Ian Hunter shares his thoughts on breaking the cycle of hospital recidivism and the evolution of medical terminology…

The dollars were shrinking to begin with, and then the focus was really shifting to the severe, persistent mentally ill. NAMI had a lot to do with that – the National Alliance for Mental Illness – understandably, because those are the parents of, and relatives of, severely mentally ill family members. They were saying, we just simply don't even have enough money to treat this group. And this is a group that was filling the hospital beds, this is a group that was causing enormous problems in the community and at home, for families that were trying to maintain these folks at home, and of course, it was very disruptive. They [NAMI] had a good kind of political presence and some real strength and they were able to really begin to shift those dollars through the State Department of Mental Health and the County Departments, so that, as the money shrank, the focus became more on the psychiatric hospitalization folks, the people that were using the most costly types of service.

And of course, those were the severely mentally ill. The revolving door at that time was that people would come in, and they'd be in the hospital for a few days or longer, they'd get their medication, they'd stabilize somewhat, then they'd be out the front door. Generally speaking, they'd go out with some medication, and the usual picture was they'd go back to their board and care [home]. There was no continuity; there was no follow-through or after-care. They'd go back to their board and care with their medication and they'd stop taking the medication, and they'd relapse, and they'd go back to the hospital, so it was a real revolving door syndrome. The question was "How can we stop that?" And the majority of the money was going to that group. The hospital would have taken all the money, had we not been able to interrupt that whole process. The way to interrupt the process was to develop a system, and over time, it's really involved developing not just the standards – [for] the psychotherapy and the medication, the case management – but building in real community supports, so that people don't just leave the hospital and go back and decompensate.

In the old days, the doctor used to analyze and evaluate the patient and they used to say, "This is what you need to do. You need to get rid of those hallucinations, you need to get a brighter mood going and lose that depression;" and no one ever thought to ask the patient what they wanted. And even the word "patient" – the evolution, for me, has been "patient" 30 years ago, to "client," which has not the medical connotation, and today it's "consumer." And you can see that those [terms] really connote very different things. A client is somebody that you're serving. A client comes to the expert, like a client with a lawyer. The lawyer analyzes everything and then dispenses expert knowledge. A consumer is someone who is using the services of the system. And [the term] has less of a connotation of one being superior to the other. It's like the consumer is using our services. So, in a sense, we're serving the consumer, and what that one change in label [did was it] brought with it a sense of equality for the client. So what happened, as we were moving in that direction – and this is called the social rehabilitation model – again, it went from the clinical model, where the concept was "let's cure, we want to cure these folks" – to saying, "No, these folks have a very deep and profound psychobiological illness, and it's unlikely that folks with severe mental illness are ever going to be *cured*. But they have levels of independence and functioning that they can attain – their highest level of functioning that they can attain."

READ THE FULL TRANSCRIPT BELOW

INTERVIEWEE: IAN HUNTER

INTERVIEWER: HOWARD PADWA

DATE: October 21, 2009

I. Early Education; Beginnings in Psychology; Suicide Prevention Center; Changing Team Roles; Licensure for Psychologists; Role of Medication; Recovery Model

HP: OK. This is Howard Padwa here, on October 21st, 2009, doing an oral history interview with Dr. Ian Hunter for the Department of Mental Health's 50th Anniversary Project. So for starters, Dr. Hunter, tell me a little bit about your background and how you came to start working in mental health.

IH: OK. Well, I don't know how far back you want me to go, but [he laughs] –

HP: As far back as you like.

IH: Well, I attended Occidental College [in Los Angeles], and I actually started as a chemistry major and got interested in psychology, I guess, from some of my own life experience. Took the first course or two and thought it was ridiculous and crazy. And particularly Freud, Freud's conception of the ego, the id, superego, and some of the psychoanalytic ideas just seemed to me like totally off the wall; because then, in those days, people were not exposed to those ideas. So you really had very little framework for really looking at human behavior and motivation, particularly your own motivation and behavior, without some constructs like that.

HP: Yeah.

