**J. R. Elpers talks about his reorganization of the Los Angeles County Department of Mental Health in the late 1970s and early 1980s:**

I set up a matrix organization, because the department's too big to run from the central office, so I set up strong Regional Deputy Directors. Five regions. Five regional deputies, and I had some central [programmatic] deputies. Central included Areta [Crowell] in training and planning and stuff; George Wolkon doing research and evaluation. I recruited Rose Jenkins back to the Department, who was a child psychiatrist with, all but a thesis, Doctor of Public Administration. She was head of Children's Services. Two of my regional deputies were Hispanic, and one Black and two Caucasians. And I recruited as far as the East Coast, the Midwest, everywhere. So we had a good group. I wanted to set it up so the authority and budget to run the services would be in the regions.

We developed [a formula] for resource distribution. One of the problems is that we had too little everywhere, but far less in the inner city, Watts and Willowbrook. So we set up a formula to redistribute resources, [based on] population and poverty. There's good data that says the need for services for people with serious mental illness is related to poverty levels, and there's a number of reasons for that, we don't need to go into them here. But it's a clear correlation and one that's reliable. So we developed this formula. Some of Areta's staff and I worked on it, and Areta. Basically, it was rigged so that any time you got a budget increase, more would go to the poorer areas and less to the richer areas. And any time there was a budget cut, it would take more off the richer and less off the poor. But in no case did anybody not get anything, or lose everything, because that was unacceptable politically. So it was a politically sensitive formula. Actually, the State picked it up and used it for disparities among Counties, eventually. That was for state resources.

Then we assigned hospital beds also, by region, so that a region had its own hospital [resources], like the Harbor Region had Harbor UCLA, which only had so many beds. But they also had some beds in Metropolitan. The San Fernando Valley and Antelope Valley had Olive View. But then they also had some beds at Camarillo. And then Big County [County USC Hospital] had plenty of its own beds, so it didn't get any beds anywhere else. And that was the Central Region. San Gabriel [Valley] had a big chunk of beds at Metropolitan. But anyway, they all [had] beds. All the beds were assigned to regions. And this we did shortly after the judge called me and said he was going to jail me if I didn't get people out of the jail.

But we put the responsibility of finding and utilizing the beds on the Regional Deputies. And before you know it, they had folks out at the State Hospitals, looking at everybody from their region to see if they couldn't get them out so they could use the beds. And our bed population at State Hospitals dropped like a rock. [The Regional Deputies] had the resources and they had to live with those resources. And sometimes the Deputies would do horse trading at the central policy meetings. "Will you loan me some beds this week, and I'll give you some next week." You know, if they had a crisis. And they did help each other out some. But the big problem was, in the Central Region, LA County USC refused to shorten its length of stay, [and to] take patients that needed to be taken.

**READ THE FULL TRANSCRIPT BELOW.**

**INTERVIEWEE:** **JOHN RICHARD (J. R.) ELPERS**

**INTERVIEWER:** **HOWARD PADWA**

**DATE:** **FEBRUARY 9, 2010**

## I. Education and Early Training; Deputy Director of Mental Health in Orange County

HOWARD PADWA: Okay. We're here. This is Howard Padwa here on February 9, 2010, doing an oral history interview with Dr. J. R. Elpers for the Department of Mental Health Fiftieth Anniversary Project. So, Dr. Elpers, for starters, tell me a little bit about your early life and how you came to be involved in mental health.

J.R. ELPERS: I grew up in a small town in southern Indiana, and learned early on I didn't want to stay in a small town in Indiana. At an early age, I decided I was going to be a doctor. I thought I'd be an internist or something, or GP [General Practitioner], I guess. But after going to IU [Indiana University] as and undergraduate and getting into med school at IU, I was doing a fellowship. When you're [on an] off quarter there, you can do research projects or fellowships, or what have you. One summer I was doing a fellowship in the Psychiatric Research Institute. It was really an endocrinology project, that's what got me into it, but I started learning a little bit about anxiety and things. And I thought, "Well, I should try and find out what that's all about." So, during the next off quarter, I took a fellowship in psychiatry at the local university-run state hospital on the campus.

HP: This was as an undergraduate?

JRE: This was in med school. And I had so much fun there and decided there was so much that wasn't known about psychiatry that it'd be fun to try to learn something about it. So then I went back the next quarter and took a cardiology fellowship, and still wanted to go into psychiatry. So after that, I started looking for psychiatric residencies.

HP: And what was it about psychiatry that drew you in?

JRE: Well, I found most of medicine, particularly internal medicine, kind of cut and dried. Once you made a diagnosis, you had a cookbook to follow. Psychiatry, we didn't have the foggiest idea what we were doing, so there was nothing cut and dried. (chuckles)

HP: And when was this?

JRE: Let's see. I graduated med school in 1963, so it was '59 to '63.

HP: Okay. So this was right around – what was the use of medication like back then?

JRE: Thorazine [chlorpromazine, the oldest typical antipsychotic medication, introduced in 1950] had just come out. Thorazine and maybe Stelazine [trifluoperazine hydrochloride, another antipsychotic medication]. Antidepressants were just beginning to be thought of. But I remember I was in residency when Valium [diazepam, a benzodiazepine often used to treat anxiety, first marketed in 1963] came out, and they were doing research on Lithium when I was in residency. I was at Columbia Presbyterian, New York. We had Thorazine, Stelazine, and Mellaril [Thioridazine, another antipsychotic medication], things like that, the old line antipsychotics. Anti-anxiety [medications] were just coming out and we had some of the beginning anti-depressants – Elavil [Amitriptyline], Tofranil [Imipramine].

But that's not anything that we knew too much about. In fact, it was a training program which was analytically oriented, and they warned us not to use medications too much because it might cloud up the patient's ability to relate to us in psychotherapy.

HP: I see. So it was still much more oriented toward fifty-minute hours on the couch and things like that.

JRE: Absolutely, yeah. Not necessarily on the couch, but in a chair.

HP: In an office.

JRE: Yes.

HP: Okay. So you went to med school, and then how did you wind up going from Indiana to Southern California?

JRE: Well, first, when I was in Indiana, I remember talking to the chairman of the Department of Psychiatry there about a psychiatry residency. And, because I had a very good record, he said I could go any place in the country I wanted to, and he gave me the list of what he thought were the ten best residencies in the country. And they included UCLA, Langley Porter [in San Francisco], Columbia Presbyterian, just all over the country.

I took a big tour around the country and looked at almost all of them, and, and I narrowed it down to UCLA or Columbia Presbyterian. When I interviewed at UCLA, they told me they were the best, so I figured if they had to tell me they probably weren't, so I went to New York to Columbia Presbyterian. (he chuckles) Which actually did turn out to be a very good decision. It was a wonderful program. And still is. And I made a lot of friends and colleagues there that [formed a] valuable network throughout my career.

HP: All right. So you were at Columbia, and then –

JRE: While I was there, I became more and more interested in community psychiatry, because I was interested in psychotic disorders, more than just the anxiety disorders. It was clear to me we weren't treating them very well. We didn't know what we were doing with them.

HP: What was the treatment like back then?

JRE: We tried to do psychotherapy with them, or gave them medication, [without] really understanding their whole lives very well. And I also got interested for a while in substance abuse, and I realized that we – in fact, some of my colleagues at Columbia were interested in it, too – so we started studying it because we had no treatment services for drug addiction. And so I learned a lot about heroin addiction. That was during that heroin epidemic in the sixties.

HP: Did you work at all with Dole and Nyswander [Vincent Dole and Marie Nyswander, New York-based researchers who pioneered methadone treatments for heroin addiction in the 1960's]?

JRE: I knew them. I actually had a young man in treatment at P.I. [Columbia Presbyterian Psychiatric Institute] who Marie Nyswander had been working with when she decided she had to try something other than psychotherapy, because he made a suicide attempt. And that's when she started looking at using methadone. I learned a lot about him. I remember when I picked him up as a patient, I started taking a history, and he handed me two editions of the *New Yorker* and said, "Here. I'm so-and-so." He had been written up by Nat Hentoff (chuckles) in the *New Yorker.* So that's how I got my history. He eventually did well – he was a Harvard mathematician and very bright – but not easy [to treat].

So anyway, along there I decided that I was more interested in community psychiatry – more of an analytic thing. They had a community psychiatry training program there as part of the School of Public Health.

HP: At Columbia.

JRE: At Columbia. So I joined that, and they wouldn't let me [do less in the regular program], because in the eyes of the professors at the time, that was a step down.

HP: Community psychiatry.

JRE: Community psychiatry was lower level than analytic psychiatry.

HP: Why was that? What was the deal?

JRE: Because that's what they all did [analytic psychiatry]. (chuckles)

HP: Oh, I see. What they do is better.

JRE: Yes, absolutely. And that was true for many, many years. Even today public psychiatry is not held in the same status as private. But I was interested in it. So they wouldn't let me out of [other obligations] – usually, people who were in that combined [psychiatry residency/public health] program didn't have to do their chief residency work; and they were basically let off the last year of residency so they can get a full year [in the Masters program], plus some other work, to get a Master's degree in Public Health.

Well, they wouldn't let me off of my time for everything, so I had to double up. I was doing both the master's work and residency. But that worked out fine, because at that time you had to get a military deferment to ever get a residency, and mine was through the Public Health Service. The Public Health Service gave me an extra year to finish my community psychiatry before I went to NIMH [National Institute of Mental Health]. So that got me a nice slot in Washington for two years.

At the completion of [my NIMH time], I was looking around the country for where I wanted to settle, and career opportunities. At that time Dr. Ernie Klatte had just taken over the directorship of Orange County Mental Health [Ernest W. Klatte served as Director of the Orange County DMH for 12 years]. I had met him and liked him a lot. He had a very good reputation. So I visited out here a couple of times and we decided that I'd come out and work for him. It was intended that I'd be his chief deputy as soon as the program was big enough to have a chief deputy, which took a couple of years.

HP: Right, because this was when they were just starting the county programs [in the late 1960s].

JRE: They were just starting in Orange County. Orange County was way behind the others. But that was also an opportunity. I learned an awful lot from Ernie. He is a very innovative, thoughtful, smart human being. So I was there, and I was on the faculty at UC Irvine.

HP: So what was it like, basically starting to build the county system from the ground up? What was involved in that?

JRE: It was a lot of fun. We accomplished a lot of things. But I remember that it was a battle every step of the way, and you'd be into a new battle before you won the old one. I remember telling Ernie, "You know, we never get to sit back and say we won something because we're always fighting for the next step before we finish the last."

In Orange County, the Mental Health Department had been part of the hospital and we got it [established] as a separate Department, so we could grow [and innovate]. And we did. I remember, when we first started our five-year plan, we said we would be a twenty-five million dollar operation in five years, which at that time was big. That was projecting a lot of big growth.

HP: Yeah. And this would be with a series of outpatient clinics?

