Bruce Saltzer talks about his early advocacy work for the developmentally disabled:

That was a nice thing about disabilities work; it was a bipartisan issue. It wasn't Republican or Democrat. There was support across both parties. Anyway, so we held a public hearing. We developed findings and recommendations. One of them, a major one obviously, was that additional funding needed to be provided. We identified the consequences of the lack of funding. We ended up working with the State Counsel on Developmental Disabilities to get money into the budget. Originally it was five million, I believe, and the goal was to maintain the day programs primarily.

I did a lot of work up in Sacramento. I was pretty young at the time but I had to go up to testify. There was a lot of pressure. It was very interesting. I always remember going up there. On the Budget Committees, the key budget people were [Richard] Alatorre in LA County from the State Assembly [1973-1985] and Bill Greene on the Senate side [1983-1992]. So we had to meet with them beforehand in LA; we met up with them again then in Sacramento. I had to testify, but…we made some big enemies on this one. So I went up to Sacramento. I ended up doing the advocacy, which was really tough because…I had all these heavy hitters trying to tell me not to do anything. Once the money got in on the Assembly side – and Alatorre was not there till the last minute – things then changed. At the last minute, you know, where's Alatorre? Alatorre comes in and he moves to get it on the Assembly side, [and he made it happen], so that was kind of weird. Then all of a sudden, once that happened, the advocates are like "Oh yeah, we gotta get this thing through." It kind of changed. There was also a lot involved on the Senate side. I remember staying up; there was a budget hearing in Sacramento that lasted until 2 or 3 in the morning.

And the way things happen up there is just ridiculous, honestly. I mean I could talk about that another day. The budget bill comes out in January, and then the May revise is in May and it's almost like all the work from the first five months in many ways is [lost]. So at the last minute, there's all this trading and stuff. People don't know what the hell is going on and what's in the budget and what isn't. It's really an awful process. But anyway the bottom line is we also got it in on the Senate as well. It then went to Conference Committee. They reconciled it [the amount to be added back into the budget] down from five to three million dollars. Then everybody said, "The Governor's going to veto it." So we did two things: I set up a demonstration at the Governor's office in LA. Set it up on the day the Governor was supposed to get the budget back from the legislature, which is June 15. This was kind of lucky, since I had read in the paper two days before the demonstration that Governor Deukmejian [George Deukmejian, California Governor 1983-1991] was unhappy that he wasn't getting enough press about his budget so he was going to come to LA to have a press conference, which was on the same day [as the demonstration]. It was really bizarre [that the Governor himself made sure that we had plenty of press coverage].

So we had 500 developmentally disabled people marching around the Governor's office while he was upstairs and talk about making enemies. I remember I was talking to Warren Olney, the reporter, as he was going up with meet with the Governor. I forgot; we also did this petition I wrote up, for which we got 40,000 signatures. We did a lot. It was an incredible amount of work. And so we had Lloyd Nolan, who was an old actor, and Joe Campanella, who was an actor, who were involved with autism, [who] were going to present these petitions to the Governor and they wouldn't let us upstairs. So I

always remember Warren Olney coming up and asking me, “So would you like us to ask the Governor about this?” And I was like “Of course, absolutely.” I always remember too, that Al Lee, who was the Deputy Director [of the Department of Developmental Services; Gary Macomber was out of town], got pulled out of a meeting by the Governor, saying “What the hell was going on here?” They got really upset about it.

Just getting the State Council involved was really hard too. There were all these politics involved and it just goes on and on. Anyway, we got a little snippet in the *LA Times*, which really helped. And I was told by basically everyone in Sacramento that the Governor was going to veto this money; …and the Governor signed it. And they kept the day programs at five days a week. So that was really nice.

READ THE FULL TRANSCRIPT BELOW.

INTERVIEWEE: BRUCE SALTZER

INTERVIEWER: HOWARD PADWA

DATE: February 22, 2010

I. Education and Legal Aid; Advocate for the Developmental Disabilities Area Board

HP: All right, this is Howard Padwa here on February 22nd, 2010 doing an interview with Bruce Saltzer of ACHSA [Association of Community Human Service Agencies] for the DMH oral history project. So for starters, can you just tell me a little bit about your background? Where you grew up? Where you went to school? How you got into this line of work?

BS: I'm from Los Angeles, born and raised. I went to LA Unified Schools, I don't know if that matters. In fact, I met up with a principal later on in life who said "How did you become a lawyer going through LA Unified Schools?" But that's another story for another topic. I graduated from Pomona College; went to law school at USC. After graduating from law school, my first job was as a Legal Aid lawyer with the Legal Aid Foundation of Los Angeles for three years.

HP: Just for some background, what does that organization do?

BS: Legal Aid Foundation gives free legal assistance for low income people, for poor people. They provide a variety of legal services: landlord-tenant, government benefits, consumer issues. I was hired in my first job under a contract that Legal Aid had with the Developmental Disabilities Area Board 10 in LA County, which was a state agency that did advocacy for developmentally disabled individuals. And it was a one year contract to represent parents and families at IEP meetings [Individualized Education Program meetings, where individualized plans for the education of developmentally disabled students are formed] and fair hearings [procedures to resolve disputes between parents and schools]. This was when special education law was just getting started [through] Public Law 94-142 [the federal Education of All Handicapped Children Act of 1975] that guaranteed special education students a free appropriate public education.

HP: When was this roughly?

BS: I was hired at Legal Aid, I think, in '78. So at the time it was very new. I actually did the first fair hearing in the State of California for Special Education. It was quite a scene actually. Back then they didn't have hearing officers, they had a hearing panel: one [member] was selected by the parent and one by the school district and one selected by the two other panel members. I was up against an attorney for the school district who was extremely obnoxious and difficult to deal with. There was a lot of theater involved in it. I remember, one time, the attorney wanted a copy of a document the witness said was confidential and he went up and tried to grab it from the witness and there was a struggle.

HP: Oh, wow

BS: Both fell. Oh well that was kind of – It was a five day hearing, so for a young attorney it was pretty challenging.

HP: Trial by fire, yeah. So what made you even decide to get into that area of work?

BS: Well, when I went to law school – actually I think it was in college I volunteered at Legal Aid. I just wanted to do work in helping disadvantaged people. As a Legal Aid attorney that was the venue, in the legal profession, to do that, but I considered a variety of other things, actually. Before I went to Legal Aid, at about that time I'd just been given, or hired – I don't know what the term is – I got into Volunteer Service to America [VISTA}, which is a counterpart to the Peace Corps, in the United States. And I had no idea what I was going to do, so I did accept them and then right afterwards I had gotten this contract, offered a job at Legal Aid. I'd figured I could always go back and do the other, but I might not have this opportunity again. That's how I got started. So there wasn't any particular interest in any particular form of human service work or work with the disadvantaged. My first job just happened to be as an advocate for students and families that had special needs. So that's how I got started in that area. And then I pretty much maintained – up until recently, with this merger – my life work has been focused on advocacy for disabled individuals in one form or another.

Anyway, so I got a job at Legal Aid representing parents and families. I did that for about a year until the grant ran out and then I was able to get a regular staff attorney position. Which wasn't easy actually; that was another [story]. My director, the director of the Special Ed project at the time, knew the director of the Legal Aid Foundation and was able to get me placed in a branch office, which wasn't easy, but once I got there it worked out well. So I did it for two years. I represented families, individuals in a variety of different Legal Aid kinds of things: landlord-tenant disputes, government benefits. Probably the most interesting thing I did, I was involved in a law suit against the RTD over fare hikes.

