

## **Harry Brickman talks about what he learned at UCLA that later influenced his work as Director of LAC-DMH...**

And then I was approached to take a full time job at UCLA in the Department of Psychiatry, in which my major task would be to run the psychiatric outpatient clinic. I had experiences there that flavored the very particular kind of organization that I wanted to set up, when I later had a chance to set up the public mental health system in LA County. What happened was, in the Department, we had a post-doc in sociology by the name of Harold Garfinkel and Harold – Let's see, I was in the job for about 4 years and at that time – this was before the NPI [UCLA Neuropsychiatric Institute, opened in 1961] was built. It was just the Department of Psychiatry in the medical school and they were building the NPI, I mean literally, structurally. And Harold and I started the first faculty seminar in the Department of Psychiatry and it was open to senior residents as well. In a lot of those seminars, Harold would talk about sick roles, sociological aspects of mental illness.

He was inspired by his mentor at Harvard, Talcott Parsons [1902-1979], and at that time Parsons was considered, I think, the father of modern sociology [At Harvard 1972-73, Parsons developed the action theory model for the study of social evolution and change]. He had an enormous influence on the field of sociology and Harold had the idea that just making a diagnosis according to a diagnostic manual was only a very, very small part of truly understanding mental illness and disability. He felt that it was very, very important to understand the sociological implications of what he called the "sick role." I learned that from him. So here what he would talk about – he and I ran the seminar together – was the embeddedness of every individual in social systems ranging from the couple to the family to the neighborhood to the community, you know, and so on and so forth, and the impact of those influences on the individual's behavior.

And that, by the way, comes very close to the outlook of evolutionary psychiatry that I have very lately, within the past decade and a half – for my age that is very lately – gotten interested in. I have begun to do research and writing in such subjects as the evolutionary advantages of depressive states. It takes the person out of the necessity to either compete or cooperate with other members of the hunter gatherer band, and so forth. But Harold Garfinkel didn't particularly emphasize anthropology. [Garfinkel is one of the pioneers of ethnomethodology in American sociology. He is now Professor Emeritus at UCLA.]

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**INTERVIEWEE: HARRY BRICKMAN**

**INTERVIEWER: Howard Padwa**

**DATE: May 1, 2009**

## **I. Education and Early Clinical Work; Understanding the Social Context of Mental Illness**

HP: To start, can you tell me a little bit about how you became interested in mental health?

HB: Well, it actually started way back in college days. I had a lot of interest in medicine in high school days. I went to a very academically strong high school in New York City and they encouraged us to form clubs around special interests. One of the clubs I belonged to and became the president of was what we called the Caducean Society, so I was interested in medicine in general. I first became interested in mental health during my, I can't remember, either my first or second year course in general psychology at NYU, where I did my undergraduate studies. There was a wonderful professor there, his name was Leland Crafts [1892-1968; chair of the Psychology Department 1949-1957]. He was one of the authors of, I think, what became a classical textbook of psychology [*Recent Experiments in Psychology*, 1938]. I told him that I was so interested in psychology and so stimulated by it that I was wondering whether I should think of doing a career in clinical psychology; and he said, "I would advise you to get a medical degree," and I said, "Well, cool, because I'm going to be applying to med school, too." We used words like "cool" back then [he laughs]. I did go to medical school at NYU, where there was a terrific department of psychiatry and almost in the very beginning decided that would be my specialty.

HP: What was it about it that captured you?

HB: Well, it was the capacity to understand people's inner worlds and their impact on what we could see as outer manifestations, in other words, various psychopathologies. And that was true – it's true of no other medical specialty, so for me it was an ideal combination of psychology and medicine.

HP: I see, interesting. So you went to medical school also at NYU?

HB: Yes.

HP: And then, from there tell me a little bit about your earlier career – where it took you, what you did?

HB: Well, again still in my training years, I was very, very impressed by the Menninger brothers. I don't know if you have ever heard of them. [The Menninger Clinic, founded by C.F. Menninger and his sons Karl and William in 1919, was the first group psychiatry practice in the US.]

HP: I've heard of them, I'm not too familiar with them.

HB: I wouldn't expect you to be [he laughs]; it was years ago. They had a psychiatric clinic in Topeka, Kansas [and trained residents at the local VA Hospital]. And, at that time, that was probably the outstanding private psychiatric service, inpatient and outpatient, in the whole country, if not the world, and I was fortunate enough to get a residency there. But first I wanted to take an internship that gave me exposure to just about every specialty in medicine, which I did; but that was in California. In my psychiatric training in Topeka, I had access to some of the most fertile minds in psychiatry, in psychology, and in psychoanalysis. It was at that time, I think, the only psychoanalytic residency in the country.

One of the many special features of that residency was that we had an anthropologist, who was part of the staff. It will take me a moment to recall his name, a French name [pause]. Oh, yes, George Devereux! [Devereux, 1908-85, is considered to be one of the founders of ethnopsychiatry.] He was a fascinating guy. He was brought in to give the residents more of the social and cultural considerations involved in psychiatric illness and mental health. I spent quite a number of hours with him. So I was moving in the direction of wanting to be a clinician, but at the same time wanting to understand the social and cultural aspects of mental illness. And that is one of the things you get, and probably still get, from the Topeka residency, which by the way has moved to Houston and is now part of the Baylor College of Medicine. In any event, following that, I did one year of residency at UCSF, it was called the Langley Porter Clinic [today the Langley Porter Neuropsychiatric Institute]. I still think it's called that, and at the VA hospital in Palo Alto; and there again I was exposed to another anthropologist, [Gregory Bateson of Stanford (1904-80), was a highly influential British-trained anthropologist who actively developed interdisciplinary links with other scholars in fields such as neuroscience, psychology, and cybernetics. He also taught at Columbia and Harvard.]. So there was a fertilization of the training I had, from the point of view of anthropology, which was interesting.

HP: That's interesting. What sort of things did you learn from that, in terms of the social and cultural aspects of mental illness, what were some of the things-

HB: I'm not sure I can articulate it at this point. I can articulate its impact later on in my career. Is this the kind of thing that you want?

HP: Oh, absolutely, yeah, this is great.

HB: Bateson was a Stanford anthropologist, very, very well known, and my exposure to him, who was very active with psychiatry residents on the Peninsula, inspired my interest in research. A number of research projects were going on and I took small parts in two or three of them. I won't go into the details.

HP: I'm curious, what sort of things were they?

HB: They had to do with mental health planning and communities and things like that. But I can't remember the actual title of them, but they were that sort of thing and that was primarily in the Bay Area. And I decided, toward the end of my residency, that I wanted to see if I could combine three aspects of my training, when I once became a practicing psychiatrist. One of which was clinical work, which has really been number one for me all along; number two was research;

and number three was teaching. They gave some of the third year residents at UCSF an actual faculty position in the Department of Psychiatry. It was called Clinical Assistant, and it was the bottom of the ladder; and I did a little bit of teaching of medical students as did other residents. So anyway, I was going to settle in the Bay Area, but where we lived in East Palo Alto, it was very, very damp and I just got one cold after another and I decided that I wanted to live in a warmer place. Then all of a sudden a job opportunity came up and that was to be the Director of a new State Mental Hygiene Clinic in Riverside.

