

Roy Marshall shares his thoughts on the shift in children mental health care and the role of the Child and Family Guidance center in the transition:

And I think there is more parent participation in children's mental health. It used to be that you just treated the kid and the parent was seen as the problem, as the one creating [the problem]. [Now] they realize the parent is not the problem. The parent is going to be part of the solution for this child's behavior issues and so it is more of a family-focused therapy.

Well, it wasn't like one day we woke up and we decided to do it. But I would say the more family-focused [therapy] started in the early to mid-'90s. As with any field, there [are] a few centers where they do things differently and then people start looking at them and then their information spreads. And there was a lot of work done with what was called the "systems of care" philosophy created by the Georgetown Training Institutes. They had these meetings biannually and people would come from all over the country and learn what was going on. That's when the whole "wraparound" concept in the early '90s came about, which was a real paradigm shift, especially for the seriously emotionally disturbed child. Where you didn't say, "Okay, we're going to plug him into this service and plug him into that service;" and hopefully the things would be coordinated. Wraparound is where you have a care team and you wrap the services around the kid rather than trying to plug the kid into individual service. It was a "whatever it takes" philosophy.

And so if their main problem was mom needed a refrigerator because [the child] wasn't eating adequately because they couldn't have refrigerated foods, you bought a refrigerator. It isn't classic mental health practice, but if that helped and made the kid better, made the kid function better, that's what you did. Or [you got the child] a YMCA membership or whatever. And you did therapy when therapy was indicated. But instead of just talking about the kid's feelings, it is now cognitive behavior therapy *and* other very focused, targeted kinds of things.

I think we are one of the leaders in the sense that when [these new] therapies came about, because we have a training program here and everything, we are attuned to doing things in new and different ways when it's warranted. And, like I say, I want to be on the "leading edge," not the "bleeding edge." In other words, one of my favorite phrases is "The early bird gets the worm, but the second mouse gets the cheese."

And so you have got to be a leader in the field, but that doesn't mean you want to jump on every new fad. So you have to make sure it is the real deal and you do research and you understand that it is something that you know. For example, when [family-focused therapy] first started, they said, "Oh, you can't treat the kids in the office. It's a sterile environment. You've got to go into the child's home. The treatment needs to be in the home. All of our services are in the child's home. That's the only way we do it." Well, that's the pendulum swinging too far the other way. Their pediatrician doesn't go into their home. And so there has to be a balance. You do some services in the field, whether it is the home or the school.

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INTERVIEWEE: ROY MARSHALL

INTERVIEWER: Kevin Miller

DATE: March 1, 2010

I. EARLY LIFE HISTORY AND EDUCATION; WORKING IN MENTAL HEALTH ADMINISTRATION

KM: OK. This is Kevin Miller and I'm sitting here with Roy Marshall. It is the first of March, 2010, in the afternoon and we're doing an oral history on his experience with the mental health profession. So I thought we'd start by just talking about your early history, even where you grew up and you can tell me a little bit about your family.

RM: Okay.

KM: Why don't we start there?

RM: Well, one could say I've been involved with mental health since my birth because I was born in Topeka, Kansas, where my father was training at Menninger's, which is a famous school of psychiatry in Topeka. It has since moved to [Baylor] University in Texas, but for many years that was its home. It was started by Karl and Will Menninger [in 1919] and he received his psychiatric training there. I was born there in 1950 and then we moved briefly for a year to Seattle. I think it was from like a year and a half to three years old [that] I was in Seattle and then from four years old on, we've been in the San Fernando Valley. After one year in North Hollywood, I grew up basically in Encino, and when my dad first moved to the San Fernando Valley, he was the second psychiatrist here. You can imagine how it's grown and how many psychiatrists there are.

So my father was a psychiatrist, a psychoanalyst, as a matter of fact, a training analyst, and head of the Southern California Psychoanalytic Institute for a while. My mother was a community activist. Those were the days when just the husband worked and my mother spent her time organizing things like the local Mental Health Association and was involved in the State Mental Health Association. And as a matter of fact, about forty-eight years ago [my parents] and a group of families helped found the very agency I direct now and so it's kind of nice that after all these years – it was twenty years ago – I came here, and I keep telling them there was no nepotism involved. The former director here was retiring and he sort of recruited me to be the director. But it's kind of nice to be in an agency where the professional library is named after my dad and my parents are in the history of the agency [The San Fernando Valley Child and Family Guidance Center, founded as the San Fernando Valley Child Guidance Center in 1962].

KM: I see.

RM: And so, personally, I grew up in Encino. I went to the same elementary school, junior high and high school. They only lived in Encino fifteen years, but it was a crucial fifteen years in my life, from five to twenty, and so I had a very stable childhood in terms of the same. I have friends that I've known since kindergarten.

KM: Wow!

RM: And so, after graduating [from] the local high school here, Birmingham High, I did my undergraduate work at UC Irvine; and after I graduated [from] UC Irvine, I got a job. Actually, in my senior year there, my father passed away rather early in his life, [at] sixty years old, from cancer. That kind of hit me hard and I wanted to do something that sort of carried on the family tradition [of] both my father and my mother. But I knew I wasn't that good in the science end of it and the doctoring end of it, but I knew I was pretty good at administration and organizing and managing things. So it was a conscious decision to go into mental health administration. When I was about twenty-two, I got a job at LA County [Department of] Mental Health – and that stuff's in the Fortieth Anniversary [LAC-DMH publication] – and I worked from there from '72 to '75.

KM: OK, let me back you up there for a little bit. So at UC Irvine, did you major in –

RM: Social Science.

KM: Social Sciences, OK. Was it partway through that education where your father passed away?

RM: Yes, yes, it was. There was a convergence of things. My father passed away – it was my senior year just as I was graduating and actually maybe I was [a] junior or senior. I think he passed away in '71 and I graduated in '72. But also during that time, I was kind of a campus activist. It was during the Vietnam War, something you were born after. (he laughs).

KM: It's true.

RM: And they had something called the Cambodian Incursion where Nixon had gone into Cambodia [President Richard Nixon ordered US and South Vietnamese troops to conduct several military operations in Cambodia in mid-1970. The invasion caused widespread unrest on US campuses, many of which were closed in protest in the spring of that year]. So we were protesting and shutting down the school and everything and I was organizing people and telling them where to go [to demonstrate]. And running off things and making copies of stuff and I said, hey, I have a knack for this sort of organizing kind of thing and managing and directing and I knew I wanted to carry on the mental health tradition. So I sort of melded the two together.

KM: I see.

RM: And that's how I sort of took that path.

KM: And do you have any early memories associated with your parents' work in mental health specifically?

RM: Yeah, oh, very much so. I told the story in the [LAC-DMH] Fortieth Anniversary book of how the first mental health law really funding public mental health was called the Short-Doyle Act [of 1957] and it was [cosponsored by] Senator [Alan] Short and Assemblyman [Donald D.] Doyle. [The Short-Doyle act gave counties 50% matching funds to support mental health services.] But anyway, my parents – we had a small boat down in Newport and we'd drive back and forth on the weekends from Encino and back then, that was quite a trek. And I'd be falling asleep, before the age of seatbelts, in the front seat and leaning against my mother, and they'd be arguing back and forth or talking

about the Act, Short-Doyle this or Short-Doyle that, and I said, “OK, that’s Short Doyle, what’s Long Doyle?” I didn’t think it was somebody’s names.

Anyway, I had memories because they were involved and very active community organizers as they say. Now that’s an epithet, I think. They were community organizers and very involved in formulating community mental health. So I do have memories of that and of their involvement.

KM: And so it was their work that –

RM: Inspired me.

KM: Inspired you? Did you feel like you were on a different path before your father passed away?

RM: I don’t know what path I was on before. You know, when you are a kid you want to be all sorts of things. I wanted to be a marine biologist. But I guess it was in college, and college in the sixties. We thought we were going to change the world. We didn’t know exactly how.