JRE: Outpatient clinics [primarily]. We started a lot of alternatives to the state hospital. At that time the State was pushing hard to get counties to reduce their state hospital use. Ernie and I came up with the proposal to use skilled nursing facilities. I don't know how familiar you are with federal Medicaid rules, but when they passed Medicaid, they tried to exclude public state hospitals because the Feds didn't want to pick up a state obligation. So they said they would pay only for psychiatric care in a general hospital or nursing facility. They would not pay for it in a psychiatric facility. They couldn't say

just state hospitals because if they did, then the state would all just privatize their hospitals.

HP: Oh, I see. And then they would become –

JRE: So they decided it could be a psychiatric wing of the general hospital they would cover, and they would also cover psychiatric services in a nursing home. But in both cases, if it were 51 percent psychiatric, then it was considered what they called an "institution for mental disorders," an IMD [also an Institution for Mental Diseases]. And that's how we came up with IMDs.

But anyway, what we did was we contracted with some nursing homes for just one wing of the larger facility, so that all the nursing care could be paid for under MediCal. And then we put in a psychiatric treatment program. So we ended up having a much better staffing than the state hospitals, at lower cost.

HP: And this was in the nursing homes.

JRE: In the nursing facilities.

HP: And were these facilities that were otherwise for the elderly?

JRE: They were just – yeah, general health nursing, chronic care.

HP: Hmm, interesting.

JRE: One of those facilities is still running as originally designed, and that was Royale [Royale Healthcare Skilled Nursing Center]. If you want to see it, it's in Orange County, in Santa Ana. Orange County has several now. But we were doing it legally so they could legally get the Medicaid [funding]. Well, then some other facilities, primarily the nursing [home] chains, decided, "Hey, we'll do that too." So they set up psychiatric facilities. But they did not keep them less than half of the skilled nursing [facility]. They used the whole facility, and the state let them get by with it, for reasons I never understood.

And so the big reduction in state hospitals was not a reduction in the chronic population. It was a shift from the state hospitals to skilled nursing facilities. In Orange County, however, we were doing a good job moving people into the community at this time. Because the way we did it, we had a big rehab budget that came available in '72 or '73. So we doubled our services [doing rehabilitation]. And then all of a sudden, that money disappeared in one of the budget crises of the state. We had promised to reduce our state hospital to zero with these grants, and we were well on our way.

HP: To zero. So even for the most chronically ill.

JRE: Even for the most seriously ill. We were well on our way, but then the whole grant was pulled, so we never made it. We made it down to, I think, fifty or -- I think we were down to about fifty people when they pulled the grant.

HP: And these individuals, the plan would have been for them to be in these skilled nursing facilities.

JRE: No. Most of them would have been in the community, in rehab services and support.

HP: So there would have been enough rehab and support in the community for everybody.

JRE: Yes. But we expected to have some that we had to keep in skilled nursing facilities, but we were expecting the vast majority to be in the community. It was very hard to find community facilities in Orange County, as you might imagine.

HP: Mm-hmm. Because there was a contract system at that point, I suppose.

JRE: Well, not necessarily, no. It was just [that] real estate was so expensive, and the NIMBY phenomenon ["Not In My Back Yard" – community members not wanting mental health facilities in their neighborhoods], you couldn't place a facility. So that's what all the fights were about.

Our Board of Supervisors, when I first went, was rather unsophisticated. I literally – people think this is a joke, but it isn't. We were presenting a new personnel series that I had designed and Ernie was explaining to the Board. We wanted to bring new careerists in and we wanted to give them a career ladder all the way up. We had arrangements with community colleges and UCI [University of California, Irvine] to do field work and academic work. And we wanted it to be possible that they could become a PhD if they wanted to. Well, the psychologists didn't think they should really be allowed to be PhDs, so they fought it. So there was a big fight in front of the Board. I remember this one Supervisor said, "Dr. Klatte? What's PhD mean?" And Ernie said, "Doctor of Philosophy." He says, "We don't need any philosophers." (both chuckle)

HP: Well, that's a fair point. (laughs)

JRE: Anyway, our series only went to Master's degrees. But anyway –

HP: (chuckles) Yeah, I can see why.

JRE: But it was fun. We brought in a lot of new people. We had a little [New Careers] grant from NIMH, and we had a community advisory board. I went overboard, I told the community advisory board they weren't just going to advise, they were going to pick our people. We had, I think, a dozen slots. They did an interesting pick. Two of the people they picked were raving heroin addicts, but they considered them leaders in the community. We had to detoxify them. We had a drug treatment program at Metro [Metropolitan State Hospital in Norwalk] at the time. One of them made it, cleaned up, and stayed in mental health for many, many years. One of them never made it. But I look back on those people that we selected, and a number of them got up to Master's Degrees in Social Work. Of the choices, about half stuck with

the program over the long haul and were still in mental health last I heard of them. And that's about as good as you do recruiting young [professionals].

HP: Why is that, do you think?

JRE: Oh, everybody's looking to move up and change jobs and things. So the record of letting the community group choose the workers was as good as we could do. It was an interesting experiment. But anyway, we had set up an independent Department. We actually met our five-year goal of being a twenty-five million dollar program, that we had set in the first year that everybody laughed at. And then they decided to form a Human Service Agency.

HP: That merged with the Department of Mental Health?

JRE: It merged Mental Health, Health, and Social Services; I think all were in it.

HP: So this was in Orange County.

JRE: This was an all Orange County thing.

HP: It happened in LA before.

JRE: It had already happened in LA. [LA County Department of Mental Health was merged with the Department of Health Services 1972-78.] Counties go through merging and de-merging. It's an interesting phenomenon. It is really a way for the elected officials to scramble the bureaucracy, because no elected official believes that if you worked for his predecessor you're going to work for him and be loyal. So they always want to be able to shuffle the cards and get rid of [the old guard].

HP: So everyone's an appointee of you, once you get in.

JRE: Yes, yes. Anyway, there had been a scandal in the Health Department. I forget what it was, but the Health Officer and his chief Deputy were both summarily canned in about 1975 or '6. So I was asked to run the Health Department.

HP: This is down in Orange.

JRE: In Orange County, for a year as interim. I was still the Chief Deputy of Mental Health, but I also ran the Health Department. And I ran the paramedic training program, and the hospital contract with UCI, which wasn't going well when I took it over. I had young men who ran the ambulance services. They were mostly contractors. But there was a lot of skullduggery and things going on then, and by then our Board [of Supervisors] had changed and we had some wheeler-dealers as Board members.

I remember it was my job as Health Officer to certify paramedics. Well, we had two paramedic training programs, one at a private hospital and one at the university. And one of the paramedics in the private hospital wasn't very

good, and he flunked the test, which had been given always by the university. And he was given another test and he flunked that. A Board member called me in and said, "Well, he's got to pass, or he's got to be allowed to be a paramedic." I said, "Sorry. He's flunked the test twice, and they leaned over backwards to pass him and he's just not safe as a paramedic." And the Board member says, "Oh, well, we'll take a vote on that."

HP: [sarcastically] The Board was qualified to decide if someone could be a paramedic?

JRE: The Board was going to take a vote, and I said, "Well, sir, the law says that certifying a paramedic is the job of the Health Officer. So you can take a vote, but it'll be a vote whether or not I'm your Health Officer, not whether this man's a paramedic." So he shut up and didn't do anything more. But I, of course, had a permanent enemy.

And then Supervisor Diedrich [Ralph Diedrich, Supervisor for Orange County's 3rd District, 1973-1979], who was – well, he spent time in jail after this for his wheeling and dealing. But he called me in because I had a young man who was riding herd on the ambulance business and trying to clean it up. Doing a good job. And Diedrich basically told me to fire him, and I said, "Well, you know, he's doing a good job. I don't think I'll do that." This was a roundabout conversation, as you might imagine, but I let him know that I wasn't going to do it. And I said "What did you really want to talk to me about? I'm sure it wasn't that." And he said "Goodbye." (chuckles)

Anyway, after the [Human Services] Agency was formed, Ernie went to become the Chief Deputy of the Agency under a gentleman by the name of Dave O'Dell, who had been an administrator in LA's health agency [O'Dell was head of Orange County's Human Services Agency 1976-78]. They told me I could have Health or Mental Health. So I went back to run Mental Health, and I did that for the last year [I was there]. Then O'Dell left, and there was a question who was going to be the Director of the Agency. Most people wanted me to be the Agency Director. I'd run Health, I'd run Mental Health. It made sense. Ernie didn't want [the Agency job]. But I had two big enemies on the Board.

Then Diedrich got the idea that [they would appoint Margaret Greer to be the agency director, because that would get her out from under the judges, because at the present she worked for the judges as the Chief Probation Officer, and they couldn't fire her, and he wanted to fire her too.] Margaret didn't like anybody in Mental Health. She hated Mental Health. She said you don't need Mental Health. If probation and the church can't do it, no one can. So you don't need Mental Health, particularly for kids. And I'd been setting up children's Mental Health programs. The third vote for her was from Supervisor Riley [Thomas F. Riley, Supervisor for Orange County's 5th District, 1974-1995], who was mad at my then-wife because she had been a leader in a campaign finance reform effort.

HP: So it sounds slightly political.

JRE: Yes.

HP: Just a tad.

JRE: That's what [Riley's] deputies told me, they said he said he wouldn't vote for me because of her, [Elpers' wife] Mary Jo. But anyway, when Margaret was appointed, I knew that Mental Health was doomed and I was doomed, so I just immediately resigned and went to work for UC Irvine. I was their clinical director [of ambulatory care].

## II. Los Angeles County; Building a Team and Structuring Services for a Diverse County; Decision to Resign

HP: Then how did you wind up coming up here to LA?

JRE: Well, even before I'd gone to Irvine, L.A. had started recruiting for a director. And because Areta Crowell [LAC-DMH Planning Administrator, later Director of LAC-DMH] and some others asked me to do it, I said, "Okay, I'll throw my hat in the ring." And I did, and didn't hear anything for months. LA, in its inimitable way, things dragged on. Then while I was at Irvine, I think, I was invited up for interviews with the Mental Health Advisory Board, and eventually the Board of Supervisors. Pete Schabarum [Peter F. Schabarum, Supervisor for Los Angeles County's 1st District, 1972-1991] said he didn't know whether I was being interviewed as Medical Director or Director. And I said, "Well, Mr. Schabarum, you may not know, but I do. I'm only interested in being the Director." Kenny Hahn [Kenneth Hahn, Supervisor for Los Angeles County's 2nd District, 1952-1992] liked that.

And then, a week or so later, they made an offer to take the job, and I said, "Give me a couple of days to think about it." It was really an impossible position because, one, it didn't pay enough to make it worth the trouble. At that time LA County had a rule that no Department [Head], including the CAO [the County Chief Administrative Officer], could be paid more than fifty thousand. I was making seventy or so at Irvine. A pay cut, little, okay, but not that big.

But the more important thing was the ordinance [governing the Department's responsibility]. When Dr. Brickman [Harry Brickman, M.D. head of the Los Angeles County Department of Mental Health, 1960-1976] ran the Mental Health Department before it was merged into the Health Department, all of the inpatient and all the outpatient services on the hospital campuses were all under [the Department of] Hospitals, not under Mental Health.