HP: Wow, so that's a pretty big jump from –

HB: That was a big jump. I was interviewed for the job by a woman who at least at that time was an historical figure in mental health in California. Her name was Portia Bell Hume [1901-1990] and Portia was a psychiatrist and a psychoanalyst and she wasn't the Director. At that time they called it Department of Mental Hygiene, at the State level, and the state was delivering all the clinical services, public clinical services –

HP: And were they doing that on an outpatient basis as well?

HB: Yes, in the form of what they called Mental Hygiene Clinics. There were already several established. One was in Los Angeles, one was in San Francisco [and one was in San Diego]. There was one in Sacramento as well, so this may have been the fifth that was established. I had the job of directing that clinic. I was able to get together a really very nice staff of clinical social workers and one clinical psychologist and one additional psychiatrist; and we started public mental health in Riverside. I was going to stay there for a while; I had already also started, on a part-time basis, a small private practice.

And so what happened was that I got called into active duty in the Navy, because the Army had paid for most of my medical school and it was a payback deal; and I always preferred the Navy over the Army anyway. So I had to take leave, military leave, from that job and I went into the Navy as a psychiatrist. Well, it was much more than seeing patients. I was stationed – I spent most of my two years in San Diego at two Marine installations, one of which was the Recruit Depot in San Diego, the other was the Navy Retraining Command, a naval prison staffed by Marines. And I got very much interested in the Marine culture and its impact on, first of all, recruits, who were coming from all over the country and had to practically get their heads shaved, not quite, but had to learn the rigorous discipline of the Marine Corps. At first, I was shocked by how I felt that these young guys were being abused by the drill sergeants, so I got very much interested in their culture and learned a lot. As a matter of fact, I have written some things about it.

HP: Just in brief, what sort of things?

HB: Well, it was this sort of thing that, they were deliberately and systematically divested of a sense of separate self. They were, first and foremost, United States Marines; secondly, they were Joe or Johnny or Howard or whoever from Kankakee, Illinois, and so on and so forth; but first and foremost they were U.S. Marines. There was a culture there, which by the way still exists, and I think is

responsible for the fact that the U.S. Marines are the most formidable fighting force in the world.

HP: So it's effective?

HB: I'm sorry?

HP: So it's effective?

HB: Yeah, it is effective, because the idea is that you are divested of your individuality and you are then trained to be a, well, a member of a band of brothers. I think there was a movie about it, with that name. And so your closest relationships were to your buddies, your combat buddies, and secondly to your rifle. At that time it was a rifle, it wasn't an automatic, like, I forget, an M14 or something like that [the M14A1 was the standard issue rifle until 1965]; and you had to be able to disassemble and reassemble, to clean and reassemble your weapon in the dark and you had to maintain it in perfect shape and this was their culture. Their culture was immersion in a group with a specific mission and that mission was combat; but also a really more implicit than explicit obligation to protect your buddy, to save his life whenever you could, to even if necessary take a bullet on his behalf just to protect him, which was very, very hard for a lot of those kids.

And those were the kids that dropped out and then we had to go over them psychiatrically and see whether there was some underlying psychopathology that would make them incapable of functioning as a Marine, or whether they were just plain scared and didn't have the robustness of personality to go through this training, in which case we recommended a general discharge, it wasn't exactly an honorable discharge – But we recommended that they go back to civilian life, and perhaps – at that time we were all very proud of the Marines. And maybe somewhere down the line they might try to join the Army and work in Supply or something like that. So I was very, very struck by the social and cultural aspects of it. Then, in the Naval Prison, it was very much the same thing. The prison was run by Marine guards who, although they were tough, were surprisingly humane. And I suggested that I conduct some seminars with them on human behavior and so forth, because they were referring problem inmates to us. And we found, very often, that the problems of the inmates reflected, let's say, limitations in the way that they were handled by staff. And this has a direct bearing on my approach to the creation of the [LA County] DMH.

HP: Well yeah, and it sounds like a lot of what you are talking about is the context shaping the behavior.

HB: That's right, that's right. The human and social context. So then, when my tour of duty ended, I was offered a job at the California Youth Authority. I had had some training in child psychiatry but wasn't certified in it and was asked to be Medical Director of a new correctional facility in Norwalk. So I served there and it was as Medical Director, it was not only in psychiatry. I mean, I was the psychiatrist there, but I was also responsible for supervising all medical and surgical services.

HP: Oh, wow.

HB: But I had a very, very good assistant medical director, a woman family physician who also did minor surgery. She supervised the more purely medical stuff and then we had access to some very fine consultants. We had a fully staffed operating room there, like a small hospital, and when one of these kids needed major surgery, we would have consultants come from the community, board surgeons, well respected; and sometimes I'd even scrub in with them, which was sort of like a fun thing for me - as was my opportunity a couple of years previously to hitchhike on destroyers out of San Diego, for a week at a time.

HP: Oh wow [he laughs], that sounds neat.

HB: So I learned a lot about the Naval culture as well as the Marine culture. I loved to go out on ships. Okay, so then -

HP: If we could just talk a little bit more about the Youth Authority, what was your experience as a psychiatrist there?

HB: Well, I felt there was an almost inherent hostility to psychiatric perspectives. The new superintendent of the CYA facility there was steeped in custodial concerns. The thing to do for him was to run a correctional facility, with a psychiatrist there only to handle the kids that were *custodially* problematic.

HP: So the "problem children?"

HB: Yeah, but particularly problematic, because they had some very hard cases there. There were kids there who had murdered and all sorts of things like that. And so his chief of custody, although he was a nice guy and we got along well, wasn't very sympathetic to my psychiatric opinions, particularly when custodial problems would be presented to me and I would make certain suggestions, all within the constraints of carrying on a correctional facility. In other words, I wasn't in any way advocating coddling them or anything like that, but nonetheless. The other thing was that I was promised a unit which would do research on delinquent behavior, based on that unit, and they never actually created it. So I decided to leave the CYA and went briefly into full time private practice in Westwood. And then I was approached to take a full time job at UCLA in the Department of Psychiatry, in which my major task would be to run the psychiatric outpatient clinic. I had experiences there that flavored the very particular kind of organization that I wanted to set up, when I later had a chance to set up the public mental health system in LA County.

HP: Tell me a little bit about that.

HB: What happened was, in the Department, we had a post-doc in sociology by the name of Harold Garfinkel and Harold - Let's see, I was in the job for about 4 years and at that time - this was before the NPI [UCLA Neuropsychiatric Institute, opened in 1961] was built. It was just the Department of Psychiatry in the medical school and they were building the NPI, I mean literally, structurally. And Harold and I started the first faculty seminar in the Department of Psychiatry

and it was open to senior residents as well. In a lot of those seminars, Harold would talk about sick roles, sociological aspects of mental illness.

HP: Can you expand a little bit on what exactly that was?

HB: Well, he was inspired by his mentor at Harvard, Talcott Parsons [1902-1979], and at that time Parsons was considered, I think, the father of modern sociology [At Harvard 1972-73, Parsons developed the action theory model for the study of social evolution and change]. He had an enormous influence on the field of sociology and Harold had the idea that just making a diagnosis according to a diagnostic manual was only a very, very small part of truly understanding mental illness and disability. He felt that it was very, very important to understand the sociological implications of what he called the “sick role.” I learned that from him. So here what he would talk about – he and I ran the seminar together – was the embeddedness of every individual in social systems ranging from the couple to the family to the neighborhood to the community, you know, and so on and so forth, and the impact of those influences on the individual’s behavior.