KM: Right.

RM: It was really [then that] it jelled more. Actually, I thought I was going to become a psychologist. When I was looking at graduate school, I was looking for programs in psychology, but then I realized I really didn’t want – Individual therapy really wasn’t my thing. It was more management and administration.

KM: Okay.

RM: So anyway, after – I don’t know if you want me to go on or do you have other questions in there?

KM: No, that’s fine. You said that you worked for the [LA County] Department of Mental Health?

RM: You are right. I worked for the Departmental of Mental Health from 1972-1975. During the time that I worked there, I went to graduate school at night at USC and I received my Master’s in Public Administration with a certificate in Health Care Administration. So I was in there in the – I wouldn’t say the early years. The Department had been in existence for ten years by the time I had gotten there. It was fairly early if you think about it now. And at that time, they were actually under the Department of Health Services. They had been a separate Department and then they were under Health Services and then they split up again. It was sort of like this amoeba that kept splitting and dividing. [LAC-DMH was merged with the County Department of Health Services from 1972-1978.]

And then I moved – I wanted to go on. I felt like I wanted to get my Doctorate in Public Administration, so I applied to George Washington University in Washington DC and was accepted and I went there. I never finished. I got all the way up to the dissertation and never quite finished, because it was pretty grueling. They always—they make you get like a second Masters so it was a lot of course work. At the time, I had a job that I really liked there in Washington. I worked for the National Association of State Mental Health [Program] Directors. So that was pretty fulfilling to be testifying on the Hill

and be doing all sorts of heady kinds of things for a twenty-six year old, twenty-five or twenty-six.

And so I never finished the Doctorate. I went all the way through and never finished the Doctorate, but it was quite a few years of work there. But then, from the job in Washington DC, I was able to secure a job as a County Mental Health Director. It would be like a Dr. [Marvin] Southard [Director of LAC-DMH from 1998 through the time of this interview in 2010] in Virginia but a smaller catchment area, and you had a city and several counties that were your catchment area. And so I was like a mental health, mental retardation, [and] substance abuse [program] director there, a governmental post, but multi-governmental. And so I did that for about three years.

KM: Did you say that was in Virginia?

RM: Fredericksburg, Virginia. And then I, being a California boy, was missing the family and the warm weather, and although, except for this year, it doesn't get as cold in Virginia as it does in some other places, but it was still cold enough for me. And [I was] missing the family, so I applied for a job. I didn't get all the way back to LA, but I applied for a job up in Bakersfield at the Henrietta Weill Child Guidance Clinic. I worked there for about three years and then a job opened up at Los Angeles Child Guidance Clinic. I don't know if Betsy Pfromm is somebody you are going to be interviewing.

KM: Yes, we hope to.

RM: Yeah, well, I met Betsy back in '79. She was the director of [one program] in the state [of Virginia] and I was in another, and so I've known her since 1979. So anyway, I got the job at LA Child Guidance Clinic and I was there for only about two and a half years, when this job [at the San Fernando Valley Child Guidance Center] opened up. It is a bigger agency and I had family ties obviously to this agency. That was twenty years ago [that] I took this job. Then I recruited Betsy because I knew her from back East from my former job there.

KM: Okay.

RM: And I've been here at this [job], ever since 1989.

KM: OK. Could we maybe compare along some criteria, your jobs in Virginia and Bakersfield and LA County, maybe at the Los Angeles Child Guidance Center?

RM: Compare in what way?

KM: Well, compare in terms of the process that was being employed or in terms of what the priorities were for the Centers in terms of mental health, what the community was like that you were serving, or how the money was being spent?

RM: OK, yeah, I guess I could. One – stop me if I'm not going in the right direction.

KM: Sure.

RM: Structurally, all the jobs had Boards that I reported to, Boards of Directors. In Virginia though, since it was quasi-governmental, it really wasn't like a 501c3 non-profit. It was governments [who appointed] the board. Even though there were lay citizens on

the board, we didn't do fundraising and things like that, because it was a governmental type thing. We contracted with agencies and they did some fundraising. So it was more providing an array of all three [services]: mental health, mental retardation, and substance abuse.

KM: Right.

RM: The rest of my jobs, which were [in] Bakersfield, LA, and here, were very similar. They happened to be child guidance centers; so I guess I developed a de facto expertise in children's [mental health administration]. The one in Virginia was all age ranges, all mental disabilities; but then, since I got the job at Henrietta Weill and it was a children's agency, when I applied for the job at LA Child Guidance they said, "Oh, he already runs a children's agency." And then when I applied here – well, here was not so much of an application as a recruitment – here they said, "Well, he's already had experience running two other children's agencies." So I guess you could say [that] since 1983, I've been running children's mental health agencies.

But I knew I wanted to be in mental health administration. I didn't necessarily say I wanted to be in children's mental health administration, but that's how it ended up. And so, I mean I don't know if that helps answer the question in comparison, but these three agencies are non-profit agencies 501c – what's called private non-profit and they contract with the government. The first job [in Virginia], I was the government.

KM: Right.

RM: Most of our services were directly operated. Very few were contracted out there in Virginia. But here, both in Bakersfield, Kern County and in LA County, we were agencies [that were] contractors of the Department, the respective Departments of Mental Health. And we provided, I think, a wide – well, it's a pretty wide array of services now at LA Child Guidance. It was a little more limited [when I was Director]. I think Betsy's done a phenomenal job down there, better than I could have in making that agency a leader in the field. But in both these agencies, we provide a wide array of services, not just mental health services but social services and training. We have a whole community family center here, for example, that sort of integrates new immigrants into the community with English as a second language courses and health education and in-home therapeutic interventions and all sorts of things that aren't considered classic mental health. Plus we have the more classic mental health services.

KM: Along those lines, what would you say the relative advantages of these kinds of contract clinics are in relation to County[-operated] ones?

RM: Well, they are much more flexible in terms of you don't have to go through all the bureaucratic rigmarole to get things done and to move faster and to implement programs. These have a lot of flexibility in that way. It's a double-edged sword. We always say we can do it more flexibly and cheaper, but the problem with being cheaper [is that] you are competing with the County for salaries. So we try not to emphasize the cheaper part and instead [emphasize] the quality of the service and the flexibility, and [the ability] to respond quickly to needs in the community. And we're trying to actually raise our economic standards too, because non-profits always have the image of scraping by. But if we hire professionals that want to do a professional job, we've got to pay adequately and provide adequate benefits.

But I think our main advantage is flexibility and [the ability] to respond to community needs in a faster way, without having to go through all the bureaucratic red tape.

KM: What takes up the most time at your job?

RM: Oh, dealing with the County contracts, no question about it, because it's 90% of our funding, and so it's 90% of my effort in that sense, in dealing with the issues involved with managing the contract, whether it be cuts or expansions or changes. That's a lot of my time. I sometimes say, "I have more in common with Hughes Aircraft than I do with the YMCA." Because government contracting is a whole art unto itself. And so it's a real challenge.

II. VIEWS ON MENTAL HEALTH; SHIFT IN CHILD MENTAL HEALTH CARE; STIGMA IN MENTAL HEALTH

KM: Why don't we talk some now about your personal, your professional, and maybe even your philosophical ideas about the mental health system itself or mental health clients in particular? When you entered the field, what would you say was the major problem facing the mentally ill and how has that changed, or how has that not changed, and how have you addressed it with your work?

RM: Well, before I go into this, the caveat is that I have no clinical training whatsoever. I'm, as I call myself, a "clinician by osmosis." I've been hanging around the field my whole life, so that's the extent of my training. Although some of my staff says I am clinical, because they say my perceptions are pretty astute. I'll leave that to them to judge. But anyway, I think the way we've – I've seen a lot of change in the way treatment is addressed, both on the adult side and the children's side. On the adult side, a lot of it was something the therapists would *do* to the client and the client really was just an object to be acted upon, either with drugs or putting him in a program. Now, I think the philosophy on the adult side [is very different]. There was a hue and cry from both the NAMI people [National Alliance for Mental Illness, the family advocacy organization] and the client network that [there should be] "Nothing about us without us." In other words, [the clients and their families] want to be active participants in the treatment and in getting better, and the whole recovery model is based on that, and that they are active participants in getting better.

