

Areta Crowell talks about her early days as Director of LAC-DMH...

And I had an absolute rule. I met with the health deputies every week so that they were never surprised. If they were surprised, I was surprised by anything that happened, but anything that we were talking about doing, we would explain, we would tell them. But, anyway, that was good. But I brought early on to a gathering of community folks, the leaders of AMI [Alliance on Mental Illness] and MHA and some of the key organizations and I said, "This is my idea for what we can do. Will you support me in it?" And I was afraid that the AMI people might not, but they did. Because they understood the purpose, and they understood the value long run, and I could explain to them what we did in San Diego. We managed with so many fewer hospital beds, and we had a good network going in the community and we were making it better there, and we could make it better here.

So that was the chief transforming thing that I could do was to use it as a signal to everybody about two things: One, the importance of real rehabilitation, and recovery [she coughs] again – although we didn't use the recovery word yet – and the importance of continuous responsibility and accountability. We talked about it, but nobody had put in place a structure that made you accountable from one episode to the next; and we'd talked about it over the years. Well, the hospital lets somebody go, they say they are fine; and this person picks them up and says they've deteriorated and says it's the hospital's fault. Well, whatever. You've got to put accountability in a single place and that was the crystallization of the concept of the Integrated Service Agency. But I think it was much more developed, as we rolled that out and we put it with the capitation so that they had the dollars, but they also had the dollar responsibility too, and trying to make the integration of the pieces of the system. Okay, they had to get to the hospital; they had to see the person in the hospital; they had to be allowed and they had to work for that discharge plan the minute the person got in there. So all of that –

I also did quite a lot of community conferences and education around rehabilitation concepts. And in the first one that I did, I talked about my ideas of what could be. The alcohol and drug abuse community came to me and said, "We've talked rehabilitation and recovery and social models but we've never heard it expressed like you just did. How would you like to take on the alcohol and drug programs again?" I said, "I don't want to be at the head of that parade. If you want to do it, you can go and work and lobby and I'll be happy to take it on." But [she laughs] that was an interesting development. I mean, the ones who had lobbied to be apart, now realized that they would get better leadership if they came back to mental health, and I think a lot of them still think so; but anyway, that continues to be debated at the state level and every other level where it happens and it hasn't always worked well when it is together. As I said to them, "Look, there would be an awful lot that's needed before it would make any difference anyway, so let's start on those tracks," and we did. We started on joint planning and talking about getting [pause] a single point of entry and being able to collaborate between the agencies at the regional level.

READ THE FULL TRANSCRIPT BELOW.

ARETA CROWELL

Interview conducted on: Thursday, May 28, 2009

Interviewee: Areta Crowell

Interviewer: Marcia Meldrum

Location: Areta Crowell's home in Hollywood

I. Childhood and Family; Education; Research at LAC-DMH; Catchment Areas; the Merger Years; Housing and Deinstitutionalization

MM: I'd just like to start out by asking you to tell me a little bit about your early life. Where you grew up, what your parents did, and you know, sort of the story of how your early life and education led you in the direction of mental health. I suspect it's an interesting story.

AC: I am a child of the Depression and my father was a minister, who met my mother when he was a student minister fresh out of seminary, on the mission field of Alberta, Canada. The population of Canada is very sparse and people spread out along a long narrow border with the United States. There weren't enough clergy to go around, so the major mainline denominations created a United Church and he was one of the first United Church ministers in that area. They had to wait a long time to get married because of the Depression, but finally did, and then I came along. I was born in Alberta and my dad volunteered as a chaplain in World War II, so I then lived with my mother and kid sister with my grandparents in Alberta, and with my grandparents in Nova Scotia for a little while.

After the war, dad wanted to settle in a place where his girls could get an education and he wasn't very confident in the Alberta educational system, although it's fine now, and it probably would have been by the time I got there. But he had a lot of reservations, so we ended up in the province of Quebec, outside of Montreal, and then in Montreal. I attended McGill. I wanted to be a doctor; so I took psychology as a major interest of mine, psychology and chemistry, so I actually have a bachelor of science degree; and my husband, for various long stories which I won't go into with you, he ended up with a bachelor of arts, although he is a physicist [she laughs]. We both got our doctorates at McGill. About the time I was working on my dissertation, he accepted a job at Bell Telephone Labs in New Jersey. And I finished up my dissertation and started working as an assistant professor at a small, private college in New Jersey, Fairleigh Dickinson. I was at the Madison campus. My goal was to teach and do research.

MM: But you decided against being a doctor at that point.

AC: Yes, I did because I got married [she laughs]; and in those days it [medical school] was a long hard slog for women. I respect the women who did that in the 30s in particular, even more. My doctorate was largely in social and organizational psychology, it was not clinical. I was very influenced by Donald Hebb, who is the foundational theorist –

MM: *The Organization of Behavior* [Hebb's groundbreaking book on neuropsychological theory, published in 1949].

AC: Well, yes, of neuropsychology. And my daughter-in-law is a neuropsychologist at UCLA and it's fun to see how it has gone from his first book on how the brain worked, which was so highly speculative and theoretical, but interesting. I was very influenced by that McGill Department of Psychology, very research oriented. I started teaching in New Jersey, looking for research opportunities, but not getting very excited about anything and realizing that to make a mark on any of my track of research was going to take a lot of outside fundraising, and a lot of time before I would see any results. So after we decided on our next move to California in 1966, I determined that I did not want to go back to teaching. I wanted to do something that would be more practical and useful.

The other part of my early life that influenced, I think, what I was doing is out of my church background. I would say I'm a very dedicated Christian. I also, from that, wanted to do something that was useful. I used to say that I learned more about what I needed for my job as a Mental Health Director in the church than I ever did from my psychology training [she laughs]. I led a lot of organizational work in the church. I presided over a large group of young people, many of them much older than I, as president of the Montreal Presbytery Young People's Group, and had to get along with a lot of different ideas and *that* was my best training ground.

Anyway, when I came to Los Angeles, looking then for something more practical, I was on the verge of taking a job at the Health Training Center where they had a research position and they were interested in doing research on the effect of continuing education, essentially, on health service delivery. And then an opening came in the Department of Mental Health with a man who had been my colleague in New Jersey. We taught together at Fairleigh Dickinson; we met teaching at Fairleigh Dickinson. We did a lot of course preparation together and I admired and respected him enormously. He was quite a bit older than I am and he had a lot of background in social science research, in [the] epidemiology type of research, and planning, urban planning and rehabilitation. I knew that I would learn a lot from him. And he had become the research director at the Department of Mental Health here through an NIMH grant, which you have read enough of that background to see that.

MM: Yes, that was George Moed.

AC: George Moed, right. Well, George and I, as I had said, worked back there. It was not George who got the grant here. It was Don Schwartz, who was the deputy director [of Mental Health] and supported by the chief psychologist for the state of California, Herb Dorkin, whom I had actually met while I was still at McGill. He did a summer seminar and I was the student assistant on that seminar the year I was married [she laughs].

MM: So many connections.

AC: Yes, that's the world, I think. Anyway, George had an assistant in the department who quit just before I was taking this other job, which incidentally he

had also made the connections for me. He gave me a few places where I might look and that was one. Well, I jumped at the chance to work with George instead of going to the Health Training Center, although I ended up at the Health Training Center a few years later. So yeah, I went into the research division at the Department of Mental Health. Again, looking to see that this would be something useful, and the Department was so clearly on a track to provide more humane services close to home in the community. All the kinds of values that any kind of liberal human scientist, I guess, would value. I think that was a lot of it. It all sounded very good.

I think I've written in the [DMH 40th anniversary] book that my first assignment, or one of my first assignments, was to try to get the point of origin in the county of all the people who were in the state hospital at that time, as part of our planning documentation. The other thing that you may have picked up was that George was also the key mover and shaker in getting the first census tract street index for Los Angeles County, a very important social science tool, working with other County departments. He was good at that and getting a whole group of County planners together. They met regularly there with the planning staff, and just shared what we were doing, so we all knew one another, which was really good.

It was quite a challenge, because a lot of those people had been in the state hospital for so long that nobody had any idea – They had an old index card file [she laughs], it was all that they had on the 5,000 people in the hospital. We worked hard to track down and phone and so on. We never did get a complete census, but enough to see where the concentrations were, and where they had come [from] and the point of that was planning for the geographic office locations. And George also was very active in encouraging us to use the Health Department boundaries, again with the idea of being able to collaborate. All these wonderful old ideas.

MM: Yeah, they keep coming around, don't they?

AC: They don't happen; we keep trying and they don't happen, so we bring them back again. So that was the early steps. I really got into it not as a mental health professional, but as somebody looking for the good in people and planning towards that. So that's kind of my early background.

MM: Now, you had done your degree in psychology. Can you tell us though a little bit about, you know, I know at that time mental health was in kind of a state of change, with the introduction of the psychoactive drugs, but can you tell me sort of how you were thinking? Had you thought about mental illness as a problem? Had you had previous experiences with it? Was it something that you thought about, that you were looking at it as a planner and an epidemiologist, or – ?

AC: I came to it more as a planner and epidemiologist, when I came to the Department here. If you are looking to see if I had the usual personal connection with mental illness beforehand, no, I did not. I had one friend in my high school days who ended up institutionalized; and my dad occasionally had pastoral visits to people in the hospitals, but it was pretty isolated and discrete. My closest contact would have been the Psychology Department. Psychologists were occasionally called on by psychiatrists at the Allan [Memorial] Institute, which

was the private psychiatric hospital affiliated with McGill, to help with statistical analyses, and so on; and candidly the psychologists would generate pretty uncomplimentary, [reports] about the research that was being done, and the knowledge of these psychiatrists; but they would make some extra bucks and help try to make it a printable paper. Not anything too particularly predictive for me.

I was aware of some of the research that they were doing and where that work was, but I guess more, I would be influenced by the questions about was mental illness caused by poverty, or did it cause poverty? All of *that* research which was going on at that time, and what I knew from what happened in World War II and the findings of people being fit for service or not fit for service, all of that part of epidemiology, I think, was of great interest to me.

I didn't become personally involved until, well, I – early on, another one of my early jobs in the department was I created and organized an inner-agency planning group for the Department, and that brought people from the other County Departments who were affected, but there were no consumers and there were no family members there. There was the Mental Health Association, which was *the* only advocacy group at the time, other than providers or other departments that had to deal with the consumers on their ground, and out of all that I started to get a lot more of the human side of the story and become far more involved in it that way. And then another track of that was that the legislation that created the Lanterman-Petris-Short Act [LPS] was being debated and discussed, just as I came into the Department.

So I'm kind of an outside observer, watching this debate go on between the advocates for the more humane, less institutionalized treatment, which I certainly responded to very positively, and the concerns which the psychiatrists in the Department were expressing about well, this wasn't going to work, it was so complicated, and these people needed long term care and they weren't capable of living in the community very much, not these guys! When they talked about Community Mental Health, they didn't mean the people who had been in the state hospital. That was pretty clear, not that they ever said it so bluntly but it came out that way.

So I was very interested in all of that and then as I started to – out of the whole movement with consumers getting active in the 70's, that's when I really became a convert, I guess. Up until then it was still very much: these are needy people, these are the things we know work, this is what we need to do for them, how do we get the resources? How do we organize the resources? How do we train the people who need to be trained to do what we're talking about? I mean, Harry Brickman, the Director I worked for so long, had in mind that, if you were trained as a mental health professional, then you can go out and help in the schools, identify the kids that needed help, and you could do all these things without any extra training. It was kind of – Nobody realized how much extra knowledge was needed to do these things effectively, largely because you had a few charismatic people who could go and do, and they did; and so they thought, "Well, everybody should be able to do that." I mean, I think that's what Harry thought. I have some stories in that book about how little people paid attention to what the real research was and what was going on.

- When I went to San Diego, one of the lead psychologists was very disturbed that I was just a numbers cruncher, I wasn't a clinician, and what was I doing there [she laughs]? And, fair enough critique, it was legitimate, but I think that that background gave me the bigger picture, rather than being absorbed in the individual clinical picture, to look at the system and the whole organization in ways that didn't come with normal clinical training.
- MM: Sure, sure, a broader perspective.
- AC: Yeah, I think that was a good track that I had, I was lucky for that.
- MM: Okay, so in your work with Dr. Moed and doing the planning and the epidemiology, you were aware of what was going on in the Department and talking about planning for the –
- AC: Oh, we *were* part of the planners.
- MM: You were part of the planning. What did you find – I mean, were there sort of highlights of that period that you remember as being particularly rewarding?
- AC: Well, I could remember some highlights, but I won't say they were particularly rewarding [she laughs]!
- MM: Well, that was my next question, so?
- AC: Well, I do remember a lot of the political discussion between the psychiatrists and the advocacy community, which led to that LPS passage. One of the key advocates at that time was a woman named Lila Berman, who was active on the state boards and local boards and had a lot of very strong political and legislative connections, so that, when she took it in her mind, she was a good lobbyist to get something to happen. And the psychiatrists and the physicians who controlled the organization of county service delivery, which was the Local Mental Health Directors' Association – at that time it was completely a physician dominated organization. By state law, only physicians could be Mental Health Directors. It didn't matter whether they had psychiatric training, they had to be a physician, and in fact quite often, that was the case. The San Diego County Director for many, many years – let's see, I went there in 1988 and there was a non-psychiatrist director before me for about 4 or 5 years; so up until the early 80s, one man had been the Director there and he was a physician, not a psychiatrist; and on top of that, he had very strong feelings about not spending government money.
- MM: [she laughs] Interesting way of approaching the problem.
- AC: [she laughs] Yeah, he made a whole lot of wrong decisions about organization and funding and structure that didn't bring money into the County; that was another whole set of problems that I had to deal with when I went there. But anyway, in the 60s, we called them the "M.Deities" and they became very opposed to the whole LPS legislation; and I can remember Harry telling me about a meeting of the Executive [Committee of the Conference of] Local Mental Health Directors up in the Bay Area where they were all plotting how they were going to

stop it from happening; obviously it didn't happen [they didn't stop the legislation]. They were mighty distressed.

Some of their concerns, I think, were legitimate and they had to do with the process; for instance, the responsibility changed on July 1, from State to County, in terms of admission and screening. There was no funding for preparation and development or anything like that. Just an immediate cutover, there was very little time, and there was no recognition – something I can remember Don Schwartz talking about a lot – the state hospital served so many functions for these individuals, and there was no provision then for how they were going to live if they got into the community. All of these were totally accurate and good concerns, but instead of listening and getting into a negotiation with state legislators who were on this other track of “this is a terrible thing, these people get put away for life with no rights,” and “these short hearings and it's a civil rights issue.”

People didn't have the political skills. Mental health doesn't teach you the political skills. Hardly anybody in the field is ever good at it, so it was a lost opportunity to make the change happen better. On the other hand, there it was and there was a lot to be said for it; and do you know, it was predicated on work that was done at USC Medical Center?

MM: Yes.

AC: With the idea that by doing screening, and working with people, you could divert them from the state hospitals, and everybody wanted to do that. Everybody thought, yeah, that's a fine thing; it was just how it was going to be done? So, yeah, I'm very aware of the politics then and the back and forth, and as I said, I was so junior in the organization, I was just kind of an observer; and then I was put in charge of the planning to make it happen. And what the first things we were going to do were going to be. So it speeded up the establishment of county-operated outpatient clinics, [the first mobile emergency mental health teams which were intended to set up community-based service plans for individuals in crisis, instead of admitting them to the state hospitals,] and the establishment of more contracts with mental health provider agencies that had already been started. There was a lot of interaction with the NIMH around what CMHCs they were going to fund, or not fund, and what applications they approved.

[There were requirements to establish and use for planning and NIMH funding of catchment areas. The catchment areas were small. We did document in the history book the appeal around that catchment area concept. Harry was absolutely right and I was absolutely with him. I helped provide all the documentation for this. If every catchment area had a CMHC, then there would have been 52 Community Mental Health Centers; and today we might be able to consider that. But back then, it was such an enormous expansion of where we were, that it did not begin to make sense, and so, when we tried to consolidate catchment areas into the Health Districts, which we had agreed on as our planning basis, they refused. I knew the woman who did that, by that time I was getting to know her or after that, I guess, I got to know her, and she was a typical

bureaucrat. She didn't feel that she had the power to change the boundaries, or do anything.

Anyway, Harry was a powerful man who made enemies, left, right and center. He had been a great advocate to get the Community Mental Health system going in California and again we've documented some of that in the book. He and some of the citizen advocates, Sylvia Marshall, Lila Berman, some others -- Frances Feldman's stories tell some of that early [story], how she and her husband helped testify on those grounds and the conspiracy theories that existed that were trying to oppose the creation of the Department. So Harry was very good at that.

But the first of his fights was the catchment area fight and whether or not to support the applications of people coming in for Community Mental Health Centers. He was at the time of a firm belief that the County should be in charge, and it certainly was the state law, and that was what was intended, to put the County in charge of the whole system, and he was trying very much -- I know we all talked [about] the whole system, how the parts are going to work together and how are these parts going to work. It was okay, but every now and then these animosities would surface and the Centers wanted us to go with the catchment areas and let -- well, there was a network of catchment areas close together, and we got several Community Mental Health Centers close together, and then the rest of the County didn't get anything.