And that, by the way, comes very close to the outlook of evolutionary psychiatry that I have very lately, within the past decade and a half – for my age that is very lately – gotten interested in. I have begun to do research and writing in such subjects as the evolutionary advantages of depressive states. It takes the person out of the necessity to either compete or cooperate with other members of the hunter gatherer band, and so forth. But Harold Garfinkel didn’t particularly emphasize anthropology. [Garfinkel, 1917-, is one of the pioneers of ethnomethodology in American sociology. He is now Professor Emeritus at UCLA.]

So anyway, what happened was I got more and more interested in that. I was running the clinic, I was teaching residents and medical students, and I was also having a small private practice. But then the chair of the Department offered me the position of clinical director of the new NPI, once it opened up – and it was about to open up – and I said fine, but I would like to do some research on staffing of the wards. I’d like to see if we could vary the usual staffing, bring in more in the way of social workers, psychologists who had been exposed to not just clinical psychology alone, and so on and so forth; and I thought this would be very valuable in teaching both medical students and residents.

HP: What would they bring to – ?

HB: Well they would bring, hopefully, a knowledge of the social embeddedness of people with serious major mental illness – and I’m not saying that what they wound up with didn’t afford at least some insight into it. And he said, “No, I want a conventionally staffed hospital.”

HP: When you say social embeddedness, you mean the sick role that people play in the community?

HB: Yeah, the sick role, working very extensively with families and so forth, even while the patient was in the hospital.

HP: So working with the families in order to help for when they get back into the community?

HB: Yes, in major part, to help in their rehabilitation and so forth. Now, at that time providentially, I was approached by the chief administrative officer of the County of LA, with the idea of becoming the first Director of Mental Health Services for LA County. They were thinking of creating a separate Department, but the Department had not been created yet; and the impression was given that I would have pretty close to *carte blanche* to set up a community mental health system that would allow for some of the ideas that I had picked up, starting in residency. Oh, incidentally in that Menninger residency, there were some of the brightest, sharpest and most productive clinical psychologists in the world, people who were, at least in the clinical psychology field, almost iconic figures, and I learned a great deal from them as well.

## II. **First Director of Mental Health Services for Los Angeles County; Building the Department**

So I started in January of 1960, as part of the Hospitals Department of the County, (which was unfortunately named the Department of Charities. There's condescension in that name. I don't think anybody would use such a name for a public department now.) The Medical Director of Charities had been carrying on the functions of Mental Health Director *pro tem*. He was a very tall, affable, avuncular, and charismatic internist by the name of Roger Egeberg. [Roger O. Egeberg, 1903-97, later became Dean of the USC Medical School. He served as Assistant Secretary of Health under Richard Nixon, 1969-71.] Roger took me under his wing and taught me some of the culture of the County and of the Department of Charities. He encouraged me to push the project forward, first of all with the Board of Supervisors, to, in a sense, remind them that they had promised me a Department Directorship. And sure enough, they created the Department in the spring of 1960, I forget exactly when.

HP: Okay, if we could just pause at this point for a couple of questions about the context that you stepped into. First of all, what did mental health services in the County look like at the time that you came in? Like what did people receive, how was the structure?

HB: Okay, good question. The mental health services that were funded by the County were almost exclusively inpatient services. Primarily at what was then called County General Hospital, now called County-USC Medical Center, at Harbor General Hospital, at Olive View in the Valley. There were some outpatient services that were offered in each of those psychiatric divisions of each general hospital. There was nothing in the way of primary prevention, nor in the way of secondary prevention. There was no network of [non-governmental] outpatient services other than by a few – let's see, there was at least one hospital, Cedars Sinai, which had an outpatient psychiatric clinic. There were other non-profit institutions that provided outpatient services and that was about it.

HP: And what did those services look like? Like what would someone who received those services get?



HB: Generally, they would get what I would call counseling; now I don't put down counseling. I think counseling is extremely important. But in those days, we were really just at the beginning of psychoactive medication, so some of them got some of the early pharmacological agents, like thiorazine and so forth, for psychotic illness.

HP: So these are people in the outpatient?

HB: Yes, they would get that. There were maybe one or two half-way houses in LA, where patients could transition between the hospital and outpatient clinic. And, of course, there were three major State Hospitals [Camarillo State, Metro State, and Patton State] that provided inpatient services, because the State was in the psychiatry business at that time. And the State Legislature had passed an act called the Short Doyle Act [in 1957]. The basic structure of it was that the State was to pay for 50 percent of the costs of psychiatric services, or you could say mental health services, provided by the Counties; and so really the Board of Supervisors, not entirely out of the goodness of their hearts, but keeping an appropriate eye on the budget and their taxpayers, figured, well, they could recoup 50% of their then existing expenditures on mental health services, which was pretty close to a million dollars a year. I'm sorry, I'll correct that. It was close to \$500,000 a year.

HP: So by transforming the system to the rules of Short Doyle, they could then get state money to help out.

HB: That is right, and the idea is that eventually, the State would transition out of the mental health business, but would retain the State Hospitals indefinitely for those with major mental illness. Now, this Short-Doyle Act was also, I think, pretty simultaneously accompanied by the first Federal Mental Health Act, the Community Mental Health Act [of 1963]. I can't remember the exact title of it and I was very much in touch with those people and I even got a job offer from them, which I turned down. I wanted to do it in a way. So what I decided to do – first of all I recruited a couple – Oh, in establishing the Department, I do have to mention this. There was formidable opposition to the whole idea by a small but surprisingly influential right-wing group called the John Birch Society.

HP: The anti-Communists?

HB: Yeah. Oh, you have heard of them?

HP: I'm a historian so [he laughs] –

HB: Of course [he laughs], you're a good historian.

HP: Why would they –

HB: Well, they had what I considered to be a really paranoid idea that if the County got into the mental health business, and if the services were to be increased, that this would be a way of seizing citizens in the County who disagreed with the putatively left wing orientation of the County Supervisors. And, as a matter of

- fact, they felt that this was what was happening with the Mental Health Services Act at the Federal level and the whole idea was to take these people and put them into a gulag. They didn't use that word at the time; but there was a large hospital in Whittier, Alaska, that had actually been built as an army hospital, but I don't think it was ever populated; it was never staffed. So it was sitting there frozen stiff on, I think it was on Prince William Sound; and that these political dissenters against the alleged left wing status quo would be sent off to Whittier and this would be a way of communism taking over the United States.
- HP: So this was around, this was a little bit after McCarthy, that it was still in the air, I guess.
- HB: Yeah, yes it was. Let's see, McCarthy was in the 50's, wasn't he?
- HP: '56, I think, I'm not sure. [Joseph McCarthy's anti-Communist campaign lasted from February, 1950, through December, 1954.]
- HB: That's right. Yeah, this was after McCarthy.
- HP: So these people, how would they voice this opposition? Were there people on the Board who felt this way too, or – ?
- HB: Not really actually, very much to my relief; because at first, I thought, "Oh my gosh, I gave up that UCLA job for all this promising possibility and these people are going to defeat the whole thing." But they didn't.
- HP: Did they actually mobilize?
- HB: They mobilized to some extent. I think they conducted, now I'm unclear about this, Howard, I think they conducted some public demonstrations. They probably scared a few gullible people, and they tried to put pressure on the Board of Supervisors; so that when a historic moment came when the Board had to decide whether they wanted to create a separate Department of Mental Health, they showed up en masse and protested very loudly and I would guess that it was in the newspapers. I haven't saved them. [On the other hand, we did have strong support from the County Medical Society.] The Board courageously, on a vote of five to zero, established the new Department.
- HP: Could you tell me a little bit about the Board, like the culture of the County politics at the time?
- HB: Well, the Board, for political scientists, and I suppose historians, had an interesting culture of their own. They were referred to by many people, including a lot of the press, as "the Five Little Kings." There were five Supervisorial Districts and each one of them really kind of ruled his District like a monarchy. And to my knowledge, there was little or no corruption, which surprised me, having been raised in New York City and having gone all the way through medical school there. I couldn't find any corruption and wondered about it from time to time, as I developed my program. They were fiscally conservative, all of them were. They were of course influenceable by certain interest groups.

