week, seventy-hour training module. We did a consulting piece with Pacific Clinics [a large mental healthcare provider in L.A. County] , which

is professional, and they were opening up wellness centers. Actually, the wellness center was named the William H. Compton, Jr. Wellness Center – in Pasadena – and we consulted with them, and the lady in charge – Susan Mandel [CEO of Pacific Clinics] – Bill was on her board and eventually became president of her board, so she would often say that her boss was Bill Compton, and, you know, for people, that's anti-stigma. And he received many awards from – national awards, as well as state and local – for his advocacy. And I wish you could have met him.

HP: Yeah. Yeah, I've heard great things about him.

CB: Yeah, [he was a] good man.

HP: So you also mentioned that you work with a network up in Sacramento.

CB: Yeah, the Office of Self-Help. They were doing a project where there was an attempt to develop a working well together collaborative. The California Institute of Mental Health had put together a proposal to get NAMI, statewide, and United Advocates for Children [a family-run organization that advocates for the mental health of children in California], and The California Network [of Mental Health Clients] at the table to offer technical assistance to their peers.

HP: OK. Alright. So what kind of stuff did you do with that?

CB: Well, we would put together trainings, of course, but we were also in the process of kind of writing our piece of that proposal and answering a lot of telephone calls about "Who do I hook up with here?"; "How do I find out about that there?"; "Do you have a self-help program, you know, in this county?" and trying to connect people, yeah. And then the other thing, of course, was the advocacy we've done over the years. I came into this back in the day when we were struggling against forced treatment – the expansion of forced treatment.

HP: When was that? That was early 2000s?

CB: Oh gosh, that was around 2000.

HP: OK, so they were looking to expand forced treatment back then?

CB: Sure.

HP: OK, and was this a state thing or ...?

CB: Yeah, there was a law, or an attempt to put through legislation to expand forced treatment. And they did eventually get something through, but it was terribly watered through because there was such an outcry from the Network and from other groups to – about the civil rights issues. See, this is always, you know – the law, as it currently exists, say that we have to be an imminent danger to ourselves or others if we're going to be forcibly kept in a hospital. People – some people would say that that makes it virtually impossible to get people help. And see, my story is typical – you know, we often fall through the cracks and end up on the street or in very, very precarious situations before we are able to access [help].

HP: And it sounds like from with what you said in your story, the hospital isn't always helpful.

CB: Well, you know, I'm old, and so my days are the bad old days. You know, my first hospitalization – when I was 25, about this LSD thing – I ended up being given shock therapy. ECT [Electroconvulsive Therapy] is unsettling. If you think mind-altering drugs are unsettling, try induced seizures. So it's – I'm sure some hospitals have changed and become much more aware, but the tendency, unfortunately – I'm gonna advocate [in saying this] – it doesn't make sense to me if you have someone in crisis who is very distraught, to put them in a locked environment with 20, 30, 40, 50 other people in crisis [she laughs dryly] – you know. The only thing, if you are working in that environment, you could hope to do, is to control the people in that environment because there are too many of them to do much one-on-one – you know, real connecting and caring and helping nurture and ground. And so you end up either with physical restraints or with chemical restraints, and you have all that stuff going on, and then people are overmedicated because then at least they're calm and they're quiet and they sit over there and they don't bother anybody. And so even in the best of hospitals – mental hospitals – how is that helping?

HP: It's more containment than curing.

CB: Right. And, see, if somebody were going to say, "Let's face it, the truth of the matter is we don't give a hoot about you guys. We're scared you're gonna hurt somebody out here, so society's gonna lock you up, and you better shape up if you ever want to get out," at least that would be more honest than, you know, "We're here to help you and we're going to – ." So what we just got through, and we don't know if it's going to get funded by the state, but in what's called the Innovations Plan –

HP: Under the MHSA [the 2005 Mental Health Services Act]?

CB: under the Mental Health Services Act – is a couple of crisis houses in L.A. County. Now, they're peer-run. Now, a peer-run crisis house is people like me – although I would be terrible because I don't have the patience any more – but people like me who do have compassion and patience, and they would go and be on a shift with a partner in an environment where there would be no more than maybe six other folks like themselves who are in a rough way. And so they would have lots of one-on-one time, there would be a normaliza- it would in a house, just a house, small house, it would be where people have to be part of the process of preparing the food and cleaning –

HP: Ok, so communal living.