HP: I see. So the inpatient beds were under Hospitals' jurisdiction.

JRE: And they controlled the budget. He had no control over them and no control over the outpatient programs on the hospital campuses, which was the vast majority of his outpatient clinics. So all he really could control and had budget control of were the clinics scattered around the County.

HP: So the majority of the outpatient care even was based out of the hospital system.

JRE: A lot of it was, yeah.

HP: Oh, I didn't realize that. Okay.

JRE: Particularly USC [Los Angeles County-USC Medical Center] and King [Martin Luther King Jr.-Harbor Hospital]. Well, not so much King, because they were just getting started when I came in for Mental Health.

HP: Olive View [Olive View-UCLA Medical Center]?

JRE: Olive View had big outpatient [services] – those were all under the Health Department. And basically, they got their money first and then Dr. Brickman got what was left over. And that's how they wanted to have the [new] ordinance, and I knew that. I'd looked at it and I knew that wouldn't work.

HP: When you came, that's when the un-merging happened.

JRE: Yes. They were talking about un-merging it. That's the only reason I was willing to take the job. I wasn't going to go to work for Health Services, because all my friends had told me you can't get anything done that way.

HP: Yeah. And you also had experience with that.

JRE: Yeah. So I sent a note back to the Board, saying “Thank you, but the authority and the remuneration is not commensurate with what's required to do the job,” and forgot about it. Several weeks later, six or eight weeks later, I got this call from Dr. Saul Bernstein, who was the acting director of [Los Angeles County Department of] Health.

HP: So the head of the super agency.

JRE: Yeah, head of the Health Department. Saul's a nice guy. Saul calls me and says, "They still want to consider you for the position." Now, you have to remember that the decision to separate Mental Health from Health, which had been a big fight carried on by the Mental Health Advisory Board and community groups, particularly Jack McDonough, chair of the Mental Health Advisory Board, professor of management at UCLA. Jack had led this battle and he was very good at it, but none of them really understood what he was talking about.

HP: What were the problems with the old setup?

JRE: Mental Health was just not allowed to do much of anything, and it was only the job of Mental Health to ship people to the state hospital. That's how they all saw the job. I can tell you more about that after I got there.

Saul calls me and he says, "They want to know what your bottom line is, for pay." I said, "Saul, my note said there are two things. The other was the

ordinance. It won't work." "Well, what's your bottom line pay?" I said, "Sixty-five thousand." He said, "Oh, God, that's more than anybody is paid, they won't do that." I said, "Well, then I won't go." So then he calls and he says, "Well, you won. They'll go sixty." I said, "Saul, I didn't say sixty, I said sixty-five." Then he calls back and he says, "Okay. You won. It's sixty-two-five [$62,500]." I said, "No, Saul, my bottom was sixty-five. Do you want to know what my top is?" (chuckles) "No." Poor Saul had to take heat from the Board, going back and forth. I felt sorry for him.

Finally they agreed to sixty-five, and I said, "Oh, remember, there's the other matter of the ordinance." And at this point, I was fighting Health, because they wanted the Mental Health bucks. So I didn't go through Saul anymore, but I had friends in LA, who worked with County Council to draw up the ordinance I wanted. And that was taken to the Board, and there was a big fight over that. They knew I wouldn't come unless the ordinance was passed, and so finally they did pass the ordinance, but it was a different three votes than had voted for the Department being separate in the first place. Because to separate it, it had been Jim Hayes [James A. Hayes, Supervisor for Los Angeles County's 4th District, 1972-1979], Kenny Hahn, and Baxter Ward [Supervisor for Los Angeles County's 5th District, 1972-1980]. Well, when I went to visit him after I took the job, Baxter said, "You know, I didn't vote for you because of your outrageous salary demands." I said, "Yes, sir, I'm aware of that, but if it makes you feel any better, I took a pay cut to take the job."

HP: There you go. It was a compromise.

JRE: He said, "That helps." And Baxter and I got along famously after that. [He and] I never had any trouble. He was always very supportive. But, because he didn't vote for it, finally Ed Edelman [Edmund D. Edelman, Supervisor for Los Angeles County's 3rd District, 1974-2994] did vote for the ordinance. He said, "Well, if we're going to do it, do it right." So I had three votes for my appointment. They were a different three votes than there were for the Department, so I was on thin ice.

HP: But you made it in.

JRE: Yeah, I made it in. And it was kind of funny. I mean, I never expected to stay there too long because my philosophy then, and still is, that, in that kind of high pressure job, you ought to rotate every five years or so. So my thought was to stay five years. And I was going to do everything I could do in the meantime to shape it up. I hadn't been there a month when a judge threatened to put me in jail, because of all the mentally ill people being stuck in jail without being moved out to the hospital. We had no [open] beds in the hospital, any hospital.

HP: And this was a situation that you'd inherited.

JRE: I'd inherited this situation. The whole idea of anybody with a serious mental illness was to put them in a hospital someplace. The outpatient clinics were primarily treating a majority of women, a majority young, a majority interesting and pretty.

HP: Oh. Back then.

JRE: Back then.

HP: And were the outpatient clinics functioning during the merger still?

JRE: They were still there. I got all the clinics, and I got the [hospital] outpatient clinics under the Department. And I controlled the budget with the understanding that, through an MOU [Memorandum Of Understanding], I would negotiate with Health for whatever beds we wanted, and we'd negotiate the price, because they weren't just going to fix the price.

I set up the new Department with budget, fiscal, personnel, new central deputies, as well as regional deputies, all the overhead factors, and saved several million dollars over what we were being charged by Health Services for overhead.

HP: Now, when you did this, had the un-merging happened before you came, or simultaneously, or –

JRE: Technically, I went to work for the Health Department. And, in fact, I went to work for my old buddy Bob White, [who was sworn in as the Director of Department of Health Services the same day I was sworn in]. When I first went to Orange County in the hospital, Bob ran the hospital, and I went to work for him. When I came to LA, because the Mental Health Department hadn't been officially established, [I again went to work for him]. There was a certain time lag in there where you had to set everything up – [personnel ordinances, etc]. I guess it was six weeks or so before everything was ready for the Department to be official.

I worked for Bob White then, but that was good because Bob and I both lived in Orange County and we commuted together. He had his county car with a radio and a driver. I hadn't gotten mine yet. So Bob and I negotiated the separation of the Departments mostly on the freeway. And there was a lot of animosity among the ranks about [the separation]. But Bob and I didn't have any animosity about it. We thought it was a good idea. He supported it.

HP: So people in Health supported it also.

JRE: At the top level.

HP: Why would they support it? You'd think that they would want more control over things than less.

JRE: Well, White said Mental Health was 10 percent of his budget and 90 percent of the hassle. (chuckles)

HP: (chuckles) That's how they saw it. It was something they didn't want to have to deal with.

JRE: A lot of the working folks in the med centers definitely wanted to keep Mental Health under their control. And that was an ongoing battle. The Health Department's very interesting. I don't know whether you've studied it. Even to this day. It used to be the Department of Hospitals, and each hospital was essentially in each supervisorial district, and the hospital administrators basically reported to one Board member and that was all. They had a lot of freedom and they ran things the way they wanted to. When they merged them together to establish the Department of Health Services, their loyalties never changed that much. I saw hospital directors absolutely refusing to get in line with what the Department of Health Services wanted done, some of them undermining [Department] Directors consistently.

HP: More loyal to their supervisor.

JRE: Not just the supervisors, themselves. I know exactly what happened when a hospital administrator told Bob White one thing, which wasn't correct, and then went and told the Board member what was correct, to make a fool out of Bob in front of the Board. That kind of stuff was going on. It was just terribly bad morale.

Anyway, we were fortunate. Mental Health was not under Hospitals. And probably the most important thing I did in terms of setting up the Department was demanding an ordinance that would function and make it a real Department. We had it set up so all the Short-Doyle money [mental health funds created by California's Short-Doyle Act of 1957], and any money coming into Mental Health, came to the Department, not to the CAO, to give it to Health, and then give us the rest. And that was made very clear in the ordinance.

HP: So how do you go about setting up a Department? What do you do?

JRE: Well, you look at what you got, and figure out who your best people are there and you bring them in. As I mentioned before, Areta Crowell had wanted me to go for the job, and I said, "Well, if I do, you've got to come back and help." She said, "Well, if you set up the right job, I will." So she came back as kind of the head of all the staff services, planning, training [the Program Support Bureau].

Harold Mavritte had been the Acting Acting Acting director. He had been, at one level, the Acting Acting and finally the Acting Director. I made him the program chief [Medical Director] and I had an administrator, Herb McRoy. Herb and I didn't always see eye-to-eye because Herb wanted to control budgets and I wanted the budgets to be open and above-board – everybody knew everybody else's budget, because I wanted honest [discussions of the] budget.

One of the problems we – we had several problems. Outpatient Services were doing a thing totally not related to inpatient and the seriously ill. All they did was evaluate the seriously ill, give them a diagnosis, and send them off to the hospital. Before that, there had been scandals at both Metropolitan and Camarillo State Hospitals, which were our primary hospitals, because they

had been overcrowded and understaffed, and were basically being run by psych techs, who felt [that] physical strength was the way you controlled a person with mental illness.

HP: This was the late seventies?

JRE: That was in 1977, in the fall. I remember watching Kenny Hahn and Jerry Brown, then Governor Brown [Edmund “Jerry” Brown, California Governor 1975-1983], [on TV] at Metro [State Hospital], with Jerry promising all kinds of resources to clean it up. And I was sitting down there happy in Orange County thinking, “Glad I don't have to deal with that.” (chuckles)

HP: Then the next thing you know –

JRE: But then Metro stopped admitting. They wouldn't put people in the halls anymore. The County Hospitals were filled. And they had lengths of stay up to about a month, which was way longer than it should have been, if they were really doing intensive treatment, stabilization. We had people being diverted from hospital to hospital to hospital, trying to get into an ER, because ERs were all busy and backed up. I remember one day Harold came in and said, "JR, we have just invented a new therapy." I said, "Well, tell me about it." He said, "Well, we had this lady who's been going from Harbor to USC to Olive View to Harbor, back to USC, in an ambulance, for twenty-four hours." And every time she went to an ER they gave her a shot of Haldol [an antipsychotic medication] and sent her on. And after twenty-four hours she didn't need to be hospitalized anymore. He said, "We just invented ambulance therapy." (both laugh) I don't know if they have Harold on your list for interviews, do you?

HP: No. Harold – who is it?

JRE: Harold Mavritte. He's in San Diego now, but he's somebody you probably should interview. He'll have an interesting perspective on things. Harold was my Medical Director.

The other big problem we had was a maldistribution of resources. The inner city had very few per capita resources. The suburban area, particularly the San Fernando Valley, had far more resources.

HP: This was in terms of resources, in terms of outpatient clinics set up?