For example, Kenny Hahn [Supervisor 1952-92], whose district covered South and Southeast and South Central LA, had a mainly black constituency. Now that area of the County is, I think, mixed Hispanic and black, maybe even more Hispanic. Frank Bonelli [Supervisor 1958-72] had a Hispanic and sort of redneck/white constituency going into the San Gabriel Valley, around Covina and so forth. Then there was one for the San Fernando Valley. Ernie Debs [Supervisor 1958-74], was the Supervisor for Hollywood, Beverly Hills, and most of West LA. And then there was another one who covered sort of a gerrymandered strip of coastal LA, starting from Santa Monica and going around to San Pedro and Long Beach. So each represented more or less discrete populations, but not watertightly discrete.

What I did was, although I wasn't specifically asked to do that, was set up outpatient mental health services in each of those districts. There were actually two in the South Central and South East areas, because I wanted to put an emphasis on underserved populations, particularly the minority populations.

HP: How come?

HB: Because they were underserved.

HP: There was the need, yeah.

HB: I also did one other thing that they consented to, but I think rather grudgingly, and that was to set up as a significant part of the regional mental health services, a Regional Mental Health Advisory Board. They had appointed a County-wide Advisory Board and this Board had no administrative power over me as Director, but was advisory. So I set up, in a sense, mini-Boards in each of the regional centers.

HP: By regions, you mean within each district?

HB: Not specifically within each district. Let me see if I could go over it. There was Santa Monica West, which included West LA and Santa Monica, which was then in two districts, Debs', and I forgot the other one. There were two centers in the San Fernando Valley, east and west San Fernando Valley. There were two in South and Southeast Los Angeles. There was one in Long Beach and one in East LA, and one in West Covina.

HP: So these regional centers, what did they do?

HB: Well, they – well, let me just go back for a moment. They had a Board of interested citizens – and what I don't remember, Howard, is whether I appointed that Board, or whether our Mental Health Advisory Board, later to become the Mental Health Commission, appointed them. And they were usually – there was at least one psychiatrist and at least one general physician on those Boards, and most of them were people who represented non-profit organizations that served the poor and the underserved. Usually with social and public health services of one sort or another, my feeling was that, and I did this deliberately and I do think that the Supervisors saw through me, but they didn't stop me – that was to set up a new constituency, a citizen constituency for the Department of Mental Health,

that was located in each of those areas that would advocate for their own local service. And they did.

HP: Advocate to you and advocate to their Board of Supervisors?

HB: Exactly. Exactly.

HP: I see, and then also it seems like, you said there was a clinic in the Supervisorial District, that also would serve a political role as well-

HB: Absolutely, absolutely. The only time I got any word of constraint was when I did, for a little while, a little lobbying in Sacramento and for instance – I can't remember the actual issue. I got in touch with a couple of legislators and even the governor, Ronald Reagan, at one point. And the County Chief Administrative Officer called me to come and see him in his office and said, "You know, the County has a lot of investments with the State. It isn't just mental health. And if you push for more in the way of funds for particular programs you have in mind, and as you know," – I am quoting him, more or less – "I have been very supportive of your programs; and if they give it to you, it might be at the expense of some other program, like roads or things like that." So I stepped back; that was reasonable to me.

HP: So it sounds like to me you had a pretty good working relationship with them.

HB: I did. I was very fond of the CAO and he was of me and gave me most of what I asked for in the way of the program. Well, he was getting 50% State money for it. Later on, it was increased to 90%, but I think that was just before I left the program.

HP: Okay. So if we could talk a little bit – so that's the stage that you came into DMH. Tell me a little bit about when you came in and you said that you envisioned having carte blanche. What was the Department going to look like?

HB: Well, what the Department was going to look like was that it would devote its professional energies and time to a mix of preventive and clinical services, with a very strong emphasis on the preventive. And the preventive services were going to be carried out according to a design that had been written about by a prominent mental health, public health figure at the Harvard School of Public Health, Gerald Caplan. [Caplan, a British-born psychiatrist, was director of Community Mental Health at Harvard 1952-64. His most noted work is *Principles of Preventive Psychiatry* (1964).] Gerald advocated a model where mental health professionals would ride on the shoulders of community caregivers, public health nurses, welfare case workers, teachers, probation officers and so forth; and consult with them, not with the idea of case finding, but rather with the idea of helping these caregivers in the community do their regular case work, or teaching, with an increased sophistication in psychological factors; mainly psychodynamic factors, that they had to deal with in their clients and in themselves.

So to that end, I recruited a part-time corps of privately practicing psychiatrists at that time, most of whom were psychoanalysts. And some of them made major

changes in their own careers, in that they did these things as a major emphasis and their own private practices were reduced by virtue of doing it. They made significant changes in the approaches of the Departments of Public Social Services (that was the Welfare Department), the Department of Public Health; and primarily in the schools. These private psychiatrists were paid an hourly fee for going there, advising them that the kids who were the quietest in their classrooms were sometimes among the most disturbed and not to concentrate their teaching efforts and their disciplines on the kids who were the loudest and the most demanding, and so forth. So that's just a small slice of what we did.

HP: So having this sort of outreach into other areas. before people would wind up in the mental health system in order to catch –

HB: Precisely.

HP: And did that work?

HB: Well, that is an important question. It did for a while; and I'm not sure if I'm historically correct here, maybe you can even correct me. At one point I was the President of what was called the California Conference of Local Mental Health Directors and I represented them to the State Government, on certain issues having to do with legislation. I had a conference with Ronald Reagan – and I have somewhere, I wasn't able to find it for you – a picture of Ronnie and I shaking hands and the handshake was that they would not close down the State Hospitals, until we in the community had an opportunity to develop half way houses and transitional facilities for those with major mental illness. We shook hands, and, I think within a month, he began to close down the State Hospitals.

And this is one of the reasons why I have a slight wave of nausea when I go by what used to be the UCLA hospital and is now the Ronald Reagan UCLA Hospital. I mean this man, as far as I am concerned, had no regard for ill people, or for people with anguish, with major mental illness and so forth. The result of it is that they began to dump them on the streets. They closed down the State Hospitals. We had a big problem with the homeless and there were some studies that indicated that something like 40% of the homeless were chronically mentally ill people. So what happened was that we were obliged to close down many of our preventive services and increase our outpatient psychiatric services.

HP: And that's because you had to.

HB: Exactly.

### **III. Outpatient Clinics and Services; the Research Division**

HP: I see, now about those services. In the beginning, what did those outpatient services look like? In the clinics themselves, what sort of services did people receive?