CB: Communal living. Very short-term, just 'til you can sort of gather your resources and get ready to go back from wherever you came. And so this is not hospitalization. It doesn't interrupt your life and throw everything off, where you might end up losing your apartment, or your goldfish dies because nobody's feeding it – and you end up going back to a horrible place where all the food's spoiled and, three weeks later, nobody knows what's going on. It's as brief and as non-intrusive a support process as is needed, and it's not medical. Now, if you come with medication because you like medication – and many of us do – most of us do – and take medication, terrific. Lock box, reminder, "Yes, it looks like this is what you told me you take – your meds. Now's the time. You have the key. Here we go. OK," and it would be a very respectful, warm, nurturing environment.

HP: It sounds like a great idea.

CB: Well, it's worked in a lot of other states, and we have a couple of programs up North that have seemed to have done pretty well. So we're advocating for that. And see – that's an alternative to hospitalization. What many of us are trying to figure out is alternatives. For example, we have a Native American group now, part of the underrepresented ethnic population, or UREP group. I hope you'll do some talking to people like them. And they've got a little of this money, piece of this money, that they hope they're going to be able to use to do some traditional healing – to have, you know, a sweat lodge, or to have a medicine man as a consultation-type thing for people whose cultural preferences are – maybe they're afraid or maybe they're not comfortable with Western medicine or maybe it hasn't helped them, who knows. And so there's a lot of looking for alternatives because the traditional medical model hasn't been real helpful. And the Department of Mental Health is looking at all of this. They're trying to see if there's a way to somehow reach out and engage people in ways that are respectful of their natures and temperaments and cultures and races and all kinds of things. So, anyway –

HP: So this vision you have of this house – what's it called? The –

CB: Crisis house.

HP: The crisis house. Would that work for somebody who is really at the height of a crisis?

CB: Well –

HP: I mean, I suppose that's the question.

CB: that's the – you are asking the question that every red-blooded [they laugh] American is gonna ask, because the answer is yes. Now, I'm gonna give you an example of something that a lady taught me, called WRAP – it's the Wellness Recovery Action Plan. Her name is Mary Ellen Copeland [an author and mental health advocate]. Mary Ellen lives in this place – it's a nice, little town in Vermont. Mary Ellen has a similar diagnosis. She also has fibromyalgia, and she's an amazing lady. But she has a similar diagnosis to mine, and so she has had crises. She does not go to the hospital. What she's got is a crisis plan. Now she stays at home. Now, how did she get her crisis plan? She wrote it with the help of her supporters. She has a women's group. She's also has a family – she's a lovely lady – she's got a husband and he's very devoted, and, you know, kids and grandkids, but they don't necessarily leap into the crisis with her because, you know, they live with her forever. So the people that step up to the plate are people from her women's group. I kid you not. Back in the late '70's or something, she had this – you know, the women's movement – she was in this women's group – and she reached out to them, and they said, "Sure." Well, she's got one lady who comes in who does body work in town – [she] gives her free body work. She's got a woman who comes in and cooks wonderful meals. She's got a woman who comes in and sets things up and keeps things going on her emails or something, I don't [know]- She's got this whole system in place.

That's what a crisis house is intended to do – you [the person in crisis] are falling apart right now, but, to the extent that we can, we're going to keep it as real and real-life as possible, and we're going to engage you to whatever level you're able to be. For example, there's another lady [who] wrote a book called *Procovery* [*The Power of Procovery in Healing Mental Illness: Just Start Anywhere*, by Kathleen Crowley] – because she says you can't go back to your original state of health – like healing a bone. You have to go forward – procovery – and her trademark is "Just start anywhere." So somebody comes in and they're in crisis. So they're sitting there like this. So you engage – and you say something and hope they say something

back, and if they don't, you may say, "Is it OK if I give you a hug?" Or you may say – take them by the hand and say, "I want to make some lemonade. Please come with me. I want you to help me." Now, people say "Oh my God, you have a knife in the kitchen. Oh, oh, lock up the knives." I'm sorry, we don't – I've been in crisis. I'm not gonna go grab a knife. But that's what people are scared of. And, see, if I were sitting here, actively as a Marriage and Family Therapist, I would say to you, "I can't work in that house" because all my professional and legal and ethical boundaries say I can't.

HP: So this kind of gets to something that I was curious to ask about – what can peers do that trained professionals can't?