MM: So sort of scattershot.

AC: In fact, several years later, as an effort to address the inequity issue -- I had been away on a sabbatical -- when my husband had a sabbatical out of the country and the Department gave me a leave of absence to go along, which was a wonderful family time. But what it did was heighten my awareness, when I came back, of problems and difficulties and what could I do that would make a difference; and decided that one thing I could do was go for a Community Mental Health Center application for a community in the San Gabriel Valley, which was so under resourced at the time.

MM: And that was La Puente?

AC: You have done your homework. I'm impressed [she laughs]. So we got that one in, and that was one of my prides. I could feel good about making some movement there. I knew by that time the Feds didn't care whether you followed the catchment area or not, you just had to say that you were going to.

So we lied; no, we didn't really lie, but we knew what we were going to have to do. It was going to have to serve a bigger area, so we worked with what they said [we had to do, so that we could get the added funds for that area]. So anyway, back to the 60s -- the catchment areas were one problem, and then he [Brickman] got into a big dispute over alcohol and drug treatment. Following the model of the County plan for mental health, the next thing that [State Assemblyman Frank] Lanterman did was put in services for the developmentally disabled, but there he put it in as a right and mental health was never a right.

[Planning for the DD Centers was placed into the Counties and DMH; and in LA, that planning was part of the unit I headed at that time.]

Then they [the legislature] moved on to drug and alcohol plans, following the County plan idea, and it's a good idea, get it organized and going on a County basis. And they put it under the County [Department of] Mental Health to start with, and Harry did not appreciate the AA or social rehabilitation model of the alcohol field. And out of that, two very prominent community leaders, one of whom was an alcoholic, a recovering alcoholic I guess, and it was widely known, whether he said it so or not. But that was Mr. Pike and Mrs. Katherine Pike and I forget her husband's name, but they were close to Reagan and they objected to Harry's medical model and everything about putting it under Mental Health and they wanted alcohol services to be independent. And they pushed for that and succeeded – state, local and national – so that those plans were moved out from the Mental Health Department to the Health Department.

Okay, then the next set of issues, big issues, had to do with merging the health entities in Los Angeles County and it was part of a national trend; it also happened at the State [level]. Everybody thought this was a great idea. Integration.

MM: Economies of scale.

AC: Well, at that time it wasn't economies of scale that was talked about so much, as it was, it's all health, and they should be working together and therefore it should be integrated. I mean, exactly the rhetoric we're talking about now, the Institute of Medicine, the values of integration. So it's funny because people asked me at the time; and I said, "Well, it makes great sense to me. I think it should work, we should be able to make it work, and it should work for the benefit of our clients, so let's go at it." I got a reputation, I think, in the Department of Health Services [DHS], as the only person in Mental Health they could talk to. Because I felt positive and wanted to help make it work. In the end –

MM: The rest of the Department of Mental Health was pretty much opposed to it? And was that for turf reasons or because they really didn't think it would work for the clients?

AC: Probably some of both [she laughs]. Whatever his experiences had been, Harry was very aware of the difficulties of getting things done with the Board of Supervisors and he, rightly, I think, was fearful that, being submerged in a bigger department, our issues wouldn't rise to the top and that's exactly what happened. They didn't rise to the top, [at least as far as flexibility of staffing and funding. The State allocation for mental health had to be returned to the state if not spent each year; and yet the entire DHS had budget problems and hiring freezes were imposed that kept Mental Health from using its allocation. That finally led to support for de-merging and re-establishing Mental Health as a separate Department.] I think List Witherill [first Director of the newly merged Department of Health Services, Liston Witherill] never really appreciated what that meant to the community and to the mental health advocates. I'm friends with List, who was the founder-director of the merger; and I see him and I kid him that he just

didn't understand what Mental Health was all about; and he kids me, because he says, "Well, you were 10% of the budget and 50% of the problems." [she laughs]

And it's true because there was a rush of legislation introduced to tweak the mental health [and] substance abuse programs of those days. It was ongoing, a whole set of issues that would come up and always needed attention. And the other thing was that the Mental Health Department had, through the years, worked with the community and had a big emphasis on community organization as part of health. I was interested, in a meeting the other day, somebody raised that and said, "So you're talking about integration, what are you talking about in terms of organizing people to empower them for health?" And I thought, wow, back to the 60s. But the Mental Health Department took all that really seriously and did a lot of it so we had a community network –

MM: Already in place?

AC: Out there, already in place, and DHS didn't have the faintest idea how to work with anybody like that. And instead of trying to learn from us, they thought they were the whiz kids, because many of them had come out of special training that the CAO's office had given them. They were the rising stars in management and administration in the County and we were just looked down on [she laughs]. Poor cousins.

MM: Yeah, exactly.

AC: So nobody tried to sit and listen and learn both sides. So Harry made a lot of enemies in the course of that and had – the Supervisors were happy to merge him in and get rid of him. The Health Department tried to organize on a regional basis, which Mental Health was, and the Public Health Department had been, and they got that much, they got that far. And then they would put their regional directors in charge, all of whom came out of the hospitals and again it was that they just didn't connect enough. So it was a culture merge that never really worked. The crowning blows came that for a few years running, the Health Department as a whole would run into budget problems and nothing new there either.

And they would put a freeze on, and the freeze affected Mental Health. At a time when our dollars were allocated on an annual basis by the State, and what we didn't spend went back to the State. Duh. So we got really angry that our services were being cut and hurt, curtailed without need. They couldn't manage it down to that level of detail. So that led our Advisory Board to take a very strong role and they did the only thing they could do, they refused to endorse the County plan that year, so that was good. I mean, I was in charge of the County plan; I didn't mind that they did it [she laughs]. Actually, when they did that, I had left. That was the year I was not there. I left to go to the Health Training Center, because I was so in despair.

MM: It was just too much?

AC: It was just not right, it was not working. And, I thought, oh well, I'll go do something right.

MM: And the major impact was that services were being cut back?

AC: Yeah, they weren't being implemented, that could be implemented.

MM: Very frustrating.

AC: Bureaucratically, there was all this time spent on arguing and struggling and trying to make integrative plans, where there didn't seem to be a lot of interest in really making it work.

MM: Really just spinning their wheels?

AC: Yeah, a lot of that. So I came back from my sabbatical. I got the La Puente thing funded. I did not like the regional director of the joint Department, who was charged with doing it. He was not taking seriously the obligation to have a local board run – because the board was supposed to run that Center – and he was again condescending, and everything was his way, he couldn't see any of that happening. We brought in Andy Robertson, who had been a state director and had retired and was running the San Bernardino County Mental Health Department at the time, sort of in retirement, brought him in as a consultant to talk about how this could and should work. And Al Karp was the regional DHS director at the time and again a guy I liked, personally, but he just wasn't interested in following the rules. He was interested in subverting them and not giving these people power. He wasn't going to give up power over how this thing was run. I'm going a lot of roundabouts for you, I'm sorry; I'm not following a straight line.

MM: It's okay. We'll go back and sort out some of this later.

AC: Okay, so you asked about the 60s and I've covered the 60s, I guess, pretty much. The first plans, yeah, they were interesting: What clinics are we going to open and when and how fast can we get people hired? I mean, the detailed planning that I was pursuing to estimate how many units of service we'd deliver so we'd know how much money we needed to ask for to get from the State. It was such micro level [she laughs] planning, but that was my job. I guess, following that, the next big thing was the 1971 earthquake and that was –

MM: The Sylmar Quake?

AC: The Sylmar Earthquake, yeah. And George decided he was so fed up with the central office bureaucracy, that he asked for, and got permission to go out there and work as a clinical psychologist and get his supervision for licensure, so he left the administration. One of our top deputies at the time was a man named Don Muhich, who appeared in *Bob and Carol and Ted and Alice*, the movie, as himself, as a psychiatrist. He came with a great vision of community mental health and got very hooked in the Hollywood scene and destroyed himself with drugs.

MM: Oh, that's sad.

AC: He left the Department, I guess with prodding, or else just too much. It was clear he was not doing well and he left. And over the years, I have heard a couple of times, his name popped up and that he lost his medical license a couple of times. Very sad, a brilliant guy, he could tell you exactly chapter and verse how community mental health should work. 1965-'66, I heard him when I came in '66, '67, he knew exactly and he was doing the right things in the department, to try to make it happen. Teach the people, get it out there, spread it out, I mean, he was part of the planning, he negotiated with the state around the use of the health districts, that the catchment areas had to be part of health districts and not overlap. He did an awful lot of good stuff, but crazy guy. So that changed the composition downtown in the early '70's. So, yeah, it was a loss to have George go, but then I was in charge of all of that planning. We were trying to do – the research we were doing was trying to keep track of all the people who got services, all the epidemiology about them, where they were from, everything we could do in terms of predicting and knowing what kind of interventions we should be doing. We started then –

MM: Okay, so let me just recap a little bit here. So basically, I mean, you came there as a researcher essentially, to form a kind of evidence base for planning the services and how they should be delivered and sort of ideally, of course, sort of long-term planning over what services would be needed and how they could be funded and how many people would be involved in them? Okay; and that got you more and more involved into planning and to some degree it sounds like, a certain amount of liaison with different people and trying to work out the way in which this information would be translated into actual programs?

AC: That's a good statement.

MM: Okay.

AC: A liaison with other county departments, other community agencies. It was a very broad spectrum, but very little representation of clients and families, in those days. It was just as I got to know clients –

MM: And they came from the advocacy organizations primarily? That's how you got to –

AC: Yes, I was never doing clinical work [she laughs].

MM: Okay, and did you – one of the main problems it seems that happened with the transition with the community was when people came out of the hospitals they had a hard time just finding a place to live. So was that a crucial part of the planning? Was it a continual stumbling block?

AC: It's a continual stumbling block.

MM: Because they can't live at the health centers.

AC: No, well, LA developed a broad spectrum of board and care homes in those days, and we also had a lot more skilled nursing facilities than other states did. That was something George used to talk about, that one of the reasons why we

had as small a state hospital population as we did, even though it was large, it was smaller than other states, was because this state had gone early on in the development of nursing homes and nursing homes often were the alternate to the state hospital. And that --- at that time we didn't pay a lot of attention, we were not clued into how much that was. We were very aware of the board and care homes and the work that went with them, which at that time was largely done by the State social workers. They were the Office of Social Services, and then Office of Mental Health Services, OMHS, O-M-H-S. And they did an awful lot of the network in the community and we talked about developing more of that kind of support and linking with them.

But in the 60s, the emphasis was not on people who would have been in the state hospital. Then, when we got the responsibility for the state hospital, it moved more to diversion and therefore, if they were diverted, they had a home already; and so you concentrated on crisis services, getting out in the community, help the family and that family member get through that crisis. And then they wouldn't go to the hospital at all.

MM: At all. Right.

AC: So we didn't get on to that next stage until the 70s [she laughs]. In the 70s –

MM: I'm getting ahead of myself, go ahead.

II. The California Model; Elpers and his Team; Regional Director in San Fernando Valley; Consumers and Family Members; County v. Contract Clinics

AC: Well, no, you are helping me sharpen how those stages evolved, because that was really why we didn't worry as much about the board and cares, or anything until later in the '70s, because there was all this emphasis on get the crisis services, get the outpatient, get them to the outpatient first, get everything going short of needing the hospital. And then if all that worked, then the demand would –

MM: Would drop?

AC: Would drop, yes. That was the whole approach. But there was still – in the '70s until late '70s, there was the feeling that this was, I shouldn't use a singular, but that mental illnesses *were* chronic forever and you were not going to have recovery. Nobody believed in recovery in the early part of the '70s.

MM: A chronic illness.

AC: Yeah, chronic illness, and therefore what you have to do about chronic illness shaped other things. The '70s were marked by budget decline again, and things not happening, so that we had a couple of strategies for how to address that. And one was the development of the California Model, which Dick Elpers [J.R. Elpers] and Peter Dubois, who was Executive Director of the Mental Health Association in Sacramento, came up and said, "Well, maybe this is a way we can explain to the legislature why we need the money and what we ought to be doing with it." Like we had park planning, well, you could have mental health planning

and for park planning, you say, how many acres of park you should have per population. And it was a public health model and Dick had been doing public health work and it made a lot of sense, and we all said, "Yeah, that's great, we can lay this out." So there wasn't a whole lot of evidence base on what you should have. There were small areas that seemed to work and you could look at the amount of resources they had. But it was a lot of negotiating that went into creating the parameters of the California Model and I did most of the staff work on that once Dick and Peter got it launched, then I had the assignment to work out the details.

Well, that brought me into contact with a lot more people statewide, and again the family members were becoming active and involved at that time. We had some wonderful family members here in LA. Don Richardson and Peggy chief among them, both now deceased. The family members were starting to say, with this deinstitutionalization, it wasn't working for them. And it was in the early '70s that we started to be aware of that and then looking at the housing and as I said, the board and care was good. And then we realized, again because of the family members being forced to tell us, that it wasn't enough that they could live at home, because of the problems the families had.

MM: Right, the problems they had to deal with.

AC: So what are you going to do? You are either going to give help to the families – well, yeah, you could keep doing crisis interventions, but you need something more and that gradually evolved out of the '70s. And they also were the first ones who brought to the professionals' attention the problem of co-occurring disorders with substance abuse. They would say, "My kid had a beer and then he just went crazy"; and they started identifying and crystallizing that as the problem. So in the Department in the late '70s, we really started to listen and pay attention. And probably you could say that my church experience helped me to value and listen to those folks more than people who were trained as psychiatric professionals, who had been trained so much in the psychogenic problems of the family and all the rest of that. I'm sure that training penetrated in a way that it made them harder to listen [to], whereas I, again, am standing back and saying, "Now, wait a minute, these people are right, they have real information to give us, let's try to incorporate it and listen and learn from it and shape what we are doing again, accordingly." So they had a big role in the California Model and the parameters of that and I had a lot of fun doing that. It was a great accomplishment. And then at the same time, we got through enough that California actually had a plan to put a big infusion of money into mental health and it was called "Old Problems, New Solutions, 1978." And then Prop. 13 passed and none of that money came. None of that came.

Now going back and looking at that, it was not as forward in its philosophy as we would want today, but it sure was a whole lot better than what we had [she laughs].

MM: Than what had been there before? Yeah.

AC: [She laughs] Yeah, and so that was just enormously disappointing, to have to gear up again. The other thread of input to my thinking and development was

that I began paying attention to the research coming out of Vermont and other places on Social Rehabilitation Services, Bill Anthony, and all of that. [See Harding CM, Brooks GW, Ashikaga T, Strauss JS, Breier A. The Vermont longitudinal study of patients with severe mental illness. *American Journal of Psychiatry* 1987 Jun; 144 (6): 718-735.]

And we had a community support project grant, which was NIMH funded to the Department, and I learned a lot from the people there who were mental health rehabilitation specialists and the State Department of Rehab. A guy who was very open to our clients and wanting to help them and what rules had to be changed and helping us work at the State level to change rules as well as locally, aware of the research, and that there were many more people thinking that you *could* have rehabilitation, you *could* have recovery. Again, the recovery word wasn't much used yet, but the concept was clearly – at least significant improvement was [she laughs] anticipated. And then again the Vermont evidence that there is long term recovery or at least remission, and life goes on normally for a lot of those folks.

So that thread was really strong and I can remember, by '78, saying, we got this research, what does it take to be used? Nobody is using it and so again, another round of planning, saying our planning has to change *and* we have to pay more attention to getting the parents and the consumers themselves to know it and the professionals to know it. So a big emphasis on rehabilitation [and] education. What else in the '70s? That was – A lot was going on there in terms of the evolution of the family members. Here's a traumatic incident in my life. What year would it have been? [Thinking to self] Nineteen [pause] eighty [pause] three or four; I was – I'd have to go back to the book to get the exact year. I was regional director in San Fernando, that's a loop we haven't gotten into yet; in fact we should go back and talk about Dick Elpers, before I get into this story.

MM: Okay, let's get the chronology straight. You were on sabbatical in what year?

AC: '74.

MM: '74, and then you came back and then it was after that you went and started the La Puente Center?

AC: Uh huh, I did the grant application for it. Well I actually, I didn't do it all myself. I hired a consultant to do a lot of the writing, a guy who had worked for me before and knew all of this and he was a good writer. And I kept on the rest of my work but got that done, got it through, got it approved, got it funded. Yay!

MM: Yay!

AC: And then I went to the Health Training Center.

MM: Okay, and that was kind of because you had just gotten very, very frustrated with the way things were, under the merger?