HB: Well, to begin with these, all of these outpatient centers were headed up by psychiatrists and the clinic services were delivered at that time – I think I have to get myself a little water. Would you like some yourself?

HP: Yes, that would be great, thank you. Let me pause this.

HB: Not have to – Would you like me to start again? [The original agreement was that] I would not have to put in more than 30 hours a week of office time for the County, which would then allow me, conceivably 10 hours a week to see private patients. I did not want to stop doing clinical work. The fact is, the understanding was that every County Department Head theoretically works 24/7 and he or she should be able to be called upon at any time. I pushed the envelope when I sailed my boat to Hawaii one summer.

HP: Oh, wow, so you were gone for three months?

HB: No, not that long. It took 16 and a half days to sail there and my wife didn't go. My two children and my brother went and a couple of other guys and altogether I was away for a month. And I didn't take the boat back, because I didn't want to take that much time away. And, of course in those days, all the communications were by telephone and I told my boss. Each Department was responsible to a particular Supervisor and mine was Ernie Debs who was responsible for the West LA area.

But anyway, what's most relevant here is that the agreement was that for those psychiatrists, and at that point psychologists, and clinical social workers who worked for the department, there was the same arrangement that they had to put in 30 hours with the County, but the other 10 hours were justified as continuing education hours, study, reading, research, whatever. I don't know if that still applies. Maybe it still does; I haven't checked. So, at any rate, let me see –

HP: We were talking about the way that the outpatient clinics worked –

HB: Oh, yes.

HP: In the early days. So these were the directly operated ones, like in Long Beach and in South Central. So if you could tell me a little bit about how those would work.

HB: Well, we – They were very conventional, in terms of clinical operations. They were psychiatric, in the sense that the psychiatrist was in charge of the clinical team and the psychologist and clinical social workers [in addition to doing various aspects of intake] had therapy caseloads. There was no really long-term psychotherapy. There was mainly crisis-oriented psychotherapy, with the psychiatrist directing the clinical team, running the case conference, allocating and assigning cases to other members of the clinical team, and so forth.

HP: And did everyone get therapy who went there?

HB: If they needed it, yes; at least in the beginning. I had appointed a clinical director for the Department. This man concerned himself with the patient services of the outpatient centers. Then the other part of it is that we set up a system of contracts with private agencies. They were – I'm hesitating for a moment to be sure that I am right – at that point, they were all non-profit agencies and we gave

contracts. For example, we gave contracts to the psychiatric outpatient clinic at Cedars Sinai, to, I think, there was one in the Valley, I forget at which hospital; and we had several contracts in the Valley. There were some non-profit half-way houses for what were then called, "delinquent boys and girls," that we gave contracts to. These contractors began to lobby the elected officials, the Supervisors, for more money for their contracts. It began to be increasingly political during the total of 16 years that I was the Head of the Department.

Some of these situations I got into were rather unpleasant. For instance, at one point, I was summoned to the office of the Supervisor who was responsible for the San Fernando Valley. He was seated at his desk and behind him, looking partly out the window, was one of my contractors and basically it was a pretty direct deal. "Doctor, why haven't you given such and such more in the way of money?" I did my best to answer it. I don't really remember any time where a supervisor – Well, they tried a couple of times to twist my arm to get me to agree to do it and I would always say, "Well, let me go back and talk to my staff about it." What I did, and this by the way was one of the pieces of advice that Roger Egeberg had given me, was [to communicate to the other Supervisors and] to try to be sure to have three votes supporting me, because there were five guys on that Board. And so I would, in one way or another, get my three votes; and once I got those votes, then I would be free to resist these arm twistings, but I was not successful every time.

HP: Yeah, I'm curious, what would give these contractors such lobbying power? I wouldn't image that a non-profit would be able to carry that much sway.

HB: That's a good question. I would have to think about that. You know, they each had boards and they usually – their boards were made up of contributors who were wealthy and prominent citizens. And every local elected official has to pay attention to the movers and shakers of his little community [he laughs], so I guess that's my answer.

HP: In terms of the services that these contract agencies offered themselves, were they different from the ones in the clinics that you ran?

HB: Some were; some were not. The ones that were providing transitional services like day hospital services and so forth did not duplicate our services. This was something that we wanted to develop, but then the dumping of the State Hospitals prevented us from doing it. By the way, they did not entirely close down Metropolitan State, but did close down most of Camarillo. Then, of course, they eventually closed it down and now it's a state college, a state university, excuse me. It has a beautiful campus; have you been there?

HP: No, but I have seen pictures of it.

HB: Anyway, so let me see what else you were asking me. What was it like then? It was a conventional kind of thing.

HP: Was there use of psychotropic medications then?

HB: Well, more and more, and this of course leads me to fast forward for a moment, just to draw a contrast. As I mentioned to you, I have been supervising UCLA psychiatry residents for many years. And in recent years, certainly during the past ten or fifteen years, I find that the clinical team is much different now than it was when I first set up the Department. The psychiatrists are fundamentally psychopharmacologists and are discouraged from doing any kind of psychotherapy. And the therapy is done, I think, mainly by the social workers and the psychologists.

I found that, like for instance, the UCLA residents rotate through the Edelman Center here and here I am in the paradoxical position of encouraging them and teaching them to do psychotherapy. And I'm not talking necessarily about long-term psychotherapy, although I teach that as well. But when they rotate through Edelman, they are not particularly encouraged to do psychotherapy. And I want to tell you, actually, I had a very competent psychiatric resident who became a staff psychiatrist at Edelman. And this particular doctor was telling me that she was doing almost nothing but writing prescriptions and then conducting twenty-minute interviews, follow-up interviews of patients who were on the more advanced psychotropics that are now in use.

So I may be old fashioned, but I'm not too terribly happy about that configuration. And I do feel that, while some psychologists and psychiatric social workers are superb psychotherapists, I do feel that the medical direction of clinical teams should continue; that the psychiatrist should be the head of the team with the provision – this is important – that the psychiatrist be a well trained psychotherapist, as well as a psychopharmacologist. And that has to do with trends in psychiatric education in medical schools and so forth, which went way, way over to psychopharmacology. And now, at least at UCLA, there is an increased interest in seeing that people like myself teach psychiatric residents how to do psychotherapy. So that's my only objection to what's going on now.

HP: But back then, it was sort of a tool that was used if necessary, but it wasn't necessarily for everyone – the use of medication?

HB: That's right, and I'm sure that there were instances, and I have no proof of this, where some sloppy decisions were made and a condition, a psychiatric condition that would have responded to intense brief psychotherapy, would have accomplished more, even in terms of neural circuits in the brain, than putting them on a course of psychotropic medication. As a clinical psychiatrist myself, I still prescribe psychotropics; but 95% of my practice is in psychotherapy and psychoanalysis.

HP: And when you say, "brief periods of therapy," what is a brief period – a certain number of visits?

HB: Yeah, a certain number of visits. Maybe a dozen to twenty visits. More in the direction of twenty, where the focus is on a particular crisis, rather than any attempt at reconstructing personality styles and things like that.

HP: So is that how the Department functioned then, in terms of those were the sort of interventions?