CB: Everything. Everything. That's the problem – not the problem, that's the beauty of it because I can take you in my car because I don't have some kind of liability with some kind of place that says you can't drive somebody. I can go with you for a walk around the block and not worry that if you trip and I pick you up, that you're gonna sue me. I know this is exaggerated, but there's all sorts of stuff. I can cook a meal with you, I can sit with you at night at 3 AM.

HP: [From the perspective of CB] I can give you my home phone number.

CB: I can give you my home phone number. I can be there if it's my turn to be there from 12 to 8 with my partner in the house if you can't sleep. We can walk the floor together. I can listen to you talk at ninety miles an hour and not say, "Uh, those are loose associations. I really think you ought to take Haldol." I won't do that, I can't do that, I'm not licensed to do that, I shouldn't do that. I can't use language like, "Obviously you're perseverating," or, you know, "You're decompensating." That's not how people talk to each other. And peers are supposed to be – and, God willing, are – real people with real people. No professionals.

HP: And you can also share your experience. I mean, I suppose as someone with experience in the mental health system, if you were wearing your MFT [Marriage and Family Therapist] hat, disclosure would kind of be crossing a boundary, and it seems, from what you said, that disclosure can also be really helpful when it comes from peers.

CB: See, if we're not professionals, we don't give advice. So the only thing I can do is disclose. I can say, "Look, I tried to kill myself once. Let me tell you what happened to me. First of all, it didn't work. It doesn't usually. And when you come back out of wherever, you're in worse shape than you were when you went in, and secondly-" [they both chuckle] – and you lay it out for real. Like, don't kid me – I live in a shared housing right now. It's temporary housing – very nice. [There is a] nice lady in the house, meaning well. One of the women was having a terrible time, and she was in deep [makes a noise indicating the anguish of the woman] down because she's getting a roommate. So the lady, in all good faith - no training, no background – says, "Oh my God, we've got to call the owner, we've got to get him over here." And apparently she did, and then he showed up, and I was pissed, but [they justified it by saying] "she's catatonic." This is what this woman says. Oy. So I said, "No, I don't think so. I think she's pissed." So when the owner comes over, who has no training, what he says is, "When my grandmother would look at this kind of behavior, [s]he'd say she's pouting." [She laughs] And the next morning, the lady said, "I was having a bad time yesterday. I'm going to go talk to my therapist." You know, if somebody had taken that lady seriously that she said she's catatonic, that woman would have been in the hospital.

HP: For a while.

CB: Yes, for a long while. And doctors would have been spending time, energy, and society would have been spending money trying to figure out – “What does it mean? Oh my God, she’s catatonic.” It’s so dangerous.

HP: So it’s dangerous – I mean, that an interesting point, and that it’s also costly, you know, trying to run a system with limited resources – you can nip something in the bud instead of turning it into a week in the hospital.

CB: That’s the whole idea. And peer support does that. Now, is it risky? Oh, yeah. Can professionals take that kind of risk? If you have peers working in a professional program, those peers are told, “If somebody says they’re suicidal, report it.” Now, that’s because the professional has to protect themselves, you understand? It isn’t just the person that’s having the hard time. But what do the peers do? I’ll tell you what they did at Project Return with somebody – and this was totally on their own, without training. Somebody said they were gonna kill themselves. By golly, that group stuck together, and they worked it out, and they said, “We’re not leaving your side,” and they took turns, and [chuckling] they worked out, they worked out- until they could get the person the next day to their case manager. They stuck by him all through the night. They took turns – that group just supported that person. OK, that’s crisis management, but it’s not professional – it’s different.

HP: Yeah, it’s much more [like] friends.

CB: Yes, but you see, in our country, our whole system – and it isn’t just mental health – [in] our whole system, there’s no safety net, there is no circle of friends. You know, I mean – Hillary Rodham Clinton – “it takes a village to raise a child.” Well, the village mentality, the community – sense of community – is lacking. And here’s where it is stigma and discrimination – that sense of community will come and rise up and step forward, even if it’s cancer, which used to be pretty anathema. But the comparison they like to make is it’s like diabetes – mental illness – it’s just an illness. Truthfully, the experience in the society is it’s more like leprosy used to be. It’s – [people think] “Get away, get away.”

HP: There’s a certain fear – [people think] that “if I’m [they are] near someone like that, it could be dangerous.”