AC: Yeah, I had done that one thing I could think of to do. I was fed up with a lot of the personalities there, it just wasn't going well. So this was an opportunity and it

fit in with this [idea of] how you get systems changed. The Health Training Center was created originally as the Center for Training in Community Psychiatry. And it was federally funded to help do exactly what I said earlier, that people didn't know how to do, community mental health; and it was created for that purpose, to help professions learn what was needed to help the system evolve. They worked a lot with the Community Mental Health Centers. As they were funded, then they had to hire people and help them get people trained to do things, so that was the purpose of it. It was a good long term purpose.

When, at the State level, the Mental Health and Health Departments were merged [laughs], then the Health Training Center could no longer be the Training Center for Training in Community Psychiatry and the Health Department said, "Well, let's make it the Health Training Center." And so they broadened the agenda and they did a lot of training in health administration, public health concepts. They continued in the mental health stream. And the center got a grant to help implement federal laws – two federal laws. One was the Federal Health Planning Act which called for every community to have health planning in order to get permission for facilities to be funded, and facility construction was largely the purpose of that health planning. And the State had a Health Planning Organization, and the County had to, too. This grant was intended to help the Health Planning Agencies in Southern California. The second one was to help the Community Mental Health Centers incorporate services for children and substance abusers.

Their mandate had not included that to begin with, but then they were required to add it, so again figuring they needed help. So again that was a helpful experience for me to get the training perspective and again looking at the way the parts interacted and it was very evident that the Training Center – this continuing tension between the county and the contract organizations. It's still there, but it was very evident there. And perhaps, I don't know where, but I always had an appreciation for a community non-profit with a board of directors that came from the community. That gives a lot of credibility and a lot of power that government employees can't have and it seemed to me this was a necessary part of building the support for the Community Mental Health system that we wanted. You needed that as well. A lot of people still don't see it, a lot of Counties still don't. But anyway, I did, and I know that made my job better and it made me more trusted on a Countywide basis than I might otherwise have been, if I'd stuck to the straight County line. So that was a piece of it.

So yeah, I didn't come back until after Dick Elpers became Director. And I got to know him quite well on that project because I asked him to chair the advisory committee that I set up for that project [she laughs]. And he was at that time the head of the Conference of Local Mental Health Directors and he had been the mental health chief deputy in Orange County and then was the Health Director in Orange County. Anyway, he had good broad experience and I lobbied him hard to come to LA as the Director. And so we talked a lot during those months while he was negotiating with the Board of Supervisors as to whether he would, and what the conditions were. And we agreed that one of the conditions needed to be that it was a separate Department again, and he writes about that in the book.

MM: So the de-merger took place –

AC: The de-merger took place under him and you said that you wanted to ask about what he accomplished. He accomplished a team that really, I think, accepted the mission and purpose of an appropriate county community mental health entity. He was far more cooperative with the contract agencies than Harry had been, he understood their role, he understood the federal role, got well-functioning regional organizations established, with a precedent that you needed to know the community, work with the community, and shape what you did into the community, that was underlying. And then he started pushing for these regional groups to start working with helping bring people out of the hospital appropriately, with enough support and care, and so on. And of course as that evolved, we came more and more into the housing problem. He made a good solid organization that hung together and understood its need to do so, and marched to pretty much a single drummer, I think. There were personality issues, of course, and things like that, but I think that's what he did.

His biggest problem was funding the Community Mental Health Center that was affiliated with Martin Luther King Hospital. Out of the '66 riots, first of all the Hospital was identified as a need, and then all of the planning work, and the construction, and design and construction, and everything, so that was opened. But there was no mental health component to it when that was done and we had lobbied for that and I'm not – I don't remember exactly how the Health Department decided to proceed to get a Community Mental Health Center affiliated with it; but they did that before the merger. And I remember my job at the time was to provide statistics and information for that grant application to somebody who worked for the Department of Health Services. And I can remember going to some of those meetings and being very disturbed that it wasn't going very well and coming to Harry and saying, "Harry, this is not going the way it should. I'm worried that won't get funded." Well, ultimately, it had to be funded, politically, so whether it was a good application or not, it had to be funded. They couldn't turn it down. But anyway, I remember that and vividly know the person who worked on it, a lovely man, but it was not his forte and DHS didn't ask us to do it, which they should have done [she laughs].

MM: [She laughs] Mistake.

AC: Another of the sore points with the DHS was that having gotten funding – great, got the funding for the construction – they never talked to anyone in the Department of Mental Health about the design. They went to whoever they wanted to go to, and didn't ask us, not that any of us had great design expertise –

MM: No, but you knew what the services would be.

AC: Yeah, anyway, oh, and when that thing opened [the Augustus Hawkins Mental Health Center], I was just heartbroken, because it looks like a prison.

MM: That's a good way of describing it.

AC: Yeah, it did. I said, "Oh my God." We had better designs than that, we knew better than that, anyway, so that was – And then Dick had to find funding to staff it and there was no funding to be had directly. He negotiated with the State

ultimately to cut some state hospital beds to get some money for it. That turned out to be – He doesn't write about this in his book, his chapter for the book; but there was a woman named Bebe Nolan, who was a public advocate, you know her name?

MM: Well yeah, I've heard her name, go ahead.

AC: Well I'll be interested to know what you heard about her [she laughs]. Bebe was a lawyer, who was a public defender and a fierce advocate for persons with mental illness, but she was only interested in hospitals. She thought the hospitals were what were most needed; they needed to be in hospitals. So a lot of this community mental health talk and trying to sort out the rest of the network of comprehensive care didn't interest her much. She was part of the San Fernando regional structure. Her brother was an Assemblyman and she had a lot of contacts in the Republican Party, and used them. She accused Dick of lying, essentially, about what he was doing in funding Martin Luther King. I don't think he did because I was there, I saw all the documents; I was in on the negotiations with the State. But that, I think, was what finally got him in such bad straits with one of the Republican Supervisors that he just couldn't take it any longer and quit. Having negotiated that he –

MM: It made his position politically tenuous.

AC: He could go to Harbor Hospital. Milt Miller worked that out, got him a position there. But Bebe continued to harass everything that was done relative to Dick as long as she lived; and she was a challenge for me. One of the things Dick did in his Directorship was he decided that he wanted to move responsibility around and he specifically wanted the two of us Deputies who had central office responsibilities, which was not direct line responsibility, to have that line experience. So he moved me to San Fernando as a regional director and moved George Wolkon to San Gabriel as a regional director and brought Roberto Quiroz, who was the regional director in San Fernando, downtown to be assistant director when Hal Mavritte moved to San Diego. Again our small world. I worked with Hal all those years in LA; and finally he was the medical director when I became Director in San Diego [she laughs].

So, anyway, I was out in San Fernando for over a year, I guess a couple of years. While I was there, I had to cope with Bebe too [laughs], because she was on the regional advisory committee. That was fine; I was very straight and she never quarreled openly with me that I could see, or argued with anything that I was doing. But the story that I was going to tell you was an example of the difficulties [pause].

Dan Weisburd is a well known advocate [who] had a role in getting the Lieutenant Governor's Task Force going and staffed, and really worked hard to help educate people around California about state of the art work going on around the country. He did a great job, wonderful guy. Their son was at a board and care in San Fernando and going to day treatment at one of the county facilities, in the days when day treatment was pretty awful. It was geared to the lowest common denominator of mental functioning and their son was brilliant. He had had his break at Harvard as a freshman and they had poured money and

everything, trying to get treatment for him. And the last time, as I said, he had been in a board and care in LA, [but had a major problem develop so they had arranged for him to be hospitalized] in Irvine with Dr. "Biff" Bunny for a long time. I mean everybody bent the rules to accommodate and try to do something for that young man, because of Dan's influence [and] his power; that was it. Nobody argued, we didn't object to that.

Time came when Biff said, "He's got to get out of here, we've got to get him back into the community." So I called together a meeting with Dan and Elaine, the parents, a woman who ran the board and care where the young man had been, the head of the day treatment program, the case manager who had worked with him, working between the board and care and the case management, the medical director for the region, and the program director for the region, so I had a pretty high powered group there trying to talk about what we could do. The woman who ran the board and care said, "I can't have him back, because he was lighting fires before he went and I will lose my license unless you can guarantee that he won't." Day treatment was happy to have him back and try to do more creative work with him to be more responsive, but he had to have a place to live.

Dan and Elaine didn't want him living there [at their home]. The recommendation from the woman who ran the board and care was, if we put him in a skilled nursing facility for a short while, and if he can stay there without any episodes of trying to light fires, then she would be clear on her license to bring him back. So that was the deal, we thought; it's there, it's time limited, we'll be watching very closely, the case manager will be working to make sure that everything is okay and then he can get back here. I got the most angry letter from Dan and Elaine the next day in which they mischaracterized everything that had happened and said that we were putting him in a facility and throwing away the key.

MM: Yeah, well, to them it probably looked like that – that you were trying to re-institutionalize him essentially.

AC: Well, we were very clear it was a very short while; and it was skilled nursing which was in the neighborhood; it wasn't all that far away. But anyway, we were all devastated and I'm telling Dick about it afterwards and he said, "Well, you know, you should have just offered to put 24-hour, one-on-one care with him somewhere at their home or the board and care, or wherever." I said, "Dick, I didn't have the authority or power to do that." He said, "Well, we should have tried." I said, "Well, yes, it's easy to say now, but –" Anyway, that became an episode in one of their films about *System in Shambles*, which was the name of the film that they put out, which was a very powerful advocacy piece, but it talked about this incident and again repeated this statement, so it hurt my feelings a lot. On the other hand, Dan and Elaine were there to give me the Peggy and Don Richardson Award a couple of years later [she laughs], and made a lovely speech, so it's funny. But that obviously left an indelible impression.

MM: Was this – okay, so it was under Elpers that you were sort of put in, made sort of the person in charge of the San Fernando area and that gave you a direct responsibility for clinic facilities, which you hadn't had before?

AC: Right. And negotiating with the local hospital, which was part of the network that served that region.

MM: Okay, okay. So, did this then, I mean, was this kind of thing more frequent that you would find yourself meeting with families and clients than it had been before?

AC: Well, I met with clients and families before as part of the –

MM: As part of the planning?

AC: As part of the planning processes and so on. It gave me more one-on-one individual case episodes, yes, client-based.

MM: And did that change your perspective at all, or – ?

AC: No, because I think I've always been very much on their side and listening to them. As I said, I figured they were better reporters than most of our staff would be, so I trusted them. No, I don't think it changed. Maybe – anyway, go ahead.

MM: I just wanted to ask, in terms of the clinics now, I mean, there are like two kinds of clinics. There are the ones DMH directly operates, and the contract clinics; and so you were beginning to have direct experience then with these clinics and you certainly have had a lot since then. I mean, what are the relative virtues of a directly operated clinic and the relative advantages over a contract clinic, or vice versa, for that matter? And I mean obviously, it's probably not possible for financial reasons to have all one or all the other. That's presumably why, we have sort of two types of clinics, but –

AC: Why we have two types of clinics? Probably because there were privately operated mental health service delivering entities before there was a County entity. LA Child Guidance goes back to the twenties. Mostly it was Child Guidance Clinics.

But there were a few where groups of psychiatrists would create a group practice. The contracts really got their power out of the Community Mental Health Center legislation, which called for community boards. And we all, I mean, I thought that was a good thing to do and we originally thought that they would be interchangeable with the County clinics, so you put a contract here, and you put a County over here. Did we want County and contract or only contract in any area? We didn't, because we had no control over their fate and we wanted to be sure that there was something there. Like, we did once have a Community Mental Health Center [that] went out of business and we had to move in County staff immediately to take care of the client load there and we did. I know the Board of Supervisors was very gratified that it went so well and smoothly, but it was [because] we could quickly bring in County staff and kept all the appointments and did everything else, so that's a major fundamental.

The other of course is the broad network of a board. Although all of our community clinics had and have a community advisory body, which again tries to stretch out the network into the community at large to be able to talk to more

people about what this entity is and how it works and what it's doing and its value to the community, so that was always part of that. [pause]

Other than that, I always tried to go on the assumption that they would be equivalent in terms of quality and care and the same system – whatever one applies to one, it should apply to the other. As it has evolved, they are different, it has been harder to be sure that a contract agency accepts the more difficult clients and the County supposedly has no option. And certainly when I was Director, I would get instances where that was happening and I always reinforced to the County, “You are the ultimate responsibility. You are the back-up; you have to redesign so that you can take care of people with the budget you've got. It may not be as good as you want, you may do more group intake or group this or group that, you may cut people shorter than you would in ideal circumstances, but you have got to be there to stretch.” Contract agencies don't see it that way; they see it as they maximize their dollars and the number of people they can employ, so they have evolved into MediCal-only entities in the current scene, which bothers me a lot.

MM: Yes, I could see that.

AC: I don't think Marv [Southard] has done enough to control that [she laughs]. So I don't know if you've got more on that question. I'm not sure what else I could say on that one.

MM: Okay, because I've heard, I mean, I have heard this, that the contract clinics tend to put their emphasis on serving the people they think they could serve best, which may then put the higher utilizers or the more difficult cases, to sort of, not abandon them, but shunt them over to the County.

AC: There continues to be a lot of resentment about that.

MM: Yes, exactly. I've also heard that because the County has to adhere to specific work rules, specific schedules, there are a lot of civil service things in place for County employees, that the contract clinics are more flexible in the services that they can offer.

AC: They can be, that's certainly true; and it's also easier to cut a contract than it is to fire staff [she laughs], especially if it's a further removed contract.

MM: [she laughs]

AC: No, that was never a part of my logic. One can argue about the benefits of having services delivered outside of the government and I do think there is a lot to be said for that. So I wouldn't go back to it as an only County-operated, if it were up to me, no.

And they should develop different specialties and sometimes they did; we got special contracts for special populations, like the Asian Pacific Counseling Centers and so on. That's, again, easier to do outside of the County constraints, very often. I don't think the County constraints are as bad as the LAUSD constraints on civil service, but [she laughs] sometimes they are. I mean, it's a

- matter of supervision. I've said to staff many times, you've got to supervise them; if they are not doing it, you've got to document it, so that you don't pass that problem onto somebody else. Do what you've got to do, get rid of the person if you have to.
- MM: Okay, it was about this time, unless I got the dates wrong, that you got involved with starting *Connections*? Is that right?
- AC: Oh, the newspaper.
- MM: That was in the book, but –
- AC: Yeah, Dick Elpers had the idea that it would be good to have a vehicle to communicate across the whole community of what was going on and we all thought that was a great idea. And I was given the job of negotiating that with the Mental Health Association, because that was the logical advocacy group to do it, and they were happy to do it and that was a lot of fun. So you've seen some of the *Connections*?
- MM: Yeah, they do look like a lot of fun.
- AC: They were, it was a great idea and of course it was one of the big blows that Dick had with the Board of Supervisors. Kathleen Snook tells about the day when the Board – [Supervisor Peter] Schabarum wanted to eliminate that contract and his deputy, Tom Hibbard, was imparting this to Dick Elpers. Dick never suffered fools lightly and he certainly hated being told by a deputy to a Supervisor what he had to do. And he basically said, "Over my dead body," and Kathleen says, "Here I am, standing between these two great big guys." Kathleen is a little bigger than I, but not that much; and they are fighting like crazy and she's trying to think of a way she can keep Dick from getting as far out on a limb on that as he did, but she couldn't, so it got axed.
- MM: That's too bad. Were there –
- AC: Were there other things? Yeah, we started the Project Return contract then too, which was the first consumer service, recovery-oriented service. And that's probably when I started really getting a lot of consumer contact, because I went to a lot of Project Return events and they would come to see me, because it was part of the deal. So yeah, I really got to know them then.
- MM: So was this changing your perspective on the mentally ill as a group of people?
- AC: I don't see it as changing, because I think of myself as having always seen people as people, individuals with their own unique stories and their interesting stories and they can do things. Probably the biggest change was that I became more convinced that we really could talk about recovery, but that even took longer than that. I mean, we talked about people thriving in the community and wanting that and seeing that they could; but assuming that it was always – [there] could be another big problem and a big break and so you needed to keep in touch.

MM: Yeah, long term maintenance.

AC: Long-term maintenance, exactly [she laughs]. So that was, yeah, I guess, I must have come to know them better, but I didn't – There had been enough over the years I didn't feel like – I just got to know individuals [she laughs], I think, was what it boiled down to. Oh, I got to know one chap through Project Return. He ended up in the state hospital for a long time, and I can remember talking to him and saying, "Why are you in the state hospital? You don't need to be in the state hospital, you were doing fine, you could do fine." Well, he was afraid of being out on his own; anyway, he has called me from time to time.

He is the only client who ever called me, although, I never unlisted my telephone. I always had a publicly listed telephone. Family members and clients never bothered me at home. Now, maybe it was because they knew they could get to me at the office, or they trusted me and liked me, because I think people did, but I never had any problems with that. I mean, people used to think I was crazy, they really did, "Are you sure, is that safe, Areta?" I've done it all my life; I'm not going to change now. So this one guy, he calls me from time to time and we have a good chat [she laughs].

MM: Oh, that's good. I have a sense that there was kind of an esprit de corps, under Elpers, which everybody had a sense of, even though things were tough, that things were going to get done.