IH: So at first it just seemed to me that, well, that just doesn't sound right. But as I got into it more and more and understood more about the various theories of personality and abnormal psychology, neurophysiology, and the rest, then it really grabbed my attention for whatever reason, and I became fascinated by the subject of psychology. And from then on, it was like I was no longer in school. It was more like a hobby. I mean, I just couldn't get enough of the information, and kind of absorbed it like a sponge. I was fascinated by every area of psychology and that feeling has persisted over the years. I've just never – I mean, I can't imagine having a life without a background where you're really delving into psychological issues and psychological facts and psychological studies, because I just find it so fascinating. So it's funny, what's really been able to, over the years, maintain my interest.

But anyway, [from] Occidental, I graduated in psychology, and then I went to University of Oregon for my PhD in psychology, in clinical psychology. I really enjoyed that department. It was great. And then after that, I went on a postdoctoral fellowship to Langley Porter Neuropsychiatric Hospital in San Francisco and the Mt. Zion Psychiatric Hospital [also in San Francisco]. So I had a year and a half or so of post-doctoral training. Actually, when I was interning at the University of Oregon, I spent a year and a half at the Suicide Prevention Center in Los Angeles.

And that was at the time when it was just beginning to – The whole idea of working with suicidal people was a new concept.

HP: When was this?

IH: It was about 1964.

HP: OK.

IH: ’63, ’64. And up to that time, if a private practitioner was working with someone who would even mention suicide, the general practice was to refer them out right away.

HP: To where?

IH: Well, to terminate therapy. I mean, it was such a frightening concept that very, very few practitioners actually worked with people who were suicidal. And essentially, they might refer them to the hospital; or they might simply just terminate therapy, because it was so frightening. And so the pioneering work of [psychologist Edwin S.] Shneidman [1918-2005] and [psychologist Norman] Farberow and [psychiatrist and first Suicide Prevention Center director] Bob [Robert E.] Litman – the people who started the Center [in 1958] – was really groundbreaking because there, we were really looking at and trying to understand the research – why people consider suicide, why people actually attempt it, and then why people actually succeed in killing themselves, what the dynamics and all the factors involved [are]. And so it was a fascinating year and a half.

And it was really almost atheoretical. Basically, we were working with people and developing theories as to why anybody would get to a point in their life where they would want to end it. And that was such a foreign concept for all of us.

HP: And what did you find? What would the reasons be?

IH: Well, basically, of course, the role of depression, and you understand when someone gets that depressed, their whole focus narrows to an almost, like, peephole vision, and they get locked into a view of the world as unchanging and unrewarding. And they feel like they’re totally immobilized and fixated in a place where the pain doesn’t stop, and they don’t have any vision or image of anything getting better. They feel totally locked in. So at that point, there’s almost like a switch that takes place, which is that the idea of dying and escaping the pain becomes preferable to looking forward in life and envisioning what life could be like.

HP: Right.

IH: So that the job of the therapist is to try to break that up and try to help them really begin to start looking beyond the immediate and look to the positive potential in their future.

HP: And is that something you kind of learned through practice, when you were working at the [Suicide] Prevention Center?

IH: Well, as we worked with a lot of suicidal people, it was kind of almost like feeling our way, but it really was learning how to relate to these folks, learning why, what were the similarities and the common elements, and why some people would get to that point in their life. And there were a lot of very surprising things. I mean, every day was a discovery, and eventually out of that came a body of knowledge and a body of theory as to how best to help someone who's in that position.

But it wasn't something that had already been developed. Now that so many theories have been developed and approaches – This was one [time] where we really had to kind of develop it as we went, in a sense. And it was a real family atmosphere at the Center and everybody [was] working together.

HP: Was it like a drop-in center or a call center?

IH: It was both. People could drop in. More often than not, people would call in. We had a hotline – suicide line. People would call in, and so there was a whole body again of theory and practice on how to relate to people over the phone, when you don't even see them. All you hear is a voice.

HP: Yeah, because that wasn't the standard practice then.