JRE: Clinics and hospitals. King [King-Drew Medical Center] didn't have much at the time, and they had a Community Mental Health Center grant, a construction grant, and they'd just started building the building when I first got there, or they were laying the cornerstone. It was not a good design, and they built something they could convert to Med/Surg [general hospital wards] if they had wanted to. But it was already a done deal, so I couldn't change it.

Also, I wanted to recruit a broad representative leadership. So I did a national recruiting for my deputy directors.

HP: When you say "broad," you mean diversity?
JRE: Diversity, ethnically, racially, socially, philosophically.

HP: Why was that important?

JRE: Well, because LA County's that way. And one of the things we know is you've got to have a program that reflects your community.

HP: Right. And before, it was mostly white males.

JRE: Actually, the black population was well represented, but not necessarily at the top of the tier. But as far as staff, we had a very representative black population. Hispanic population was way under-represented. And there was not much representation of Asian populations either. Within the first two weeks I was there, every ethnic group in the County demanded to see me and marched through my office, telling me what I had to do.

HP: So it was on their radar.

JRE: Oh, yeah. In LA County, it's big on the radar all the time. And I told every one of them I didn't believe in affirmative action. [They said] “What?” I said, "I believe in getting the best people for the job and, yes, getting people of a minority community is important. But I am not going to do it just because they're a minority." But, on the other hand, I went out and recruited from all over the country.

HP: And you got a very diverse team.

JRE: To get a pretty diverse team. But I said, “It's not because of affirmative action.” I didn't want anybody to feel they were there because of their [racial] status.

And also I set up a matrix organization, because the department's too big to run from the central office, so I set up strong Regional Deputy Directors.

HP: This was in five regions.

JRE: Five regions. Five regional deputies, and I had some central [programmatic] deputies. Central included Areta [Crowell] training and planning and stuff; George Wolkon doing research and evaluation. I recruited Rose Jenkins back to the department, who was a child psychiatrist with, all but a thesis, Doctor of Public Administration. She was head of Children’s services. Two of my regional deputies were Hispanic, and one Black and two Caucasians. And I recruited as far as the East Coast, the Midwest, everywhere. So we had a good group.

I wanted to set it up so the authority and budget to run the services would be in the regions. We developed [a formula] for resource distribution. One of the problems is that we had too little everywhere, but far less in the inner city, Watts and Willowbrook. So we set up a formula to redistribute resources.

HP: What was the formula based on?

JRE: Population and poverty. There's good data that says the need for services for people with serious mental illness is related to poverty levels, and there's a number of reasons for that, we don't need to go into them here. But it's a clear correlation and one that's reliable. So we developed this formula. Some of Areta's staff and I worked on it, and Areta. Basically, it was rigged so that any time you got a budget increase, more would go to the poorer areas and less to the richer areas. And any time there was a budget cut, it would take more off the richer and less off the poor. But in no case did anybody not get anything, or lose everything, because that was unacceptable politically. So it was a politically sensitive formula. Actually, the State picked it up and used it for disparities among Counties, eventually. That was for state resources.

Then we assigned hospital beds also, by region, so that a region had its own hospital [resources], like the Harbor Region had Harbor UCLA, which only had so many beds. But they also had some beds in Metropolitan. The San Fernando Valley and Antelope Valley had Olive View. But then they also had some beds at Camarillo. And then Big County [County USC Hospital] had plenty of its own beds, so it didn't get any beds anywhere else. And that was the Central Region. San Gabriel [Valley] had a big chunk of beds at Metropolitan. But anyway, they all [had] beds. All the beds were assigned to regions. And this we did shortly after the judge called me and said he was going to jail me if I didn't get people out of the jail.

But we put the responsibility of finding and utilizing the beds on the Regional Deputies. And before you know it, they had folks out at the State Hospitals, looking at everybody from their region to see if they couldn't get them out so they could use the beds. And our bed population at State Hospitals dropped like a rock.

HP: So it set up kind of an incentive structure by giving more local autonomy.

JRE: Yeah, right. And they had the resources and they had to live with those resources. And sometimes the Deputies would do horse trading at the central policy meetings. “Will you loan me some beds this week, and I'll give you some next week.” You know, if they had a crisis. And they did help each other out some. But the big problem was, in the Central Region, LA County USC refused to shorten its length of stay, [and to] take patients that needed to be taken. They were [saying] “No, we don't need to do that.” They thought they didn't need to. So finally I just cut the budget and gave the resources to the Regional Deputy to use elsewhere. They lost several wards because they wouldn't cooperate. They had more than they needed anyway, but it was still just being obstinate. They were very hard to get to change.

HP: Now, in terms of structure, another thing that comes to mind is, say you have a region that has certain populations with certain needs. Would that Regional Director have some autonomy to be able to create new kinds of services?

JRE: Absolutely.

HP: What sort of other things were developed like that?

JRE: I know Harbor wanted a Crisis Unit, which they did [set up]. Out in the San Gabriel Valley, Allan Rawland [one of the regional deputies, later Assistant Director of the County's Department of Mental Health] had several very innovative programs going. He was the only person I brought on my staff from Orange County. Allan is now the Director down in San Bernardino County. But he's been the Director umpteen places. He's very energetic and I needed some energy out there. He had a lot of interesting rehab programs going.

Most of them had contractors. That was the other big issue. The contractors, when I came to LA County, said, "The County skims off the money; we don't get our fair share." The County said, "Well, they skim the patients; they won't take any sick patients."

HP: "They" being the contractors.

JRE: The contractors.

HP: And this had been the case under the super-agency.

JRE: Yeah. And the contractors had political clout because they all had connections with their respective Board [of Supervisors] members [and Board Deputies]. So you had to deal with that carefully. But the fact is, both the County and the contractors were right. The County took the money, and the contractors took only the easy patients. So my solution to that was using the population poverty formula, saying, "Contractor, do you want to take a district within a region? Here's the amount of money, here's the amount of beds you can use. Go to it. We can write you a contract." And most of them backed off pretty quickly. They didn't want to do that.

HP: Why not?

JRE: They didn't want the responsibility. It's easier to bitch than switch.

HP: So in terms of, if I have someone and they become really sick –

JRE: You can dump them. [Under a district contract,] they could still send them to a hospital, but it's going to come out of their budget.

HP: And that's a huge cost.

JRE: Right. But they had the budget, so, theoretically, they couldn't send them and not [pay for] it. One organization, one contractor in the whole county, agreed to do it. And that was -- oh, what was his name? Gerry – he's dead now. [Gerald Jacobson, founder of Didi Hirsch Community Mental Health Center] But it was up in the Center near Santa Monica.

HP: Oh. Didi Hirsch?

JRE: Yeah, Didi Hirsch. The Director at Didi Hirsch said, "I'll do it." I had to fight the regional staff, Milt Miller's [Milt Miller was Deputy Director for the Coastal Region] staff and others, because they didn't like Didi Hirsch. They'd been fighting with him for ages. They didn't want to let him do it. I said, "You're going to let him do it." So they agreed. Finally, Miller became one of Didi Hirsch's greatest advocates because they not only did it, they did it well. They cut their state hospital use, they saved their money, they built services in the community, and strengthened that center. Gerry Jacobson was his name. He was a smart cookie, but he just had this abrasive way to make everybody not like him. But he was very good in terms of what he was doing. And he made it work. But none of the other contractors would do that.

HP: So what happened to all the contract services?

JRE: Well, we went ahead and contracted with them, but they couldn't complain about what they got, because then we were writing specific contracts for specific things. So they didn't have the freedom to develop as they would have had.

HP: And what was the balance between contract versus the directly operated at that time?

JRE: Oh, I would say it was about – if you kind of broke down the County budget at that time – it had shifted some while I was there – but it was about a third contract, a third direct outpatient operation, and a third hospital. And over the time I was there, the hospital shrunk and both the contract and the direct operation expanded. I think, under Areta Crowell's administration, the contract grew more than the direct services.

At the time I was there, I needed a core staff that I could control and make sure things happened, because turning around LA County is kind of like turning around a super tanker. You push a little here, you push a little there. I remember saying, "Our job is to take care of the people who are most in need and have the least resources to get help anywhere else," which meant the people who are psychotic and the people who are poor. Those people were not being treated when I got there. So we put out very strong statements that that's how it was going to be.

The first six months I was there, it was, “He too shall pass. We won't pay much attention to him.” Then after about a year, I started hearing them regurgitate my statements, but the data hadn't changed at all. I was just looking at very simple things, like the sex ratio. Psychosis occurs equally in both sexes, but lightweight depressions don't.

HP: Right. So trying to see –

JRE: I was just trying to see if the population shifted so we had as many men as women. Little things. We didn't have a real good data system at the time, so I couldn't get into specific diagnoses. We were trying to develop a data system.

But then, gradually, after a year, the data began to switch. I would say after two years, I think people were really into trying to take care of the seriously ill. Part of it was they had to keep them out of the hospital, they had to take care of them. So they were developing some alternatives. They were developing model rehab programs, things like that.

About a year [after I arrived] – well, a couple of things happened. Our department didn't have a lot of credibility because nobody trusted my Assistant Director for Administration, Mr. McRoy. Herb wanted to play games with the budget and he wanted to keep things close to his chest. We had a parting of the ways [when he found a better-paying job]. Mostly, it was a philosophic difference [that caused him to leave]. Then I hired Kathleen Snook. Have you interviewed Kathleen?

HP: No. I've come across the name, though.

JRE: You need to interview Kathleen. She's up in Sacramento County. I can find her for you, but you'd probably have to go up there to interview her.

HP: Okay.

JRE: Kathleen had been our budget analyst in the CAO's office. She's tough as nails, but delightful. So I hired Kathleen to be the [Assistant Director for Administration]. That gave us credibility everywhere, and we had no more fights with the CAO. I mean, Harry [Harry L. Hufford, Los Angeles County CAO 1974-1985 and 1993] and I would arm wrestle over positions and things, but we got along well.

HP: I want to go back to something you just mentioned about how no one had really wanted to take care of the seriously and mentally ill before. What happened to them?

JRE: They went to the state hospitals.

HP: So they were in the state hospitals, and the state hospitals were overcrowded.

JRE: Yeah. And after care, the State had an organization called the – oh, what was it? At one point it had been called After Care Services, and then it was called Continuing Care Services, where they had clinics around the County, taking care of patients who came out of the state hospital.

HP: State-run clinics.

JRE: State-run. A few social workers. It wasn't a very strong operation. And we negotiated to take them over when I was there, because it didn't make sense to have it separate, particularly with my model of having my people getting their people out of state hospitals.

HP: And in charge of their turf.

JRE: And the other thing I did, before I came there had been Advisory Committees, but they were all basically run by the contractors. Had a few clients or families

on them, but it was mostly contractor-run. I said, "That's a conflict of interest." So I set up two different Advisory Committees. I set up a Contractors' Advisory Committee, so they would have access in each region to meet with the Regional Deputy [and staff]. But I also set up Citizens' Advisory Committees [the Regional Citizens Liaison Committees, or RCLCs] and said no contractors could be on them.