- HB: Yes.
- HP: And did it provide, what in the clinics today they call case management services as well, in terms of helping people with housing or getting Social Security or disability benefits, things like that?
- HB: I think they did; I did not particularly identify that. In terms of case management, I saw that as part of, and a significant part, of the work of any of our social workers.
- HP: Right, and was that novel to have social workers working at mental health centers then?
- HB: No, not novel, although it was in the early years of that kind of subspecialization, of psychiatric social workers. One of the most prominent members of our Advisory Board was Don Howard [1912-], who was Dean of the School of Social Welfare at UCLA [1948-60]. Another very prominent supporter of our Department in the community was a very effective professor of social work at USC, Frances Lomas Feldman, and she was the one who did the –
- HP: Yes, who did the previous interview with you. Right, and when you talk about people in the community, I'm curious because you mentioned that there was a lot of providers who ran the community clinics. What about people with mental illness themselves? Were they involved or politically active?
- HB: Well, there were a couple of organizations of mentally ill people. I think there's a national organization, or at least there was, N-A-M-I; and there are others who actually defined themselves as representing the mentally ill population. And we did have some of those on our local boards. So whenever I've heard of that, I've always encouraged it. I thought that was a very important part of the community. I'll tell you – I don't know whether I should wait for you to ask me the question or not; and that is the research function of the Department.
- HP: I was actually next going to ask about some of its functions and that was one of my questions.
- HB: Oh, okay. What I hoped we could do was appoint a psychologist to be head of research who was in the image of the brilliant psychologists I knew in Topeka, who would be able to do, or to mount, or to arrange for, a series of funded projects, mainly by NIMH [National Institute of Mental Health], that would be epidemiological but also would focus on outcome studies [of consultation and clinical services]. I wasn't able to find a psychologist who was interested in doing it; and I appointed one [George Moed], who was very keen on doing an epidemiological study and did it. And [pause, picks up paperwork] for the purposes of recording, this was a mental health survey of Los Angeles County by the Welfare Planning Council in June, 1960. Actually, when I think about it, it wasn't the director of research that did it. This was the Welfare Planning Council. Wait, let me just see [looks over paperwork; pause].

We had an Evaluation and Research Division, and I'm just looking through one of the brochures that they put out. They got a Mental Health Project Grant awarded by NIMH, a five year grant. They mainly conducted an in-depth study by voting districts of population characteristics, although the grant – Well, it says, for instance, that there were four high priority problems that the grant was to address. One was studies of the place of residence, as well as other characteristics of applicants to County mental health facilities. That was to try to understand social and economic factors in mental illness. Now, the second part was studies of the effectiveness of the Department's large scale program of mental health consultation, including the evaluations of programs and in general, the mental health education information and coordination of the community services as they developed. They did very little of that.

HP: So that would be measuring outcomes?

HB: Outcome in terms of consultation. Then the third was ongoing evaluations of clinical programs to be established and run by the Department in the future. They did just about none of that. Then they also provided research consultation to the staffs of both public and private mental health agencies. And so I was frankly not satisfied with the research methods of that Division.

HP: Well, what was the bigger goal behind the Research Division?

HB: Well, I envisioned really was not so much the epidemiological, the basic population characteristics, but rather, outcomes. Outcome studies of the consultative services and of the clinical services. The psychologist that I appointed to be head of that Division had no clinical experience and did not particularly seem interested in clinical services. I encouraged him to contact Harold Garfinkel, who by that time had left the Department of Psychiatry and had gone to the Department of Sociology at UCLA and subsequently became the chair. He told me that Garfinkel was not interested in seeing and consulting with him. I didn't pursue it, I was very busy at that time, and I just thought well, Garfinkel did not regard our Research Director as equivalent to an academic, and that would be one shortcoming in our program.

HP: Is the shortcoming being that you couldn't really look at outcomes because you didn't have the data?

HB: Right, and despite an NIMH grant, we did not satisfy the agreed upon goals of the grant.

HP: Right. Tell me about some of the other organizational aspects of the Department in the early days. So there was the research division, what else was there?

HB: Oh, let's see [looking through paperwork]. I had a Chief of Administrative Services who took care of the general administrative aspects like budgeting and the ordering of supplies, the personnel management, and so forth. Then a Chief of Consultative Services, a Chief of Clinical Services, which was the one that I mentioned to you, who checked with all the various clinical services, and then a Chief of Evaluation and Research. The original Advisory Board included two psychiatrists, one internist, Don Howard, the Dean of UCLA Social Welfare, and

the judge of the psychiatric court and one black MD, which we thought was appropriate. We wanted that kind of representation.

HP: So that was kind of the organizational aspect?

HB: Yes.

HP: Now, in terms of funding, and funding challenges, can you tell me a little bit about your experience with that as Director?

HB: Well, I made a little mention of it. Every County Department Head has to prepare a budget every year. Those Department Heads, who themselves were administrators, would be very much involved in it. Those of us who were specialists in a particular field – this would include not only Mental Health, it would include Public Health, it would include Highways, it would include Social Welfare – would have administrative, you might say vice chairs, who would take care of that. And so they would put together a budget and go over it with me and I would go over it with my cabinet, so to speak, having asked each Division to submit budget proposals. We would spend literally weeks going over these; and finally I would have a budget proposal which I would then submit to the Chief Administrative Officer and quite often he would come down or send one of his deputies to sit with us and work out the details.

And finally I would have a hearing with the CAO. And the CAO at that time was tough, tough as nails, but very avuncular and very caring about the Department Heads, and would often go to bat for the Department Heads with the elected officials. My recollections of Lin Hollinger [County CAO 1958-70] were almost entirely positive. The only rebuke I got from him was when I was too enthusiastically lobbying in Sacramento, which rebuke was earned, as far as I was concerned. So it was a pretty smooth process.

HP: Now, how about when the burden shifted more towards the State, or the Federal level, in terms of funding at that level as well?

HB: Well, it was the Federal funding, let me see, was there any Federal funding other than the NIMH grant? I don't think so.

HP: Okay.

HB: The State funding was really what I was lobbying State officials about and I was doing it on behalf of LA County, and also on behalf of the organization of Local Mental Health Directors, but in that particular instance when Lin took me to the woodshed, I was lobbying as the representative of all the mental health directors; and he was telling me, "When you do this, you are working against our own special lobbyists for LA County." I think that was the issue, anyway.

HP: Then you mentioned your thoughts on Reagan and –

HB: You know, this lionization of Reagan nationwide, that was something I couldn't really understand, but anyway.

HP: Okay. So overall, just looking at the Department while you were there, a couple of questions: First of all, you mentioned about how you became interested in the social aspects of mental illness in your early training. How did those translate into what you did during your time with the Department?

HB: Well, by the very fact the way that the Department was set up with a major emphasis on prevention. And it had very much to do with the fundamental program philosophy of the Department, that I actually presented in several published papers in the *American Journal of Public Health* and I think even in the *American Journal of Psychiatry*, where I talked about the importance of concentrating on community care givers and increasing their capacity to deal with the sick role petitioning, if you will, that went on when people reported themselves as being sick and so forth, or where teachers would observe certain kinds of behavior in the classroom in students that they would be eager to refer to a mental health clinic. One of the reasons we had a very good core of mental health consultants in schools was to discourage teachers from immediately getting rid of “problem kids” and sending them to psychiatrists, but to rather work with them and work with their school psychologist and so forth, to see if some of these problems could be handled within the scope of classroom activities and also working with the parents of kids in more effective ways, so that was how it was.

HP: So in terms of how trying to keep people who maybe seemed on the track to mental illness from going into the “sick role?”