HP: RTD?

BS: Rapid Transit District. That was the main bus line in the County at the time, now it's the MTA.

HP: Right.

BS: Legal Aid sued them over fare hikes, claiming they were violating state laws. The year before, I was not involved in the suit. But a temporary restraining order had been granted which was big news; it was on the front page of the [Los Angeles] *Times*. Even though ultimately, the permanent injunction was not approved, the next year they filed a similar suit but a little bit different; and the attorney that had done it the first time didn't want to do it a second time, so I argued the case. It was a bit intimidating, and actually I believe it was the first time the camera was [allowed] in the courtroom. It was quite the experience.

HP: And I'm sure going up against a major Department like that or the whole city like that – It's got to be daunting.

BS: It was a little nerve racking, but I got through it. It was pretty memorable though.

HP: I bet. And tell me a little about the work in terms of disability law back then. You mentioned that it was new. What was it like maneuvering in this relatively new field?

BS: Well again, at that time, parents didn't have a whole lot of representation and one of the things that this new law offered was that parents could get free legal assistance provided on their behalf. And anytime individuals or parents go up against a large bureaucracy like a school, I mean it can be very intimidating and they're often not aware of what their rights are. And so, on an individual basis, it's important they have support, and have an advocate that explains their rights and can act on their behalf. And I think that's just generally true. Of course, advocacy creates enemies, because people don't like you to challenge what they're doing. And it took me a number of years to kind of get over the sense of people not liking you, because you've got to be aggressive in advocating on behalf of these individuals.

HP: Because you're kind of rocking the boat.

BS: Well, yeah. And anytime you challenge something somebody does, they often take it personally, and so it's not easy doing that kind of work. Actually, I honestly think being a good Legal Aid attorney – and I only lasted three years, there were cuts at the time – I think it's one of the hardest things you can do. Because you have to deal with the constraints of the legal profession and you have to go in front of judges and play by all their rules; and at the same time, you're dealing with some life and death matters on behalf of individual families.

One of the things I didn't like about it on a personal level was that you can never do enough, I think, in those cases. So it was an extremely draining feeling. For example, if you lose a case, somebody gets evicted, or they lose their benefits. So for me, I took it very personally. Some people can deal those with those things better. Fortunately, I was successful a lot, but you're never 100 percent successful. So I decided – I don't remember exactly when, but at some point – I would get more involved in systems advocacy, which is what I ended up doing in my next job at the Area Board, representing larger groups of families. Basically, the Area Board is a state agency that provides systems advocacy for developmentally disabled individuals and families in LA County.

HP: So by systems advocacy, you mean advocating for more resources?

BS: Well, not necessarily for more resources. You're just not providing individual representation. You're addressing issues on a larger systemic basis. Which I enjoyed and I found – I always have worked very hard, but I just didn't have to worry as much about the immediate consequences if something went wrong.

HP: Yeah, it wouldn't immediately mean having to look someone in the face and say you're getting evicted.

BS: Yeah, that was really hard. I did not like that.

HP: So what were some of the issues that you would work on in terms of systems advocacy with the Area Board?

BS: The Area Board? Well, cuts were probably the biggest issue. There were a variety of things. We oversaw the Regional Centers [state centers that serve individuals with developmental disabilities and their families] – there are seven LA [County] Regional Centers. The most significant advocacy thing that we did, I mean, I could spend a lot of

time on it but I don't want to go into too much detail. But of all the things I've done in my life, probably one or two of the most significant things that impacted a lot of people [was addressing] some significant budget cuts. Back then, five to ten million dollars was a huge cut. It's funny how things have changed.

HP: Yeah, now you have that in a month.

BS: Yeah. But back then, [the State was] proposing major, multi-million dollar, five to ten million dollar, cuts in the Regional Center's budget. And what they were going to do was cut back adult day programs from five days to three days [per week]. And LA County, our Area Board, held a public hearing where we had a number of legislators involved. I was really happy; I mean that was pretty amazing. We had maybe 20 legislators and/or their representatives at this public hearing that we sanctioned.

HP: Just here in LA?

BS: Just in LA. I would say at least five to ten actual legislators participated. I don't know if you'd get that today. I mean…

HP: Yeah, how do you go about getting them to come down for something like this?

BS: A lot of work. There's a lot of planning involved. You know it's an important issue, bipartisan. And that was a nice thing about disabilities work; it was a bipartisan issue. It wasn't Republican or Democrat. There was support across both parties. Anyway, so we held a public hearing. We developed findings and recommendations. One of them, a major one obviously, was that additional funding needed to be provided. We identified the consequences of the lack of funding. We ended up working with the State Counsel on Developmental Disabilities to get money into the budget. Originally it was five million, I believe, and the goal was to maintain the day programs primarily.

I did a lot of work up in Sacramento. I was pretty young at the time but I had to go up to testify. There was a lot of pressure. It was very interesting. I always remember going up there. On the Budget Committees, the key budget people were [Richard] Alatorre in LA County from the State Assembly [1973-1985] and Bill Greene on the Senate side [1983-1992]. So we had to meet with them beforehand in LA; we met up with them again then in Sacramento. I had to testify, but before I did, I had a lot of pressure from a couple of our Sacramento advocacy groups because they had been threatened by the [State] Director of Developmental Services at the time, Gary Macomber [1983-1991] that if you do this it's going to be – I don't remember what he threatened exactly, but there were threats and they didn't want me to testify. And I had come up to do that.

HP: This is what you're talking about advocacy making enemies, sometimes.

BS: Oh yeah, I mean, we made some big enemies on this one. It's actually a funny story and I know you've got a lot more to cover, but this is kind of interesting. So I went up to Sacramento. I ended up doing the advocacy in spite of these threats, which was really tough because I had all these heavy hitters trying to tell me not to do anything. Once the money got in on the Assembly side – and Alatorre was not there till the last minute – things then changed. At the last minute, you know, where's Alatorre? Alatorre comes in and he moves to get it on the Assembly side, [and he made it happen], so that was kind of weird. Then all of a sudden, once that happened, the advocates are like "Oh yeah,

we gotta get this thing through." It kind of changed. There was also a lot involved on the Senate side. I remember staying up; there was a budget hearing in Sacramento that lasted until 2 or 3 in the morning.

HP: Oh, my God.

BS: And the way things happen up there is just ridiculous, honestly. I mean I could talk about that another day. The budget bill comes out in January, and then the May revise is in May and it's almost like all the work from the first five months in many ways is –

HP: Thrown out the window.

BS: A lot of it. So at the last minute, there's all this trading and stuff. People don't know what the hell is going on and what's in the budget and what isn't. It's really an awful process. But anyway the bottom line is we also got it in on the Senate as well. It then went to Conference Committee. They reconciled it [the amount to be added back into the budget] down from five to three million dollars. Then everybody said, "The Governor's going to veto it." So we did two things: I set up a demonstration at the Governor's office in LA. Set it up on the day the Governor was supposed to get the budget back from the legislature, which is June 15. This was kind of lucky, since I had read in the paper two days before the demonstration that Governor Deukmejian [George Deukmejian, California Governor 1983-1991] was unhappy that he wasn't getting enough press about his budget so he was going to come to LA to have a press conference, which was on the same day [as the demonstration]. It was really bizarre [that the Governor himself made sure that we had plenty of press coverage].