I think when you talk with Dick Van Horn – you'll be talking with him?

KM: Marcia Meldrum has interviewed him [Richard Van Horn was Executive Director of the advocacy organization Mental Health America of LA, from 1980 through 2009, and continues to be a major leader in the field.].

RM: Yeah, well he's the guru on that and can give you a much more articulate view than I could, in terms of how the philosophy has changed. And it's not that there weren't kernels of it earlier in the clubhouse model and social rehabilitation services, where the clients themselves would be participating, but I think it's changed now where the clients are more active participants in their treatment. That's not to say that there still isn't a role for medication, because I think you see what happens.

Like recently [in February 2010], [the singer] Marie Osmond's son committed suicide, and most of these [tragedies] happen when people are off their medication. Now that should tell you something. That medication must be important because these

things happen when they either go off [their meds] and they don't think they need it anymore or whatever. So [social support services have] always got to be [provided] in concert with medication. I think that's the new [direction], and social rehabilitation with client involvement and client directed. It sort of becomes a partnership with the doctor rather than the doctor just dictating this is what needs to be done. And I think you see more of that with client-run centers and services and what not.

On the children's side it used to be very classic [treatment], psychotherapy, what's considered a psychodynamic model. You'd go for an hour. You'd leave and that would be it and hopefully you got some changes made. You gave some parenting tips to the parents. Now it's much more segmented and defined based on the presenting problems of the kid. You don't give everybody the same kind of therapy anymore. It used to be you almost did.

If you have behavior adjustment problems, there is a whole range of interventions for that. If it's depression, there are interventions for that. There is [an appropriate] intervention depending on the presenting problem. And I think that right now, especially the [recovery] movement now, is to do much more time-limited focused interventions that have proven, effective outcomes. And there is also, for some, a role for medication in that area, but it used to be that medication was a blunt hammer. Yes, it may [have addressed] the problem but it created fifteen more problems. Now it is more surgical, where you have medications that target a certain symptom without creating all the side effects that make it worse than the original problem. As they say in the field, iatrogenic. I don't know if you've ever heard of that term. It means where the treatment makes things worse.

KM: OK.

RM: Like when you go into the hospital and you get an infection that you didn't have before because you were coming in for appendicitis. That's iatrogenic. And I think there is more parent participation in children's mental health. It used to be that you just treated the kid and the parent was seen as the problem, as the one creating [the problem]. [Now] they realize the parent is not the problem. The parent is going to be part of the solution for this child's behavior issues and so it is more of a family-focused therapy.

KM: When did that shift occur?

RM: Well, it wasn't like one day we woke up and we decided to do it. But I would say the more family-focused [therapy] started in the early to mid-'90s. As with any field, there [are] a few centers where they do things differently and then people start looking at them and then their information spreads. And there was a lot of work done with what was called the "systems of care" philosophy created by the Georgetown Training Institutes [run by the Georgetown University Center for Child and Human Development]. They had these meetings biannually and people would come from all over the country and learn what was going on. That's when the whole "wraparound" concept in the early '90s came about, which was a real paradigm shift, especially for the seriously emotionally disturbed child. Where you didn't say, "Okay, we're going to plug him into this service and plug him into that service;" and hopefully the things would be coordinated. Wraparound is where you have a care team and you wrap the services around the kid rather than trying to plug the kid into individual service. It was a "whatever it takes" philosophy.

And so if their main problem was mom needed a refrigerator because [the child] wasn't eating adequately because they couldn't have refrigerated foods, you bought a refrigerator. It isn't classic mental health practice, but if that helped and made the kid better, made the kid function better, that's what you did. Or [you got the child] a YMCA membership or whatever. And you did therapy when therapy was indicated. But instead of just talking about the kid's feelings, it is now cognitive behavior therapy [a time-limited, directive, collaborative model of psychotherapy, developed between 1950 and 1970, that teaches the patient more effective, goal-oriented thoughts and behaviors] *and* other very focused, targeted kinds of things.

KM: And so what was the role of the Center here in this transition?

RM: Well, I think we are one of the leaders in the sense that when [these new] therapies came about, because we have a training program here and everything, we are attuned to doing things in new and different ways when it's warranted. And, like I say, I want to be on the "leading edge," not the "bleeding edge." In other words, one of my favorite phrases is "The early bird gets the worm, but the second mouse gets the cheese." (he laughs)

KM: That's great.

RM: And so you have got to be a leader in the field, but that doesn't mean you want to jump on every new fad. So you have to make sure it is the real deal and you do research and you understand that it is something that you know. For example, when [family-focused therapy] first started, they said, "Oh, you can't treat the kids in the office. It's a sterile environment. You've got to go into the child's home. The treatment needs to be in the home. All of our services are in the child's home. That's the only way we do it." Well, that's the pendulum swinging too far the other way. Their pediatrician doesn't go into their home. And so there has to be a balance. You do some services in the field, whether it is the home or the school, and you do some services in the office, depending on what's appropriate. So you've got to have a balance.

KM: And related to that, why do you feel, if you agree, that the stigma persists for the mentally ill?

RM: Well, I think – I wonder if you are going to be interviewing anybody from Didi Hirsch Mental Health Center, like Kita Curry?

KM: I don't have a full list of names.

RM: Yeah, that would be the [place to talk to] there. You know, it's hard. I think, if you look at the news about crazed people taking a gun and shooting up things. That's in the news every day. Or somebody jumping off a building, and people see it in the news and they don't see the success stories and we see them all the time. Where a professor at USC says, "Yeah, I was bipolar and hospitalized several times, but look at me now. I'm a professor at USC and I still have to take medication and I do this just like a diabetic would, but I function. I'm intelligent." And so I think the media [emphasizes the tragedies, because] it's more dramatic to portray the extremes in the field, especially when it's violence against others, and it scares you. And it happens, but I think it is too easy to blame the media. You see it happens; people do shoot people up and they are considered "crazy," quote-unquote, when they are doing it. So that's just a reality. You

don't hear about diabetics going crazy or people with heart conditions going crazy because they have a heart condition. But you hear about people doing violent things to themselves or others because of their mental condition.

KM: Right. And at least out here in Los Angeles, it seems that perception of the homeless is related to that stigma.

RM: Yeah, and not all homeless are mentally ill, but many are. And if you took the mentally ill out of the jails – I mean, there are so many mentally ill who are in there because of their mental illness. They may have committed a petty crime or something, but it's basically the mental illness that they are in there for. The LA County Jail is the largest mental health system in the United States. In my personal opinion, I don't think we've come to grips with how much of it is medical and biological versus social. And I think, depending on our culture, it will always be a shifting line.

There are [cases that are] clearly biological; and it depends if you are talking about children or adults. One of the misnomers that people have is, "Oh, you want to catch them early so they don't develop into the adult mentally ill." But there are really two different disease processes. Because children's mental health – if it's conduct disorder [where a child has difficulty following rules and behaving in socially acceptable ways], they either resolve themselves with treatment or the person matures out of it. Or sometimes they go on to a lifetime of crime, but a lot of that is [the result of] their social environment. Adult schizophrenics didn't start out as children schizophrenics. They usually had a psychotic break classically around college, near that age or [in] early adulthood. You hear where he's doing great, all As in college, and all of a sudden in his senior year or junior year, something happened and he flipped out and his roommates are wondering what's going on. Well, that's when they usually have a psychotic break.

And so I don't think we fully understand the difference in the disease processes. Nor have we fully resolved what is medical versus what is social. I mean, we've gotten a lot further and we know that regardless of what is exactly medical and what is social, you need medication [as an] adjunct to social rehabilitation in order to have the person be in recovery.