AC: Yeah, oh yeah. Dick held people accountable, he expected things to be done, and they did, they got done.

MM: And so did you want to talk anything more about that period, is there some development that I've left out?

AC: Not that I am thinking of at the moment. The model, Old Problems, New Directions, the regional strengths, the Hawkins Mental Health Center. Nothing else that is really significant, I mean, as I said, there was personality stories, but that's not relevant [she laughs].

III. The Quiroz Years; Director in San Diego County; Return to LA as Director; Working in the System; Trading Inpatient Beds for Outpatient Dollars

MM: But then he left. And so talk to me a little bit about the next few years. I guess you –

AC: I was moved to San Gabriel and Floyd Martinez was given the job in San Fernando. San Fernando was a natural fit for me, because not only had I been there, but I belonged to a church there. I knew the community organizations, I knew the structure, I knew the people, I had that broad network that is the purpose. And of course, then I had the commute [she laughs].

MM: Yeah, quite a ways.

AC: Quite a ways. So, okay, gird up your loins and go do. I did [pause]. I got lots of positive reinforcement from people out there in the San Gabriel Region; and the

good thing was that I got to know more of the County and more of the providers and more of the issues and it was very good experience for me [pause], in the end [she laughs]. The next year he (Roberto Quiroz) moved me back downtown to head up another Bureau, Community Support and Residential Services, which he created. Hadn't quarreled with what that structure was; it was needed. We had a lot of contracts with residential services that had evolved from base legislation which created residential programs, and we applied for them under Dick and got some of them funded; and then we had board and cares and we had these various levels of residential care. We needed to regularize and make some rules about that, so I took that job on and the people who were there from, from those pieces of the department that were put together, they were good people and we got a lot done and that was solid. And again, I learned a whole lot about things that I hadn't known in detail.

MM: So that was a valuable experience?

AC: Yes, all the organizing, and also learning what the OMHS did and how they did it. Oh, and that was the other thing, the OMHS transferred from the State to the County at that time and that came under my purview, so I got to really know all those guys [she laughs]. All the rules and regulations, how they used to do it and what was good and what was bad. That was another year, and then I came back from a vacation and was reassigned to another bureau job with planning again. Now, I started out in planning and I don't mind planning; but there was a lot going on in the County and I can't even remember exactly what it was.

MM: Okay, so you went to San Diego. So tell me a little bit about how San Diego was different from Los Angeles and what kinds of things you wanted to accomplish there? Oh, let me ask you this one stupid, really stupid question. Your husband was still working here, so did you have to both move or did you pick a place halfway in between?

AC: No, we kept this house and we actually put this house on the market and thought about Clarence renting down by USC for a few nights a week and moving permanently down there, but didn't get this sold; and we ended up with a very nice arrangement. I spent three nights a week there for sure, and he spent three nights a week here for sure, and I went to evening meetings and did all of that kind of stuff and worked late. So I had a capsulated life there and he could come down on Thursday nights after his classes and spend the weekend, or whatever. If I had meetings up here, which I often did on Fridays, then I would come up here on Thursday and be here for the weekend, so it worked very well. In fact, it was very good.

SESSION II

Date: May 28, 2009

MM: Okay, this is part two of our interview with Areta Crowell. Go ahead.

AC: San Diego was different from LA in two major respects. One, Mental Health was part of a Health Department.

MM: Oh, yes [both laugh]. Quite different!

AC: And two, far fewer institutional resources and less relative funding as well, so both of those went together. I was drawn there largely, I guess, because of a colleague that I met in the statewide advocacy and planning over the years, who was a member of their Mental Health Advisory Board and very active in the community – an advocate of rehabilitation and community support services and had worked very hard on getting that going there. And I knew that there was a good network of rehabilitation-oriented services there, that was ahead of what we had in LA, and so I was looking to strengthen consumer participation and community services, was what I was looking to do. [Pause] The merger – The fact of being part of a merged department improved our collaboration with alcohol and drug programs.

MM: Oh, that's good.

AC: I was able to start some joint planning and hold people accountable. We've got them in for training; and then at the end of the training in each of the regions of the county, we made them get together and plan something they were going to do to improve services and hold them accountable for doing it, and follow up on them.

See that it happened! That was wonderful. I loved that. So that was one track that was good out of that. And I liked the people, they were good thinkers, the heads of the other units there, and we met together collaboratively and talked about joint strategy. I mean [she laughs], it was good. I could appreciate that a lot. We had two big things happening while I was there. One was that the County had a psychiatric inpatient unit that was physically located on the grounds of the UCSD [University of California at San Diego] Hospital but was separately licensed, so it did not get any MediCal money. Duh, dumb! Really dumb, and the Psychiatry Department wanted the extra space. So they had pushed the County to leave and the County had built a new hospital, which was opened after I got there, but it was still a free standing hospital and therefore no MediCal revenue.

[Pause] So they had actually – The reason the university tried to get rid of them was that they had been featured on *60 Minutes* as the only hospital in America that ever lost its Medicare certification. Before I went there.

MM: Wow.

AC: But they had a wonderful woman [Karen Lee Robinson], who I didn't know until I got there, but I found her heading that hospital and planning the move and orchestrating it. And the facility was designed in such a nice open way, and it was immediately adjacent to our headquarters, so I got to know inpatients too, in a way I had never known before. I could go over there, and I did and go in there, and Karen Lee and I would go around. She was an absolute believer in what you expect of people is what you get and she was a very modern hospital administrator. So it was not the old institutional lock them up and abuse them, and all of that. There were very good standards, very good.

She brought artwork in and artwork on the walls, it was never damaged. She was a good mentor to me about inpatient services; and there was a wonderful medical director of that facility; and Hal Mavritte, who I had worked with here, was the Medical Director [for San Diego County].

MM: You met him again, yeah.

AC: Interestingly, after I had been there a while, the head of the Department, Dr. Bill Cox, a retired Navy Admiral, who had been involved in setting up the Naval Hospital there in San Diego and had a lot of high assignments and then retired, and then was teaching health policy at SDSU [San Diego State University] when they recruited him to come in and head the San Diego County Department of Health Services. He was a great guy. Anyway, after I had been there for a while working for him – Harold [Mavritte] and the administrative deputy were there when I came and [pause] I was advised to get rid of both of them and didn't. And after a year, Dr. Cox said to me, "You know, I guess you were right. I didn't have any respect for them, but they seem to be doing fine now." [both laugh] That's my management style. Anyway, that hospital and all the opening and the things to do with that, that was just wonderful and they had monthly times when everybody was invited in and we went in for picnics and it was great.

The challenge was this funding thing; because that [Department] had no extra revenue and we were shortchanged and then still [after] a year, not much revenue coming in. So it happened that the State was getting some money and I'm not quite sure how, but they were getting money to expand skilled nursing facilities; and I talked to the State officials and said, "You are expanding facilities, you should put some in San Diego because we are so under resourced." San Diego had 72 state hospital beds when I went there. Los Angeles had 1,080. San Diego's population is roughly a quarter of Los Angeles'.

MM: Makes no sense, does it [she laughs]?

AC: How they ever managed was beyond me. Well, I learned a lot about how they managed and that was good for me to see. I mean, it gave me confidence when I came back to LA, we could do with less hospital beds. We can, because look what they do, but we did get 90 or 100 skilled nursing facility beds in San Diego out of that, which I facilitated for them, because I knew enough and had the connections. If they had had somebody in charge without that knowledge, they wouldn't have known and they wouldn't have gotten the extra beds. And besides, there were people who respected and liked me in the State and so they would try to help.

They would try to listen, so we got that. And the rest of it was teaching people about rehabilitation principles and how to get more of that going into the services they were delivering, so we redesigned the system to be more focused in that way rather than short term, acute. And another wonderful thing that happened for us – it was serendipitous – Lew Judd [Lewis L. Judd, NIMH Director 1988-1992] went to head up NIMH in Washington, left the UCSD Department of Psychiatry, on leave. His significant other was a high official in the Housing Authority for the City of San Diego; and in Washington, she worked with a woman [Irene Levine] who had worked with me briefly here in Los Angeles.

MM: [Both laugh] Ah, connections.

AC: On homeless services [she laughs], and of course we were all struggling with homeless services at that time. Here in LA, in fact one of the things we did – I guess during Dick's time, I should go back and mention this. That was when the research on Skid Row, that John was involved in, that evolved out of services we were providing. And we got an NIMH grant for that and Roger Farr, a psychiatrist with whom they all had a lot of problems, worked for me in Program Support. But nevertheless Roger got it going and had the connections with the Skid Row DPSS [Department of Public Social Services], because he was in there consulting with them, trying to help them deal with all the homeless mentally ill persons coming to them, so that little piece of development I forgot to mention. [See Koegel P, Burnam MA, Farr RK. The prevalence of specific psychiatric disorders among homeless individuals in the inner city of Los Angeles. *Archives of General Psychiatry* 1988 Dec; 45 (12): 1085-1092.]

And Dick certainly supported all of that. Anyway, I recruited this woman, Irene Levine, to work for us while Dick was Director. She only stayed for a short while, because she had just started a relationship with a psychiatrist in DC; and she went back and married him and had very significant jobs at the top of CMS. And I guess, by that time, it was ADAMHA [Alcohol Drug and Mental Health Administration 1973-92], I can't keep track of when it was federally, with all those agencies. But whatever, she was up at the top there with homeless services and the woman from San Diego worked with her. She [Judd's significant other] helped develop a request for proposals, and when she came back, we worked on that RFP, with Dick Hough who was at SDSU as the principal investigator and myself as co-principal to deliver the services. And the project was a demonstration project grant that was intended to show what you could do with chronically mentally ill homeless persons, picking them up off the street.

And what you could do directly with them; so our grant was to put them into housing – oh, and the grants had to have a housing component. And you had to have that agreement from the housing authority. Well, with her there, it was easy to get the agreement and we had good homeless outreach service teams already in the County. In fact, the woman who ran that joint substance abuse mental health training section for me also ran the homeless outreach services for the County and she would go out herself, quite often, so she knew the people. She was very clinically adept, so we got that grant, one of six around the country, and was really pleased about that; but that was –

And that helped the County to get it some visibility, get some resources; and along with that, I had an advisory project built up and we were doing a – oh, I know, we were doing a special other project, it was – We created the idea of doing something special for the people who were using the emergency room a lot. It wasn't my idea, it came from the medical director of the hospital, to do something special. Special case management. OK. But what I did add to that was that you have to have an advisory panel with family members and consumers on it, and you have to hire consumers. And the guy who ran that program. Bob Quinlivan, later came up and talked with us here in LA, to the PARTNERS providers; and he said, "I thought Areta was crazy [she laughs]. Oh

yeah, I'll go do that, yeah, yeah." But he became a convert and people did when you started doing these things. They started to get so excited and really – "Hey we could do this, it really works!"

MM: Wow, that's great.

AC: Yeah, that was. The other – What was the other good thing down there that was going on? There was another one that went through my mind, came out again. [Pauses, thinking] Oh, it will come back again, maybe I can't think of it now. What was the third thing? The NIMH. Oh, I was going to say about the NIMH. We – actually, we're in a way a failure of a demonstration project, because we contracted for the grant funded enriched services for the clients. The control group was our ongoing social service case management group. [See Quinlivan R, Hough R, Crowell A, Beach C, Hofstetter R, Kenworthy K. Service utilization and costs of care for severely mentally ill clients in an intensive case management program. *Psychiatric Services* 1995 Apr; 46 (4): 365-371.]

And they took it on themselves to show what they could do without the extra resources and they did very well; but both groups succeeded of course, and the ultimate objective, which was showing that you could bring homeless people off the street into housing and stabilize them and keep them. And we were fighting that myth [that homeless people needed more intensive services before they could have their own housing]; but yes, it was a major breakthrough.

MM: Homeless people won't leave the streets.

AC: Right, and they don't want to do that.

MM: And they are resistant to care.

AC: Yeah, yeah. So those were the two big things that I did when I was there. So it was a pretty good four years. People still remember – They named the Center for me down there [she laughs].

I went back to see it. They moved recently, so I went to see the new location and the staff and the clients were so excited, "Gee, there really is a person!" [both laugh]. That was fun. No, I think people felt I left a real impression there in San Diego, because I moved it so much more towards client focused, outcome focused, and radical rehabilitation concepts – that weren't really radical, but they were to the standard operating procedures for most of the state. Still are, I think, unfortunately. So that foundation enabled me to make the changes that I did when I went back to LA. So again it was a vital part of my experience. I was very fortunate [she laughs]; I couldn't have done what I did in LA if I hadn't had the San Diego experience.

MM: That's great.

AC: Yeah, it was good for me.

MM: Was there anything that you wanted to do in San Diego that just proved impossible, or something that you wish you could have done, or you thought you did as much as you could while you were there?

AC: I felt I did as much as I could. Oh, I can talk a little – some other stuff we did accomplish, not that I wanted to have to accomplish this. Again in the cutbacks, what do you do? We came up with the idea that this hospital that I've talked about with no money – it was evolving over time, and we could see that about half of the people in the hospital were no longer on acute care. They were on long-term care and we could not place them in the community, so that was the big disappointment. We didn't have a place, we didn't have a PARTNERS program for them to move to in the community, not that we had conceptualized it at that time either, exactly; we just knew that they weren't good to go. So we got that re-licensed and then we'd get federal money for this, for the nursing care, and that was some revenue. The doctors on the emergency room – oh, that's the other piece I want to talk about. The doctors on the emergency room got very nervous about this, because as far as they could see we were cutting down the number of acute beds they could admit to.

The truth was, we weren't, and the medical director of the facility, of both them and the whole hospital kept trying to explain it to them; but they decided that they would make this a battleground with the Board of Supervisors and try to get more money. I think their hearts were in the right place. They thought they'd get more money and that would help everybody and we wouldn't have to worry about this; or we could do that and they'd have some other resources. And in fact that delayed my coming from San Diego to LA because, when they presented their objections to the Board when our budget was up for hearing, the Board got nervous, because when the docs talk, the Board gets nervous

So they ordered us back in 60 days to re-examine and come back with a new proposal. So in the interim there, when [Supervisor] Ed Edelman talked me into coming back to LA, I said okay, but I have to wait until this Board hearing, I can't bail out before that Board hearing, so I waited for that and then I left. And the Board adopted it; but that was part of my working with David Janssen; before he came here as CAO [Janssen was CAO of LA County 1996-2007], I had worked with him there. He was assistant CAO and he was still an assistant at that time, but he handled all of our budgets; and I went over every piece of our logic with him on all of these things, so he would understand and be supportive and I never had any problems with him there. Had a funny one with him here, but it was not his fault, it was just one of those things.

But the other piece of what was good in San Diego was, I mentioned that they had progressed in some areas that we didn't have here, and that was the crisis residential beds. That was another part of how they succeeded. They had 60 crisis residential beds and they used them well and because they had enough, was what I finally concluded, they had enough that the ER knew them and used them and the ER would place people in those crisis beds, instead of into the hospital, if they thought they could.

Now, we tried – We had some crisis beds in LA, and we had like one crisis house per big hospital and each one of those had 5 or 6 beds. Well, with the volume –

this is what I figured out after I went down there and worked with the people in San Diego. What it had to be was this: The volume at Harbor [General Hospital in LA] was such that the fact that they had a five-bed crisis bed [unit] never registered on the residents as they rotated through the ER. It was just wasn't big enough; it wasn't there all the time; they couldn't count on it. So they ended up being admitted to crisis beds out of the outpatient programs, [usually from the parent contract agency,] rather than from the [hospital ERs or] inpatient. So they were never seen as important to the medical system in Los Angeles County and I think it was simply a manner of –

MM: Perception.

AC: Well, adequate size. Critical mass. No, I think it was [that] they didn't reach a significant amount in terms of the decisions that had to be made so – in fact, I gave a talk with the man in the agency who ran all the crisis houses in San Diego. We went to APA [American Psychiatric Association] Community Psychiatry Institute one year to talk about the numbers and the statistics and why this – you needed a significant amount of this and then the resource would work. Anyway, so that was fun. But that was a significant part of how San Diego's system functioned better than Los Angeles.

MM: Better than Los Angeles, yeah.

AC: We had good case management out of the ER and we had the crisis beds and the hospital was right next door [she laughs], so, yeah, that was good. When we added the nursing facility, the SNF [skilled nursing facility] beds, that helped. It helped in terms of dollars that then could be used if they wanted to cut them; they didn't cut those beds. I think they still have the same facility, although that facility has changed its operation to be far more rehab oriented than it was at that time, but again, that's evolution of knowledge, so that brings me back to LA [both laugh]. I am getting a little tired. Anyway, well, maybe I can finish it and save you a trip.

MM: No, no, we're going to do this in two trips anyway. So why don't you just tell us a little bit about how it happened that you came back to LA, and then we can conclude for this time, if you want; that's fine.