HB: That’s right, that’s right.

#### **IV. Merger with Health Services; Outreach and Diversity**

HB: Now, there’s one thing I didn’t mention to you that led up to my resigning as Director. In their wisdom, the “Five Little Kings” decided that there should be several super agencies in the County and I remember practically begging the Mental Health Advisory Board to oppose it. Because what they were thinking of doing was having a Super Health Agency, which would include the Department of Charities, the Mental Health Department and the Department of Public Health, all under one super agency.

HP: That’s huge.

HB: And so I would no longer be a Department Head and so the perks would be diminished. I had some very nice perks, including, as my budget grew, a more and more expensive County car [he laughs] and nobody to ride herd over me, on a day-to-day basis, other than the CAO who really did not have supervisory authority over the Department Heads. But it was a quasi-supervisory role. So I found myself having to report to a Health Services Agency manager who was a former CAO administrator. A very smooth, silky smooth, administrator who then put my Department under a medical director for the Super Health Agency who was a surgeon, and who had an abysmal ignorance of mental health issues, and on top of it, I think, something that was present and may still be present in many physicians, an antagonism towards psychiatry.

HP: Tell me a little bit about that person.

HB: Well, he was very unreceptive to the programs that I was then required to have him approve. It was around budget issues, largely, and he considered them dispensable and sought budget reductions that I thought would be destructive to the program. And I had to really kind of battle with him in the office of the Health Agency Administrator, who was marginally more conducive to mental health concerns than the surgeon. I found that more and more of the lobbying done by contract agencies was getting to the Supervisors more effectively; and I was being issued orders to change the mental health programs in ways that I felt were not consistent with the agency philosophy, even though I had been performance required to develop a much greater emphasis on clinical services. And I just thought, "Well, I don't need this;" and I quit.

HP: What were some of the changes that they wanted you to make?

HB: They wanted a reduction in consultative services and I don't remember the details.

HP: By consultative, what do you mean?

HB: These were the consultations to community agencies, that were, as far as I was concerned, the very heart of our program.

HP: So consultations to community providers?

HB: Yes, but not mental health providers. The new chief of medical services for the super-agency – I won't go into names, although I do remember his name – was himself primarily a clinician; and to my knowledge, he wasn't even an academic in the medical school. He may have been. He was markedly in contrast with Roger Egeberg, who I mentioned was a very, very gracious and charismatic physician that I would have followed to the borders of hell, gladly. [He laughs] Anyway –

HP: Yeah, and you mentioned that there were some people who seem to be antagonistic toward mental health. Can you describe what that antagonism was?

HB: Well, that seemed to fade into the woodwork after a while, because they got no traction with the elected officials. And so then the only organized, if you want to call it that, antagonism I felt from anywhere in the community, was from the Scientologists.

HP: Did they make any sort of impact?

HB: No impact. But they mainly carried on, I wouldn't even call it a correspondence – They wrote letters to me telling me, asking me to renounce all of the abuses that had been carried on against innocent people by psychiatry and I – They didn't get any traction with my elected bosses, so I sent them polite responses which said that I'm sorry they had those concerns; but made mention that there were many community organizations that supported the work of the Department, and I suggested that they talk with them.

HP: And how about the stigma about mental illness itself, both amongst providers and in the community. What did that look like back then, and as it changed?

HB: I don't know how I could answer that question. We carried out some educational programs with various citizens groups that invited us for presentations which were, you might say, directed not only at general education about mental health, but at the reduction of stigma. But I don't think, I don't remember having had to confront specifically the issue of stigma.

HP: Really?

HB: And it may very well be because of the rootedness of our regional mental health centers in the community.

HP: So stigma with mental illness was never really an issue that –

HB: Nothing that came to my attention specifically.

HP: I see, and have you seen – How about just the way the general public views mental illness, perhaps not directly, but just in general, were there stigmas about mental illness back then?

HB: I'm sure there were. But, in a certain sense, as a clinical psychiatrist, the patients that I would have, that I would see, even in consultation, or in therapy, were seldom the victims of stigma. Just for some reason, although I know it was there, I didn't feel that I was called upon to contend with that specifically.

HP: Okay. So you mentioned before efforts to outreach to the underserved minorities. Can you tell me a little bit about what specifically the Department did and how it went?

HB: Well, I could give you one instance, just an instance. I decided, again with the support of the local Supervisor, to appoint only a bilingual Director of the East LA Mental Health Service and to encourage that Director, more or less require him or her, to appoint only bilingual mental health staff. The problem with that part was that the Department of Personnel was really in charge of who got onto the County payroll and bilingual principles, I don't think, were enshrined in the Department of Personnel. But, as the Director of the Department, I had the latitude to require bilingual competence of the Director of the Regional Mental Health Service in East Los Angeles. I made a mistake. It wasn't that easy to find a bilingual psychiatrist who could be comfortable with, and feel comfortable to, the major Hispanic source of caseload in East LA. At one point, sort of almost in a panic, I appointed a man who was really from South America and was a member of a social and intellectual elite in that country, who had very little capacity for compassion for economically and socially and racially deprived Hispanic people; and his attitude was one of almost contempt toward those people. That was a bad mistake on my part. I don't remember how I got rid of him; but he may have just voluntarily resigned.

And then at one point, I did get somebody who was just about ideal for that and that was Marvin Karno. Do you know who he is? Marvin Karno was a psychiatrist who went through the UCLA residency, married to a Chicana, is bilingual and actually had become junior faculty in the Department of Psychiatry. I got him to take that job and he went at it with enthusiasm. He was apparently quite fluent in Spanish and had a compassionate nature and so we had a good several years. But Marv didn't want to stay in that job. He wanted to have more of an academic career, so he left it and went back to UCLA and did a whole academic tour of duty, became a full professor, did research, and so forth. I don't remember who we appointed in his place.

HP: So it was really hard to find people?

HB: Exactly. It was, yeah, but that was one example. And I hired black psychiatrists to head up the services in South Central and South East and several of my major psychiatrists in the central office were also black. [After Don Schwartz resigned, I appointed Herb Robinson, a very capable black psychiatrist, as Deputy Director.] So I walked the walk, as well as talking the talk.

## **V. Closing Thoughts**

HP: Right, right. So overall, looking back, what would you say are the biggest successes of the Department during your time there?

HB: Well, it had many successes in the consultative services, in enriching the capacity of public agencies to deal better with mental health issues in their clients. I would say that was the major accomplishment. It was also a success in recruiting and making use of community organizations in various parts of the County in supporting mental health development.

I suppose the major accomplishment was the increased provision of the whole range of mental health services to the people of this County, which at one point had more population than 42 states.

HP: Yeah [he laughs]. So what were some of the things that you offered that weren't offered before?

HB: County and community based clinical services. That's not entirely true, because the County had been doing inpatient psychiatric hospital services for some years, before the Department was created. Consultation services – this did not exist before – in a continuum of mental health services starting with preventive services, consultative and preventive services in public agencies, going through outpatient care, inpatient care and rehabilitation. We didn't have that before in LA County.

HP: And all of those things were things that fell under the Department?

HB: Yes, yeah.

HP: Okay, anything that you would say is any major disappointments from your term there. Things you wish you would have accomplished, but were not able to?