And I think that's a big switch. You will always be mentally ill just like you will always be diabetic, but you will be in recovery. Or you will always have a mental illness but it is in remission. I'm sure there the vast majority of alcoholics say, "I'm an alcoholic," even if they haven't had a drink for twenty years.

KM: Right.

RM: Some, a smaller group says, "No, I don't want to be labeled with that all my life. I'm not an alcoholic anymore, because I haven't drunk in twenty years." Is that semantics or is that a paradigm shift?

KM: Right.

RM: And I don't think that's really been resolved in the mental health field.

KM: How does the Child and Family Guidance Center incorporate this blurry line between the medical and the social, in terms of its policies?

RM: That's the sixty-four dollar question.

KM: Right. I realize it is probably a long answer to that.

RM: No, I don't know how long it is. But a large part of our children are on medication, but it's an adjunct. It is not the end-all [and] be-all. In other words, if the therapist does an assessment and they figure out what the issues are – Is it a behavioral thing? Is it depression? Whatever the issues are, then, if necessary, they refer to the psychiatrist for a medication evaluation. If the psychiatrist, based on the symptoms and what the child is doing, feels that medication is warranted, they put them on medication. But it's always in adjunct to the therapy or whatever intervention there is.

So that's the way we do it and that's the way most people do it. Now, it's always a difficult issue, because there are always the side effects of the medication. And apparently people hear stories, sensationalized stories in the media and what not, and they are a little leery, but we explain that this is what we are doing. This is the purpose of the medication. And in ninety percent of the cases, there is so much improvement in the child's behavior that the parent is pleased. They are doing well in school; they are socializing. Now how much of that is the medication versus the therapy, it is hard to tell. But when they go off it and there are problems again, then there are some issues.

KM: So at the Center here, your clients are all eighteen and younger?

RM: Yeah, we have a few transitional age youths who may be a little older, but eighteen or younger, but with their families. We [always] treat [children in the context of] their families. Our one exception [is that] we do have a CalWORKs Program where it's not a therapeutic program, it's a jobs program [California Work Opportunities and Responsibility to Kids is a program through the State Department of Public Social Services to provide assistance to low-income families, especially in finding employment]. But some of the parents are parents of the kids that are here in treatment and some are just community parents.

KM: I see. And so what happens when the client reaches that transitional age?

RM: Well, a lot of our clients are in short-term therapy and/or they are here eighteen months to a year, so they transition out of service. If we feel that they are more severely disturbed, something we consider more a long-term serious problem, we can keep them up until [age] twenty-one. We refer them to the adult mental health services, like the San Fernando Valley Community Mental Health Center.

KM: Okay. Let' see. You've talked towards this a lot. One of our questions here is how would you define "recovery" and what is the optimum service model for helping clients toward recovery?

RM: Well, that's hard. I mean I'll talk about the children's. I'm not an expert in this sort of thing, but it's in a sense being symptom free. And not just from the therapist's point of view, [but] from the client's point of view, and I think that's the important thing. In other words, where you are functioning in the world with healthy relationships and productive work and feeling a part of and connected to society and the world and your family. That would be recovery. I think that's the truth and it's for the adult as well as a child.

KM: Right. Do you keep in touch with a lot of former clients?

RM: I don't. I don't see the clients. Do my therapists? Not really. It is very hard, because you go in and they leave and they go on with their lives, but some do. As a matter of fact, at the school we run, they come back and they say, "I'm in college now" or "I'm doing this." And they do, and we've actually, I think, employed some former clients at one time and I think we still do. So we do, but in a more anecdotal way.

KM: Uh-huh.

RM: We don't have the funding for long-term studies of following up with the clients.

KM: How about we talk more now about the Department of Mental Health?

RM: Okay.

KM: What would you say are some of the primary challenges facing the Department today as is relevant to your experience?

RM: Well, I think some of the challenges are to try to provide service. There has really been a decline in resources even with the Mental Health Services Act [of 2005 (MHSA), which] came on at a time when the first year or two was in coordination with a rise in tax revenue and everything that the base is funded by. So we really didn't – we were talking about expanding programs and it was the "shining city on the hill" finally for mental health.

Well, then the recession hit and all bets were off. And we are really a system in decline right now. The adult mental health system has been devastated. And the children's system is now facing major upheaval right now, where in order to maintain our funding, we have to totally change the way we do services, and we're very worried that some kids are going to get left behind because of this.

KM: What's an example of that?

RM: Well, it's kind of complex. In order to maintain our funding, we have to use a different source of money from the Mental Health Services Act to leverage MediCal. We used to use the County General Fund to leverage MediCal at like five cents on the dollar. For every nickel we put up we got a dollar [in matching funds], which is pretty good. But now we have to use different funding to do that, and that different funding has big strings attached to it. It's really tied to prevention and early intervention, which means you have to use evidence-based practices that are tied to that. And these evidence-based practices are for very specific types of populations. So a lot of the depressive or ADHD kids don't really fit into these evidence-based practices [for their] diagnoses, so it's going to be a challenge to try and provide them services under the new model.

III. RELATIONSHIPS IN MENTAL HEALTH; CALIFORNIA COUNCIL OF COMMUNITY MENTAL HEALTH AGENCIES AND THE MENTAL HEALTH SERVICES ACT

KM: I see. How would you describe your working relationships with Directors and staff at the Department?

RM: I think very good in general. I think there has really been a paradigm shift, or a cultural shift is a more accurate word, in the last ten years. I think they see us, the

contracting agencies as partners more and realize they need us as part of the system whereas before [the County viewpoint] would be, OK, water rolls downhill and we'll just take care of ourselves [first] and if there is money left over, we'll contract out. But we now think that there has been more of a sense that they need us, especially in the children's services, to be partners.

But it's very much a challenge in these days, because they have all the civil services rules and everything like that. I think they are well meaning and with good intentions, but sometimes what happens is when people make decisions in silos, it may be a very good decision from a fiscal point of view ["Silos" are service divisions for institutional, financial, or political reasons]. This may be a very good decision from a programmatic point of view. This may be a very good decision from a data point of view. And they are, but when you put them all together, the de facto combination of the things we have to deal with makes it much more difficult to run our business. So I think the challenge is going to be seeing it as a system and designing things in a way that doesn't hinder us as contract agencies for providing the services we need to provide.

KM: OK. Before talking about other relationships like with family members of clients and advocacy groups, could we step back and talk about the history of these sorts of child guidance centers and how they came into relationships with the County Department [of Mental Health]?

RM: Well, the classic child guidance clinic concept, I think, started in the twenties when there were like five around the country or six, and LA Child Guidance is one of the originals. It was a grant from this woman who was a great philanthropist [that] started the centers around the country. [The first eight Child Guidance Centers, including the LA Center in 1924, were established with funding from the Commonwealth Fund of New York, a philanthropic foundation established in 1918 by Anna Harkness and her family.] And that was the first recognition that there are mental health issues with children. And then it grew and there came other child guidance centers. And it just grew after that. And then the Community Mental Health Centers [Construction] Act [of 1963], which was the next major piece of legislation in the Kennedy Administration in the early sixties – I think things really bloomed after that. But the first one was in the twenties. But anyway, Dick Van Horn or maybe even Betsy [Pfromm] would know [about] that. Are you going to be interviewing Betsy?

KM: I hope to, yes.

RM: Well (he laughs), you are in for a treat because, whereas I stumble to try and find the right words, she will be a fountain of information for you. I mean, you will really enjoy that interview.

KM: Well, speaking of that, what sort of relationship professionally do you maintain with other child guidance centers?

RM: Well, I think a strong relationship. Obviously Betsy is a close friend and colleague besides. And there are other agencies that may not be 100% children, but they have a large children's component and they are my colleagues and friends. We have a state trade association and local association, and I go to the meetings there and I go to the national meetings. And so we keep in touch with each other a lot.