HP: Only consumers and family members.

JRE: Yeah. Or community leaders, whoever had a reason, but weren't contractors. I gave them the responsibility of reviewing all budgets and program plans for each year, with the Regional Deputy. And they had to sign off on them before they went into my budget.

HP: Was that pretty novel at the time?

JRE: Pretty much.

HP: What was the thinking behind that?

JRE: The thinking behind it was to keep the contractors from running to the Board of Supervisors and getting everything they wanted.

HP: So you could say, "Well, the contractors want X, but the citizens want Y?"

JRE: When I took a budget to the Board, it had all been approved by the Citizen Committees. And if the Board [Deputies] wanted to change it because the contractor wanted something, my response was, "Well, you know, you have to take that back to the Citizens' Committee. Do you think that would be a good idea?"

HP: And did that work with them?

JRE: It did. It got me fired eventually, but it worked.

HP: Tell me about the time when –

JRE: I won't say fired, but anyway – well, it was because two board deputies, Antonovich's [Michael D. Antonovich, Supervisor for Los Angeles County's 5th District, 1980-present] and Deane Dana's [Deane Dana, Supervisor for Los Angeles County's 4th District, 1980-96], were wanting to meddle in the Department and tell me who I had the contract with, and I refused to go along with that. Also, when Mr. Antonovich was elected, he was one of them who never thought that I could be loyal to him because I'd been loyal to Baxter [Ward, Antonovich's predecessor]. Actually, I wasn't loyal to anybody. Harry Hufford said, "The only time you've got to be loyal is when there are three votes sitting at open session telling you what to do." And that was good advice.

But these Health Deputies started wanting to tell me how to run the Department, and that I should have more state hospital beds, and I should set

up more beds. The fact is, everybody looks at beds as a solution, but it's not, because if you have more beds, they'll be filled. You've got to have something, a rehab program, on the out[patient] end, so that you stabilize in the hospital, [and] then you start treating in the community.

HP: And they don't wind up going back.

JRE: And they don't wind up going back. You have good support services, good rehab services, that sort of thing. So, basically, it was trying to look at it as a whole system of care, and if somebody's going to sit there and say, “No, you can't have this, you've got to have this,” it doesn't make sense. So I didn't go along with it.

Eventually, I remember at one point, Antonovich asked Hufford to find out what it would take to get me to leave. I'd been there about five years, and I hadn't had a vacation, and I said, "Oh, [for] about three months pay, I'd probably go." So he went and asked the other Board members and they didn't want me to leave, so I stayed. I was going to leave after about five years. That had been my original plan. But there was a huge mental health budget cut. Deukmejian [George Deukmejian, California Governor 1983-1991] just whacked the heck out of it, after five years, so I couldn't leave because the staff liked me and I just didn't think it would make sense to abandon a sinking ship. So I stayed and fought for the budget and [survival]. I finally left when Antonovich said, "You cannot go to Sacramento and fight for the budget."

HP: Why not?

JRE: [Antonovich said] “Because Mr. Deukmejian had enough to do. He doesn't need to worry about mental health.” They were close.

The State Director works for the Governor. He has to say whatever the Governor puts in the budget is right. So it always fell to the Counties to fight for the budget [before the legislature], and so it fell to LA County because I had the resources, I had the staff, I had the computers that most of the Counties don't have. So the LA Director always had to go and fight for the budget in Sacramento.

HP: So being the director of LA-DMH was effectively the most important advocacy position in the state then.

JRE: Right. And when Antonovich said I couldn't go fight for the budget anymore, that's when I resigned.

HP: And that was in '84.

JRE: Yeah. I arranged with UCLA to have no County position [when I took a job there], so I was never paid by the County after that, so the Board couldn't tell me what to do. So I went to Harbor [Harbor-UCLA] and worked there for fifteen years, I guess. Sixteen. But I continued to fight for the budget in Sacramento. I was on the MHALA [Mental Health Association of Los Angeles]

Board, the State [MHA] Board, on state advisory committees. I continued to be an advocate and fight for things –

HP: But without anyone telling you can or can't do that.

JRE: Nobody could tell me I couldn't. I knew the University wouldn't tell me I couldn't.

**III. Working with Family Groups and MHA; Budget Issues; the California Model; the ISA Concept**

HP: Okay. So, if we could get back to a couple things from your time as Director. How did services change during your time?

JRE: Well, as I said, we switched to start taking care of [the] seriously ill, we set up more rehab programs, we had a lot of socialization centers. I worked closely with the then starting family groups, which evolved to become NAMI [National Alliance on Mental Illness].

HP: Tell me a little bit about your work with them.

JRE: Oh, they were just a small group. Don Richardson was a retired school assistant superintendent from LA Unified [School District]. He was a very good -- Don and Peggy [his wife Peggy Richardson]. And several others were really getting together to make the parents' point of view heard. I supported them, worked with them, met with them, helped to get them some resources, because I thought that was very important, that we really had advocates from the families.

HP: Because they could be another constituency.

JRE: A huge and powerful constituency, and they did become so. Don eventually became – I don't know if he was the chair of the Statewide Advisory Board group, but he became quite influential statewide. He led the big plan[ning effort] that became what was eventually put in the bill that was the Realignment Bill [the Bronzan-McCorquodale Act of 1991]. I guess it was the Planning Council that theoretically had been doing that plan, but Don led it. He was very good about getting all the various points of view into things. Unfortunately, you can't interview him; he's passed, as has Peggy. But they were very important people.

After I'd been there about a year – I remember when I first came – I'd worked with the Mental Health Association [MHA] in Orange County, which had been a good advocate, and I looked for a Mental Health Association when I got here. I found there was one, but I met with the director and he was not a strong advocate.

HP: It was before [Richard] Van Horn [Executive Director of the Mental Health Association of Los Angeles], I assume.

JRE: Yes. The original director wasn't going to do anything. Eventually, one day this gentleman walks in and said, "I thought I should introduce myself to the Director of Mental Health. I'm the new exec of the Mental Health Association." I said, "Glad to meet you." It was Van Horn, and we started talking. I knew right away he was gung ho. He asked "What do you want to do?" One of the first things I said is, "I'd like to have a mental health newspaper for the County." Because I didn't want a house organ that was everybody blowing their own horn. I said, "How would you like a contract to run a newspaper?" He just happened to have a friend who had been an editor, and they put together a great newspaper.

HP: Was that *Connections*?

JRE: Yeah. And for the County staff, it had an inside sheet for the County. For the contractors, it had one for the contractors. For the community at large, it had other things for the regions. It was like a *Newsweek* or something. It had different things for different folks. They did a great job for several years. We lost it when Pete Schabarum's [Health Deputy] got mad at them for their advocacy and killed the contract.

HP: Why did he get mad at their advocacy?

JRE: Because they didn't want to put money into mental health budgets. Pete always supported me and my administration, but he *never* supported the budget. In retaliation, they finally cut that contract at the Board. I wouldn't cut it but they cut it.

HP: So the Board itself has the power to terminate contracts.

JRE: Oh, yeah. You report to the Board. And this was in a budget session and they could cut it. I couldn't stop it. But it had done its work. In fact, it made the Mental Health Association eventually have an independent power, because they got a big bequest. Are you familiar with that?

HP: I'm not sure.

JRE: What was her name? Oil money, Beverly Hills. Burton (Bertie) Bettingen [daughter of the founder of Bellridge Oil. She was a very wealthy woman who had a remainder trust. She had already taken care of all of her kids and family, and a remainder trust that had about thirteen charities in it. And she had started reading *Connections* – for some reason she got it – and started sending the Mental Health Association money. Richard would always call her up [and ask] "Can I talk to you?" [She replied] "No. I don't need to talk to you, I do my own research." Finally, a few weeks before she died unexpectedly [about 1983], she put the Mental Health Association in as one of the remainder charities, which brought in about seven million bucks, which they set up as a board controlled [trust fund]. It had no strings attached.

HP: Yeah, because it gives you a good deal of independence from the politics.

JRE: Yes. And they still use that. Anyway, Richard got the Mental Health Association organized such that it could, on [a few] hours notice, pack the Board [of Supervisors meetings with mental health supporters].

HP: You mean show up at a board meeting.

JRE: Show up at a Board meeting, and have speakers, and ready to go to fight for the budget and [policies].

HP: Was there an example of what comes to mind where that came in handy?

JRE: Every budget year. Every budget season. Because that's how you kept some County money in the budget.

HP: Yeah. And that leads to my next question, actually. All this was happening in the shadow of Prop 13 [1978 initiative that capped property taxes in California].

JRE: Yeah. I guess you have to question my judgment on anything I say, because I took that job three months after Prop 13 passed.

HP: What was that like?

JRE: Oh, it was chaos. Before Prop 13 passed, because of the scandals in the state hospitals, mental health people from all over the state were sitting in Jerry Brown's conference room to design a new mental health budget for the whole state. Some of it was picked up from the California Model [a plan for the future of California's mental health system devised in the late 1970's and early 1980's] which we had done a few years before.

HP: Oh, I didn't realize that was done before Prop 13.

JRE: Yeah, it was.

HP: Oh, wow.

JRE: No, wait a minute, I take that back. I'm sorry. It was after [in 1981]. No, there'd been another study before that saying what needed to be done. But anyway, everybody was putting all these wonderful things in, and then Prop 13 passed and they went down the tubes immediately. Well, Mental Health first thought, "Well, we're funded by the state, it won't hit us because it's a County property tax loss." But, of course, they reshuffled everything, and mental health and all the human services took it in the neck. So as I said, I saved several million bucks, [by] moving Mental Health out of Health Services, on overhead, which didn't touch any service cuts. Almost all those savings, instead of going to better services, or more services, went to cover the Prop 13 loss that first year.

HP: So it's a good thing you were able to do that.

JRE: It was a good thing I could do it, but it was also a damn shame that [those savings] couldn't have been put to some use other than a budget cut. But [the cuts did come] eventually – I mean, every year after that it was painful. And the Counties didn't have any money. Prior to Prop 13, Counties were semi-autonomous. They had their own tax base. And they could stand up and do things that the State didn't do. So you always had to fight for everything with the State, and then you come down and try to get what you didn't get from the State from the County. After [Prop 13], it was [little] use to talk to the County. It was a matter of you fought like hell at the State level, and then you hoped that the County didn't pull out every dime it could. It had to keep a certain percent in [mental health services]. But it was a small percent, and some of them were overfunded, meaning they had more money in, and you hoped they wouldn't pull it all out. And we, in LA, kept a little overfunding it, but not much.

HP: When you say "over-funding" –

JRE: More than their required minimum.

HP: Oh, I see. Required legally.

JRE: Yeah. But, I mean, it was just – it was difficult all that time. I'd always felt that LA had a good set of resources, because they were better funded than Orange County was, but after Prop 13, we didn't have it either.

HP: Right. And then – you mentioned the families a little bit. How about the client movement here in LA?