AC: How I came back. I had friends in the system here and knew what was going on, saw the huge cuts that the clinics took the year before, heard from my friends how demoralized the system was. And at the same time my husband was here, my family, I had lots of family and friends back here, and I had always assumed, yeah, I'll come back to LA sometime. So people said, "Apply, apply, apply." [for the Directorship of DMH in LA] Dick Van Horn [Executive Director of Mental Health America (MHA) in LA] said, "Apply, apply." So I put the paperwork in and then the cuts kept coming and it would get worse.

I thought, I don't think I have the stomach for the politics of LA. I don't think I can cope. [Pause] And I didn't go through with the interviews. Time came for the interviews and I said [gestures that she dropped the idea] – And a friend of mine had died that summer, one of the guys who worked here. That didn't help. They

all looked so demoralized, so depressed, it was, it was horrible. And why do I want to do that for? I've got all this stuff going down here, it's good.

Anyway, people kept asking me and I said – Bev Abbott, who was Dick Elpers' wife, was one of the finalists. I said, "Bev can do it just fine. Don't worry, hire her." I told everybody, "Hire Bev." They kept coming back to me, and the "they" were essentially two people, Marv Karno [she laughs] and Cynthia Telles [Karno was a Professor of Psychiatry and Telles a staff psychiatrist at UCLA]. And they talked to each other and Cynthia talked to [Supervisor] Gloria Molina and Ed Edelman. So Ed called me personally down in San Diego. I nearly fell off the cliff. I was stunned and he asked me what it would take. And I said, "Well, I don't know. You've got to stop those cuts. I couldn't stand it."

MM: Yeah, that's a lot.

AC: "I want a promise of support. Well, let me think about it, anyway." I thought about it and I asked Kathleen Snook if she would come back and be my deputy and she said, "Yes," and then I thought, "Okay, then I guess I can do it." So that's how they persuaded me, but it was Ed calling me and offering me his support, and saying they really didn't want to hire any one else.

MM: Any other people.

AC: [She laughs] Yeah, and I had by that time spent enough time thinking about it that I had an idea of what I could do to make a difference. It wasn't enough just to come back and be the Director and have to do all the same stuff, that was not going to please me at all. I came up with the idea, because of realignment, that I could trade some state hospital beds to start the wraparound community intensive service agencies and that was the core that I told [pause] Richard Dixon, who was the CAO at the time. I said, "I think this is what I can do." He obviously didn't care. He didn't know from squat. "Got a plan, fine." All he cared was, get a problem off his plate [she laughs].

He clearly didn't care; but he had to agree to let Kathleen move because she had just been placed somewhere else, and he wanted her, because she was close to him over the years. He had great faith in her, with good cause, and he had to agree that he would let her move back to my Department, so that was another part of the dealing that went. And, I found, yeah, that the politics was horrible and I hated it, but I managed; and I never felt [pause] I never felt too victimized by all of it, the way it had seemed to me before, and maybe it was just because I came in with a lot of community support, and the Board knew that, and they heard it, I'm sure.

And I had an absolute rule. I met with the health deputies every week so that they were never surprised. If they were surprised, I was surprised by anything that happened, but anything that we were talking about doing, we would explain, we would tell them. We still had plenty of the Supervisors calling and complaining about this, that, or the other, and Gloria's staff were always very difficult to deal with, very difficult to deal with. She was difficult to deal with. In spite of her role in getting me there, you'd never know it some days, the way she talked to me about other things [she laughs]! But, anyway, that was good. But I

brought early on to a gathering of community folks, the leaders of AMI [Alliance on Mental Illness] and MHA and some of the key organizations and I said, "This is my idea for what we can do. Will you support me in it?" And I was afraid that the AMI people might not, but they did.

MM: Oh, good.

AC: Because they understood the purpose, and they understood the value long run, and I could explain to them what we did in San Diego. We managed with so many fewer hospital beds, and we had a good network going in the community and we were making it better there, and we could make it better here.

So that was the chief transforming thing that I could do was to use it as a signal to everybody about two things: One, the importance of real rehabilitation, and recovery [she coughs] again – although we didn't use the recovery word yet – and the importance of continuous responsibility and accountability. We talked about it, but nobody had put in place a structure that made you accountable from one episode to the next; and we'd talked about it over the years. Well, the hospital lets somebody go, they say they are fine; and this person picks them up and says they've deteriorated and says it's the hospital's fault. Well, whatever. You've got to put accountability in a single place and that was the crystallization of the concept of the Integrated Service Agency. But I think it was much more developed, as we rolled that out and we put it with the capitation so that they had the dollars, but they also had the dollar responsibility too, and trying to make the integration of the pieces of the system. Okay, they had to get to the hospital; they had to see the person in the hospital; they had to be allowed and they had to work for that discharge plan the minute the person got in there. So all of that –

MM: So there was continuity?

AC: Yeah, I also did quite a lot of community conferences and education around rehabilitation concepts. And in the first one that I did, I talked about my ideas of what could be. The alcohol and drug abuse community came to me and said, "We've talked rehabilitation and recovery and social models but we've never heard it expressed like you just did. How would you like to take on the alcohol and drug programs again?" I said, "I don't want to be at the head of that parade. If you want to do it, you can go and work and lobby and I'll be happy to take it on." But [she laughs] that was an interesting development. I mean, the ones who had lobbied to be apart, now realized that they would get better leadership if they came back to mental health, and I think a lot of them still think so; but anyway, that continues to be debated at the state level and every other level where it happens and it hasn't always worked well when it is together.

As I said to them, "Look, there would be an awful lot that's needed before it would make any difference anyway, so let's start on those tracks," and we did. We started on joint planning and talking about getting [pause] single point of entry and being able to collaborate between the agencies at the regional level. As I understand it, it's still not working very well, but –

I mean, we had the right ideas and we started down the track of you do the ground work of what would be needed, whether you are part of this Department

or not, you are going to have to go through this mutual education and training and planning; and I tried to get the same thing I'd done in San Diego, get some training events where the people are obligated to do something that they designed for their region [she laughs] and follow it. It never quite got people doing as well here, as we did there, so –

And what else? Challenges. The challenges when I first came here, the first challenge was that there had been a lot of scandal about psych patients in the ER at the [Los Angeles County/University of Southern California] Med Center. That they were being held on gurneys in the hallway, they were not having privacy, they were not getting into treatment quickly and so on. And so, based on my San Diego experience, I went to the Med Center and said, "One, you probably need to put more attention on your aftercare planning and getting intensive follow up for these folks and divert them, instead of keeping them in the gurneys waiting for a bed, and concentrate on using beds less and other resources more." So I put in place, right away, a move to transfer people from Quality Assurance in the Department over to fill positions at the Med Center for them to have aftercare and social services. Augmentation! They should have been impressed, they weren't [both laugh]. In fact, they just didn't, they didn't want to do it. It wasn't their model of care, so if you want to talk about a disappointment over the years, it was never being able to get medical training turned around to reflect modern concepts.

MM: Yeah, yeah, they are still stuck in the rut.

AC: Probably the single point of demonstrating my power, which I again don't talk about, ever, but sometimes you have to use power and you have to do it if you've got to get things changed, you've got to move. So back to the Med Center. Made this change, offered them staff; and the reason I cut Quality Assurance staff because they were clinicians, so we can cut those clinical positions and put clinicians over there. And we hired some consumers to help with it too, which was also a big move. We insisted we have some consumers there, which is another long track of stories about Pearl Johnson, who was part of that, yeah. They were so recalcitrant that I called for a meeting with the Dean at the Medical School and Rod Burgoyne, who was the Medical Director at DMH, he was there when I came and I kept him on. I said, "Rod, we've got to have this meeting and tell them they've got to shape up, because Psychiatry is not helping us with this problem." So we had a meeting with the top people, in which I said, "You either have to get them to change their behavior, get a new chair of the Department of Psychiatry, because this is not working." But it was so clear to me that that's what was needed and if they weren't going to move, then the whole system goes down.

MM: Yeah, exactly, that's the bottleneck right there.

AC: It became, it was a problem forever, throughout my tenure. And then the [1994] earthquake, and they couldn't use that building; so they had to contract for beds, so they had fewer beds which, in a way, was okay. But it just still continued to make problems for the whole system, they used beds at Metro [State Hospital], they tried to contract beds there. They tried to use the aftercare model, but it wasn't enough. So that was why we needed the PARTNERS to expand and we

got the PARTNERS to expand over the years I was there. And then we put in some other approaches to the same thing of continuity and real responsibility and accountability, which in a way is a non sequitur to talk about recovery and the consumer's own responsibility for their health and well being and all of that, which I believe; and at the same time the system has to have a place of accountability [she laughs] and single point of authority, so that was a piece there.

The next time I had problems with the Med Center, the hospitals, was [when] DHS cut the psych budget in '95. [DMH paid for beds, but DHS said we did not pay full cost; hence they were cutting their operational budget to match our contract amount.] Thus we had to cut the number of beds and that meant a terrific effort on the part of the community agencies, contracts and county operated, to take more people and be more creative with what they did with them now. We tried to keep track of it and keep the lid on it and keep the pressure on.

MM: It was difficult.

AC: It was difficult. I can't say that we ever had the measures that said we succeeded or failed. We did see the increase; we did see the reports from everybody of how they were rearranging and reorganizing their services, but that falls away very quickly. That was also, I don't think I wrote in the book about when we had – I had to cut state hospitals because as our budget [was] cut, I had a choice. Was I going to cut the community programs, which had already been devastated, or was I going to cut the state hospitals? And I continued to cut state hospital resources.

MM: I see.

AC: [Pause] Not happily.

MM: No, but the community was critical.

AC: But I felt the long term future was that we had to maintain strong accountability and capability in the community at large and we had to have it with accountability so that this – the Integrated Service Agencies and the PARTNERS were vital to the long term of taking care of the people who had been in the hospital. But the hospitals were not doing anything to prepare people for the future. They were lost causes. But in the end, again, it didn't come back personally to haunt me, it wasn't vituperatively brought back to me, but our decisions were what led to the closure of Camarillo [State Hospital].

MM: Oh.

AC: Because it reached the point that it wasn't a viable enough entity to maintain. And, instead of turning it into the forensic facility, which the state then built up in the San Joaquin valley, near Bakersfield, whatever that place is called, which they are still having trouble getting operational – They didn't do that there and the state was happy because they wanted, there had been a lot of pressure from the community to have that [the Camarillo site] for a university campus, so that – Well, it wasn't the pressure to close it; it was the pressure to want to use it for

- something else, which made it easy. It made it a viable resource, a valuable resource; but it meant we had to bring the kids unit from there to Metro [State Hospital], and that was a disaster. That was a thing that was my biggest failure, probably, because that never worked.
- MM: The kids unit at Metro.
- AC: The kids unit at Metro never, never got off the ground as a well functioning unit. There had never been complaints about the one in Camarillo, and we all thought, logically, to have them close to home, it would be better. You would think, it was logical, but it never worked. So, fortunately, I think it's closed now altogether and the kids are in group homes spread around and they're, I think, much better cared for in those than they were at Metro, but –
- MM: But it was hard. So did it not work because they weren't getting enough attention or – ?
- AC: I don't know.
- MM: It was just too hard to get –
- AC: Staffing, it was new staff people up at Camarillo who didn't want to move down here, not all of them. So they didn't have the same staff. The facility wasn't as good, because they didn't have the space. Camarillo had lots of outdoor space and things like that. You'd have to ask the kids' expert what really went wrong. I don't know. But the kids' advocates just got on my case royally, practically from the day it opened, it was always a complaint [she laughs], one thing or another, yeah, so that was –
- MM: That's too bad.
- AC: Yeah, so that was the big hospital thing that happened.
- MM: Okay, so on balance, the hospital situation, it just kept getting worse and worse in some ways. On the positive side, the PARTNERS program came out pretty well.
- AC: Yes, it created the foundation for all the successive pieces of legislation that enabled us to prove that you could do this and save the money and fund Prop. 63 [Mental Health Services Act of 2005].
- MM: Yeah, great. That's great. Okay, so I want to talk about that in more detail next time. I think we'll stop this session now. Thanks very much for giving us your time.
- AC: I'm so glad this project is happening.
- MM: Oh, it's going to be great.

SESSION III

DATE: JUNE 18, 2009

IV. Evolution of PARTNERS; Outcome Measures; Consumer Stories; Recovery

MM: Okay, so we're starting part three of our interview with Dr. Areta Crowell. It's Thursday June 18th and we're in the Director's office at the Department of Mental Health. We had talked last time about your coming to Los Angeles and some of the things you did there, but we had not really talked yet about the development of the PARTNERS Program, and I think you were telling a little bit about how that was based on your experiences in San Diego. Well, now you tell the story of how the PARTNERS Program got started. [PARTNERS = People Achieving Rehabilitation Together Need Empowering Respectful Support.]

AC: Well, to give the full story related to Richard Van Horn's program in Long Beach, first of all, there was legislation that was developed by the attorney general. Not the attorney general –

MM: Lieutenant Governor?

AC: Lieutenant Governor's [Leo McCarthy] Task Force and the work that Dan Weisburd did to get that going and directed and get them going around the country and learning about psycho-social rehabilitation and the recovery movement, and all of that. It wasn't called recovery in those days. And what Richard wrote into the program grant application that he got funded was very much exactly what was written in the legislation [AB3777], so it was very proscriptive legislation and they followed the legislation and that was okay, because it was summarizing the best practices as people knew at that time. We – Various counties tried and I did do an application from San Diego County, which did not get the award for the county program. Ventura County got that at that time, and it was – I mean, my friend Dick Elpers was on the review and had been the Director here; Dick said, "Well, Areta, you hadn't been there long enough for them to get sufficiently creative yet." Whatever it was, I mean, it was a different situation, and that's fine.

When I came back to – when I agreed to come back to Los Angeles, I knew that the Department was in a shambles, because a lot of the County clinics had been closed and so it was shrinking to be County hospitals and State hospital and not very much else still operating. I mean, there were County clinics; but they were so few and far between and we were still in declining budget times. And I thought, "Well, yes, it sure is nice to come back to L.A.," but what are you going to do? You've got to have some goal in mind, some way that you think you can make things better." And I thought that I could reduce state hospital beds and transfer that money into wrap around community programs on the idea of the Long Beach Village program [the MHA program funded by AB3777], but building on what was in the legislation.

So you had the Village, which was good. But the implications of doing that for all persons with serious mental illness were fiscally impossible and everybody knew that; and around the state there had been a lot of [she sighs] a lot of unhappiness

about the Village and its funding just because of that fact. Every parent in the state said, "Yeah, I'd love to have my loved one, child, adult in that program, but we can't afford it and what are we going to do?" And everybody knew that that was the way it was going to be. So I thought, "Well, we can do something like that;" and struggled with how can we make it so that it's sellable and had the idea to do it for – in San Diego we called them the Frequent Flyers, because we had done some programs for Frequent Flyers in San Diego. We had created the idea of diverting people from the emergency room and doing a special outreach and so on for them. And so it was a merging of those two ideas that I think made then possible a PARTNERS Program because I couldn't have sold just simply "take anybody" or – so it had to be people who had a history.

What was unique was that this County had the service utilization history documentation. Nobody else had that. In fact, one of the things I would have loved but never could get enough research money together to get somebody to do research papers on where you could find that long term history and what it translated into. And what we did find was that there was – It was not year after year after year constant high cost, it would be fluctuations. And that fit the model of mental illness that existed at that time, that it was cyclical, continuous, but cyclical, high and low; and that therefore you needed the flexibility to deal with people with the high need and then drop down to the low need. And that was part of what went into this capitation rate was, okay, you take the responsibility, so that capitation rate was again modified somewhat from what was in the contract that Richard had. And Richard had no need to bill MediCal, because it was just totally the grant money and they had flexibility to use the grant money as they wished. Well, again, applying it to a larger system you had to modify that to be more fiscally accountable and so on. Frankly the credit for the Village goes to Martha Long [director of the Village] more than anybody else.

If Martha hadn't made it work [she laughs], it wouldn't be what it is. And part of the evidence for that is that when we conceptualized it in the PARTNERS – it was written along the same model of what was in the [Village model], except I required that they hire consumers and that they have a consumer or family member advisory panel for each program and both of those came from what I was doing in San Diego. Although Richard did talk about hiring consumers, he wasn't at that time hiring very many and in fact the research on most of the programs funded over those years was that the work experience success rate was not as good as the other areas of rehabilitation. People were happy with the quality of their life and they may have been more stable in their housing but the work history was not improving. We haven't done as well on the work history dimension of our quality of life indicators, I think.

So that's how that got started. We decided to do it so that it covered the County. I considered this a first step in moving a big ship, turning it around and that would be getting everybody invested in that kind of program approach. Getting all parts of the County, so that nobody could just dismiss it and just be jealous and say, "Well, we don't like that," because people do that in bureaucracies a lot, and get Supervisors on board. So we had all the Supervisorial districts in it, to do all that. As we implemented, the executive directors of the agencies, who were very invested in this because they saw it clearly, I mean the way I did, as what we were trying to do and where we were going. And they, of course, were very

supportive after they got the grants, of course they were, but they were to begin with. In fact, it was wonderful. I had a meeting in, not this office, but in my office, shortly after I took office, with the major stakeholders and clients and family members and everybody, and went over what this concept was and got terrific buy-in, at a time when some of the family members still were resistant to doing anything that would cut down state hospital beds. That was like their last resort and their security, but I didn't experience that.