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BS: So we had 500 developmentally disabled people marching around the Governor's office while he was upstairs and talk about making enemies. I remember I was talking to Warren Olney, the reporter, as he was going up with meet with the Governor. I forgot; we also did this petition I wrote up, for which we got 40,000 signatures. We did a lot. It was an incredible amount of work. And so we had Lloyd Nolan, who was an old actor, and Joe Campanella, who was an actor, who were involved with autism, [who] were going to present these petitions to the Governor and they wouldn't let us upstairs. So I always remember Warren Olney coming up and asking me, "So would you like us to ask the Governor about this?" And I was like "Of course, absolutely." I always remember too, that Al Lee, who was the Deputy Director [of the Department of Developmental Services; Gary Macomber was out of town], got pulled out of a meeting by the Governor, saying "What the hell was going on here?" They got really upset about it.

Just getting the State Council involved was really hard too. There were all these politics involved and it just goes on and on. Anyway, we got a little snippet in the *LA Times*, which really helped. And then later on there was a gentleman who was the head of TRW [an aerospace/defense company] at the time, meeting with the Governor separately on his own disability issue and it's a long story, but we also got him to also to ask the Governor [about our issue]. And I was told by basically everyone in Sacramento that the Governor was going to veto this money. And anyway this guy, I don't know if his name matters, but he met with the Governor and he did talk to him about this issue and the Governor signed it. And they kept the day programs at five days a week. So that was really nice.

HP: That is a great victory and also a good lesson on how to really get these things done against all odds.

BS: It's a lot of work.

HP: And a lot has to go right.

BS: Well, what I tell people generally is you never know exactly what makes a difference. It's everything. You've got to do it all. But yeah, there are times when you can do things that people say you can't do if you just keep pushing it.

II. Executive Director of ACMHA; Budget Struggles; Integration with LAC-DMH

HP: But no, it's interesting to hear a little bit how this process works in terms of being an advocate. So tell me a little bit how you then made the jump into mental health world.

BS: So I had this job [on] the Area Board for 6 years and that was after Legal Aid. And then I went back to school to get a MBA and I was looking at nonprofit management. My first job back was actually at Legal Aid again as the Controller, or Chief Operating Officer, which didn't go well. And I was really unhappy. I left without having a job actually. I found this job [his current position] in the *LA Times* strangely enough, for the Association of Community Mental Health Agencies [ACMHA]. I found it in the paper and applied and I got the job.

HP: So what did this organization look like when you came here?

BS: Well, it was the Association of Community Mental Health Agencies.

HP: Is that the same as ACHSA?

BS: No, it's totally different. We're two merged organizations now. I'll talk to you about that later. So basically it was about 40, 35 to 40 community mental health agencies, all non-profit. ACMHA had formed in the early 80s. Susan Mandel from Pacific Clinics helped found it. There were a couple of different mental health organizations that were set up [that joined together]. I can't remember exactly what their names were, but she had started a similar organization in Alameda [County]. They set up a formal association. I think it was initially the Association of Mental Health Contractors or something like that. They met for a number of years without staff. They would write letters and they would use their own staff. Mainly the two main things that they were founded on, or that they were involved with, were contract issues and the budget. Those were the two big things.

HP: So contract issues, contracts with the State?

BS: The County of Los Angeles.

HP: And the budget being the County budget?

BS: Yes. And the idea was they could be more effective in advocating on behalf of their clients and their organizations collectively than they could individually.

HP: Right, I mean, because there are so many of them.

BS: There are. But sometimes the County would try to cut individual deals or they'd try and do things independently, or they could. And so the idea was that collectively there would be a stronger voice on behalf of the agencies vis-à-vis the County.

HP: Oh I see, so before the County could have played one agency against the other.

BS: Potentially, yeah. I'm sure that could have that happened. Or they would do something and an [individual] agency might call [to protest] this or that. But it didn't have as much influence as an organization that would represent all of them together. So they were around for a number of years. In the late 80s, early 90s they hired a half time staff person who was mainly into public relations. And then I was the first full time executive director in, I think, it was September of '91. And it's kind of interesting. At the time I was told they wanted the Association to be comparable to the Mental Health Association, which at the time was the main advocacy organization in the County. Over time things evolved and we became much more prominent and became, I think, the preeminent advocacy organization in the County.

One of the things that took time to evolve that ultimately was nice was becoming integrated into the fabric of the Department of Mental Health. I think it's one of the things I'm most proud about overall as an organization is that we really have become integrated into the fabric of the Department. They consult with us, we're included and referenced in meetings and documents. And it's a very collaborative relationship, at this time. And it wasn't always this way. We continually refer to DMH as a model for how the County should work with its private providers. They've really come a long way. They do believe, I think, in collaboration and we jointly solve problems together, which benefits everybody, honestly. I can't say that about every County Department.

But anyway, so when I first started, there were about 35 to 40 agencies. I was the full time staff. I started with a half time assistant who was half time working for me, half time with one of the agencies. By the time [ACMHA merged], and that was 10 years later, I had a full time secretary that worked for ACMHA. We incorporated at one point. But I basically did all the work other than the administrative work. I staffed the board, the membership, all the committees, everything. So it was a lot; but by the time I left. it was kind of running like a machine. I had it all down. And honestly, we did a lot of things over that time.

Probably the most significant in terms of our clients was really doing a very good job of avoiding budget cuts. And for a number of years, there were cuts throughout the County that we survived without any reductions. In fact, the first year that a cut happened was very painful for me. It's really amazing how the system has grown, I mean, it's just staggering. I mean from, it might've been a hundred million or less, today the DMH budget is 1.6 billion.

HP: Just in the County

BS: Yeah. 1.6 billion just from County DMH and the number of agencies has gone from 35 to 40 contract agencies to maybe a 140. I mean it's just unbelievable. Anyway, so just in terms of finishing the structure in the organization, well almost 10 years ago, 9 or 10 years ago, ACMHA merged with the Association of Children's Services Agencies

[ACSA]. And we became the Association of Community Human Services Agencies. So not only now we do mental health but we do mental health, foster care relative to DCFS, and juvenile justice relative to Probation. So we have three County Departments to work with.

HP: But it seems like these are things that all overlap to some degree.

BS: Oh, there is a lot of integration. Mental health does flow through all of them. There's a lot going on with child welfare and mental health these days in the County, with lawsuits and resources and things that weren't really happening a number of years ago.

HP: Well, tell me, you mentioned you had some victories in terms of that there were cuts, but they did really hit the clients.

BS: Well, for our agencies.

HP: Tell me a little bit about some of those.

BS: We used to pack the boardroom, the Board of Supervisors, would be full. We'd have buttons. We would talk about the impact [of proposed budget cuts]. I know right before I got there [at ACMHA] actually, it was maybe worse; they were talking about closing the entire system down or eliminating all the contract agencies.

HP: Wow, when was that? Like late 80s?

BS: Probably late 80s, before I got there. The Director was Quiroz [Roberto Quiroz, Director of LAC-DMH, 1984-1991] at the time. They wanted to eliminate them or something close to that and the contract agencies fought that off. That was certainly significant. The other thing I've worked hard for that is still not quite there is trying to get respite care for families in the mental health system. Because of my understanding and background in terms of the developmental disabilities system, where there's sixty, seventy – I don't know how much it is today – but tens of millions of dollars going to respite care for developmentally disabled families. I found out there was no respite care in the mental health system, basically none. Those families need it certainly. Developmental disabilities are a widespread spectrum of disabling conditions. Autism is probably the most severe, so certainly those families need it. But some of the other families, honestly relative to families with mental health issues, would not need respite care as nearly as much.

HP: And by respite care, what are you referring to?