JRE: The client movement started more in northern California, the real [vocal] clients speaking out aggressively for themselves. In LA, the Mental Health Association, one of the staff had started Project Return, and Project Return was basically staffed by [regular] people. It was gardening and caretaking and clubs. But the clubs were all staffed with professional or semi-professional people. Project Return had done a lot of good. It was one of the more innovative programs, in terms of having a clubhouse model [providing] support for the client population in multiple places around the County. And when you're dealing with the severely ill population, that was very valuable. But [eventually] the Mental Health Association figured out that, “You know, this is probably out of date now.” I remember it was right after I quit as Director and went back on their Board that their staff brought it to a committee I was chairing to just do away with it. I said, "Maybe you should just fix it."

Before I quit the County, County Departments always threw big parties for Directors going away. It's a tradition in LA County. It's outrageous. They used to buy people computers and things when computers were a big deal. Fancy stuff. And I said for my going away, I didn't want to do that. I said I wanted to have all proceeds go to Project Return. And instead of having people get up there and tell lies about me, I wanted to have a roast.

HP: (chuckles) That must have been fun.

JRE: It was fun, inside and around the State. My friends all came and we had a party. But we raised fifteen hundred bucks for Project Return. When Harry Hufford quit a few months after I did, he did the same thing. He wasted it, he gave it to USC [sarcastically]. (chuckles) But he did the same thing of making it a charitable donation.

HP: Now, what is it that – like in those days, did people think it was a radical thing or a strange thing for organizations like Project Return to be around?

JRE: No, because at that time, Project Return was, you could say, very benign, benevolent, didn't fight for anything. They were taking care of [people], and that was good, but it wasn't enough. But the client groups in northern California were very vocal and controversial. They probably had to do what they did. Some of the stuff they could have probably had a better effect if they'd been more gentle. But maybe we wouldn't have listened, so I don't know.

But anyway, what we (MHALA) did is [to] pull all of the staff out of Project Return and made it totally client run. And it prospered very well. It's done extremely well as an independent client-run organization. They wanted to stay under MHA's fiscal [umbrella] because they didn't want to deal with the budget. But basically they called the shots; it was their money, their funds.

HP: Yeah, and they still are.

JRE: And still are. So it's been a good client movement for Southern California. Very strong.

HP: So you mentioned the California Model. Tell me a little bit about that, and your involvement with it.

JRE: I'm trying to think. Oh, the chairman of one of the state committees, who had been friendly -- I guess it was Bates, [Thomas H. Bates, Assemblyman for California's 12th District, 1977-1992, and California's 14th District 1992-1996], who said, "You guys are always wanting more money and you say you don't have near what you need. What would it really take to have a decent mental health system in the state? Not Cadillac, but decent." So there was this challenge to try to do it.

Peter DuBois, who at the time was the exec of the Mental Health Association of California, took that on as a statewide project. I think he had been testifying when [Bates made the challenge], and he took it on. So a bunch of us worked with Peter's leadership, and Peter was a very good organizer and would bring people in. So they really did have the support of the mental health constituency.

A number of people started thinking about it. I remember nobody knew quite where to start, so I got some of my Deputies sitting in my office. I had just come to LA at the time. My office was still in the Health Services building, I remember. We just sat there at a blackboard and said, "If you're going to design a system where it's not all inpatient and people are going to move

through, what do you need in outpatient? What do you need in rehab? What do you need – how many beds, how many slots, and –" We scoped out a first draft that got things started, [but a wide array of people were involved before a final product was developed]. But then, it wasn't too long after that that the State Director changed, and the new State Director wanted to do his own model. So nothing really came of it.

HP: But the report was published.

JRE: Oh, yeah, it was published. It was updated several times. Dr. Crowell updated it two or three times.

HP: And what was the essence of it, like in a nutshell?

JRE: Well, it was a comprehensive -- I think it has many of the things that we've been doing in MHSA [the 2005 California Mental Health Services Act], but under maybe some different rubric. And I think under MHSA, we're much stronger now about client involvement, client-run services, having clients employed. We didn't have the trust, nor did [the clients] have the trust to do it then. Probably wouldn't have.

HP: What were the commonalities between it and the MHSA?

JRE: It was a [shift of treatment] emphasis away from hospital [care and toward] rehabilitation. It wasn't the intensity of a Full Service Partnership [Full Service Partnerships are intensive programs for the severely mentally ill funded by the MHSA], but certainly had similar kinds of thinking behind it. I mean, thinking matured from the California model to the AB2034 [1999 legislation that funded demonstration programs for the homeless mentally ill] and through the ISAs [funded through the earlier AB3777 legislation of 1989]. So the AB34 experiments were very valuable, because they taught us an awful lot about what worked and didn't work. The Village [an ISA in Long Beach] has been extremely influential. You've been to the Village?

HP: Yeah.

JRE: It's been extremely influential, and continues to be.

HP: What did it teach you about what didn't work?

JRE: Trying to coerce people.

HP: Can you expand on that? What do you mean?

JRE: We have come to the conclusion that you can't coerce someone to get better, to do anything. Putting people in hospitals, on conservatorships, and such things, you only do so in the most extreme conditions where they're totally out of contact and can't deal with it. And even then, we now try to use a system where we would have people write out, when they're not psychotic, what they would like to have happen if they become psychotic, and try to follow their

wishes, even if we have to commit them. You have to find a way to offer the client something that makes it worthwhile for them to want to get better.

HP: And AB34 was lacking in that in some way?

JRE: No, AB34 was the first to do it. You could offer people housing. And one of the real big things we've learned – we used to always say you have to get people out of their psychosis and doing well before you give them housing. Wrong. What we know now is housing first. Give them a place to live, a place where they can feel secure, and a way to get some reasonable food. And then you can start working with them on other wishes. But the first thing you've got to do is get them off the street, and get them into a reasonable place to live where they're comfortable and secure.

HP: Something better than a shelter.

JRE: Yes.

HP: And I guess the question would come –

JRE: Richard [Van Horn] can tell you all kinds of stories about the Village and what they did. One client I know lived in the bushes in Long Beach and he was afraid and wouldn't have anything to do with anybody. I think they eventually just left a little food there for him, or left something, and finally he would talk to them. Finally, they said, “Would you like to have a place to stay?” And they finally got him to go into a – I think it was a room above their office or something. And before long, he was hanging out in their office and wanting treatment. But he was paranoid, he was frightened, and he had to have a safe place that he could go to. Then you can deal with people. But you can't if they're terrified and have no place to retreat to. So that's been a big one. The other thing we've learned is – I had a great experience at an ISA type program I set up at Harbor [Harbor-UCLA].

HP: AMI-Able. Yeah, I was going to ask you about that.

JRE: One young man, who had jumped off a bridge and fractured his pelvis and his legs and was in a wheelchair, that nobody wanted to do anything with. We took him. We worked with ortho [orthopedics]. We had him walking before too long. [Health care was available] because we had the hospital right there. He was an excellent typist, and so we hired him as a halftime secretary for the service.

Well, at that time, we had the responsibility of typing up some paperwork for commitments or something for Eight West, the inpatient unit [at Harbor-UCLA]. So he was doing it. Now, he had taken an oath of confidentiality and everything, but one of the senior faculty running Eight West said, “He can't do that, he's a patient." I said, "No, he's not, he's a secretary." [He said,] "He's been a patient. He can't work here, can't do that." I said, "He's taken the same oath of confidentiality you have. And he's a good typist. Anything wrong with his typing?" [He said,] "No." [So then I said,] "Okay. What are you complaining about?"

Then we had a psychopathic fellow who decided that he was going to stir up trouble. He tried to say that this guy was giving out information from his paperwork, which of course he hadn't. But the faculty was all over me that this guy had violated confidentiality. I said, "He didn't." And we proved that he didn't. And then the other patient backed down. It was that kind of a fight.

By employing people at [AMI]-Able, with the residents coming through there, working there with [the clients], it was very valuable because the residents saw that the clients had a lot to contribute, and it got away from the whole stigma thing. Some of the most stigmatizing people against people with mental illness are mental health professionals.

HP: What kind of stigma is it, and why do they have it?

JRE: Well, we were trained to believe that they were crazy, they couldn't think for themselves, we had to take care of them, we had to be very paternalistic with them, that the primary issue is their symptoms. In fact, the primary issue isn't their symptoms, it's what can they do in spite of their symptoms. We can help control the symptoms, but even if they're quite symptomatic, sometimes people can do quite well.

HP: That sounds like Recovery [the Recovery Model].

JRE: Yeah, it is. I mean, Recovery, the whole Recovery movement has evolved from that, or this kind of thinking. And that's happened mostly in the last ten, fifteen years.

HP: How has stigma gotten better? What would you say stigma looks like today versus what it was when you went through the field?

JRE: It's a good bit better. There are a number of successful people [who] now admit that they've had major psychotic episodes. There are lots of books out, while before there weren't any. Interestingly enough, I think drug company advertising has reduced stigma.

HP: Tell me about that.

JRE: All of the ads for antidepressants and [other psychotropics].

HP: And even their ads for Seroquel [quetiapine, an atypical antipsychotic medication] and Zyprexa [olanzapine, also an atypical antipsychotic].

JRE: Yeah. They have said, “You're not the only person that's got this, a lot of people have. That's why we're advertising and we show people getting well.” There's been enough reduction in stigma that we've made a lot of progress on insurance equity. I don't think we would have gotten the parity bills [laws stipulating that mental health insurance benefits should be the same as medical/surgical benefits] through the feds or states without a big improvement in the stigma issue.

HP: And when did the major parity bills pass?

JRE: Oh, God, the Feds just [it] passed a year or two ago [The Wellstone-Domenici Mental Health Parity and Addiction Equity Act was passed October 3, 2008]. It just now got the regulations out [in the *Federal Register,* in February, 2010] so it [can become] effective. I remember we were fighting for parity when I was chairman of the board of the National Mental Health Association, now Mental Health America, and that had to be six years ago.

HP: Okay, so they're both relatively recent.

JRE: Well, we didn't get it. We were having a big fight but didn't get it through. That was the year that the Senator from Minnesota, Wellstone [Paul Wellstone, Minnesota Senator, 1991-2002], was killed in the plane wreck [2002]. We were kind of thinking that we almost had it at that time, and then his death took a lot away from that. So it must have been eight years ago that we started the fight, and it took about six years to get it through, so it's a couple years ago that federal parity passed.

## IV. AMI-Able at Harbor-UCLA; CIMH; Thoughts on MHSA; Clients in the Workforce

HP: Now, I guess we've got to move on. A couple of things we just talked about, actually. First of all, if you could tell me a little bit about AMI-Able, what it was that sparked the idea and how it went.

JRE: Oh, it was because of the experience that I'd had helping design the models for AB34. I was on the AB34 advisory committee. I'd help set up – in fact, I'd reviewed some of the grants. I had helped spec out the final bill, because you recall it started out with a [Task Force] that was mostly non-professional advocates under the Lieutenant Governor's [Leo McCarthy's] [sponsorship]. They ran out of money and that's when MHALA [Mental Health Association of Los Angeles], (where I was on the Board) Richard [Van Horn] said, "Well, we'll help you have the last hearings, but we get to have input on what the bill says." So [Richard, with my and others' help,] made it more reasonable. They [initially] had something that we didn't think was feasible.