Now, there was one person who was probably most symbolic of that resistance and her name was Bebe Nolan. And Bebe was not as active by the time I became Director. She had been on my community advisory group when I was in San Fernando and she had been a major agitator against Dick Elpers, because he did reduce state hospital beds in order to pay for the Augustus Hawkins MLK Mental Health Program. Again, he had no choice, he had to do that, and he was fortunate to be able to negotiate that with the State; because there was no realignment, which made it possible for me to do it without having to worry about, could I bring it off? Yes, I could. I could say that to the State, that is what I'm contracting for and they had to live with it [she laughs].

MM: Because of the local control?

AC: Yeah, I had [the ability], because of local control. But the big buy in made a big difference. But also, okay, so we get to the implementation stage and I met regularly with the executives of those agencies and the senior staff from the Department who were involved in the whole thing. And they acknowledged, as time went on, it was much harder to walk the walk than it was to talk the talk. And I think everybody was surprised at what a culture change, what a mindset change, it was and of course it's still going on. The effort that goes on to getting people to be more focused on real empowerment and support for the consumers is still very much needed. It's evolution [she laughs].

So that was a big thing. And I brought a chap up from San Diego who had run this family consumer advisory panel for the project that we got, which was the getting the high users out of the emergency rooms and working with them on an individualized basis. And that advisory group which dealt with it by getting a pseudonym for every one of the consumers that were targeted for that project and they got so involved. And that man, who was a social worker, who is now dead, you can't interview him, unfortunately. He came and talked one time at my request to the executive [mental health] leadership group about using this kind of an advisory group and what to do and how to do it and the hiring of consumers and meaningful work and so on. And he said, "I took the job and Areta told me what she wanted," and he said, "I thought she was crazy, she didn't know what the hell she was doing, but she's not a clinician and she couldn't do this." [she laughs] But he just was a convert and he gave a wonderful talk to them; but they still – well, they are still moving, but they – it took a long time, that's the bottom line there.

So that's how PARTNERS evolved. And then as we were facing more budget cuts, the agencies came and volunteered to add capacity to their existing dollar contract, which was in effect lowering their cap[itation] and they have struggled with that over time. They were trying to deal with the fact that over time that

people don't need the same intensity, and we started with high users and they needed quite a lot of intensity. And we judged the dollar figure based on what we were getting at the Village and how that was working and so on. And Dick was good at trying to keep track of that and come back to us and say, "Okay, you know, we think we could do this, if we had this capacity of clients, then we could spread the risk a little better;" which is what insurance is about and capitation is a kind of insurance. So anyway, he tried and we were working on that when I left: how to formulate the contract so that you could expand the number of people and cut down the level of intensity for some of them – and almost call them graduates – but still have them [have] access to the program and I don't think –

MM: What they call Wellness.

AC: Yeah, and I don't think that's been solved yet. I think it's still a work in progress. But the name PARTNERS was conceived by the Pacific Clinics folks and they created the name and we all liked it so they have become PARTNERS [laughs].

MM: Yeah, that's a nice name.

AC: Yes, it is a good acronym. So that's where that came from.

MM: How did you – I mean was there a process of selecting that –

AC: Oh, yes, you go through the bid process that the County goes through. We put out an RFP, which was very specific and it was rated by a panel of community representatives. I didn't do the ratings, so it was the way they usually do the contract evaluation, it's been pretty standard forever in government and all of that.

MM: Okay, so they had to be interested and they had to meet the specifications?

AC: Yes. And we put in a lot in terms of viability and accountability and being able to, so that a new agency really couldn't come in and start up. And then we expanded them with another round and we got a couple of agencies like Floyd and Barbour that had not had a County contract and yet they were doing enough and there was enough community support that we thought we could do it. And they came and stepped up to the plate and they've stayed in the game, as far as I know, they are still doing it. So that's kind of how it evolved, but very much everything you do in the County is constrained by the County rules. Selection, open, transparent, all those things you try for to make sure that it's honest and above board.

MM: Okay, now, and then after – at a later point in 1997, then, you had to select some people for Targeted Case Management (TCM) – The high users had to go into a different category?

AC: Uh, huh. That evolved out of the adult services folks thinking that they were having problems getting the PARTNERS agencies to take the most difficult clients. And some of that is undoubtedly the continuing tension that exists between County people and a contract agency; and the County people, I think, always feel that those people get away with murder [she laughs]. Whatever it is,

wherever it is, they always have that feeling. “Well, we’re [DMH] the court of last resort;” and it can go on at great length. [pause] There was a tension for the agencies, because they were getting a contract based on their enrollment and so if you hire staff, then you have to have your enrollment up there, so that you have enough money to pay for the staff to do what you want. And so they all had people [clients] who technically met the criteria, but there would be anxiety that these people were not the toughest and sometimes it was that the toughest didn’t want to go there. So then they came up with this other program design, to try to narrow and get the more difficult ones into community programs and more intensive follow-up and so on. I have no sense because that was really just starting as I was retiring and I really don’t have a sense of how that played in with the other programs; and whether it did indeed prove that it was the right mix, because it’s all kind of blended now in the Mental Health Services Act [MHSA; Prop. 63] wraparound programs. Full service partnerships [FSPs] are kind of the same thing. It’s all evolved, yeah. So it includes all of those people. It should.

MM: Isn’t there – I mean, because these programs do sound quite wonderful when they are described and certainly, for many consumers, or clients, they’ve been really wonderful – but given the shortage of resources, which you continually struggle with, isn’t it the case that not everyone is going to be able to benefit from these programs and that there may be people who need them, who just can’t get them? I mean, isn’t it a sense that some people get a Cadillac program and other people don’t?

AC: Well, they’re never supposed to be Cadillac programs.

MM: That’s probably a bad descriptor.

AC: Yeah, they were never intended as that. That was –

MM: But more intensive services?

AC: More flexible and intensive when needed; and that’s that issue of one always assumed that on intake, there would be a very heavy need until you figured out and got connected with the person to the stage that they were willing to do and say and take more control. And so that was very front end loaded. I guess the assumption has been that, if you ever got a system that was operating properly, to identify young people at their first break, to give the support and training and education *then* to them and their families and support systems, that you would really cut down on the ones who have been, since the dissolution [of the state hospital] system, the very high need people; and that that number should diminish over time, especially as you make inroads. Again, if you parse that out and say, these are the high need people and they got *here* because of the failures *here*, we assume. That over time those ones should diminish and the need for that should diminish because you’re catching people here. However, whatever, I can’t think of a graphic to describe that [she laughs].

MM: I think I got it.

AC: Yeah, but I know you’ve got it. I just, for my own self. Anyway, but that’s the theory. The people who wrote the Mental Health Services Act made a couple of

major errors and one was the assumption about how the base program would be able to continue, which would, in a way, be a transition. Keep the moderately needy people and the people who were never going to benefit from the wraparounds, who incidentally are still very high cost. The ones who are never benefiting are staying in hospitals or in nursing homes and that's far more than the PARTNERS cost per year. So assuming that, whatever you do, there will always be some outliers and some failures and I think that's just statistics. That's going to happen. And assuming that what we have done and was the basic services for other people is okay, it won't get you the same outcomes, but it may not lead you to the high cost people, so you are going to keep that going. But that stuff has been shrinking and so the County has ended up taking everything they do and converting it into Mental Health Services Act and Full Service Partnerships. And then we're trying to get the early intervention and prevention stuff going, but what's happening in the middle here is disappearing and I don't think the model works without that.

MM: Yeah, there's no continuity.

AC: Yeah, so it's a terrible challenge for the Department right now, I think, or for the whole State, everybody else. It was good that the advocates were able to beat back the effort to divert the money from the prevention and early intervention, that was good. But, in the meantime, this middle area is getting hurt more and more with the cut in the Medicaid Managed Care Plan, which is the fee-for-service component. I was just talking to the woman who runs that on the way in and she said 26,000 clients are in the fee-for-service MediCal System right now. And the Department is planning to eliminate that.

MM: And what will happen to those people?

AC: Well, exactly. Now, just between you and me, she says they tell her, "Oh they don't need help anyway."

MM: Yeah, I've heard that before.

AC: When things are managed so that you don't have too much of it, there are an awful lot of indicators that there are people who are maintained with regular support. And so do they look like they need it? No, not as long as they are getting it.

And you can cut down and you can say you can't see a person more than X amount of time, you can do a lot of management things like that, but still leave that connection for the person, with the knowledge that, "Okay, I'm really in bad shape today and I need my therapist." I mean, I guess one of the most convincing things of that is the woman lawyer at USC, who has just gotten a lot of honors in her book. I was looking at it this morning, what's her name; do you know who I mean? No? [Elyn Saks, *The Center Cannot Hold*.]

MM: No, it's not coming to my mind.

AC: Oh, it will come to me. Anyway, there is a lawyer who has written a book about her history. She's on the faculty at USC [University of Southern California], a

respected faculty member living a very solid good life. And what she's disclosed in her book is that when she was in Law School, she was diagnosed with schizophrenia and has been maintained with psychotherapy and medication, and very intensive psychotherapy. And she's now on the Psychotherapy Institute and becoming a psychotherapist, as well as a lawyer, and so she's one who is testimony to the ones for whom that intensity, but not hospitalization, is vital.

MM: It works.

AC: Yeah, it works. So it's too easy to write people off and to write options off, I think, especially as things get stressed and strained. So, I've – and it's on the other end of it, on the Healthy Families board, we're looking at the mental health benefit for the Healthy Families kids and it's very complex and difficult. But what they do know is that the amount that's been spent on the Healthy Families kids has increased dramatically over recent years. And that goes along with a lot that's kind of been rumbling around here in the Department about services for children, that it has become very expensive per child, and what is being done to manage that and are we trying to monitor? You could call it rationing if you like; but there are creative ways to use what you've got, to stretch it and spread it over more people, or you just spend the high amount on fewer people.

And in my tenure, when we went through the reduction of the County hospitals and we worked with the clinics and said, "Do group intakes," people do that, do more group intervention with people. And that can be a good support system for them and you could use it creatively to make something more, so that you aren't turning people away. And I know Marv [Southard] has tried to emphasize that too. But I think it gets, when you have a secure civil service system, it's too easy to not be creative; and on the other side of it, if you have a contract that depends on the revenue, it's too easy to just take the easy revenue. So as I look at national health reform – it's tough.

It's very tough, we all know. I mean this article that has gotten so much press lately, the McAllen Texas Comparison, you know everybody has read that now and it's a good statement, it's like we see here, for one contract and another. [See Gawande A, The cost conundrum. *New Yorker* June 1, 2009. McAllen's health care costs are the second highest in the nation.] The average here is the average there, what can we, how can we use what we know to make it work better? And I know the – I think the leadership really tries to struggle with that and it is difficult.

MM: Yeah, but, as you say, it is difficult. If the revenue is sort of guaranteed, it becomes –

AC: Way too easy to –

MM: One of the things that I think you stressed when you were Director, though, was performance outcome measures.

AC: Yes

MM: And trying to set targets and measure each, I guess, each agency in terms of the outcomes they were showing. Do you think that's been applied successfully?

AC: No, none of the data stuff has really worked. The only area where it did work was on the PARTNERS and the subsequent service delivery; and thank David Pilon for that and MHA, because he really got the original grant to be able to help us start measuring on PARTNERS. But at the State level, when we taught health reform, or mental health reform and mental health plans, with the leadership of the family members, we emphasized that everywhere we went. And I guess it was when we did the State plan in nineteen eighty something, where I vividly remember we highlighted there the fractional, fractionated, discontinuous measurements that were done. Hospitals said, "We've taken care of the person and we've stabilized them and we've put them in the community;" and the community says, "Well, we got them or they don't got them, and so we don't have him and so we're not responsible." Trying to make the system accountable over time and recognizing that it was an over time measurement that was necessary, not episodic. That really, really was so visible and so evident in the meetings that we had around developing that State plan, with all the stakeholders and the family members and everybody just emphasizing it. We all agreed that that's got to be the way to go and some of the Mental Health Services Act says that but what happens? Data collected and nothing happens. I've never seen a report on outcomes since I've been gone. So, you know, whoops.

MM: What's sort of happening with that?

AC: Yeah and again, I know David has done them and they were used in helping get the legislation out, and that stuff you see. But the kids stuff, there I am working for kids at Healthy Families and I can't say that – we have a benefit that the County is responsible for, the SED [Serious Emotional Disorders] Benefit. SED was already by State law, the responsibility of the Counties whether they had money – whether they were MediCal or not.

A hundred percent if it was a non-MediCal kid. So, when you go to Healthy Families, you could say, "Well, [for] those kids who were SED, County is setting up an SED system, they should serve them too, and then they get the federal match for those kids." Fine. Well, it's a complex, difficult system and people want to take it away from the Counties. Can I say to them, "We did it because we thought the Counties were developing the systems and they knew better what to do and they would have better outcomes?" I don't have any outcome measures to show. If I can't tell them that, then why not just let it be with the health plans, because at least that way we have accountability and MRMIB [Managed Risk Medical Insurance Board]. MRMIB has no accountability from the Counties. They don't answer to us. In theory they do, but it doesn't mean anything to them. We can't make them do anything.

They say, "Yes we'll serve the kid; or we don't." Some Counties are saying we don't have enough match[ing funds] to do it, no matter what. That's what's happening now, with that erosion of that basic core set of programs. So, given that case, put it all in the plans, because they will charge us and we'll pay, as long as we are covering anybody. And when we're not, well then, the Counties are going to get them when they are severely ill any way, one way or the other.

MM: One way or another. Wow.

AC: So it gets discouraging, I have to say. When things are tough like this, [that's] when I wonder if it has been worth all the time and energy and effort that I have put in to trying to make things better. Now, I know that we're a whole lot better than we were when I came into the system, not by virtue of me, but we are as a community wide system and what we know and what we can do. Thank goodness for the whole set of people who work on making that happen. But it does make me feel like a lot of my energy was very futile sometimes [she laughs]. So it's discouraging.

MM: Well, we'll try and think more positive.

AC: [She laughs]

MM: In terms of – you did work in terms of employing more consumers and I wanted to know if you wanted to talk about that a little bit. In particular, if there were clients who made a particular impact on you or changed your thinking or whose stories you were really impressed with.

AC: Yeah, you asked me a lot the other day about, did I change my view of consumers and I thought, "I don't think so." But, since then, I've thought, "Well, yes, of course I did." I learned a whole lot more over those years and, when I started, the prevailing view was that if you had a serious mental illness you were sick forever, beyond recovery. And even if you did rehab things, well, it was nice, but it was not going to help most of the people who had serious illness. It would help people with intermediate levels of mental health problems. [pause] And obviously, I have come to see that that was far too pessimistic and that to some extent, you could argue that without doing anything there is a certain percentage who would go into recovery anyway. I mean that's some of the Vermont story, and we know that that happens. And I always said, "Well, that's nice;" but we don't have to [she laughs] worry about those people, because who knows.

But no, over the years, a lot of consumers and family members. So let me just give a few of those stories. I told you the story about the Weisburds. That made an enormous impression on me in how difficult it was. Their young man had been in contact with the most prestigious people in the country and had had very expensive interventions. He had weeks at Orange County, at Irvine with Biff Bunny, and he had lots of other times when they struggled in hospital and they would keep him a long time and think they had him well and put him out and of course he wasn't, he would be reverting back. And then over time, as David [the Weisburds' son] got on the new medication and had what looked like a miraculous recovery and then was found to have that disorder that means that his life was threatened and they decided to take him off [the medication]. And he's gone back and I see him now at The Village things and he's much more like the old picture of the chronically ill person, so watching that, my heart was involved and what did I learn? I learned a lot about trying to be more creative and trying to work more closely with families and consumers and staff and so on.

I guess I have to give great tribute too, to Don and Peggy Richardson. Don was one of the earliest leaders of the Los Angeles AMI movement. There were others, but he had been an executive in the LA Unified School District and he understood better how to work with bureaucracies and not to be angry and confrontative, which would turn everybody off. He was just wonderfully smart and able, and a good leader and worked well with us and worked to moderate the more stereotypical family members who lived out why at that time the staff didn't want to deal with family or consumers or anybody – they all thought, they were, they had so much of that psychogenic idea in them and some of the parents acted like it, [she laughs], so it was. But Don and Peggy bridged that beautifully. And when Peggy was attacked by their son –

MM: Yes, how horrible.

AC: You know the whole story?

MM: Yeah, Stella March told me.