BS: Respite care is basically giving caregivers a break from their caregiving responsibilities on a periodic basis. You can have someone come in while they're shopping or going to a movie or you can send their child to camp for a week. Something to give them a break because the pressure – it's hard enough in this day and age keeping a family together without that. But there are a lot of broken families; kids get placed out of home because they just can't deal with it anymore. Respite care is very cost effective. They provide respite care also for elderly families, not in this system, but that's basically the idea.

HP: And isn't there something in MHSA [the 2004 California Mental Health Services Act] for respite care?

BS: Well yeah, we got it in there and then we got it into the LA County plan. It's been very difficult to get it up and running. I don't really want to get into that. But one day my hope is that it's available to any family member that needs it, because it's really an important service. And actually we got it previously in the State budget. Basically it was me and a couple of others, Luis Garcia from Pacific Clinics and Carmen Diaz from DMH, a parent advocate, but I kind of led the charge. Basically the three of us, with the help of some legislators along the way, got it into the State budget, which wasn't easy. And then Gray Davis vetoed it twice; so I don't think I ever voted for him after that.

HP: You said it's cost effective, I guess because it's something that can help keep families…

BS: It keeps families together and keeps their children at home.

HP: Keeps families together instead of under the care of the state.

BS: Exactly. And also from a personal note it saves marriages and all kind of stuff. That was really difficult to see. That was going to be a pilot project where it was going to be set up statewide. It's sad that more families don't demand it because it's a really, really significant service. I remember taking a family member up to testify [before the State Legislature]. It's really hard, they talk about an 18-year-old son having a [psychotic] break right in front of their younger daughter and continually hitting his head against the wall. Just some awful stories, you know what people go through and what they live with. And people often don't see that. Any family like that, I mean, deserves to have some help. So there has been a victory, but it's still ongoing [the campaign to create and widely distribute respite services to families within the mental health system].

HP: But it hasn't yielded direct fruit yet.

BS: Some families have gotten benefits. We've gotten a pilot going; we did get some MHSA funds. It's not institutionalized, but people have benefited from it. Some families have already. So it is a start.

HP: One other thing you mentioned is about how when you first started with ACMHA, and now ACHSA, how you weren't really integrated into DMH and now you are. Tell me about how that integration, that relationship evolved?

BS: Well, not willingly [at first] among the Department actually.

HP: Was that something you guys had wanted though?

BS: Oh yeah. I mean we're half the system or even more. On the children's side we were more than the majority, so why not integrate us into your planning, into what you do? And it's just not always seen that way. I mean, I'm talking generally, the County always talks about public/private partnerships, but my sense is often it's like pulling teeth. And a lot of times with the County, nothing happens unless you make it happen, you know? They're not going to go out of their way to do something that you want them to do unless you basically make them do it. Now that's not always the case. So anyway, we had some bruising battles over the years with the Department.

HP: Without naming names, can you tell me a little bit about them?

BS: Well [hesitating], some of them had to do with budget cuts and how much we would get cut versus the County cuts. Some of them had to do with providers. There was a big provider issue. But basically on two or three occasions, we would have to go the Board of Supervisors, because the Department was unwilling to make any changes at the time and through Board intervention – these were in the early days – ultimately they were told, "You know, you need to change what you do on this issue." And eventually they kind of saw the light, I think. I mean that's my sense. My sense always was that to be effective, you have to have some kind of watershed event where they take you on and you win, and then they know they can't ignore you. So I can go back and look at my notes, I don't remember exactly what it was, it was a variety of different things that we were fighting on over time. But once we went a couple of times and had the Board's involvement, that helped.

In terms of advocacy, generally my philosophy has always been that you resolve issues at the lowest common level. I mean, there's no reason to get into it and waste a lot of time if you don't need to. But the County Departments always need to know that you're ready, willing and able to do whatever it takes to be successful too. And you have to have been successful once or twice, because if you weren't, they're not going to bother with you.

HP: Successful with these advocacy issues?

BS: Yes. And you know, with the County, it's the Board that ultimately makes the decisions.

HP: So in terms of the way that you guys are integrated now, I suppose with the [Los Angeles Department of Mental Health] stakeholder process and the SLT [Los Angeles Department of Mental Health System Leadership Team, which is part of the broader stakeholder process].

BS: Even separate from the stakeholder process, we have a very good relationship with the management, and in terms of day to day stuff, the chief Deputy [Director], Robin Kay does the bulk of the coordination. Robin is very collaborative. We talk regularly. We try to solve problems jointly together. We had an issue recently about implementation, some significant things. And she said, "Help me understand what your concerns are." I think it's a smart way to do things but it's ignored a lot of the time [by the County], and I give her a lot of credit, because she's willing to listen and after we talk, she says "OK, that makes sense." You know, for so many [other County Departments] I deal with, it's a zero sum game you know. You win, we lose. We win, you lose. It's awful. It's like everything is fighting and it feels like a battle. It's just totally different.

HP: Fighting in terms of funding our system versus yours.

BS: Not just about funding. It's about policy issues, about contract issues, about a variety of other things. I'm just talking about in general anything, not about the budget per se.

HP: So it [DMH] really has been a model.

BS: Yeah, it has. And I think it has been more productive for everybody because you're trying to solve problems together, you know? I mean, I'm an advocate. I'm not a hired gun. I care about what I do. I believe in the work. I believe in what they [ACHSA

agencies] do. I'm actually here representing their clients. That's the way I see my job. And the day I can't do that I won't be doing what I do, cause that's my background. That's what I believe in and that's what I like doing.

III. County v. Contract Services; Budget Issues under MHSA; Stigma; Recovery Model

HP: So when we talk about a private/public partnership, what is it that the public gains with partnering with the private and vice versa?

BS: Well, first of all, our agencies provide half or more of the services. In my ideal world, the County would not be delivering any services. The private nonprofit sector should be delivering all the services.

HP: How come?

BS: Well, it's more cost effective, first of all, because they get paid less. The salaries are lower relative to the County when you throw in their benefits and everything else. And they have the ability to be more creative, in terms of bureaucracies. You can get rid of bad staff people a lot easier. In the County bureaucracy, you can have a bad staff person hanging around for years.

HP: And also, I suppose the fact that the County is all unionized makes it even more –

BS: Exactly. Going back to the benefits [of the contract system], I just think it's the most cost effective way to do things. And you can hold them accountable in terms of contracts. You can pull a contract. So the government ideally, in my mind, should be overseeing the expenditure and monitoring and those kinds of things. And the private non-profit sector should be delivering all the services. I think it's the best model. I think it serves people the best, and I think the system overall would be better served by that.

HP: Well, what's the argument against going to an all contract system?

BS: I don't know. I mean, you have to ask [someone else]. Here's an analogy: You have a dues system set up. It might not be a good dues system, and you could have a much better dues system. But you're not going to move away from that dues system, because people get used to the way it's operating. It doesn't mean it's the best way to do things, but when you're looking into a new dues system, not only do you look at "Is it better?" but you're also looking at which agencies are better off and not better off [relative to where they were before], so it's really hard to do. Similarly, again, the main reason why it's not going to happen is because the union is not going to give up the union jobs, honestly. And they donate to the campaigns and all that. It's just the way it is.

HP: And I guess one other question you can not answer if you like, but you mentioned about the salary difference.

BS: We've done salary studies over the years, two of them particularly. Our social workers are the core positions, like keystone positions. And we did one about ten years ago. And we did another one a couple years ago. And they [ACHSA agency salaries] were like 15 to 20% behind the County salaries.

HP: And I guess the question would then be: Is that paid off in terms of the services that are delivered?