HP: What was that?

JRE: Oh, it was just too extreme, and you wouldn't have gotten any of the professionals involved because it was anti-county, anti-government, and it wasn't any use to have something anti.

HP: What was it pro?

JRE: Pro totally new, independent of everything.

HP: Of setting up new agencies?

JRE: A whole new model, new agencies, everything.

HP: I see. So you convinced them to build upon the existing agencies.

JRE: Yes, to some degree. The County Directors [said], "Well, if you're going to put this kind of money in it, anything will work if you put that kind of money in it." So we had both some County models and some contract models. Ventura County was one of the County models. It worked for a while but it doesn't now.

Well, actually, we'd [planned on] two County models, originally it was supposed to be [two County and four contract], I think, and then the budget got cut, so it became [one County and two contract]. So Ventura County got the County model, Van Horn [The Village] got one of the models, and the other was [in] Stanislaus [County]. And that was a contract agency that didn't have the wherewithal to really pull it off. But actually, it's been somewhat rescued. That's a very good County operation.

HP: So the AMI-Able was around that same time.

JRE: Well, after I'd had that experience, I thought it'd be really good to have a program like that at Harbor [Harbor-UCLA]. So I said we would only take clients who cost the county forty thousand dollars or more in a year. Our costs were not low. They were about sixteen, seventeen thousand a year. Because we were getting AMI [Alliance on Mental Illness] involved, we did take a few of their expensive patients. I'm not sure they all met the forty [thousand dollar] criteria, but they were expensive and chronically ill. But if people pitch in and help you do something, you help them too.

HP: So AMI being NAMI?

JRE: Yes, [two local chapters helped plan the program].

HP: Okay. So people like the family members [of clients].

JRE: Yeah. We took a few of their family members. And we needed a base of people who weren't just coming out of the hospital to help build the program. But then we only took people that were very expensive from the hospital. And we showed that we saved beaucoup bucks on those individuals.

HP: And how long did that program last?

JRE: Well, theoretically, it's still there, but it isn't. After I retired, first they were – well, there was a bunch of shenanigans going on. We agreed to take more clients with more staff. We got the clients, we didn't get the staff. So your ratio of staff to clients went down. Because the whole idea of it is do whatever it takes, and that means you have to have a pretty high ratio [of staff to clients].

HP: Right. Ten to one, fifteen to one.

JRE: No more than that – actually, I like ten to one or less. But we had people with drug counseling experience and all kinds of different types of folks there. And

we had a client or two working. It was going quite well, and then they wanted some people out of the justice system, and we were supposed to get more money. That was after I'd left, They got a bunch of people out of the jails, too, which changed the climate. Mostly what I heard after that was secondhand, people saying, “Hey, it just isn't an ISA, Integrated Service Agency, like it should be. It's become more day treatment.”

There are still parents involved and [they still help out]. One of the things that I did, because the County couldn’t -- you can't have flexible funds from the County. I got NAMI to set up what I called our slush fund. Well, I started it off by writing them a check for five hundred bucks and saying here's the first check. Then they all started kicking in and we got [a nice loan fund established]. That is used when clients are moving into an apartment to help them pay first and last [month’s rent, and] help them get furniture. But it was a loan, and they were very good about paying it back. They had a loan committee made up of some of the clients and – the majority [were] clients -- and a couple of staff [and AMI] people. And the clients are tougher than the staff people on their colleagues about making sure they could pay it back. But they did pay it back. It was a revolving fund. Actually, it was more on that model that Areta Crowell started [setting up ISAs with] a whole bunch of contract agencies [the PARTNERS program]. Because again, the contract agencies could do that kind of thing [with the necessary] flexibility.

HP: So tell me a little bit about some of the work you did after you left DMH, in terms of the CIMH [California Institute for Mental Health]. You've mentioned some of your work with Mental Health Association, some of the major things you've done.

JRE: Well, leaving out the Harbor [Harbor-UCLA] and the academic stuff, I wrote a few papers and things that I had to, taught residents. But I continued to work on statewide committees, advisory committees. Then got elected to the National Board of Mental Health America and served my six years. At the end of six years, they asked me to come back because they wanted to make me be Chair.

HP: And what did you do during your time with them?

JRE: Oh, it's a Board membership. You're on committees, you're setting policy, and watching the budget and fiscal [status].

HP: Were there major things that you –

JRE: Yeah. When I went there, the thing was, they were [nearly] bankrupt, and they had some really dumb ideas of how they were going to sell their building and lease it back for more than they were paying on the mortgage to get cash out of it. I remember Andrew Rubin, another LA person on the Board, and [Richard] Van Horn, who was on the Board as a staff person, were horrified. So the three of us said that didn't make sense, and we proposed that LA County Mental Health Association fund the building. So we had a lien on the building for a while. The Board fired the President/CEO, got a new

President/CEO. And the new CEO pulled it out and did a very good job, built a strong staff.

HP: How about with CIMH?

JRE: CIMH, I've been on that board for many years – I'm not one of the first members on the board, because initially it was all Mental Health Directors, but then they decided they needed to set it up as a separate entity, so they [elected] some other folks, including me. It was then a very small organization. And you have to give the credit for the building of that organization to Sandra Goodwin [founder of CIMH in 1993], who's been an outstanding [Executive] Director.

The organization was small and loose. It's getting more sophisticated and squared away as it grows. It has made itself, I think, *the* [premier] training and technical assistance organization for the state. In the old days when the State ran Mental Health, they provided some TA [technical assistance and other support]. But after Realignment, they basically gave it all up, so CIMH was developed by the Mental Health Directors to [fill the need].

One of the things I've always watched is their investments and [financial stability]. We had an accountant before the dot-com bust who was wanting to go more "go-go." [He thought our reserve funds] weren't invested aggressively enough." I was the treasurer, I said no. I said, "You know, if you don't make a lot of money in this, it's no big deal. If you lose it, your ass is grass. Do you want to follow his advice?" (laughs) But the Board controls that kind of thing, and so that's been my [primary focus], trying to protect the organization, not let it go down the tubes because somebody takes a risk.

I'm nearing the end of my two years as chair, and in this time I've aggressively sought to diversify our Board, both for racial and ethic balance and areas of interest. It used to be that the Mental Health Directors required that they have a majority on the board. [They] backed off of that, because, one, they're so damn busy they don't want to do it anyway; and, two, we just think that if we're at arm's length from them, it's better for getting grants [and contracts]. Also, we brought in [folks] from the contract agencies [and other helpful perspectives. There were always slots for clients, families etc.] So now the Board is more balanced, and it will be, I think, seen as much more serving the entire constituency, not just the County Directors. Generally speaking, County Directors *are* wanting to work with their contract agencies, but it varies from county to county. This is a way to break down the animosity because it has to be one system.

HP: I wanted to ask you, what do you envision the relationship between contractors and the County to be?

JRE: I think it's always going to be there; they need each other. Neither side's going to go away. I don't think contract agencies can do some things that County government can do. Along that line is in the realm of emergency services, legal status, 5150s [placing a legal hold on an individual who represents a danger to self or others], working with the police and things that

requires [a] “we're in the same government” kind of [attitude]. Counties have the force of the government behind them, which is hard [to contract out]. Even if you [delegate] to the contract agency, they don't feel it, nor does the citizen feel it. So there are certain emergency and hospital care [responsibilities] like that which are probably going to always be County, and that means they've got to have some outpatient services.

HP: Why do they need to have outpatient as well?

JRE: Because if you're going to do emergency care, you [usually] can't get them to a contractor right away. If you're well enough integrated, you might, but I'm not sure it's going to happen –

HP: So that's as an intermediate.

JRE: Yeah, an intermediate. And there's also places where you have to put in [services] because the contractors won't. There are places that aren't fun to serve. That's why when I came to the County, [most of our] federally funded Community Mental Health Centers were in the suburbs, [there were few] in the inner city. That's why the inner city didn't have many services, because nobody wanted to go down there and do that. There were a couple of inner city Community Mental Health Centers, but they were not as well funded. Well, one was. That was Central City. But that was because of particular movers and shakers in the black community who knew the Feds very well and did it in spite of the County.

HP: So that's where there are things that the County can or should do. Are there things that contractors can or should do that the County maybe shouldn't?

JRE: Well, I think, for example, an integrated service [agency] – it's a mixed bag because if a contract agency really wanted to do a good job, they would be the preferable agency to do an integrated service, like MHALA.

HP: Why is it that they can do that and the County couldn't?

JRE: Because they have flexibility of funds. They can go out and help someone. I mean, I had to create that little slush fund at AMI-Able, because the county wouldn't let you have a revolving fund. You just can't do that. In order to control it, they'd go bonkers.

HP: Well, don't they have that now with MHSA though?

JRE: No. I don't think the County runs one.

HP: Oh, well, the FSPs do though.

JRE: If they are non-County, they do.

HP: Oh, but County ones don't.

JRE: I know AMI-Able is now supposedly an FSP, and they may still have the NAMI fund, but they don't have a County fund. But the flexibility of a contract agency is something that I think is very valuable.

[When I was] in Orange County, Ernie Klatte and I tried to set up the whole department as a non-profit. We had a grant to do it and everything until Richard Nixon killed the grant. He did away with the section of HEW [United States Department of Health, Education, and Welfare] that was going to give us the money. We even had the Board agreement to do it.

HP: Oh, wow, it was all set up.

JRE: Yeah. Ernie and I were arguing about who would stay with the County, because somebody would have to stay and administer the contract. (both laugh) But I think for that kind of flexibility and you also have to have the commitment to take care of the most difficult, hard core folks. Some of the folks can be very difficult, and contract agencies tend not to want to do that. They like to have their escape valve. Even the contract agencies that Areta [Crowell] set up as ISAs, many of them did not function as such because they were dumping their most difficult clients.

HP: How do you dump a client?

JRE: You find a reason why they have to go somewhere else. We thought by setting it up this way that we could keep them from dumping.

HP: Right. If you give them the resources to deal with the most difficult clients.

JRE: But there's never enough resources to do it. We thought with MHSA the mental health programs would finally get the [necessary monies themselves]. However we have lost huge amounts of our realignment money, so we're right back to square one, about where we were before.

HP: Using MHSA as a band-aid.

JRE: So MHSA gets distorted, used as – everything's converted and they just say [it's MHSA], whether it is or isn't. The big question is, and I don't know what's going to happen and nobody's even thought about it yet, but when the economy recovers and the sales tax goes back up, [how will it be handled]? The reason Mental Health suffered so much is because the first call on new sales tax money went to out-of-home care, children, welfare departments. And we've only got our base. The question is, "Where's the base?" If the base is reset down low for realignment, they'll never get it back, because all the new money will go to welfare.

HP: And MHSA has filled in that gap so it's not going to fulfill its original purpose.