KM: But otherwise, are the centers rather autonomous?

RM: Yeah. They are not connected with each other.

KM: Right.

RM: Originally, it was just a grant that started them. There was one in Dallas, and one in New York, and one in Detroit, and one in LA, but they were never really connected with each other at the time.

KM: How about advocacy groups? Are there groups that you work with?

RM: Oh, yeah. You know, different CEOs have different abilities and proclivities. And there are some that are more internal and focused on the management of their own organization and there are some that look toward the outside and forming coalitions in the advocacy realm. And I'm more of that [latter] kind, and, I mean, you have to manage your organization; but there are some who never go to the meetings and never go to or don't get involved in [advocacy]. I get very involved in that. I am fairly well known on the state level and somewhat on the national level. And on the state level, I was past president of the state association – the California Council of Community Mental Health Agencies – and I'm very much involved in that and have been for thirty years.

And then on the local level, we have the Association of Community Human Service Agencies that used to be Community Mental Health Agencies and then we merged with the Child Welfare people. I think Bruce Saltzer is probably somebody you [are] going to interview?

KM: OK.

RM: He's our CEO for that association. So I'm very active in public policy and trade associations and when there are issues that need to be pushed, I personally get involved and am known as a trouble maker (he laughs), that sort of thing.

KM: In the best sense.

RM: In the best sense of the word. Well, it depends. If I want something from somebody who doesn't want to give [it to] me, it's not the best, but it's never for personal gain. It is always for the children and our services. But, yeah, I think I'm respected in that sense.

KM: So groups like NAMI that you mentioned –

RM: Yeah. I don't work that closely with NAMI, because NAMI is mainly an adult group.

KM: I see.

RM: So the adult mental health providers would work closely with them. There are children's mental health advocacy groups, one called California Mental Health Advocates for Children and Youths (CMHACY). We work with them. [CMHACY, founded in 1980, is an advocacy, lobbying, and educational organization supporting mental health services for children, with a diverse membership including parents, providers, and community agency representatives.] NAMI is mainly on the adult side.

KM: I see.

[BRIEF BREAK]

KM: We were talking about the various relationships in your work professionally. Do you deal with many state organizations?

RM: Yeah, well, I was the past president many years ago and one of the founders of the California Council of Community Mental Health Agencies, which is headed by Rusty Selix. But I'm very involved with that state organization and we meet three times a year. We do public policy and have all sorts of public policy forums and try to effect changes in the state legislation as well. It was our group who promoted and started the Mental Health Services Act.

KM: Okay, so when you meet three times a year, what's often the result of those meetings or what is on the agenda?

RM: Well, as a matter of fact, I've got one here. It's divided into a couple of [days]. [shows hardcopy of meeting agenda]. On Thursday, there is a training session, maybe jointly with the State Mental Health Directors, like [this one] was on national health insurance and what was happening and everything. And then on Friday, we have a public policy forum where we go over things like the Governor's budget and different things that are happening, [as for example] AB3632, that's a law [passed in 2009 to provide mental health services for special education students], what's happening there. We're talking about cuts in programs and what not. So these are the kinds of things that we do.

KM: Any other state level organizations?

RM: This is the main one that I'm involved with and through this one, we're involved with others like the California Institute for Mental Health and the California Mental Health Directors Association.

KM: Are you satisfied with the level of interaction you have with state level groups?

RM: Well, whereas I'm satisfied personally with my level of interaction, you always want to do more. But we always feel [that], if the staff is not pushing hard in this direction versus that direction – it is those kinds of issues: what the emphasis should be on and different people have different opinions. And so there are issues there.

KM: Has there been any particular person or persons with mental illness that had an influence on you or your work?

RM: Mmm, not really. I deal in the children's area more and so it's not the parents; it's the child. There are a lot of inspirational stories. At our school, they do a play every year when the parents come, and they do a play or a musical or something and the parents [think that] "there is no way my kid can ever do something like this." And here he is the star of the *Lion King* and they are just blown away by that, that they didn't see this in their child, because of all the problems that they had. That kind of thing. And I know that's not exactly what you are talking about, but it's what makes it worth while.

One of the problems with my job here is that it is a large agency – about a twenty-two million dollar budget, 375 employees – and I don't get to see a lot. I don't get the daily interaction with the kids. But when I go to those things or when I hear a parent say at a testimonial, maybe at a fund raiser: "You know, my kid came here a mess with this problem and I've seen such an improvement in our lives, and it's so much better because of the services you provide." Or I go and I see the play or whatever and it really makes a difference.

KM: I notice in your newsletter, I think. was it *The Wizard of Oz* recently?

RM: *Wizard of Oz* yeah, I guess, right.

KM: Maybe it wasn't a recent one.

RM: Yes, they put on the *Wizard of Oz*.

KM: Well, apart from your parents, are there other figures you would say have been influential in terms of your mental health tenure?

RM: Yes, you mean like colleagues or mentors?

KM: Colleagues or mentors, anyone.

RM: Well, there was a mentor. I guess my greatest mentor was a guy named Harry Schnibbe who ran the National Association of State Mental Health Program Directors, where I worked from when I was like twenty-five to twenty-nine. And he was an ex-newspaper man so he had no real mental health experience, but he ran that Association for years and years before. And he taught me a lot about getting the message out and being clear and don't use jargon. It was that newspaper mentality: hit them with the salable points and be a strong advocate. And he had a great influence on me, I think, in doing that.

And I think I'm influenced a lot now by my colleagues. As I said, you are in for a treat when you interview Betsy. She is one of the most brilliant policy thinkers you'll hear. I think you will be somewhat awed by her. I don't want to build her up, but she is really very bright and really sees the big picture, and understands what the ultimate goal is, and so people like that inspire me.

And then also the skillful administrators like my colleague Ian Hunter who runs the San Fernando Valley Community Mental Health Center. I don't know if you are going to be interviewing him or not, but he's a psychologist, yet a very skilled administrator, and has grown that center. They used to be smaller than us and now they've surpassed us and they are a large multidimensional service from birth to old age, and he does a wonderful job. He's just a very brilliant administrator. And so people like that always inspire me both to have a skill on one hand and a real global knowledge base on the other.

KM: Sorry to jump around.

RM: Sure, that's all right.

KM: But since this is an oral history project, do you have any other memories or

recollections from your years in the '70s with the L.A. County Department of Mental Health?

RM: Oh, yeah. This is probably (laughing) probably the stuff that is better in the archives and not in the edited version. But it was very interesting. Actually, as I said, I did put it in print. Did you get a chance to read [my account] from the Fortieth [Anniversary LAC-DMH publication]?

KM: Yeah, I did read it.

RM: Yeah, well, I was at the Department. Believe me, when you are twenty-two years old, at that point it's a job. You are not thinking. I never knew I was going to end up here doing this at this level. So I was basically a budget gnome, [as] I said in [the book]. We worked. There [were] very few contract agencies at the time. We weren't a large Department. And I did all sorts of administrative and jack-of-all-trade things. It was basically more about being twenty-two and twenty-three than it was about some great vision you had of the future, especially if you work in a bureaucracy. It's basically keeping your head above water. I had a boss who would push all the work on us and he would go out in a sailboat or something. And so we had a lot of fun and work got done in spite of it, and it was a heady time. It was an interesting time for somebody my age.

As I said there, I met my wife there at the Department of Mental Health and we just celebrated our thirtieth wedding anniversary.

KM: Congratulations!

RM: So it was good. But my main job was to try and lay low and keep out of trouble, which I didn't always succeed at. And I learned a lot there though. I learned a lot about the finances and whatnot and what goes on and the politics of it. Because when the [LA County] Board of Supervisors called, you just dropped everything and did whatever they needed and whatever information they needed or anything. So you learned a lot about the political situation. As I said, one of my major jobs was keeping cars out of Harry Brickman's parking space. That's what you do when you're low man on the totem pole. You know how they say, "Stuff rolls downhill." They don't use the word "stuff." I was at the bottom of the hill.