BS: Well, I mean, we'll compare our quality of service to the County any day. I mean, there are good people working in the County. But I think as a model, it makes more sense to have a private nonprofit sector deliver human services. And I would have them deliver all human services.

HP: Greater efficiency.

BS: Greater efficiency. Then also there's a conflict of interest honestly, when you have County employees monitored by County employees.

HP: That's true.

BS: So why not invest all public money in overseeing and ensuring quality and that kind of stuff, and let the private nonprofit sector deliver the services. I think there's more control over it. The biggest thing honestly, or one of the biggest things, is accountability. You know you have to meet a payroll. You've got to, you're still operating like a regular entity. Also bad people are fired. And that doesn't mean everything works perfectly [in contract providers], but certainly that's a big drag on the County system if you ask me, the lack of accountability. And if you talk to anybody [in the County system, they'll say] "Well, we can make something happen, but it takes years." And that's very troubling to me.

HP: Now would this apply to also to even things that are perhaps too big an undertaking for a private nonprofit, such as hospital services or 5150-ing [5150 is the code for putting a hold on an individual who poses a threat to self or others]? Things like that?

BS: What? I'm sorry.

HP: Would you envision those services going to the contract world as well?

BS: Well, there are nonprofit hospitals, but I'm not an expert in that. 5150s, our agencies have done some of them. I'm pretty sure they were authorized to do that at one point. I don't know if they do now. Obviously there's a liability. I guess that's one of the things the County has is some protection against liability sometimes. I mean, these jobs are very high risk and even if you do things perfectly, bad things happen from time to time. It's even more acute on the child welfare side, which I deal with now too.

HP: Yeah, I can see that. We'll get back to this issue in a little bit. We jumped ahead a little bit. So, thinking back to when you first entered the mental health world, what where were the major problems facing consumers then and how have they evolved? What are the major problems now?

BS: The biggest problem is still inadequate resources. That's always been. Now that's true of almost any human service area. But even back then, there was a hard time finding services for everybody. And it is kind of a strange dynamic that the amount of resources has so significantly increased, but yet it seems almost like people are almost worse off in some ways. And I'm not sure exactly why, relative to the amount of services we're able to deliver. Because back when I first started, people were concerned that agencies were

seeing the quote unquote "the worried well," and people with a little bit of anxiety, and that the level of need wasn't nearly as great. But today, we are only seeing the most seriously involved, and there's a lot of people we can't see – we have to turn them away. I have no idea why that dynamic is. I can't answer that. It's a real strange question that comes up

HP: Yeah, I mean, especially since the MHSA. That was supposed to [provide adequate funding].

BS: Well the MHSA is really targeted. It's a great model [for clients with] the very highest intensive need. The irony, the big problem today, is that the rest of the system is underfunded; the outpatient system is slowly dwindling away, so more people will need higher levels of care.

HP: I mean, the rest of the system has gone down more than the MHSA brought it up.

BS: Relatively, yeah. So we are trying to get more flexibility in the use of MHSA funding. Basically, we want to fund outpatient programs with MHSA funds, which they're not allowing you to do right now.

HP: And that's because of the supplantation [clause in the MHSA, that MHSA funds cannot go towards the maintenance of pre-existing programs]

BS: I honestly don't know. I mean, initially the idea was that the system would allow MHSA to fill in the gaps and see people. And the PEI [MHSA Prevention and Early Intervention programming] also was supposed to fill in the current gaps in the system as well as start preventing mental illness up front, and providing early intervention to minimize the impact, and therefore you'd have a perfect system.

HP: And by the gaps, you mean the homeless mentally ill?

BS: That, and if there were other pockets of individuals and types of needs that were unmet. So it was kind of to fill in the gaps and do more upfront, and ultimately we'd all work together and everything would work well. The problem was that the economy has made a huge difference relative to the funding of the core [regular adult outpatient] programs. So a lot of MHSA has had to be relied upon, and no one anticipated this, to fill some of those holes. Now that doesn't mean it's supplantation – and this is a really important point, because you can't deliver the same services under MHSA that you do in your outpatient programs. So even though those funds help mitigate the impact, it's not a one-to-one correlation. So somebody who's getting outpatient services may now be getting Field Capable Clinical Services. It's a different kind of service, it's not the same; it wouldn't necessarily be as intensive. And they're just making do with the best they can.

HP: Right. But with the way the other budgets are, what choices are there?

BS: There is none. So they're doing everything they can do. And I think again, Robin and the Department have [done their best]. There is a big difference also in that it used to be a big battle fighting over these resources with the cuts and how they would be distributed. DMH did not take a lot of the cuts at the beginning and they wanted them

[the cuts] go to us [contract providers]. And they found other revenues to cover themselves.

HP: They would find money after the cuts were made.

BS: Oh, they had control over a lot of money that was just kind of hidden here and there. It's a very complex budget, so we would have to find those pockets and once we did, that kind of mitigated it. The pockets are gone, that's a big change. The credibility of the Department has gone way up in terms of the budget.

HP: Tell me a little about stigma regarding the mentally ill, if that's…

BS: Just in general?

HP: How it's changed or what it was, what it is.

BS: I'm just giving you my general sense. You know, I'm not a clinician. I'm not an expert on stigma although, I have a cousin who's in the system that I can talk about because I've learned a few things through him. I think overall things are much better in terms of stigma compared to twenty years ago. And I think every year it gets better as more prominent people come out and talk about it. You know Terry Bradshaw who was a quarterback [with the Pittsburgh Steelers has spoken out about his depression].

HP: Oh, I didn't know that.

BS: You didn't know that? Major depression. It's funny. He was honored by Didi Hirsch [Didi Hirsch Community Mental Health Center]. He's talked about it. [Former Vice-President Al Gore's wife] Tipper Gore [has also suffered from depression, as have] a lot of the actresses and actors. There's Rod Steiger.

HP: Jim Carrey.

BS: I hadn't heard about Jim Carrey, actually.

HP: Yeah, bipolar [disorder].

BS: But I think that's really helped a lot. You know it's an illness of the brain, as opposed to an illness of the body. I think, if you look relative to hundreds of years ago, it's like night and day. It's not even close. I think more and more people are accepting it. They're accepting medication as appropriate. Just looked at the use of some of the depression medications – Prozac, Zoloft – millions and millions of people use them now. It's relatively common. It just takes time [to educate people]. But I think it's just getting people out there and having people understand that it's you and me. And a lot of people acknowledge it in their families too. Didi Hirsch every year has a program where they ask, "How many people know people [that have a mental illness]?" and everybody stands up now. Stella March [of the National Alliance on Mental Illness] is the big stigma person.

HP: She's part of this project also. And tell me from your perspective, what is recovery? What is the recovery model?

BS: Well, it's involving consumers or clients in their care and in their moving forward basically. That's the core, as well as really focusing on – well, medication is important – but being able to live a productive life is the goal. It's not just reducing symptoms. It's not giving people a bunch of meds and working on symptoms. Obviously medication is really important in terms of getting the right mix and all that. But the real focus is involving consumers themselves in a joint journey to have them lead as normal a life as possible.

HP: And has this something that has gained steam or maybe wasn't the case, let's say, twenty years ago?

BS: Well, it's certainly much more prominent now. It's very different now. I mean one of the good things about the private agencies – Portals [a contract provider in Los Angeles County] for example – Marv Weinstein [President and CEO of Portals from 1965 through 2001] was the leader in psycho-social rehabilitation in LA County. Many, many years ago, [the County mental health system] was very medically oriented. So, over the years absolutely, the focus has changed dramatically. One of things I'm working on now, interestingly enough, is trying to get MediCal to pay for some of these recovery model type of services – employment-related services, transportation, socialization, all these things. Because it [MediCal] is also based on a very medical model.