IH: No, absolutely not, and it's like, suddenly someone calls and says, "I'm standing on a bridge and I'm about to jump off." But see, the main concept there that was helpful was if someone really was going to [jump], really wanted to do it, and they were unambiguous about it and unambivalent, they would do it. So the fact that they would call the Center, that was our hope, basically, because it was a cry for help.

And one of the main slogans that came out of that Center, was that suicide – when someone reaches out, that's the cry for help. They're really saying, "Show me why I shouldn't do it."

HP: And this was one of the first Centers of its kind?

IH: Yeah, I think the very first in the country. To my knowledge.

HP: So it kind of became the model then.

IH: Yes, that's right, and since [then], it's proliferated and they've been replicated. But yeah, it was the first that I know of in the country.

HP: And where would you get clients?

IH: Well, from all around, [but] mainly from the LA area. But therapists would refer their clients, people who heard about it, or family members who were worried about a family member or a loved one that was exhibiting some signs or threatening suicide. So from everywhere, doctors in the community, all kinds of sources.

HP: So there was definitely support for it.

IH: Oh, yes, definitely. Yeah. And it grew, I mean, it grew tremendously. It was just a very exciting place to be. And occasionally, we would lose someone. Occasionally, we would have a client that would suicide. And then there would be – the staff would meet, and there would be a lot of discussion around why it happened, how maybe we might have been more helpful. And also a lot of support for the therapist that was working with the client, of course.

HP: Right. Now what did the rest of the community mental health landscape look like at that time?

IH: I don't know much about the public mental health sector at that time, because [in] '63, I was still a student at Oregon, in the doctoral program. And the private sector, to my knowledge, basically was private psychiatrists primarily. I think the licensing law for psychologists didn't come in until '69, I think it was, because I was one of the first to actually get a license. But I think they actually had a certificate. [California required psychologists to be certified in 1959 and upgraded to licensure in 1969.]

So psychologists could, with that certificate, do some private practice. But really, the psychiatrist was like the top person and the "real" therapist. And the psychologists were fighting hard to get those rights, but basically I don't think at that point, [that] they really had the legal authority to diagnose and treat. And then of course, the social workers were also scrambling behind the psychologists.

But at that time, the psychiatrist was the one who treated, and then medicated the person; and the psychologist was primarily a researcher and a tester, [who gave] the Rorschach [inkblot test] and the TAT [Thematic Apperception Test, a picture interpretation exercise to reveal repressed aspects of the personality] and all the tests that were administered. And the social worker was more like the case manager, working with the family and the community. But they tended to work – like if they worked in psychotherapeutic groups, you'd have the psychiatrist, then *they* would hire the psychologists and social workers.

HP: So was it like a team approach?

IH: Well, not like it is today, because more today it's like everyone has kind of equal status as a role. But when it comes to working with clients, particularly in psychotherapy or counseling, everyone basically does the same thing. But the psychiatrist still has the role of being the one who assesses for medication and provides medication. The psychologists still do some testing, although much less, and of course, they're involved in research activity. And the social workers, at this point – primarily, most of the social workers and the Master's level people have moved into the MFT license – the Marriage and Family Therapist license. Psychologists have their own license, and then psychiatrists, of course, have theirs. But when it comes to these days, everybody is seen as kind of an equal team member. In most venues, there isn't that hierarchy or structure, and so everybody has a role to play, and plays a role. But when it comes to, like, assigning cases for psychotherapy, by and large, there's not much distinction made between the disciplines.

HP: Right. So when did that hierarchy start to flatten?

IH: Well, it's happened over the years, gradually, but of course, when licensure came in, which, I guess [was in] 1969, that's when I got my license. I was teaching at UCLA. I went from my post-doc fellowship, I then went to the faculty at UCLA, and that was '67, I think. So in '69, I was still there, and that's when the licensure law came in and I took the licensure test. And that then gave psychologists – they could then practice, be an independent practitioner. They could hang a shingle and see clients, and that went a long way. And of course, the psychiatric groups fought a lot of that, understandably. And then when the social workers pushed for their licensure, the psychologists fought that.

So I would imagine [that], probably in that 1970 to 1980 period, a lot was going on to really bring the disciplines into some level of equality. But I think now, when I took my post-doc, I did experience some of that, because that was at Mt. Zion, and the psychologists had real stature there and the social workers, and so it was already happening at that time.