KM: I see.

RM: But it was good. It was fun.

KM: You said you tried to stay out of trouble, but you didn't always succeed in staying out of trouble. What does it mean to get in trouble in the Department of Mental Health?

RM: Well, with civil service rules, unfortunately not a lot. But well, I would do things like – you didn't always feel like working and so I would carry around a sheaf of papers walking very purposely from one end of the building to the other; I was just going to someone's office to shoot the breeze, probably. And I had a very smart boss. This was my first woman boss, and I was a committed feminist before that, but it taught me that there was no difference in competency just because they were female. She was very competent and a very hard worker and knew bullshit when she saw it. And she called me into the office one day and it was my evaluation, and she saw I was "more heat than light" as they say. A lot of fluff and this and that, but how much did I actually produce?

And she said, “I got your number. I know what you are doing.” (he laughs) I mean, it sort of woke me up that I had to apply myself and work harder than I was. And so she sort of turned my head around there and so I guess that would be it.

KM: Let’s see. So what do you think has been the most important change or development in mental health services in LA during your professional tenure? Is there one that jumps out or perhaps a series of things?

RM: I think the change away from classic one-hour therapy in the office to a more multitude of service interventions where the client is more involved and service is not something you do *to* a client but *with* a client, with the use of better medications, has been a big issue, a big change. And so I think that’s a lot and now the push for evidence-based practices and making sure that what you do actually has a positive measurable effect: the whole philosophy that if you can’t measure it, you can’t manage it.

KM: Uh-huh, and you agree that this is evidence that can be measured?

RM: Well, that’s the sixty-four dollar question. Not always. I think the pendulum is swinging in a way, in [that] what we call evidence-based practices are really promising practices. It’s hard; with so many confounding variables, it is always going to be difficult to say, this was the black box that changed them. They went in and they came out and it was that [that made the change], because there could be other variables in their life that have both positive and negative effect. I think we’re getting better at that, but it’s always going to be difficult to sort out what’s the positive intervention. I think the main thing is – especially when clients rate themselves and say, “This is what I was feeling, this is what I was doing afterwards, this is what’s happening” – that I think that is going to be the main [outcome]. I think you can measure it, but I think it is going to be more client-centered measurement. Just like in physical health. The client knows if the rash is gone or if they are feeling less fatigued or whatever. And so I think it is possible and I think it’s going to be more of that. It is going to be client-centered, the measurement.

KM: It sounds like it’s more of an evolution over many years than a particular moment. And you mentioned the Mental Health Services Act (MHSA). And I’d actually like to ask you some more about that.

RM: OK.

KM: And you mentioned that you were involved with – was it the CCCMHA [California Council of Community Mental Health Agencies], which was part of –

RM: Which was actually the group that started the push. It was really an idea formulated by the executive director of the CCCMHA, Rusty Selix and he brought it to our board and he says, “I have this idea and here we have an opportunity.” We liked the idea. We were part of the community that helped develop it. We brought in other stakeholders.

KM: Is this in the late ‘90s?

RM: Yes, brought in other stakeholders, late ‘90s or early 2000s, I think actually, 2003. We brought in other stakeholders and everybody said, “Yeah, let’s make this

push.” And we put it on the ballot. It wasn’t the first time. We [had] tried a nickel-a-drink tax on alcohol [to fund mental health services] many years ago and that failed. The alcohol lobby [was too strong]. We realized there are [fewer] millionaires. Go for the millionaire lobby. Anyway, and we did do our research and [decided] it was something that people would respond to. And we worked very hard in creating [the ballot initiative, Proposition 63, which created MHSA] and I flew into many meetings up north where we were writing the sections of the Act. And we got it passed. And if we didn’t have that [the MHSA], we’d be in much worse shape than we are now, because we’re facing tremendous budget cuts, and being able to transform into the services of the Act. Our system would be devastated if we didn’t have that.

KM: Do you have any recollections of the kind of discussion that took place when the Act was taking shape, since you are one of the authors or architects?

RM: Yeah, well, let’s see. If I remember, there was a lot of discussion – I think one of the major philosophic discussions was about the purpose of the Act. Was it to fund services for everybody or was it to fund services for the indigent, who are not [eligible for] MediCal? Because you could use the money on the adult side, for every hundred dollars, if you used it in MediCal, it brings down a hundred dollars of federal [matching] money, so there is leveraging. And in the children’s side the leveraging is even greater because it is 5% local and 45% state and 45% federal.

So there is a big temptation to say, “Well, we could take a million dollars for the Mental Health Services Act and turn it into ten million dollars” – I don’t know, it’s actually a hundred million dollars of children’s services for MediCal. Well, but what about the kids that are not eligible for MediCal? In other words, do you serve more kids and more people who do have MediCal because it leverages? Or do you serve less people who are indigent or undocumented and are not qualified for MediCal? So that was always one of the conflicts.

The other was how much is devoted to children’s services versus adult services. How much for early intervention versus regular community services and regular mainstream treatment? So there were discussions along those lines but I don’t know exactly how, but we all came to an agreement on it.

KM: Then it passed in [November] 2004?

RM: Yeah, something like that.

KM: So you described it earlier as the “shining city on the hill.” [Ronald Reagan used this phrase in a speech in 1974, but he acknowledged the original source as the Puritan leader John Winthrop In 1630, referring to the new Massachusetts Bay Colony.]

RM: Yeah. I hate to use a Reagan term.

KM: “A thousand points of light”? [a quote from President Reagan’s successor, George H.W. Bush.]

RM: Yeah, there you go. Can’t you choose a Democrat? (he laughs) Anyway, I don’t think we have any phrases like that on our side of it. Anyway, go on.

IV. IMPACT OF MSHA; LOOKING BACK ON A CAREER; VISION FOR THE FUTURE

KM: Right. So I take it the way the bill passed in terms of the final language met your expectations?

RM: Yeah, it was a little complicated. I thought there were a lot of silos but I understood if you want – there's Facilities and Technical, there is Early Intervention, Community Services and Support [separate funding streams]. But in their wisdom, in like five years or within five years of the Act[s implementation], that all goes away and it just becomes a pot of money, which is better, I think.

KM: And was there an immediate impact on the services?

RM: Yeah, we applied for the money and we were able to, depending on the agency, some applied more aggressively and they got more. So we applied for some money and I think we got a couple of million dollars of the money. Some agencies got even more than that, so there was an immediate impact.

KM: And were there any steps that the Center had to take to meet the requirements?

RM: Yeah, a lot of the requirements of the Act that were called Full Service Partnerships and that's sort of like a wraparound type concept. So we sort of had to change our paradigm. I mean we were already [using that model], because we had wraparound money. But it's sort of that changing the paradigm to enveloping the client in services, whatever they need, so you had service teams who looked after their social service needs, whether it be a gym membership or this or that, besides their therapeutic issues. And then also later, we have Field Capable Services where you provide more services out in the field.

So I think in children's mental health, to go back to our other question, that is another big change. More of our services are being provided in the home, in the community, at schools, we meet the client out in their community. I think that's happening more and I think this Act helped promote that.

KM: So that was sort of a harmonious development in terms of what the Center would be doing and moving towards?

RM: Right, exactly.

KM: Do you think that was true for other child guidance centers or other similar mental health centers?

RM: Well, they needed to do it and it's part of the new culture of the way you provide services. You are not an institution. You are out in the community. How reluctant they were – I think most centers embraced it. It is hard for some people to change so they wanted to do things the old way. But I think most centers embraced it. And there was another point I wanted to make. Anyway, I think that it was serendipitous that it all came at the same time.

KM: And were there any drawbacks to the bill or the way that it was implemented?