HP: Yeah, billing is a very big issue.

BS: It is a huge issue. So we're spending a lot of time now. A couple of years ago, ACHSA developed a document where we identified ten areas of types of services that we feel should be billable to MediCal. And we are trying to get clarification because it's kind of hard to get people to agree. That's one of the issues we have – no one wants to commit to anything. The federal rules come out and then there's all these interpretations. And the State doesn't want to commit because they are afraid of getting dinged on it [not getting reimbursed by the federal government for services provided]. And the County won't do anything, so it's like "it's up to you" [the contract agencies]. And the agencies don't have that level of [liability] protection, so if they're not sure [if recovery-oriented services are covered by MediCal] they're not going to deliver them, or they're only going to be able to bill them to a non-MediCal kind of source.

HP: Well, that would be a huge change when that goes through.

BS: Well, we're really pushing that now. We wrote like a ten-page document. It's very specific, very concrete, and now there's this work going on in the State, actually with the 1115 waiver [which allows for the expansion of coverage not normally allowed under the Medicaid program], where they're renewing the MediCal waiver for California. Our push in LA, our group of providers – myself, David Pilon from Mental Health America -- is to get these types of services integrated into the billing of MediCal. So we're really pushing that now with the State level.

HP: I guess the next question – this touches on it – what would a recovery oriented system look like? We hear often about how DMH is moving towards a recovery-based system. On the system level, what does recovery look like?

BS: Well, it's a good question. But I think the County is moving towards that, towards Wellness Centers and client-run programs and client-based programs and client

integration in planning. Client involvement in everything that basically gets done in the system, which I think is there in some ways. Here's an example: What's really challenging is in employment. More consumers are involved in employment in the County, they have jobs within the system, but I still question whether the level of support is there to make that effective. And that's one of the things.

HP: There has to be support for them as they react to the working world…

BS: Yeah. It goes back to my cousin who's been involved in the system for quite a while now. He's been sober, thankfully, for 7 or 8 years and then he had to get the right medication and all that stuff. But once you get to that point, then you have to live your life. It's one thing to dig out of that hole, but then to go to that next level is incredibly daunting. For anybody without resources, it is. But when you think about it, to get an apartment, to get a job, to keep the job. He's got three kids. It's pretty overwhelming. So you can even get a job, but then it's like, "OK, so what happens if he has to get a car to get to the job and the car breaks down, who's going to pay for that?" There's an amazing amount of things that can go wrong in somebody's life that you don't realize unless you're dealing with them on a day to day basis, which I was. So individuals that are in the workforce, I think, need a lot of support. And it's hard for them to get it sometimes.

[pause]

IV Dual Advocacy Roles; Writing MHSA; Implementation

HP: OK, something we've already touched on a little bit, and obviously don't feel like you have to go into too much detail, but I see your organization has having a dual role: one as an advocate for your member agencies, one as an advocate for the mental health system.

BS: I agree 100 percent.

HP: How do you balance it, or how do you balance that sort of dual advocacy role?

BS: I don't really have to balance it. It's funny. I once had a board president that was saying, "Why do you do any advocacy, we should just be doing the other [advocating for the mental health agencies]?" And to me, they go hand in hand. I mean, it makes it easier to advocate on behalf of the members if you're doing other advocacy. That's not why I do it, as I said. But I think the two are completely consistent for me, because again, I believe that our agencies do a really good job and they should be delivering all the services so –

HP: Advocating for the clients *is* advocating for the agencies.

BS: It's basically the same thing. Now I do sometimes do pure advocacy work that doesn't at all [affect member agencies], like for respite care. Fighting for respite care is not an agency issue whatsoever. I just did it as an advocate on my own. My Association let me do it. It's something that I'm passionate about, but it didn't help them at all. So we often do things that are advocacy that don't benefit them [the ACHSA member agencies]. Now sometimes they go hand in hand.

I mean, on the child welfare side, probably the biggest thing I've done is – we got this thing started called MAT (Multidisciplinary Assessment Team), which is that every time a youth is put into out-of-home care, the idea is to do a comprehensive multi-disciplinary assessment. When the merger [that created ACHSA] occurred about 9-10 years ago, there had been discussions about developing such a comprehensive assessment for years apparently and they never did it. So I helped develop this very detailed model that was very prescriptive. That was the problem before: the models were too general. So we had to get into very precise things about who would do this and what we would call it. It got complicated and that's where [these types of things] usually kind of fall apart. So anyway, we worked out those details. [Then, once the model was developed], one [DCFS] Director would like it; the next Director wouldn't, and on and on. Honestly, our persistence [was critical,] because it almost died a couple of times.

Today, it's ingrained in DCFS; it's really neat. For almost every kid now. I think it's in every Service Area now, but they're just starting it up in a few Areas. But it's been really effective in identifying what these kids need and in developing [individualized] plans [based on those needs]. Now it's tens of millions of dollars [Countywide]. So it's pretty neat.

HP: So an innovation from a contract side that's revolutionizing.

BS: Well the contract agencies deliver and coordinate the MAT teams. That's kind of hand in hand where our agencies benefit, but they do a really good job at it. And that was why it was important for us to make that kind of a privatized model. The County does it in a couple of Areas, but I just think our agencies are the best equipped to do it.

HP: Now I guess, thinking on the mental health side, an area where maybe that would apply would be like with the ISAs [Integrated Service Agency programs]. So the AB 34 program, maybe AB 2034 [pieces of legislation from 1999 and 2000 that expanded ISAs] was something that started with the private agencies and has now expanded.

BS: Exactly. Because it became so successful that if the County didn't do it, they'd go out of business basically. They were forced to develop that kind of a model, basically.

HP: All right; so let's move up ahead to the story that I touched on before of ISA programs and the Mental Health Services Act. From the beginning, was your organization involved in the drafting, the campaign?

BS: ISA?

HP: And then the MSHA as well.

BS: Yeah. Well, the Mental Health Association really started it [ISA programs] with the Village [an ISA program in Long Beach]. In terms of the design and all that, our Association didn't have much to do with that. The Village itself, [which had been] MHA designed, was involved more in the actual design, I would assume. They were involved in the state legislation. But ACMHA was [only involved in local] contract and operational issues.

HP: And then how about the Mental Health Services Act?

BS: I can tell you about five to ten people who claim they wrote it.

HP: Are you among them?

BS: No, I'm not one of them. I'll take credit for other things, but things that I actually did.

HP: Were you consulting on it?

BS: It was done at the State level. A lot of our agencies were involved, but I didn't need to be. I'm sure I reviewed drafts, made comments, like anybody else. And certainly it was going to affect our members. But it was really the State Association, it was a statewide initiative. We were heavily involved in the advocacy in LA. We did fundraisers and got people out to vote and that kind of stuff. Whatever was in the legal constraints of what we could do at the time. We had a legal opinion on that. So we were heavily involved in the campaign, honestly. That was the main thing.

HP: So your advocate role.

BS: Exactly. And we did a lot.

HP: And when you say the State Association, is that the – ?

BS: The California Council.

HP: The CCCMHA [California Council of Community Mental Health Agencies]

BS: Yeah.

HP: OK. So you weren't really involved in the draft and you helped with some of the campaign, getting out the vote, things like that.

BS: And money. A lot of money

HP: From the member agencies?