CB: “I might catch it. It’s going to be dangerous for me in some way.” And I understand because God knows there are people that can be – you know, rare – but there are people that can be scary. I’ve run across a few in my life.

HP: But there are a lot of people without mental illness who can be scary too.

CB: Who can be scary, too. Yeah, that’s right.

#### **IV. Experiences with the Client Coalition; Thoughts on the MHSA; Recovery and a Recovery-Based Mental Health System**

HP: One more specific thing – tell me about the Client Coalition.

CB: Ah. The Client Coalition was started by a director of Mental Health, by the name of Areta Crowell [Director of DMH 1991-1998] – marvelous lady – and I think she envisioned it as a loose association of clients getting together for socialization purposes, just for fun, and also, possibly,

for advocacy – although I don't think she had some sort of guideline. She sort of reached out and kind of- because she was respectful of clients, always has been. Wonderful woman.

Anyway, the current director [Marvin Southard] encouraged it, and it sort of grew, and then Ron Schraiber [mental health advocate and prior Director of DMH Office of Consumer Affairs] and Gwen Lewis-Reid [a mental health advocate in California] took it to the next level, and they had different kinds of coalitions and chapters. So you have a Latino coalition, you have an affiliate called BLACC – the Black Los Angeles Client Coalition – you have an Asian coalition, and they have these Hope and Recovery conferences every year – with translators and all the rest of it – for each of the major ethnic coalitions. And then they also have meetings once a month, where the mission is to serve and advocate for people like ourselves.

HP: What are some of the things you do to do that?

CB: OK, I'll give you an example. Most recently, we've been talking about how we can support an assemblyman – I'm trying to remember his name – who's looking into the possibility of people in California on SSI getting food stamps. People in California – as you know, with the budget cuts – their SSI has been cut to 845 dollars a month. This is pretty grim.

HP: Right. It was cut, like, 20 a month. Something like that.

CB: Yeah. Down, down. Twice. And they're looking at maybe again. So we're saying, "boy, would we –" But the problem is, in the original agreement, the SSI was higher in California because there was a provision for food. But now, of course, it's cut, cut, cut – you say, "well, gee, couldn't you at least sort of make the case that the provision for food was cut? – in which case you would qualify for the federal program, which won't harm Arnold." [California Governor Arnold Schwarzenegger or the state budget] So we're advocating – we write letters, we make phone calls, we pass out flyers, they go out to community meetings, to health fairs, they share information, they tell people about what it is to be mentally ill, they have a little speaker's bureau, they go to groups and classes and stuff and talk about their wellness and how they got better and things like that.

HP: Right, OK. More generally – we've touched on this a little bit – how would you define the recovery model?

CB: Well, I would define the recovery model first as it is defined in the Mental Health Services Act, which means that you have a totally voluntary system of services – totally voluntary – that is committed to the belief that people can get well and that affirms people's rights to self-determination and to make choices about – within their limits and within their abilities to pay – where they want to live, what they want to do, do they want to go back to school, do they want to get a job, do they want to be an artist? You know, what will be a meaningful way for them to contribute their core gift to society? It's the notion that everybody has something to give and that if we are willing to affirm that, we can find a way to help people do that.

HP: Now, how does this differ from the medical model that it's often cast in opposition to?

CB: Well, if the recovery model says you can get well and stay well, the medical model says you can get stable if you take medication and do what we tell you to do. There's quite a difference. And most clinicians, now, are moving away from the medical model because they find that it is limiting. They burn out, too – it's very hard on them – because it's nice to see people getting better [she chuckles].

HP: Yeah, that's why you get into this business.

CB: Yeah. You want to see people getting better, so if you can figure out ways that they can do that, this is a good thing, right?

HP: Yeah. So if you were in charge of it all [CB laughs], how would you create a recovery-oriented system? What concrete changes would you make?

CB: Oh. [a pause] I'd turn it upside-down. I'd really let it be client-driven, and family-focused – family-driven, too. I would go to the people – the clients and the family members - and I'd say, "What do you want?" And then I'd build it from there. And it would turn things upside-down. I respect the medical director at DMH very much, but I don't know a lot of psychiatrists who will actually say, "What do you want?" and listen. Now, Dr. Finch is an exception in my opinion, and I'm grateful I found her, but you'd have to turn your entire system upside-down, your entire health system. Doctors still think that they know best, and the truth of the matter is the only one who really knows what you're experiencing is you, and if the doctor's really good, they listen. But the problem is they've been trained to think that they're supposed to have the answer. So even if they don't, they're going to pretend like they do and they're going to say [mimicking an authoritarian voice], "Well, we're going to try this because I think that's the best – " you know. And that's that whole authoritarian thing. And it makes a terrible mess in the long run, and it costs money, and it causes people – I have been given medication that hasn't been good for me.