RM: Well, yeah. Because of the fact that you had to – The main drawbacks are [in]

the way it's implemented. On the County level, there were a lot of programs that had slots for kids, especially more severe [cases], and you didn't control who was in the slots. There was a gatekeeper and some sort of a County system and so you could have capacity [to serve more children] and people weren't giving you kids because of no fault of your own and the kids needed the treatment. So there were bottlenecks. Sometimes bottlenecks were created and they are working on it, but they still exist today, some of the problems.

KM: So what do you think the impact has been on the clients themselves, just from the Mental Health Services Act?

RM: Well, I think it's hard to say. You'd have to talk to some of our clinicians. But I assume these clients – it depends on whether it was a client that used to be treated another way and we moved them over to Mental Health Services Act [programs] or somebody new who wouldn't know any difference. We haven't done a study. But I would imagine the clients appreciate the fact that the services are more custom [designed], are more fit to what they feel like *they* need, hopefully, rather than something that *we* feel that they need. Where they are part of the treatment planning.

Now, some clients – Something I was talking about is it is not always that good that you go out to the homes because some of the clients don't want you at their home. I don't think I'd want some therapist in my home all the time, doing stuff. So it's not always automatically beneficial that you need to be out in the home. And I think that's where the balance comes in. Clients like boundaries as well and so that's always a challenge.

KM: How about staff at the Center? Did you get a sense as to whether the Act had an impact on them?

RM: Yeah, I think so. Because the older staff who are used to more office-based [treatment] come to me [wanting to say]: "I'm the professional and you are the client." I think they had a tougher time with it. The newer staff who don't have that paradigm yet and are taught maybe that this is part of the deal, they are used to it and are more used to going out to the field.

KM: I see. And my understanding is that another one of the goals of the MHSA was to improve the public opinion or public perception of mental illness.

RM: Yeah.

KM: Again that's a kind of thing that might be hard to measure. Do you think it's had an impact?

RM: Well, I think it depends, because before the Mental Health Services Act, the baseline funding was called Realignment money [that is, realignment of state funds to local programs, a program begun in the early 1990s], and that's dried up with the economy, because it's based on sales tax revenue and car purchases and stuff. So it used to be that this was going to be building on a base. Now the base is shrinking, so this is going and so [in] the adult system, I think frankly right now we've kind of gone backwards because the base funding is not there.

The original idea and the way it would [work] – How do people's most public perceptions [of mental illness take form]? Well, the homeless guy on the street with the

cart. And this was really, especially on the adult side, focused a lot towards that, towards those interventions and a lot of monies went to those programs that would get the homeless off the street into programs and that was supposed to help.

But I think with the funding and the problems they are having with the funding right now, that's a challenge. Maybe going in the other direction. But hopefully that's a temporary thing, and when the economy turns around, things will change.

KM: So what is the status of that money right now?

RM: Well, the Mental Health Services Act right now – they built a prudent reserve because they knew it's a fluctuating income source, because it's based on people. When millionaires have that kind of income, it's based on investments. They don't earn three million dollars in salary unless you are a baseball player, I guess. But they earn it on investments and investments have gone down. So we know in the future, in the next two years, the money is going to go down, but hopefully a lot of the prudent reserve will smooth that out and then it will pick up again. So we know that's going to be reduced too, as well as in the future.

KM: Are you still optimistic about the overall impact of the act?

RM: Oh, yeah. I think if you look in the long term, it will help change the way mental health services are provided. The problem is in the [State] Legislature, because they are always looking to fund other things. They are looking at it as a pot of money they can raid for their [other] issues, so we always have to be very vigilant on that.

KM: I see.

RM: It's the same thing with the Prop 10 people [and] the cigarette tax. [Proposition 10, passed in 1998, imposed a state tobacco tax, with the proceeds earmarked for early childhood education.] Right now they are looking at ways of taking some of that money and using it for something else. And of course the Prop 10 people are not happy with that. So we always have to be vigilant. Fortunately they would need a vote or an initiative to do so.

KM: I see. And you mentioned, when you were talking about the formation of the MHSA, how you worked with the stakeholders. Are you still involved with the stakeholder process?

RM: [For the implementation of the] Mental Health Services Act?

KM: Yeah.

RM: When we can, we are. It's a pretty involved process. When there are meetings, we try and go. The trouble is it is such a wide ranging process that it depends on who shows up at the meeting that day. I just think the process needs to be a little more organized where you have a set committees looking at things and it's not so dependent on which community person shows up to the meeting on the certain day. So that's the trouble. There are lots of meetings in the stakeholder process and we're busy running our agencies. So it's hard to do it. People in the County [agencies], there are some of them paid just to go to those meetings and coordinate things and everything. But in the contract world, we're not. And so it's sort of an uneven playing field in that sense.

KM: I see. OK, is there anything more you wanted to say about the Mental Health Services Act in particular?

RM: No, I just think [that] the mental health services in general is going through a rough time now with the funding. Without the Mental Health Services Act, it would have been a lot rougher. So at least we had that.

KM: Something to help keep you afloat?

RM: Yes, exactly.

KM: Well, we've reached the part of the interview where we can get to what we call assessment questions or evaluation questions, which are a bit philosophical, like: "if you could have done something different..."

RM: OK.

KM: Looking back over your tenure in the mental health field so far, what would you say have been your most important achievements?

[BRIEF BREAK]

RM: OK, the question was, what do I think are my greatest accomplishments?

KM: Yes.

RM: Well, it depends, because I've done a lot of things in a lot of different agencies. Well, I guess on an ongoing basis, my ability to advocate, because when there is an issue coming up, I join with my colleagues and I'm somewhat of a leader in policy change advocacy [or] advocacy – I just made up a word. And I think that's one of my better accomplishments and it happens a lot. It is not one particular thing.

There was, for example, a particular EPSDT audit that [the State was] doing, a system that they used that punished people needlessly. I worked with my colleagues and we got that overturned to a more reasonable system, and if we hadn't done our work, it would have never happened on its own. So I feel pretty proud about that. That doesn't sound very dynamic, overturning an audit [methodology].

But the other thing, I think, in terms of building up services, is when this certain kind of MediCal came into being called EPSDT, Early and Periodic Screening, Diagnosis and Treatment. But EPSDT was a kind of MediCal [program] where the County at that time didn't have to put in any match. It was all state and federal money and there was a consent decree by the attorneys. There was a lawsuit saying you can do as much of that as you can do, we don't have to pay you for it. And so I really made a concerted effort to build up this agency and double the budget of this agency and served more clients because of that program. Because I did it, I feel pretty good about that.

The other agencies that I worked at, I kind of left a lasting mark. They were kind of in chaos when I came to them. This agency wasn't. This was a well-run agency and my predecessor did a super job. I just had to make sure I didn't screw things up. But in the other agencies that I've run, there was a lot of chaos, staff turnover, turmoil, and uneven systems of compensation and stuff. But I kind of went in there and righted the ship so I felt pretty good about that, I guess. They still remember me fondly at those

other agencies. So I guess I must have done a good job, those that are still there. After twenty years, not a lot of people are still there.

So I've had a lot of accomplishments over the years. But I think mainly the advocacy with my colleagues to get things changed that weren't right or to add things that needed to be there. So it's those kinds of things.

KM: I know I've put you in an uncomfortable spot. I know it's not a natural thing to speak of one's accomplishments.

RM: Yeah. I'm sure there are others. I can't remember them all.

KM: Were there any areas where you felt that things could have gone better or that you failed to achieve a goal?

RM: Yeah, I think about those more often probably. I guess there is internal management where you see you are going in the wrong direction or whatever. You are not moving things fast enough to correct things or you misjudge the adverse affect of something; and you kind of miss the boat so it has more of a negative financial impact than you thought it was going to be, because you thought you had done enough to correct [the problem] and you hadn't. Things like that, I would say, mainly or maybe getting too worked up and emotional over an issue where you burned a bridge that maybe you should not have burned, but you usually can rectify that later.

By and large, it's those kinds of things, I would say. If I had transformed my agency to a greater degree to [conform with] Mental Health Services Act programs a couple years ago, I think we would have been hit less hard with this downturn, because it's our more mainstream programs that are being hit. But there are always regrets on those kinds of things.