JRE: Right.

HP: Of expanding [the mental health system].

JRE: Right. Even though we had a maintenance of effort [requirement in the MHSA]. I assume that if they don't say the base is where it was before the cuts, we'll probably sue on the basis of the maintenance of efforts requirements in the MHSA, Prop 63 [Prop 63 was the initiative that created the MHSA]. But that will be a long slog. We may win it, but it would be a long slog.

HP: If we could actually rewind back to the MHSA a little bit, were you involved in the campaign?

JRE: Mm-hmm.

HP: Tell me about your work with it in its early days.

JRE: Well, I was involved as a board member of the MHAC [Mental Health Association of California]. I donated money mostly. (chuckles) I helped organize some meetings and things, but Rusty [Rusty Selix, Executive Director of both the Mental Health Association of California and the California Council of Community Mental Health Agencies] was in charge of that. Rusty did that job very well.

HP: Yes, clearly.

JRE: If I did anything, it was trying to calm flack for Rusty, which – he wouldn't even know about when people were picking on him. No, I can't take much credit for it, other than like everybody, I was kicking in money and [talking it up]. It was a very broad-based effort.

HP: And what was your vision for it?

JRE: Well, my vision was to try to get some new money, and I thought we knew how to spend it if we could get some money.

HP: Based on the ISA experience?

JRE: Yeah. And, basically, that's what it was designed to do. About half the money is supposed to go to what's been termed Full Service Partnerships. I think when the bill passed, we all expected it to be running about the same model as the Integrated Service Agencies. Interestingly enough, the ISAs required an enrollment, and the clients didn't want to enroll.

HP: Why not?

JRE: They saw it as a control thing. It rubbed them the wrong way. They didn't want to be an enrollee or a member, per se. So the folks writing the draft plans and policies came up with the Full Service Partnerships, so it's a partnership rather than an enrollment.

HP: But there's still a formal enrollment process.

JRE: [hesitates] Not exactly. They don't have to sign as a member.

HP: Oh, okay.

JRE: Yeah, you know who they are, but we always knew who our patients were. But it's not exactly a sign on the dotted line thing like it used to be, or like it might have been. That was under Carol Hood's direction in the State Department [Carol Hood, Deputy Director of Systems of Care with the California Department of Mental Health]. All those specifications got written with [much client and family input], and a lot of the writing was done by Beverly Abbott and Pat Jordan, [who were] consultants for the California Department of Mental Health. [They had also worked together for many years prior to that in Marin and San Mateo Counties.]

HP: I've heard of Beverly, yeah.

JRE: Beverly Abbott's my wife. (laughs)

HP: Oh, okay. I didn't know that. (laughs)

JRE: A lot of people in the state didn't know it for years, because we use different names, [and] because we don't always agree. But most people know it now.

HP: Okay. So anyway, when it first passed – or I guess looking at it now, what would you say have been its biggest successes and biggest shortcomings?

JRE: Hmm. Not being on the front line, I'm not sure I'm the one you should ask. Marv [Marvin Southard, director of Los Angeles County Department of Mental Health 1998- ] would tell you better than I could. Most of my thinking about front line work these days is “Glad I'm not there.” (chuckles) But I think – I mean, if it hadn't passed, God, we'd have been in terrible shape now, with what's happened with the Realignment monies. But it's not going to save us, either, by itself. I think it has done a really important thing, and that is bringing in a lot more clients into the workforce. And I think that's valuable, for several reasons. One, they have a lot to contribute. Two, when they're working on a team, in the staff meetings and [work settings], the attitude of the professionals is so different than when they're not there.

HP: When you say the "workforce," you mean the mental health workforce.

JRE: Yeah. They brought them into the mental health workforce.

HP: How has it changed staff attitudes?

JRE: Oh, it changes tremendously. They don't see them as a patient, they see them as a colleague. And they don't make any disparaging remarks about people with mental illness, like they do if there aren't any clients in the room. It changes their attitude. I mean, the fact that at Able [AMI-Able] we had two or three people who had been clients working on the staff made a huge difference in the way people thought about it, and the way residents learned to respect them as people, not [just] as patients.

HP: And even in terms of the sort of treatment plans they come up with and things like that.

JRE: They're not too different in that respect, but the client has an input as to, “Hey, do you really think that makes sense from that person's perspective,” which is valuable, very valuable. But it's just a different tone, and I think that in turn breaks down the stigma. Professionals are the most stigmatizing [agents] about people with mental illness. And worse than the mental health professional is the general healthcare people. I mean, right now there's a movement to get better integration of primary care and mental health. I say, for God's sake, don't let Health run Mental Health, because they just don't like people with mental illness. They don't understand it, they don't have the time to deal with it, to work with [mental illness].

HP: It's a very different art in terms of treatment.

JRE: Yes, it's different. But our success rates are a hell of a lot better than most of medicine, if you stop and look at it.

HP: Really!

JRE: Yeah. We can rehabilitate the vast majority of people now. We do much better than the people dealing with cancer and stroke and things like that, by a damn sight. So I think it's a huge difference. But, yeah, it's a different thing. The scientist who goes into medicine doesn't like it, even though [the theory of mental illness] certainly has a scientific basis, and we've certainly learned an awful lot about brain function and [chemistry]. But they still don't accept it as the same thing.

HP: Right. Okay, so you mentioned getting customers into the workforce is one thing. Some other good things it's done?

JRE: Well, I think it's generally gotten people to realize that, if you have the funds, the whole approach of you “do whatever it takes” to help that person have a decent life [really works]. It's not just a matter of they take their meds and shut up, or they come to day treatment. When I set up Able [AMI-Able], I didn't say people needed to come in every day. In fact, I discouraged them coming in. I'd rather they be out working in the community, doing something. And I've always felt that. When I was in residency, I set up a halfway house in New York City, and the rule was that the people could not be in the house during the daytime. They either had to be in school, working, or doing volunteer work.

HP: So you've always been a believer in this.

JRE: Yeah, it goes way back.

HP: Where did you pick that up from, do you think?

JRE: I think probably my training at Columbia, in the Community Psych program. You've probably heard of Fountain House [a mental health service provider in

New York City]. I first learned about Fountain House back then and spent time there. Things like that.

**V. Closing Comments**

HP: All right. So I'm going to ask you three more questions and then we'll wrap up.

JRE: Okay.

HP: So, in a perfect world, what would a recovery oriented system look like?

JRE: (pauses) It would be – again, I assume you're talking about someone who has had a very serious mental illness.

HP: Mm-hmm, yeah.

JRE: It would be in really a Village-type program where staff and clients both expected that the client's going to get better, and then that client's going to have a decent life. Recover in the sense that they may still have some illness, but they're going to be able to control it, live with it, keep it within bounds.

And I'll go way back, an old story. When I was setting up this halfway house, I went to visit a bunch of them, and I visited a halfway house that was well-known at the time in Washington, DC, Woodley House. And it was run by this very smart lady. She had very chronically ill folks in there, and she had this one man who was always talking to himself. He'd go out in the street and talk to himself, and the neighbors would get upset. So she called him in and said, "If you're going to talk to yourself, you can talk to yourself here, but you can't do it out in the street." He said, "Okay." He didn't talk to himself out in the street anymore. (chuckles)

HP: (chuckles) There you go.

JRE: And like a lady I was treating at Columbia, in the outpatient clinic, very sick, chronically ill, schizophrenic lady. She always had hallucinations that a group of people were always [calling her names]. I said, "Well, how do you support yourself?" [She said] "Well, I clean houses." And I said, "Well, how does it work when you go in to clean a house and those people are talking?" She said, "Oh, they stay out in the street." Which tells you that people can learn to control anything. I mean, that was before we had the meds and things to make it easier.

So folks with mental illness have phenomenal abilities that we don't see and pick up on and use. And that's where the attitude change has to come. I mean you have to see what the assets are of these folks, and what's going to be really positive in their lives.

HP: Right. And using those assets.

JRE: Yeah. And they have a lot.

HP: Okay. So where do you see the future of the public mental health system here in California going?

JRE: The public mental health system in California is tied up in the whole governance of California, and it's not going to get any better or improve until our government really hits bottom, which I think is getting near, and there is a massive upheaval, change in how we function. We are unable to function at this time. Period. Schools are going down the tubes, infrastructure is going down the tubes, this impasse in Sacramento where you can't get anything done just makes it impossible. I'm hoping that maybe this little step of more fair redistricting might help. I don't know. Maybe it'll bring some moderation into the parties. I don't think that's enough to do it. I think that there has to be something [drastic] happen. Between Prop 13, term limits, gerrymandered districts, we have radicalized both sides of the political spectrum, and nothing is getting done. So I don't think mental health will get any better until there's something that [allows] state government to get better.

HP: Just in terms of getting mental health the resources.

JRE: Yeah. I mean the whole State Department of Mental Health right now is totally dysfunctional, because of all the craziness in Sacramento.

HP: Yeah. Do you think that, let's say, the economy going south, damaging Realignment, and forcing MHSA to be used the way it has been, if that hadn't happened, or let's say Realignment could be restored, would the MHSA be the right track?

JRE: I think so, yeah. I think it has a lot of good ideas and a lot of good directions. You don't get everybody to buy in immediately in anything like this. But I think, in the long run, it is the right direction. It incorporates the current ideas as to what ought to be in mental health. It doesn't necessarily have to be structured in a very narrow and detailed way, but it is the latest thought. It's the best we've got.

HP: Yeah. Okay, so final question. Looking back on your career to this point, what would you say has been your greatest achievement and the thing that you most would have liked to accomplish that you weren't able to?

JRE: Honestly, I think my greatest achievement was getting the new [Los Angeles County] Department of Mental Health structured with a decent ordinance.

HP: In terms of that thing with the hospitals?

JRE: Well, giving the department control of its resources, because I think the LA Department has done relatively well since then, and it hadn't before. That may not be something that sounds like a glorious achievement. I mean, you might say being Chairman of the National Mental Health Association Board [would be]. Those things are great honors, but as far as getting something done, I really think setting up the Mental Health Department in LA in the right way was [my best accomplishment]. It's been undermined some since, but I still think that was the best way to go.

HP: Something you wish you could have accomplished that you weren't able to?

JRE: Oh, that's an awful lot. (chuckles) I wish I could have been a benevolent tsar of California and fixed all this mess. (both laugh)

HP: (laughing) I'd vote for you for governor.

JRE: Nobody wants the damn job today, I don't think, anyone that's got any sense.

HP: No one who should have it wants it.

JRE: Right. Anybody that's got any sense doesn't want it. Let's put it that way. I don't know. I've had a good and exciting life. I've gotten to do things I wanted to do. I would have liked to have been able to accomplish more when I was at Harbor [Harbor-UCLA] to really make it a more community[-oriented] training program, but the powers that be weren't for that, so I didn't get to do that. But all and all, I've been a lucky man.

HP: Okay. Well, is there anything else you'd like to add?

JRE: No, not really. Thank you.

HP: All right. Great.

**END OF INTERVIEW**