HP: Right. So this would do beyond even just if you were an administrator, but [also] changing the way they're taught in medical school.

CB: Absolutely. From the ground up. But, you see, who gives up power easily? Do you know anybody that says, "Oh, gee, won't it be great, we're going to share the power with you"? I mean, we're allowed – they talk a lot about transparency – we're allowed to give input. They're happy to hear what we have to say, but they're in control of the money, and as long as they're in control of the system –

HP: By "they," you mean DMH?

CB: Sure. [Of] course. I mean, not just DMH – all the systems – but yes, in terms of mental health, that's their responsibility. And for me to go in and say, "Here's how you want to spend the money, and here's how I want you to do it"? I'm sure there are a lot of family members and clients that could sit around and make a wonderful plan, but it would turn things inside out. We're talking about a billion – in L.A. County, more than a billion-dollar bureaucracy. Can you imagine what that would do?

HP: So when you say "inside out," you mention the way that the psychiatrists –

CB: The power structure would be flipped. [As if speaking to a doctor] I would be employing you, doctor. You would do what I want you to do. And, you know, first of all, they're going to claim the Hippocratic oath and everything else, that they can't do that, because I [the consumer] don't know what's good for me, they do. I'm sorry, I'm being very cynical, but if I had the power, sure, I'd turn it upside-down. And it would be a terrible mess for a while, but I think we'd come out with a better outcome [she laughs].

HP: Beyond the doctors, how about in terms of the way the social workers and case managers do their work?

CB: Well, same thing. Same thing. I mean, you know, in the Village [an integrated service agency, provider of mental health services] in Long Beach – you come into the Village, you may not want to take meds, and you may be talking rather strangely, and they say, “What do you want?” First day, Martha Long [founding director of the Mental Health America Village program in Long Beach] – she’s now retired – said somebody came to her like this – ‘cause she [the person who came to Martha] was a new hire – and she said, “I just had my first conversation, and he wants to be president of the United States and I- [breathing nervously, imitating the social worker],” and Martha said, “Well,” she said, “Do you know what it takes to be president of the United States? The girl goes, “No.” She says, “Well, find out, tell him, and help him.” [HP laughs]

HP: There you go.

CB: And she did. And the first step was that the guy hadn’t voted, he needed I.D., he needed all sorts of things, but he was motivated because she listened and she was responding to what he wanted. So, by golly, he let her help him get some I.D. and [helped him with other tasks]. Well, after a while he decided he couldn’t get the 10,000 or whatever signatures he needed, although he had tried to get on the ballot. And he said, “But it was a good try,” and he went around telling people, “I ran for President of the United States.” He felt better, he got things accomplished, she didn’t get into a, you know, “I don’t want to do this, you should do this [instead], you better do this.” It was a very – it was a win-win. That’s the kind of relationship that people need to build, but it only happens if you think the person you’re talking to has something to say that’s worth listening to.

HP: Right. Right.

CB: And Martha understood that brilliantly. Now, she was a social worker – I think – psychosocial rehabilitation. Wonderful lady. Anyway.

HP: Interesting. Now you talk about having – giving consumers more of a voice, and this kind of leads into my question on your thoughts I guess about the stakeholder process, and more broadly, about the Mental Health Services Act and how it’s unfolded here in L.A.

CB: Well, we got problems, but I think there’s great good will, and a lot of my peers don’t believe that. They think folks are trying to keep them quiet. I don’t think that’s the case. I think the problem is [a pause] if I [an administrator at DMH, for instance] think this works – this certain thing that I do – I’m invested in continuing doing it. And if some folks over here, who are not only not professionals, but they’ve been labeled mentally ill, tell me, “No, that doesn’t work. What you need to do is this” – which is different – I may, with all the good will in the world, be happy to take down what they say and write it in a report and say, “The consumers say, ‘Blah, blah, blah,’ and isn’t that interesting?” But I’m going to tend to continue to do and fund what’s – maybe I’d modify it somewhat. Maybe I even hire a few of those folks. And I say, “Come on along and I’m going to show you how we do things.” And then, of course, God bless ‘em, we go along and we learn how to do it that way, and we say, “Well, this is pretty good. At least I’m trying – I’m doing something here. I’m helping out.” And nothing much changes.