AC: That was just so tragic and again, oh my goodness, how we failed, and yet we didn't know. We thought he was doing well and they put a finger then on the substance use and the other parents did too, that even one beer and there seemed to be a change in the behavior of their kid. And that gave birth to the whole dual diagnosis, with substance abuse as opposed to developmental disabilities, which had been the only dual diagnosis we'd ever talked about before. And so learning again from them, and I guess I've always believed that you listen to people, and you trust them and you accept them, as opposed to many professionals who wouldn't listen and wouldn't believe and wouldn't trust what was told to them; and I think that's maybe a major difference of mine, which probably comes out of my religious background. So that was the next major force on me in terms of the consumer and family groups.

Then, when I was in San Diego, I had some friends who were consumers and family members and they were wonderful advocates and smart and reasonable. And we could sit down and talk and say, "Now, how do we make this work, how do we do this?" And I had staff who taught me a lot there and staff who did the homeless outreach and talked about this person that she met under the bridge every week. I got just a lot more comfortable and knowing that you could do a lot if you are just flexible and get out there and don't stick to a [she knocks on the desk] in the office, all that old stuff that was so rigid. You've got to really, really get out there and be flexible. I had one friend down there who was a poet and we were cutting services at the University Clinic and she was one, like this lawyer [Elyn Saks], who said, "This is what keeps me functioning. I need that frequency of contact." And so I learned from her.

Then here probably, there was a consumer named Gilbert Tolliver, who was a homeless drop-in who ended up doing some work at MHA in their outreach program in South Central Los Angeles. And when we started doing rallies around the state budget in Sacramento, and the contract agencies here and MHA took a great lead in getting busses and getting consumers to come up and rally on the steps of the [State] Capital, and so on, and getting a huge turnout, people talking about what they needed. And so that was all terrific. And Gilbert

collected, he wore bib overalls all the time and he collected buttons, all kinds of buttons, so I've collected buttons. I have them on a ribbon and when I go to one of the consumer things, I wear that and I say, "In memory of Gilbert," all the buttons [she laughs].

MM: That's great.

AC: I'll never forget Gilbert, I mean he was just a lovely guy and he could talk to me and tell me stuff. And then, I guess, probably the two other people with the biggest impact would be Pearl Johnson and Bill Compton. Pearl was one who was hired at the USC Medical Center when I – remember when I said I came and I tried to get them to work on their high users and set up a follow up program there to work with people out of that clinic? Well, Pearl was one of the ones they hired and she had been with the MHA and was hired there. And Pearl became very comfortable speaking and telling people her story and Dick Van Horn did wonderful things for her, when she had been as an advocate, he brought her to international gatherings. And she came back from one and was picked up from on an old arrest warrant. Do you know that story?

MM: No, I don't think so.

AC: She was, well, Pearl was in her 70's when all of this started. I think 60's or 70's, and she might have been a little younger, but she was not a kid. And she'd had a long history of hospitalization and drug use and all kinds of stuff, and jail, but we didn't know about this last jailing apparently and it was like a ten-year-old warrant. When she had been working with us in the County, in MHA, and going on this trip with MHA, which was to talk to consumers in other countries, came back, got arrested. Ended up in jail –

MM: You mean at the airport?

AC: Yeah, at the airport, coming in. [She laughs] And so Dick Van Horn, we got our mental health staff at the jail. Anyway, it took all the strings one could to get her out in a reasonable length of time. And I don't remember the details of the story, you might want to go back and ask. But that's one of the stories that Cora [Fullmore] knows the family and Cora has a lot of the contacts and I have said, "I want that story for sure written up in considerable detail." Pearl used to say, she'd cost the system a million bucks, before we started getting smart and putting her to work and getting her involved as a productive consumer. So she would say, "I'm the million dollar baby." Pearl also was rather typical of the African American community in her faith statement. And over the years she became more open; and in the last years, every time she got up to speak, she would thank God and praise Jesus for where she was and what was happening to her and then she would go on and told her story. It didn't start out that way, but that's a very important part of cultural competency for people to know that that's okay. It doesn't mean she's crazy [she laughs], that she could do that. Anyway, bless her heart. One of the first times I met Pearl, she was a volunteer MHA brought up to work at the registration tables at these rallies in Sacramento. And she would be all dressed up with her hat and her fancy dress like she was going to church, and at first, I didn't know she was a consumer at all, so she

could do just fine. She could pull herself up. She was good. And then Bill Compton, I'm sure you heard all about from Dick Van Horn.

MM: I don't think so. Tell me about it.

AC: Bill. Well, first of all, I have to go back and say, when Dick took over the executive directorship of the Mental Health Association in Los Angeles, Dick Elpers asked him to do one thing, which was to start the newspaper, *Connections*. Dick Elpers didn't say, "Name it *Connections*;" that name evolved. And so we had that contract. And the other thing that Dick Van Horn, by virtue of his openness and connections – there was a rehab counselor at the VA named Rhoda Zussman. I'm so pleased I'm remembering some of these names. Elyn Saks is the lawyer [she laughs] E-L-Y-N-S-A-K-S. Okay, anyway Rhoda was doing rehab work with the veterans out there and some of it was a club and they did some gardening and then they started to do improv acting and the idea was to expand that. And so with consultation between Dick Elpers and Dick Van Horn, [we] came up with a contract for consumer clubs, and that became: Project Return.

Now, the early Project Return clubs were staffed by some DMH staff who volunteered to help them, and some of Rhoda's staff, and a lot of people who have been prominent in mental health in LA County kind of got their start there. Bill was one of the early people who came out of one of the clubs and out of that club he became then – They had started hiring consumers to do the staffing support for the club. It was like a ten-hour-a-month job and it didn't threaten their Social Security or anything else, but gave them something to do and some income and some dignity and some function and built on that.

Bill had a history in the arts. He had a master's in theater arts and was working here in LA as, I don't know, something in theater, production or something like that. He wasn't an actor. He had a major break, lost everything he had, his apartment, everything he owned, ended up homeless, using drugs, the whole works. Ended up in a board and care home, obviously because he had been hospitalized, and went from the hospital into the board and care home; and there was a Project Return there and he got into the Project Return. And with their help and ongoing clinical help, and so on, he started to recover and moved up through the ranks of Project Return to be the Executive Director of Project Return for the County. And he was in that role, either already in it when I came to LA, back as Director, or quickly moved into it. And we used to – he'd come to talk to me to defend the contract and [say] we should keep the contract and expand it and so on and what we were doing and he would give me the whole story and he always did a very good job. He was always so nervous. And yet outside, I'd been interacting with them at Project Return events and go to their picnics and so on, and I think they all thought of me as a friend. But he would get very formal, which is appropriate, and I would be very formal and would go through the program as Director and [discuss] the contract. It was a lot of fun, he was a great guy.

He became very active in the Mental Health Association nationally and with Dick Van Horn's encouragement and everybody's from The Village, took a leadership role in consumer development around the country. Now, they have an annual

conference called the Alternatives Conference, do you know about that? The consumers do and it's a national conference and they do it every year. [The Alternatives Conference is organized by the National Mental Health Consumers' Self-Help Clearinghouse, with partial funding support from Health and Human Services. The 23rd annual conference will be held in Omaha in the fall of 2009.]

During all these years, the support for the consumer movement was built up at the national institutes, at CMHS and ADAMHA and all of them involved in that and supporting some of that; and so the network of leaders from various locations got involved in that, so Bill became that. But he became also very active with the MHA and that brought him into other spheres. And then he also did a lot of going to the International World Health Organization, and what's the name of the international mental health group [IMHRO, a consumer and family based group]? Anyway, he would go to those meetings, so he got a lot of bonuses, international travel and acknowledgement and recognition, and so on. So his is another story that needs to go in, in some detail. He died recently of complications that arose from his IV drug use. He needed a kidney transplant and never got it; he also got cancer, so that was the end.

Other consumer people were not local. But Sally Zinman, who was a very strong leader of the statewide effort, the NAPA group which was called Network Against Psychiatric Assault. And in the 80s, NAPA was a very strong force and they were very hostile and belligerent to all systems and existing programs and a lot of Counties had a lot of trouble with them. And NAPA tried to get a foothold here, and I think they didn't succeed because Project Return was doing as well as it was. And that gave a productive forum for people to be involved and try to have input to what was happening and they didn't have to be so combative. But over the years, Sally and I have gotten so that we can be on boards and meetings and [get along] just fine. She's no longer angry at me, although in those days I represented the establishment and people were mad at me.

Another good consumer lesson for me was a man who is a psychiatrist. His name is Dan Fisher and he is a psychiatrist, not a psychologist. And he also had schizophrenia during his younger years and went through all the treatment and all the illness and came out the other side recovered, but a very strong consumer advocate and he runs a social support program in Boston. He was named by the National Mental Health Association, which is now Mental Health America, [which] started many years ago honoring consumers who made a contribution to recovery and wellness and they call it the Clifford Beers Award. [Clifford W. Beers, 1876-1943, founded the National Mental Health Association in 1907 after his recovery from mental illness; NMHA later became Mental Health America.] And Dan Fisher was a recipient; Bill Compton was a recipient; Judy Cooperberg, who runs the MHA program in Antelope Valley, was a recipient.

Judy is another consumer I should talk about, because she has been in recovery so long that one almost forgets that she's a consumer, because she's been running the MHA programs for MHA in Antelope Valley for so long that she – But she was back in Washington, because it was the hundredth anniversary of the MHA and they were honoring all the past Clifford Beers winners who came. And she did come and there she acknowledged some of the difficulties that come from her illness. Like she said, "Well, you'll notice I sit with my back to the wall

with no doors where anybody can come out me and surprise me,” and things like that, “I still have to do that when I’m in an unfamiliar setting.” And, of course, at the MHA meetings, they have rooms where support is available and people can get help if they do find it too stressful and difficult.

Other consumer stories – Yeah, Dan Fisher and I became friends, I don’t know why, well, because I brought a lot of advocates of psychosocial rehab here to speak. We had conferences, we sponsored them, we tried to get people here to get indoctrinated to learn more about it, and I guess I had Dan at some of those. Who else would be on that menu – Oh, Larry Fricks who was a consumer man in Georgia, whom I met on the MHA Board, and he helped design their Medicaid program so that they would pay peer supporters, in other words, hiring consumers to be in that support role; and they changed their whole Medicaid system rather profoundly with Larry’s effort. He is also on the MHA Board and I met him there. So Larry and Bill were the best consumer advocates on that Board at that time. Now we have a couple of young women on that Board, both of whom have suffered from various – one, I think, is diagnosed bipolar and the other may just be severe depression – both of them taking a role in being advocates on campus. And they are both in college, so that’s again progress of the movement. It’s really good to see.

MM: That is cool. So I don’t want to put words in your mouth, okay, but we started out saying, okay, we’ve changed our idea about the mentally ill about them not having them to be –

AC: Yeah.

MM: But when we talk about recovery, we talk about wellness, which is what, we throw these words around a lot, but I mean it does sound as if you are talking about people who are quite high functioning, but they need their, how would you put it? They still need –

AC: Some support?

MM: Yeah, ongoing.

AC: Yeah, well, I actually think most of us do [both laugh]! I mean, long ago we had a campaign here in California: Friends Are Good Medicine.

MM: I like that.

AC: And we had posters. It was a wonderful one. Well, now, you turn around and you look at divorce rates [which] are associated with ill health of all kinds. Married people live longer, [and] it’s just all of that. We need, we are not intended to be in isolation.

MM: In shells, yeah.

AC: So we need various kinds of support and some a little more than others. And some people we say, well, they are very needy [she laughs], and they may never have a psychiatric diagnosis, they survive with friends who tolerate their

neediness and they figured out how to get all that. Yeah, no, I don't think – it's a titration and I think, if you are working with a professional, they can help you find the ways to get that support that may need less of the professional. It's very hard for professionals to do that because that's cutting out their income in a way –

MM: And their role in life.

AC: Yeah. And there's now a nice campaign that MHA is running, "Live Your Life Well" and it's online. And you can get to it and it will, it's kind of like a daily dose of things you need to pay attention to for yourself. Now, I don't go to that, I've just gone to it enough to look at it and say, "Oh, this is cool." I'd like to get more people to know about it and so there are talking campaigns. It's part of the early intervention and prevention stuff is to get some of that out more broadly and I think that campaign is funded with national dollars, or Federal dollars, I'm not sure. Anyway, it's that kind of stuff that I think, that's good, but if it is a severe disability, then I think it takes that much more skilled support to keep it going. Although Judy, I don't think, is in therapy, but she's had enough to know what she needs to function well and to recognize, "Okay, this is what will keep me from going really off the deep end again." Well, then, she succeeded. But I go up and down with my physical health, my mental health, and I think I know enough to know when I'm down, what I need to do about it, and it's up to me to go do it [she laughs]. That's where we are, right?

MM: I hope we are. We all probably need to know how to do that better.

V. Disaster Response; Services for the Incarcerated; Rewards; Work on Healthy Families; Retirement and Aftermath

MM: Okay. A couple of specific questions about things you had to deal with. Right after – very soon you became Director, there were the Rodney King riots and I guess that required a big special effort on the Department's part.

AC: Yeah, we ran Disaster Responses the whole time I was Director, it seemed. Yeah, that was right after and it was a shock; and I knew from nothing about what we should do. I had been around when the airplane crash in Whittier took place. That was, well, you got to read in front of the history book. You read Supervisor Don Knabe's statement and he talks about the mental health response to that disaster and how it helped him and helped him realize how important mental health was to everybody. It's a wonderful statement.

MM: Good for him.

AC: Yeah, good for him. So I was around then and knew some of that story and we went out and tried to be there and provide crisis counseling and so on. Nationally, people learned a lot more about disasters and how to do the mental health response after Hurricane Andrew in Florida. They did a great job and we learned from them. We had some disaster training things here in LA; I guess that was after I was Director, I'm not positive when, but I think it was after I was Director. And it was in between Disaster Preparedness before the '94 earthquake, which was the next big one after Rodney King, and we got some people from UCLA, [Dr. Robert] Pynoos, who did some consulting, and then

there were people from the faith community and we tried hard. In the end, it seemed that what we did was not as creative and responsive as I would have liked or some of the people might have said, but again you end up with what you've got and you've got to work around it and do things. So, and we got a lot of help from surrounding counties that had done disaster training, and they sent staff for a week at a time to help just be there for crisis counseling and available to talk with people and try to calm things down. I also was in the Department after the '65 [Watts] riots.

And, see, I came to the Department in '66. But it was still very much a part of the ethos of the Department, the fact that good mental health included helping the community be strong and understand its power and so it was almost a community organizing philosophy that was part of what prevailed in the Department at that time. So I had some of that and I think that colored and gave permission to more community organizing in a way at that time; but in the meantime, of course, the Department had shifted from anything with the remotest community organizing.

Anyway, so yeah, that was hard. Kathleen Snook was the chief deputy and Kathleen was very good at organizing and getting things like that together and getting the billing and all of that stuff organized. So it went on okay and learning out of that then, we had a massive response after the '94 Earthquake and a lot of help from surrounding Counties on that and a lot of disruption of everything else for staff to go and do and be and help out and so on. We ended up having some people who we were convinced were fraudulently billing and some of that persisted until quite recently, before those accounts got straightened out, the lawsuits, the appeals, whatever. I mean, Kathleen came back from her retirement and testified a few times; and I happened to see one of the people who worked for us, who is in the Disaster Office down at the CEO, and she said they had just finished some of the last construction-related claims from the '94 Earthquake.

MM: Holy cow, yeah, I believe that though.

AC: [She laughs] So I confess, it got not as much of my attention, once the initial was over and we got more or less organized, again, Kathleen being very vital in all of that. It wasn't where my heart and my passion was. Mine was much more on the rest of the system, clearly. Some fault me on that, that we didn't do enough. Anyway that's the way it was.

MM: Do you think, I mean was that in any way, did it help the ongoing programs possibly by identifying people who needed help or making them more aware of the services?

AC: I never saw that.

MM: Okay, so just a sort of a leap?

AC: Well, it was a long big leap. It was more disruptive than anything else. We did not feel that we identified many people out of all that, who really needed serious ongoing help. A few, you know, a few. But mostly it was very situationally

oriented crisis intervention. I suspect that it's one of these things that you get it started and it's very self perpetuating.

And [pause] that's kind of where we ended up, I think. Not that you would ever say, don't do it, or cut down on the response. *Au contraire*. You need it, absolutely, but try to, well, on any of these things, you try to do it quickly, you try to get to people as quickly as possible. Help them over that hurdle and then have some residual access for the ones who have ongoing distress. I think that's hard to organize. And then we had fires and floods and we had to respond to those. And so every fire, every flood, we would follow the fire; we had continuous disaster response from the Rodney King, right up until I left. And as I said, the '94 claiming stuff was still going on.

MM: And certainly fires have gone on, right up to the present day.

AC: I don't know what the department is doing in response to those now. I think it's a lot more minimal than it used to be, than it was for those two [disasters]]; that's probably wise [she laughs].

MM: Okay, now throughout the time that you were Director, there were ongoing concerns about the incarcerated mentally ill; and there was a task force which published a report and said this was horrible and nothing much happened and then there was a lawsuit, I guess.