HB: Well, I would have appreciated a more well-rounded and a more capable research director and I just wasn't able to recruit one. I might have leaned on people like Garfinkel; or at one point, one of the social workers in our UCLA outpatient department was the wife of Wally Goldschmidt [1913-; professor of Anthropology at UCLA 1946-69], who at one point had been the head of the Department of Anthropology at UCLA, and my wife and I even socialized with that couple then. I might have asked Wally to help me. I was so busy with other things that I just didn't put enough energy into getting a really, really productive, well-rounded research department going. [Those were the times of laissez-faire in the US culture, and, although I had learned crisp and directive medical administration in the military, I guess I was reluctant to be perceived as dominating and authoritarian.]

The Director of Research that I was not happy with recruited an Assistant Director who was also not a clinician, but an amiable, highly intelligent, epidemiologically oriented, but still administratively competent, person who left the Department to become Chief of the Mental Health Department in San Diego, subsequently. Her name was Areta Crowell. You know about her?

HP: Yeah, well, she was also later the head of the LA County Department of Mental Health.

HB: Yes, she was. They decided not to recruit psychiatrists to be the head of this Department and there were several other people who headed up the Department, after I resigned. One was a psychiatrist. I don't know Dr. Southard at all, I understand he has a doctorate in social work, and I don't know whether he has had any clinical experience. [It's very likely that he's an expert in planning and organization of community services, and that's a plus.]

One point that was a serious issue was whether the administrator of a public agency should be basically an administrator, and a member of the specific professional discipline or disciplines represented in that agency should not be given the overall responsibility of the agency, but should be perhaps given the role of a deputy director. I had colleagues among the Department Heads who, at the time that they put all of us into an overall health agency, agreed with me. As I say, there were people like the Head of Public Social Service, who himself was a social worker, or the Head of, I think, Roads, who was an engineer and so – At one point there was quite a bit of debate about it.

HP: Well, something that you bring up that is interesting in terms of the Department being headed by social work versus psychiatry now; is there significance in that shift?

HB: Well, I hope not. But I'm inclined to wonder about it, in view of the way the clinical teams function in at least this particular closest mental health service, the Edelman Service, where the psychiatrists are not recruited for being well-rounded psychiatrists but rather for being competent and compliant pill pushers, and the allocation, the assignment of patients, to individual members of the clinical team is not done by psychiatrists. I would rather think that, if a psychiatrist was the head of the agency that (to me) regrettable practice would



not be carried out. Also I think the Department would offer more attractive careers for well-rounded graduates of psychiatric residencies. [When I headed up the Department, I saw myself as setting program and clinical policy, and had competent administrators as deputy directors to oversee personnel and other management functions. I was perhaps a role model for clinicians.] I regret that psychiatric leadership hasn't prevailed, I must say, and I don't mind going on record saying that.

HP: Okay, so that's what you regret about things that developed later. How about from and during your time, are there other things that maybe you wished went differently?

[Pause]

HB: Not really. Not really. I don't think I could have been more multiracial. [I had a very competent special assistant, Margaret Molina, assigned as liaison to the Mental Health Advisory Board who was Hispanic and encouraged the Board to be aware of the special needs of that growing group of people.] You know, at that time Asian Americans did not form any significant cluster of population in this County. It was even before the areas around Monterey Park and so forth, in the west San Gabriel Valley, became so heavily Asian in nature. And so, when we thought of multiethnic, we thought primarily of black and Hispanic. And they were the ones who were very heavily represented in the central office, as well. I was pleased with our central office staff, with that one exception I mentioned earlier.

HP: So you talked a little bit about this in terms of the roles of psychiatrists. What other major changes have you seen in the public mental health system since you left?

HB: I have not been aware of any other changes. Primarily because I'm a person of intense interests; so that if a primary interest of mine, like public mental health, is something that I have chosen to steer away from, I get very intensively interested in other aspects. Presently my research and writing on what I call Darwinian Neuro-Psychoanalysis is an intense interest in my part and I do research in it; I do teaching in it; I've written and published a number of papers on it; and so I don't think in terms of public mental health and haven't been for at least a decade.

HP: I see, so since you have left the Department you haven't really remained involved or –

HB: No, other than in one of the seminars I conduct with psychiatric residents, every once in a while, they'll bring up a patient that they have picked up in the Edelman Center and I get a snapshot of what it's like at the present time.

HP: I see, and that kind of informs your views. One thing I'm curious about, that's very big in the system these days, is the Recovery Model. Do you have thoughts on that?

HB: I'm not even sure what you mean by the Recovery Model.

- HP: Okay, well there is a lot of talk about services being recovery-oriented today instead of medically oriented, so being a little less asymmetrical in terms of hierarchy and focusing more on hope as a key component of recovering from mental illness.
- HB: You know, it's interesting. I have been exposed to some of that at one of the seminars I am part of at Anthro[pology] on the upper UCLA campus, where there are really very well thought out and documented critiques of the medical model that come up for discussion. And the concerns of medical anthropology, which is to apply critical inquiry into a whole variety of medical services. And there are mentions of programs such as what you've described and what they are like. Often the studies are ethnographic and very interesting to me, so I'm learning a lot. [I don't know that a recovery model would be inconsistent with psychiatric leadership. When I was full-time director of UCLA outpatient services, I taught residents to be members of a full-spectrum team that followed up patients when acute symptoms had subsided.]
- HP: All right, is there anything else in terms of where you see public mental health going in the future that you would like to add or on mental health in general?
- HB: No, because the concerns I had with the prior administration in Washington would really no longer apply. I think we have an administration now that is very open to public health issues and, just as in the case of stem cell research and other medical issues, I think, and the increase in funding of NIMH research, I am optimistic that things will move along well.
- HP: Great. Well, is there anything else that we haven't covered that you would like to add?
- HB: I don't know whether I made enough mention of the fact that my advocacy of psychiatric direction of mental health centers, in particular clinical services, also contains within it a critique of psychiatric teaching in medical schools, because I am critical of that and yet less critical of UCLA than I was, because they seem to be expanding their requests for psychoanalytic clinical teachers over the past few years. For a while there I felt, well, as an example, there was one resident assigned to me who got so uncomfortable with my discussion of psychodynamics, that he decided not to continue to see me. That was the only time I have had such an experience. I've always had very positive reviews from my residents. I think psychiatric education is moving more in the psychodynamic direction, somewhat paradoxically maybe to some, because with an increase in our knowledge of neuroscience, we are able to see that psychotherapy has literal impacts on brain neural patterns so that it is a neuroscientifically justified treatment modality.
- HP: Right, that is interesting actually, because you think that they would pay attention.
- HB: Yeah. Eric Kandel, the Nobel Prize winning molecular biological researcher at Columbia, says that psychoanalysis, in order to stay alive, needs neuroscience; but neuroscience also needs psychoanalysis to develop a better explanation of

the human mind. [Eric Kandel, a neuroscientist, is a professor of biochemistry and biophysics at Columbia. Born in 1929, he won the Nobel in 2000.]

HP: That is an interesting thing to look out for [in] public mental health, and mental health in general.

HB: I think so, and [in] neuroscience. The other thing is that psychologists and social workers are getting better and better informed in neuroscience, which I think is a very positive thing. In fact, a lot of psychiatrists are falling behind in that and I regret that.

HP: Right, interesting. Anything else?

HB: Nothing else for now. Thank you very much for coming by.

HP: Well, thank you.

**END OF INTERVIEW**