HP: So it kind of clots.

CB: Yeah. Now the system – transformation – I don't know the answer. I wish I did. I wish I had the answer for you. I don't. I do the best I can to do what I do, and that's what I think my peers do, and, you know – I'll tell you, somebody you want to talk to is Ruth Hollman [Executive Director of the Self-Help & Recovery Exchange]. She'll tell you she has the answer [she laughs]. She absolutely has the answer.

HP: Well, I'm curious if you could give me an example of one thing where perhaps the clients have one perspective and the establishment has had another – in the MHSA or the stakeholder process.

CB: Well, I think this example that I would use would be the Wellness Centers. See, it's a great idea, conceptually. You have these centers, and instead of, you know, clinics that are kind of – you know, with bars and stuff – you have this sort of friendly, welcoming atmosphere and you have a lot of self-help groups and you have art therapy and fun things to do and outings. And you have this for people that are well. See, the problem is they're having trouble now – in some of them – if they go that route because they have low numbers, because the essential element is it's voluntary. Well, people vote with their feet. If the center has something that I really want, I'll go there. But most of us, when we get well –see, I went and found some ladies that didn't have a diagnosis to play this board game with. I've joined a folk dancing class, where I think – I may not be – but I think I'm probably the only one in there with a diagnosis. It isn't that I'm avoiding – I'm very active with my peers and I have friends and colleagues and all the rest of it – but my tendency to get a life is to get a life in the community. The centers are not quite in the community. Not quite. I mean, they're not – they're sort of- but what they often serve a purpose for is folks that don't feel real comfortable in the community, or folks that really, desperately need and want the medication and they're finding it terribly hard if they're on Medi-Cal, to get somebody who's willing to accept Medi-Cal payments and give them the time and the effort to get psychotropic medication. So it's a practical thing, but I really see that as an example. They really didn't listen to the fact that most clients are saying – they didn't ask the clients. They took some wonderful ideas that had been tried in order to make it possible for people to get meds and possibly some help around physical wellness – you know, taking blood pressure or developing diets for people with diabetes –

HP: Focusing on healthy eating and –

CB: losing weight and, you know –

HP: So if you had designed Wellness Centers, what would they have offered?

CB: I wouldn't design a Wellness Center. I wouldn't have it be that. I would have, I don't know what, I guess I'd have a- I guess I'd have to ask my peers who go to Wellness Centers, "What would you want?" Or [those] who don't go to Wellness Centers who are supposed to. Now, wait a minute, I'm supposed to go to a Wellness Center at Edelman, so I suppose I should think about what do I need [HP chuckles]. Oh, the classic response – "I need housing." I'm 70 years old. I need housing. I don't want to be living on the street at 70 years of age. And the place where I am is not permanent housing. But the Wellness Centers have absolutely no – because they assume that, and they usually, it's true – that the people who go there are housed in some way. It might be a board and care, but they're housed. I don't want to live in no board and care [she chuckles], so I've got a problem – see? So I guess I suppose it would be that I would make the money available if I can come up with a plan that passes muster. And I'd have like a jury of my peers. I'd have my peers and professionals, and I'd have to come in there and defend that I want you to pay for my dental work, and I want you to use the money to pay because that will

help my physical health, which will help my emotional health, which will help my mental health. You know what I'm saying? And I'd go in there and I'd say, "And I want you to help me find housing that's not just in a place that's for people like me." See, that's the tendency. You know, you cluster folks. But really, if you want me in the community, I want to be in the community, and I'd like you to help me find this and that, and then the board of my peers and professionals would say, "Well, OK, here's our list of resources. Let's see – we can plug Catherine in here and we've got this one over here," and that's how it would be. It would be so individualized, it would be awesome.

HP: It would be – yeah, it sounds it. That would be great. [CB laughs] I know you need to get going. I'm so sorry – there was more I wanted to get to, but unfortunately –

CB: Well, thank you, and I really appreciated you interviewing me and talking to you.

HP: Oh, I appreciate it. This was wonderful. Is there anything else you'd like to add?

CB: Thank you very much for the opportunity.

HP: OK, great.

END OF INTERVIEW