AC: The Department of Justice came in and claimed basically control over our programs. Well, they investigated, they didn't take on control, but they had regular monitoring. What did I think about all that? Stop and think a bit. I was pleased that we *had* services in the jail, thought that was a necessary component. We had had services in the camps for juveniles and in the adult correctional facilities all the time I had been around and that seemed reasonable and right. A lot of the problems that evolved in the jails ended up with a good deal of finger pointing. The mental health staff saying, "We didn't have the information, we don't know, how can we do this?" being very upset when the jail people released people in the middle of the night without – We had one classic case which was the stimulus for the lawsuit. The guy was released at midnight with no money, no nothing, and he had a mental illness and there was no connection with services or support, there was no –

MM: That's horrible.

AC: Oh. it was horrible, indeed. So we blamed each other a lot. And I was in a situation where every year, we were cutting services. I cut state hospital services, beyond what I did for the PARTNERS, practically every year. If there was a year that we had no cuts, it was good. We never got a year with increases, so where was I going to find money to expand the services in the jails? We planned for the new jail and to get services in there and we tried hard to collaborate in terms of the design of the units and how they were going to work. They closed, as part of budget cuts, they closed the women's jail out east towards where the Edelman Courthouse is now, the Sybil Brand Institute [the Sybil Brand Institute for Women, which opened in 1963, was forced to close in 1997, after sustaining damage in the 1994 Northridge earthquake which the

State and County have lacked the funds to repair]. But I visited out there and it was at that time that they had some substance abuse services there, tried to get that fixed up and talked to my staff. And the staff seemed [as if] they were trying hard, they were doing the best that they could.

But the sheriff and I would have regular showdowns in which he would claim it was all my fault and I would claim that it was all his fault. Jerry Harper was the deputy sheriff and I said to him, "Jerry, you've got to do that. It really should be in your budget. When I keep people out, I save your budget." [she laughs] Anyway, before I left, we did get an infusion of money, and I budgeted to put a large amount of it into an expansion of the jail services, so that the new jail could open with adequate staffing for the mental health units. And a lot of people in the County and the community were very critical of me for doing that and they said that I should continue to hold that it was the jail's responsibility to budget. And I said, "No, I can't do that. We're a team in the County; and where we have some money, then we have to use it and this is a priority that has to be taken care of."

MM: It is the people who suffer.

AC: Yeah, well, the people who are in there. So that's where that was [she laughs].

MM: Okay, so sort of a summing up question then. And you could answer this in any way you want. I usually say, "So tell me what you thought was most rewarding about your time as Director and then tell me what you thought was most frustrating about your time as Director."

AC: I think what was most rewarding to me was the feeling that the community and the staff and I came to share a vision and had a lot of energy and enthusiasm to turn things around and to implement the better practices that would be more responsive, more forward looking, more recovery- oriented, and recognizing that the broad needs that people had [for] housing and so on, those were part of our mission and doing it in a comprehensive and thoughtful way and looking to make things better. And I think I thought that was pretty well established; and that we had good working relationships and we had teamwork with other entities, such as the criminal justice people, and we knew we were there and working together. Now, there's a lot to be done in many areas, no question that there's a lot to be done; but that felt right. I felt that I was respected and that I deserved respect, because I had done hard work [taps the desk] and had done some hard things and that it was with the right values; and that people understood what was going on and that the contract agencies and County staff and the families and consumers all were pleased. I think I was probably *most* pleased that the consumers seemed most pleased about the turnaround, that I got a reputation among consumers that I pushed for consumer hiring and I pushed consumer rights and I didn't perhaps realize it as much when I was there as I have since, how they've still come and talked about that, in San Diego as here. So that's very satisfying to my soul.

MM: Yeah, that's nice.

AC: It was satisfying that I got along well with the Board [of Supervisors]. Shortly after I retired, the CAO asked me if I would come in on an interim basis to run

another department, DCFS [Department of Child and Family Services]. And he said that I was the only person he knew he could get a unanimous Board vote if I would do that, which was a great tribute, to blow my own horn a little bit. I said, "No, thank you, I don't want to do that."

MM: Not sufficiently flattering.

AC: Flattery will get you nowhere in that case. [pause] What was *most* distressing was not having more resources, knowing that more could have been done had we had them. Feeling we didn't make enough progress on dual diagnosis with substance abuse, we didn't make enough progress on medical school reformation, so that the psychiatrists would do better and work with this new system better; that's still going on, that's still not there. This long laundry list of things I would have liked to accomplish that we didn't. Don't need to go over all of them.

[Pause] I went into the Healthy Families Program. I actively lobbied to be the mental health representative on the Healthy Families advisory panel. The Board that ran it, I had no interest in, although I am now on that Board. But with this new program coming, and recognizing that mental health was part of it because we had a slot on this advisory panel, I thought it would be a very exciting way to continue my interest in getting better care and better integrated care for everybody; and in this case, it was an opportunity for kids. And I really looked forward to working. I thought, "Oh, we'll be working with pediatricians to get them to identify the kids that need mental health services and therefore would be able to get them their services and won't that be wonderful;" and I have been disappointed at how difficult that has proven to be. But I'm still hanging in there on that, with that same goal of getting the kids who need it and tracking who's getting it, and I'm sure a lot of that wouldn't happen if I weren't on the Board. So that's kind of a nice sequence to what I was doing here in terms of system improvement efforts and again recognizing how hard it is to make those efforts. So I could feel good in retrospect about the success that we had and it looked good at the foundation that we made for the Mental Health Services Act. People have continued that effort and used it and that's good.

MM: So was there any particular reason that you decided to make this transition in 1998?

AC: Well, I was a believer that 5 years is a good length of time, and I had gone beyond it. I missed Kathleen, although I knew what my target date was when she retired. I was pretty sure it was going to be about then. I particularly wanted, while I was healthy and able, to be able to spend my whole summer at the cottage [she laughs]. That was my real incentive and I just thought it was time; and as I said, I thought I had done enough of the foundation laying for future work that I could go away and not feel like I just put my hand in the pot and stirred it and it all went back to where it was before. That's a metaphor that my former boss in San Diego, the Navy doctor who was the head of the Health Department there, when I was the Mental Health Director – and I told you that mental health was part of the Health Department – and he retired from San Diego a couple years after I left San Diego. And I went back for his party and I was talking about something with him and he said, "What we do is we just stick

our hand in the bucket and stir it around as long as we've got our hand in there and we pull it out and it settles back where it was." [She laughs] I said, "Oh come on, Bill." I hope not, and I don't think that's true, because he did things that brought people together, that were constructive, and I think I did too.

MM: And can you tell me anything about how Marv Southard got to be Director?

AC: Dick Van Horn took an active role in getting Marv. Dick liked Marv, and I like Marv very much. I think he has all the right values and he's a wonderful speaker. He's a better speaker at events than I ever was [she laughs]. That was not my strength. [I could] never do a good job as a speaker. My dad was a preacher and people wondered why I didn't become a preacher; I said, "Well, because I wasn't good at that!" [she laughs]

MM: Okay, since leaving the Directorship, you have been involved as the mental health representative to Healthy Families and what else have you been doing?

AC: Well, the Healthy Families advisory panel goes on, but I was asked if I would go on the Board proper and with the support of the – it's a five member board called Managed Risk Medical Insurance Board [MRMIB] and they run three programs, one in which is the risk pool for people who can't get insurance [due to pre-existing conditions (MRMIP)]; and one is Assistance for Infants and Mothers [AIM] and the other one is Healthy Families. And the infants and mothers (AIM) is a way for low income women to get their pregnancy care and their maternity care, so that new citizens are healthier than they would be otherwise.

Anyway, the [Assembly] Speaker's representative on that Board wanted to retire and knew me from my work on the advisory panel because I chaired the advisory panel one year. And while I was chair, they asked if I would go on the Board; so in the end Bob Hertzberg, who was then Speaker, appointed me to the panel and then I was reappointed by [Speaker Fabian] Nunez. This term expires at the end of December, so I will be asking [Speaker] Karen Bass to reappoint me, I think. I mean, I think I will ask. I am going to wait until the end of the summer. There is no point in talking to anybody now, anyway, because they are all so crazy with budget and have been all spring that they can't think about this, so that's fine. Anyway, that is a major responsibility.

Then, when I retired, [I remained on the Board of the California Institute for Mental Health, which I had been on since it was established. I was active in the American College of Mental Health Administrators, which gave me a Lifetime Achievement Award in 2005. In 1998,] I was elected to the Board of the National Mental Health Association [now Mental Health America, in Washington, DC; no conflict of interest because it was a national organization] and I served two three-year terms on that. And four of those years, I chaired committees of the Board and that put you on the Executive Committee. I chaired public policy two years and that's all they would let you do, was two. So, the first year I was on, I didn't chair anything and then I chaired public policy for two years. And then I was on adult services and children services and strategic planning and the nominating committee; and so I was busy with that for six years and then I remained on committees of that Board since then, which I go back for. They have quarterly meetings, so I go back to Washington [DC] for that, or I do it on conference call.

And I have just resigned from those committees and said that it was getting too hard to do it. To go back there for one day of committee meetings is a lot of time and energy and, of course, I was doing it as a volunteer and paying my way. And I concluded I am sufficiently far removed from what's happening on the ground that I did not feel my advice was still useful. Now, people are very kind and say, "Well, that's not true, you have a lot of knowledge," but at this moment I'm off. The chair is asking me to come back on, so we'll see. I don't know.

I am on the California Mental Health Association Board and I have been on the MHA of LA Board. I waited a while after I was retired to do that; I waited two years. There's no statute in LA, but that's a fairly standard time period so that you are not accused of conflict of interest. And I felt okay about doing it, because they are the only organization that is a major advocacy group and that has pushed for the consumer in a way that no other agency does. I mean, they all do some talk, but MHA has walked the walk. So I have done that, and went from being on the Board to being chair in the past year. Now I'm off the Board this past year. Those are the only mental health things that I do. I do a lot of church things.

MM: So a very busy retirement?

AC: Yeah, too busy. Too many committees.

MM: So what observations do you have on MHSA? I mean, as you say, you are speaking out from a more distant perspective.

AC: I appreciated that Marv asked me to go to be on the [LA County] Stakeholders group as part of planning to implement the MHSA. So I have seen most of the Stakeholder process and I was just blown away by the extent of the participation and the organization of it and getting it systematized and so on, and that was terrific. When I was director, I had regular meetings with, of course, the Commission and the NAMI groups and the consumer groups; and then I had fairly regular times, when everybody was invited for a kind of a "Here's what's going on" session, which was as close to what happens at the Stakeholders meeting as I had. But it was smaller and there was far less outside [non-mental health] agency and consumer participation in those meetings, so I was very, very pleased with that change. I think that was a very good thing. It is part of the whole community empowerment. It's very time consuming and expensive and all the rest of it, but I think it's good.

Now, as that morphed this year into giving the leadership group [System Leadership Team] more power and the Stakeholders less, that's okay. It still seems to be holding up okay. And then the effort at the local areas to get more people involved, that's good. That needs to stay, that needs to expand into more communities and get more people involved in the local areas and perhaps find more ways to get more focus groups. You know, people aren't going to go to a series of meetings forever; but if you could use that group and get – so in this community, let's get all the clergy and schools and some other people together and get a focus forum for them, just once, and just do that and go on. I think that would educate those people more; because we're not, we're still, in spite of all the numbers, I have a strong sense that it's still very much [that] the inside group

stays the same and has not expanded enough. It has expanded, and I am very, very impressed and pleased about that.

As far as the program expansion, I haven't seen any data to know what's really happening and that just makes me sad. They try to get it, I guess it's on the web; but you've got to make an effort to go read it. You go to the meeting and they talk about the projects that they are working on at that moment, but there's not a vehicle in which [they present] "Here's what we've done so far in terms of numbers of people and what's coming out and outcome measurements," which would be good. But they'll get there.

MM: Do you have a sense of what they're asking clinics to do was too difficult or too complicated or – ?

AC: I have no direct feedback. All I know is [there are still a lot of difficulties in getting people the care they need in any system. I get very disturbed] when I hear that nobody is serving anybody but Medicaid patients and somebody will say to me, "I need help, how do I go, and where do I go?" My son is a clergyman and had somebody in his congregation that needed help and he sent him to one of the clinics. Well, no, he didn't have insurance and he wasn't poor enough, so he couldn't get any help. Then I called the County and got a County clinic to agree to see him; by that time, he wouldn't go. So he'll be back probably in worse shape. That's just one example. And the other similar kind of experience – my granddaughter [was] suicidal. Well, before she was suicidal, she was depressed and so they found through their insurance a therapist whom they liked. But, when my granddaughter ended up in the hospital after 2 years of therapy, I said, "Well, what's the matter here, come on!" And I got serious about what she should be getting and they got more serious about listening to me and using the Department's connections to find somebody who was using evidence based practice for the situation she was in. The therapist she'd had didn't know what those words were.

MM: Oh, dear, that makes you wonder.

AC: And on top of that, [the therapist] felt so connected to the child that she threatened legal action for child abuse for taking the child away from her. She said, "She needs me." So we know there are an awful lot of bad practitioners out there and we should talk a lot more openly about these things. We rely on the evidence from clinical trials, where we know people and they are outstanding, it's all going to work; and we know all that. But sometimes I feel, am I being dishonest when I'm pushing what we can do and all the good that can happen, if it's not standard practice everywhere? [taps the desk] So I would like to see more of an emphasis on that everywhere, including in the public sector system. I'm thinking of letting the mental health benefit of the Healthy Families go back to the health plan.

MM: Really?

AC: Well, if the Counties can't guarantee to do it, and some Counties are saying they won't do it at all and I have no data to prove that it really is better, how long could I go on claiming that? So, and I get the impression that the Counties don't care.

MM: Well, maybe, now they are getting the funds they need.

AC: Well, no, they are not getting the funds for that again, because again that core amount of money is shrinking and the match for the Healthy Families, even though it's a two thirds match, the match is coming out of that shrinking thing. And they see that they have a legal mandate from Medicaid, but the Healthy Families – the SED is as resources are available. So we continue to fight that. It's like the parity law nationally; if you offer more mental health benefits, then it must be at parity with anything else, but you don't have to offer it.

MM: Yeah, that's the way you get out of it.

AC: And in a way, it's exactly the same thing with S-CHIP [the State Children's Health Insurance Program, a federal match program]; we are not required to offer mental benefits. Yeah, exactly.

MM: There's always a way out, isn't there? So the last question is if you have a particular vision for mental health. If someone gave us a billion or 2 billion dollars, what would you like to do with it? What would you suggest to Marv that he do with it?

AC: Well, I guess, I would put a lot of investment into the IT to make sure that we can track and monitor down to the individual outcomes; and then I would be putting a lot into continued feedback and work with people to be the flexible treatment and support system that we need. I am happy with early intervention and prevention activities, especially the ones that really can get heard by people, the population at large, getting them aware of that. So there would be a lot of what's in that early intervention package that I certainly support, but I think those things are needed. I'd like to see psychiatry trained to be more relevant [she laughs], understanding how to be more relevant with the changed system.

We know from the Institute of Medicine we've got to do a whole lot better at getting the health and mental health people together in order to get the maximum outcomes. We say it, but we don't know how to do it. I mean, we do know a few places where it works and it a lot seems to be in the Federally Qualified Health Centers that seem to do a good job at that. Our Department isn't doing a thing to really systematically enter into partnership with the community clinics here in LA, and that's too bad. And I know some of that comes from the history of being placed in the Department of Health Services, health centers, with that same idea there, then. They should integrate; it should make it easier for people to go back and forth, there should be less stigma. Why it didn't work, and we just need a lot more of the support people to help things work. And I think people get trained to be therapists, who don't have that system skill and we need people with the system skill to work alongside. So to some extent, if we had all the money in the world, there would be a whole lot of double staffing, while we transformed.

But, as far as the Full Service Partnerships and the Integrated Services, I just like to see those again live up to their promise and I'd like to see the flexibility to see people, as we talked about Elyn Saks and the poet in San Diego, who need ongoing support. You know that they need it and that it keeps them going. Now,

can we pay for it? Yes, we can, because it keeps people out of those expensive, even once a year, hospitalizations cost so much. But I could just go on and on about the savings here, that aren't in their budget [she laughs]. When we make savings for the law enforcement, they don't know it, because they are all in such an abysmal state of needing change. I'd like to see a lot more done with kids, early ages and stages, that work that we know in terms of helping parents and families. I just think that's a major investment that should pay off. More parenting help, every teenager who's in the special schools should have real in-depth work. Now we know, from prevention field visits by nurses to every new mother, [that] that saves all across the board. It's good for mental health, it's good for health, it's good for the family. It's just amazing what that one single little intervention can do. That's documented, it's well established, those kinds of things. We just need to do more of them.

MM: We just need to follow up on that knowledge.

AC: Yeah, making things standard practice.

MM: Okay, anything else you want to add?

AC: Not at the moment [she laughs].

MM: Well, thank you very much.

AC: Thank you for taking the job and doing all this.

END OF INTERVIEW