BS: And from our Association.

HP: And was that seen as a risk at the time?

BS: Risk? I don't know. A lot of the things we do, I suppose, could be risks, but it was important. I don't think there was any question that people were going to support it, and provide any funding they could and provide whatever support they could. That was important to everybody.

HP: So when it first passed, and you first kind of became familiar with the details of the MHSA, what did you think? What were your hopes? What were your fears?

BS: There was no fear; it was only to enhance services, actually. I talked about that earlier. I think whatever I said earlier is pretty consistent which is that the idea was to fill in the gaps and target the high-end people that for some reason were outside of the reach of the current system. And then at the same time [through prevention], try and get people

before they got particularly ill to really allow – at some point ideally – allow the resources that were already there to be used on the people that really needed them. And ultimately to try and see everybody that needed help, [while at the same time] one day minimizing as much as possible the number of people that we see, so that the resources that we had before would be adequate to serve everybody that we would need to. So that was the goal.

HP: OK, so that was the goal. We touched a little bit on this earlier also. What is the greatest accomplishment of the MHSA and its greatest shortcoming?

BS: Well, [in terms of accomplishment] not what was [originally] intended because of the huge decline of resources in the rest of the system. Honestly, I think the biggest shortcoming is that I don't think, even with the additional funds, it was ever enough. There are so many needs that people have. I mean, respite care hasn't even been touched. I think the expectations were much too high relative to what it could deliver. I think that was the biggest shortcoming. People expected everything, and it just wasn't possible. And when you are looking at all the needs that people have in the system, it ended up being not a lot of money [having to be divided up into] a lot of areas.

Now in a couple of areas, there was heavy investment. You know, like in the Full Service Partnerships [very intensive programs created by the MHSA] for the highest need individuals. They've done a lot of really good things. [But for everything else] – respite care is a perfect example – even half a million dollars, which is what they allocated, is a drop in the bucket. You know, they could use 50 million dollars in the State of California for respite care, easily. And right now, with all these cuts it's not going to happen. There's a lot of huge unmet needs.

[With the MHSA], a lot of people have been helped. Unfortunately, it hasn't been able to do what it intended in many ways, in terms of filling a number of the gaps, because some of it has had to be used by the people already in the system to avoid them being totally curtailed. So it just hasn't been able to be used as much in an enhancement mode as it was intended to have been. It's not the same exact service, relative to supplantation.

HP: But it's for the same people.

BS: Not always even. But it mitigated the huge impact of the [curtailments]. In some ways, it was not close [to being the same type of service that was cut], but it was at least some help to stop some of the bleeding in the rest of the system.

HP: Yeah, I mean, if would have been – all these cuts would have been truly disastrous.

BS: Well, they already are. I could talk about that. We just sent to the Legislature some scenarios of people that were cut recently and people that the system cannot see today. It's shocking how bad some people are that we are not even able to see today. There are really awful stories – people [with] suicidal [ideation] and people of all ages that are in serious need cannot get help today. A lot of them. A lot of them, particularly without insurance. And I don't know how they survive sometimes, honestly. It's really tragic.

HP: OK. Well, overall what would you say your vision is for the public mental system both in LA and in the state?

BS: Well it's the same – State, LA. It's so hard because the resources are always so limited. But ideally, the goal obviously is for each person to reach their potential. I mean, that's always the goal for every individual. As much as you look at things on a systems basis, it's really millions of individuals' lives that are at stake, where people need help to get through what they're dealing with and to be productive. So it's really hard to compartmentalize the systems vision without looking at individuals. Ideally there will be more resources and now it's a tough time to be talking about that, because we are so far away now from even the maintenance of things.

HP: Let's say we could fix the budget. What would you do with the system?

BS: You know, what MHSA is based on is whatever it takes. And honestly, it's not brain surgery. It's true of every human service. You do an individualized plan for this individual and then you provide services to meet the needs of the individual. It gets very tricky because how far do you go? Because there's never going to be unlimited resources. Obviously, [you start with] medication, get that settled. But then, you want to find that person a job, want to find them a place to live and you want to try and make their social life something that is meaningful for them. Those are the basic elements.

HP: For everyone.

BS: For everybody, absolutely. And [you want to make sure that] their healthcare needs are met. So that is what MHSA is based on. So it's really hard, for me at least, to go beyond that, because oftentimes people generalize. They have to, to some degree, but it still comes back to [assuring that] the individualized care that each person receives is adequate for them to be the most productive that they can be. And that level of resources in this country has never been adequate, they've never invested enough and that's why there's a lot of prisons and [not a lot of] everything else. I guess ideally too, there would be a huge investment in upfront, school-based services. If every kid who had a problem in school was dealt with at that point, it would be great. But [at the same time,] part of the problem is that you can't just deal with that kid's problem. That kid lives in a family, that family lives in a neighborhood; and because of poverty, there's a huge number of family issues, there's a huge number of community issues, there's gangs, etc. So everything is interlinked and it's really hard to just solve one little thing there, without dealing with everything else. And this country has really never invested adequately in resources that you really need to comprehensively address those kinds of things. They tried in the 60s.

HP: So it's more than the mental health, it's really the entire social safety net.

BS: It's everything. And they all interrelate. When somebody loses their dental care or their medical care, you don't think it affects their job and everything else? It absolutely does.

HP: It affects their quality of life.

BS: So that's the sad part. Some people get it and a lot of people just don't seem to care. They're able to kind of, I guess, cut it off. That's something I can't do. It just makes it hard, because every day you starting thinking about it.

HP: But it's interesting, because it connects these questions of policy and outcomes to the broader political or social priorities.

BS: Everything is connected to that, always. So that's why, what are the problems we have in the system [today]? They are the same problems we had twenty years ago. It's really funny. If you come back (and people have told me this and I know it), twenty years from now, it's still going to be the same kind of stuff.

HP: We'll have to do this interview again in twenty years, see how it goes.

BS: [laughs] If I'm around, I'll be happy to do it actually.

V. Closing Comments

HP: Yeah, that's interesting. So that's kind of what you would like to see happen. What do you think actually will happen? Where do you see things going?

BS: Well, it's like everything else; you do the best you can with what you're given. Right now that's a tough question, because we're not looking at enhancement and advancement; we're looking at staunching the bleeding. And trying to get back to where we were, where everyone in need can be seen in an outpatient program. My biggest fear is that because of the way this money has been funded, and I think it's been too – one of my big criticisms of the MHSA, that I didn't talk about before – is that it's been too inflexible. And I know why in the beginning they needed to focus on the highest need people and be very structured but I don't think the rest of the system has been given the resources it needs, while the MHSA has been very heavily resourced.

HP: The two-tiered system

BS: Yes. And that has been one of my biggest complaints from the beginning. I want to see more people. I want to prevent people from becoming more involved [in the mental health system]. And the outpatient system is really jeopardized. It really scares me. And I still think it's one of the most cost effective ways of seeing people. [Some people] want [almost] everything community-based and I don't think that's going to work. Some people, some families really benefit that way [from outpatient care], and it's very cost effective. Sadly, it's really slowly being disintegrated, on the adult side particularly.

HP: So when you say "community based," I always thought that "community based" was the outpatient programs.

BS: Well, yeah, it is community based. relative to residential and other kinds of things.

HP: Exactly. So when you say community based, you mean something less than outpatient?