KM: And thinking about all that, what is, broadly speaking, your vision for mental health in California? What would you like most to happen or if you could have it any way that you chose, what would you do?

RM: As they say now, what I'd like to see is "No wrong door." In other words, if a child – I can speak for children's mental health right now because that's the field I'm in – if a parent, or a caregiver, if he or she's in the foster system, is having a problem with a child, they should be able to go in to get service and not be told to "go to this place." (points off to one side) "Oh no, we can't see you because you have this," [where things are so compartmentalized. [They should hear] that "Yes, we can help you, and if we can't help you, we'll take care of arranging that and we will follow through and make sure [the child gets the help needed]." So there is really no wrong door anybody can walk into. And that there is a comprehensive array of services, when people are hurting and they don't know what to do and they are at wit's end with their child. Or the foster care mother doesn't know how to get help for the children or there is a whole runaround there, where people can't get the services. They [should] have access to the services they need without having to navigate the system themselves. I guess that would be my vision of the future.

KM: What would it take to implement something like that?

RM: First of all, it takes more funding than we have now. It takes cooperation among all the different systems to see that as the goal and to create a system that fosters that

goal. I think – and I think everybody does – if you talk to anybody, nobody is going to say they don't want that. But they always see it as somebody else's fault, that it's not happening. And we need to say [that] if we all got together and stopped blaming each other and just figured out how we are going to get this done, it would get done. And it has in certain areas. There are model programs where that does get done. So it is possible.

KM: It seems as though the paradigm for mental health services in California epitomized by the Mental Health Services Act is relatively new still. Would you say [that it's been in place for] at least a decade or so?

RM: What [exactly] do you mean? Say this—

KM: I think the expression is “help first versus fail first.” And all the programs you were describing, or the Full Service Partnerships.

RM: Yeah.

KM: With that in mind, do you see any direction that things may go in the relatively near future?

RM: Yeah, I think more, in a sense, Prevention and Early Intervention would say help first instead of fail first. Because by the time we see a client, they've failed many systems or they haven't had treatment by their local therapist or the school system or whatever. And I think if we get help on the line earlier, we can prevent smaller problems from becoming bigger problems. And yeah, I think that's the direction in the future.

KM: Okay, well, thus far we've covered a lot of ground. Are there any questions I haven't asked that you would [like to talk about]?

RM: Yeah, you want something to spice it up (laughing).

KM: Juice it up a little bit.

RM: Juice it up (he laughs). No, no, no, no, no.

KM: Is there anything that we didn't cover that you want to talk about?

RM: Oh, I don't know. Let me think about that. I can't think of anything right now.

KM: I mean, what would you want, for example, for a historian fifty years from now to know about what was happening with mental health services in Los Angeles County during this period?

RM: Oh, I don't know. There are so many other things to write history about. I'd be more concerned about what was going on fifty years from now and make sure we were providing services and not repeating the same thing. That is interesting, because I was reading some of the stuff from ten years ago and still some of the same issues and problems [exist]. What I would like to see is just a more enlightened future where people realize that it is a moral issue and we need to take care of our brothers and sisters in society. We are our brothers' keepers, brothers' and sisters' keepers. And that issues

of mental illness and emotional problems affect us all. Even if we are not personally affected, it affects the quality of life we live and the people around us. It's just the right thing.

It disturbs me that it is not more of a moral issue on this whole health insurance thing. It is immoral to have thirty-five million people without health insurance. And I think it is immoral not to be treating people with mental illness and providing them the services they need and people with emotional problems. And I hope that they would look back fifty years from now and hopefully they would be astonished, pleased by some of our progress, but astonished that we haven't solved it yet and that they are committed to solving it. What we haven't solved. So that's my hope.

I don't want to use [this oral history] just to glorify us so we can glorify our own history. But the purpose of history is to use it to make it a better world. To understand it so you don't repeat the same mistakes, and make it a better world.

KM: Exactly. Since you mentioned it, and I'm a bit ignorant on this, but in terms of all of the proposed federal legislation around health care reform, assuming that anything actually happens, is it relevant to or does it impact mental health services?

RM: I'm not sure. It depends. I don't think it will have as much [impact] as we think because what we do in technical terms [of] specialty mental health services, in other words, [is] carved out from general mental health. Unfortunately mental health services in a general health insurance program are usually pretty paltry. And even when they have equity when they talk about parity – parity with what? The lousy benefits you are now getting in physical health? So I don't see this parity issue as being our savior. I think the first thing we ought to do is decide what is adequate mental health treatment and go for that. Because you could have parity with the same inadequate health treatment that you have [in physical health]. I don't want to have parity with an inadequate system. Do you understand what I'm saying? I want it – it will be interesting to see what kind of funding it will be, because good mental health care is not cheap if you are going to provide the wide array of services that people need. And whether health care reform will step up to the plate on that or not, I'm not sure.

So, I'm not as sure as others that health care reform is really the answer for mental health treatment, because insurance reimbursements for mental health services are very low. We have very little insurance money here. They just don't pay that much. And of course our clients that are insured [are few]. We have a lower socioeconomic [demographic]. The only insurance they have is MediCal. Anyway, so it remains to be seen. The jury is out as far as I am concerned, on what health care reform will do for mental health.

KM: Well, maybe we can end on this somewhat personal note. I think it is so interesting how you came full circle back to the Child and Family Guidance Center.

RM: Yeah, the agency that my parents helped create.

KM: So, when the recruitment for you first started and you first came back, what were you feeling and what was happening?

RM: That's a very good question. I did. I said I'm not a spiritual person, but I felt a connection. I figured if I was going to be religious, the religion that would make the most sense would be ancestor worship. I mean that connection with your past and it did. It felt really good. It felt good to walk into the library of the building over there and seeing

my dad's picture and knowing that we had donated a lot of his books there. My mom gets less credit and deserves more credit than my dad, because she wasn't the professional, but she really did the work to help form this agency with her friends. I mean they didn't do it alone. I hear a lot of people say, "Oh, your parents started that agency?" Well, no, it didn't work that way. There was a group of them. They were the leaders, but there was a group of them. But it just feels good. How many people can say that, unless they are running a family business, that they are working at an agency that their parents helped create? When I first came, it was just a really good feeling. I don't think about it as much now, because it's been so long. But I thought about it a lot then and I still once in a while think about it [and] how good that feels.

KM: I would imagine so.

RM: But the other thing is it is also a lot of responsibility, when I'm thinking about [how] any one of these agencies is one County check away from demise. We don't have a lot of reserves and things like that and so it's a heavy responsibility. So I think about that too. Geez, I don't want to be – and everybody in my family knows the history and everything. So it's a lot of responsibility to make sure the agency survives and thrives.

KM: And you must be several years away from passing the torch on?

RM: Yeah, well, I'm turning sixty in three days, whatever Thursday is. Is that three days from now? Yeah. And I would have liked it to have been sooner in passing the torch but my 401k is now 201k. So somebody your age, you don't have to worry about it. By the time you retire, it will all be over with. But it hit me at the wrong time, so I am here for several more years until I can afford to retire. But I also enjoy running the agency.

KM: And I suppose there will be some kind of process to find your replacement?

RM: Yes, there would be some kind of [process]. Yeah, I'm thinking about that right now. That there would be, I'm sure, at that time.

KM: Yeah. OK, well, I think we can probably end it there unless there is something else you want to say?

RM: No, I think that's it. If I think of anything else that's important to say can I give you a call?

KM: Of course.

RM: OK.

KM: Sure, we can add it as an addendum.

RM: As an addendum.

KM: To the typed transcript.

RM: Yeah, right now, I can't at this point. Yeah, my aunt was involved in one of these. She was a union official and they did an oral history at UCLA about the union.

KM: I see.

RM: So, anyway, very good.

KM: Let me get this.

END OF INTERVIEW