BS: Yeah. [In this particular context,] we've had a difference of opinion [with the Department] about how much flexibility to give Field Based Clinical Services. They wanted it to be higher [with less flexibility]. I fight all the time over people's desire to have an ideal world that doesn't exist. And I think [people sometimes] make poor policy decisions because they [envision] an ideal world [that isn't practical]. We are really in a difficult situation now, and people should be seen where we can see the greatest number of people. If

we can see more people in the clinic, it might not [always] be ideal, but let's get it done. Let's do it that way. And some people are so rigid in terms of [saying] "Oh, we need this system to look exactly like this." They are so unrealistic; [it just doesn't make sense to me]. It doesn't maximize the use of resources in the best way possible.

HP: Why do you think people are stubborn on that?

BS: I have no idea. It's the same problem in child welfare too. It's like [some people say,] "Every child should remain with their family" -- it's just not practical. People get these visions in their minds and they're not practical, they're not realistic, and I think that hurts the people that these services are designed [for] when they do that. But that's true of some advocates even. I fight against advocates all the time that say "Every kid should be here, every kid should be there." Maybe I thought like that 30 years ago at Legal Aid, with that mindset, but the older I get, I just don't think that's productive. I don't think it's a smart way to go. I think people get hurt ultimately because some people don't deal with the realities and you have to take each case on its own. Most people maybe [fit a pattern,] but not everybody, and you can't be rigid about it when you look at that.

HP: And the dollars and cents, you wind up serving less people.

BS: Yes. So I think that's hurt people overall, unfortunately, just in terms of human services the way they're delivered sometimes.

HP: I guess in the mental health example, of being married to the field based model.

BS: There was some flexibility they built in, but I don't think there was enough, and there were some limitations from the State too. The Department was trying to help. They went a long way, but I was kind of still pushing the envelope further. Like I said, I think outpatient programs should be funded with MHSA funding and they're not. I think [the State and the County] should flat out say, "You can provide outpatient services with those dollars." I think initially they were worried about siphoning MHSA funds off [to fund the core system]. I do understand that they were worried about the Counties and everybody else taking MHSA funding. That's why the supplantation [clause of the MHSA] was in there. But the other part of the system went down just because of the economy, and so it wasn't like the County was taking [the MHSA] money [to replace its own funds].

HP: So the fear was that the counties would cut outpatient programs and say "let's use MHSA funds to fill in the gaps."

BS: And they would save the money for something else. That was why supplantation was in there. Now [ironically,] the State [itself, rather than the County] has done some of that. They've taken some money, like the [AB] 2034 [program] or something like that [for their own budget purposes], and said you can now fund [that program] with MHSA. Well, we're [the advocates] claiming that's illegal. It's still in a lawsuit now. But I'm not dealing with that. Leave that for somebody else.

HP: So overall, what would you say have been the most important changes and your biggest accomplishments in the mental health field since you've been working in it?

BS: Well, the biggest change has just been the scope, the size.

HP: The size of the budget.

BS: Yes, and the number of providers. It's harder to run an agency today, honestly, a lot harder.

HP: Why?

BS: It's a lot easier to run a million dollar agency with 25 staff than it is a 15 million dollar to 20 million dollar [agency] with 300 staff. More responsibilities. More accountability in terms of oversight. More risk involved. It's like running a big business as opposed to running a small community clinic. It's a different way of doing things and there's just a lot of pressures involved in that. In terms of accomplishments – well, over the years, in all my time in mental health, for me it was ten years of no cuts for our agencies. That was huge. How we did it sometimes, I don't even know. And the first year where we got cut, it was really, really hard for me.

HP: Which year was that?

BS: I honesty don't remember. But it's been 7 or 8 years ago now. It maybe was around the merger time, because I know it was 10 years where there were no cuts. And there was that one year that was a big deal where – and I give credit to the Department Head-- but we were given information that the County was trying to take 10 million dollars of our [County DMH contract] money. And they were at the time. They took 10 million dollars to fund something else and they weren't supposed to do it that way and we found out about it and I went back and explored the realignment rules [realignment refers to the way that the public mental health system has been funded by the state since 1991] and found out that it was improper and we made a big deal of it. The [County] CAO at the time –

HP: So you worked with the Department Head at the time?

BS: No, we kind of did it on our own. She just kind of tipped us off [as County DMH could not get directly involved] and we did the work on our own. And it pissed off the CAO at the time, who we later became very friendly with. We kind of had to do it like a sneak attack because it was most effective for our advocacy and raise this once. It was like he was speechless for the first time. We caught him. And so what ended up happening was [that the County] took the money as a loan. Burke [Yvonne Braithwaite Burke, Supervisor for Los Angeles County's Second District, 1992-2008], I remember was the Chair [of the Board of Supervisors], and she said, "So we'll repay you next year, 10 million dollars." Since we were relatively flush that one year, [we were OK with the loan concept]. And they were going to take it.

Then next year everybody forgot about it, lo and behold. And I raised it, what about the 10 million dollars? The County didn't want to hear about it. It went away. The following year I raised it again. I got a bunch of people involved and the County paid it back. So we got 10 million dollars back into the mental health system that we wouldn't otherwise have had, if it wasn't for us [our Association].

HP: So that's an example of a private public partnership also, because it's good for the Department as well.

BS: Oh absolutely. They thanked us. They thanked me. 10 million dollars back then was a lot of money they otherwise wouldn't have had, if it wasn't for what we did. So over the years – I'm sure there's a lot of things I could mention – there's been a lot of contract issues. We've added due process into our contracts, that was a big deal to our agencies.

HP: Due process in terms of?

BS: Basically it's that before you do something, you have to give people notice, a hearing, etc. [For example, the County might] take money [from your contract] and not tell you [before doing so]. So we made a lot of changes in the contract that made it fairer for our agencies to do business [with the County]. Although that's an area we continue to struggle with, in terms of the County. Dealing with County Counsel can be very difficult, although the mental health County Counsel were pretty good, compared to the others. I mean, they actually always have been. It's the County perspective and they want to protect their interests. The County, though, is very big and our agencies are relatively small, so there's a lot of risk involved. A lot of the contract changes were important and that wouldn't necessarily be seen as a client benefit. But a lot of that is the more we can help them do business more effectively and not worry about some of these liability issues, the more they can concentrate on service delivery and those kinds of things.

I can go back and find a ton of other things that we did honestly. But the most memorable, and I'm sure that had the most impact on the agencies and the clients [were related to preserving] the dollars. That was probably the most significant thing over that time. And respite care for me personally was probably the most significant, although it's still not nearly where I want it to be. But I was very proud about that, we got it in the budget a couple of times, and then we finally got it in MHSA. But we've got to keep working on it. I have too many other things [to focus on] now – that's part of the problem.

HP: OK, great. Well, is anything else you would like – oh, one other question actually. We talked about your greatest accomplishments. Maybe something in the mental health field you wish could have done that never came to fruition.

BS: Well, respite care, the way it should be done – it's really troubling to me, personally. And probably right now, what's more immediate, is seeing more consumers gainfully employed and supported in the system. But that takes a lot. That's not easy to do. There's a lot of resources required for that.

HP: It's a lot more than paying for someone's salary.

BS: Exactly. But again, it's like people think, "Oh yeah, look at all these people we are hiring," but it's not that simple. I think that's part of the problem. Problems are often more complex than they seem, and sometimes they take a fair amount of resources. It costs a lot of money and resources to really help [vulnerable people and families] in the right way. And I think that's part of the problem with this country generally, in terms of its willingness to provide resources at the level that really, could really make things better. But that's another story.

HP: Well is there anything you like to add?

BS: No. I've talked enough.

HP: Great.

END OF INTERVIEW