HP: Now is Mt. Zion here in LA?

IH: No, Mt. Zion's up in San Francisco. [Mt. Zion Hospital on Divisadero Street is part of the UCSF Medical Center.]

HP: Oh, that's in San Francisco. OK.

IH: But I think that basically, now and since that time, the real issue has been, you know, how good are you at what you do? Not what's your license, [or] what's your background? [But] can you bring something to the table that is of quality?

HP: Yeah. And I'm curious also. Back then, what was the role of medication compared to the role medication plays now?

IH: Interesting. Well, of course, the basic medications back in those days were the phenothiazines [chlorpromazine and its neuroleptic relatives had been introduced in the 1950s for the treatment of schizophrenia and other forms of psychosis], which were much less specific than the medications that they have today, and much more like general tranquilizers. And they were seen as the panacea at that time, back in the mid-'60s. Now I remember, when I was in my doctoral program, they were still doing lobotomies [removal of the prefrontal lobe of the cerebral cortex], certainly not on the scale they were doing ten years before that, but in some cases [of] particularly severe depression or persons who were so depressed that they couldn't shake the depression. Maybe they were psychotically depressed or they were hallucinating and depressed.

I remember one case was a woman whose husband had died and she really just went into a severe depression and couldn't even get out of bed, and she hallucinated that her husband was there with her. At any rate, I remember that they performed a lobotomy on her. And in some cases – no one knew why – but it seemed to lift some of the depression, much like also shock therapy, which they don't do much of anymore, I don't believe. But again, in extreme cases, back in those days, they performed those procedures. They always seemed kind of inhumane to me, but I was convinced that in some cases, where depression was intractable and there was no other real obvious signs that anything positive was happening, that maybe it was worth trying.

HP: Right, right.

IH: And then the phenothiazines, of course, played a great role for a period of time. But again, that was the doctor prescribing the phenothiazines. And I think that it depends on the group [of patients] you're talking about. In those days, we talked about the psychoneurotic group.

HP: OK.

IH: And those were the group with the anxiety disorders, the obsessive-compulsive disorders, the hysterias, the conditions that were non-psychotic. And then you had the psychotic disorders, which involved either aberrations of thinking or perception or mood, so like the schizophrenias or the bipolar disorders, or extreme depression, extreme anxiety. The phenothiazines were more geared towards, obviously, the psychotic disorders. The others – there were some anti-depressants, some anti-anxiety drugs, that were coming in about that time and were primarily prescribed for the psychoneurotic group. Anxiety was the main feature of that group.

And at that time, the public sector also worked with that full range of clients. When I first came into the public sector, it was about 1974. And at that time, there was enough public funding to allow the clinicians to work with a full range of problems – married people, married couples having problems in their relationship, or folks that were having problems at work, and fairly mild situational adjustment problems; and then the psychoneurotic issues and the psychotic disorders. So the full range were really being treated at that time with the public monies. And when I first joined, we were even doing community organization work and community consultation.

HP: What kind of work was that? The community organization?

IH: Well, we would go into a community [where there was], particularly, let's say, an organization that wasn't as effective and efficient as it should be. We were doing organizational consultation.

HP: Oh, I see.

IH: So you had to help people organize maybe their management structure or maybe the type of people they were hiring or the way they were structuring the responsibilities, just trying to help the organization become more effective [and] more efficient in its mission. And so looking at [and] analyzing all aspects of it. Of course, that money's not available any more. Those were the old days.

But it really fell into the area of prevention. So our feeling was, if we could help the DCFS – the Department of Children [and Family] Services – be more effective, or we could help the hospital be more effective – that many times, they're the first line of defense. So if someone comes in with a minor problem and they were more able to deal with that – the problems – in an effective way, then perhaps the problems wouldn't develop to a more serious level.

HP: Right, so actually training is the first line of defense.

IH: Working with the staff. In addition to the organizational consultation, we would work with the staff, and [in] training staff of various organizations – like DPSS [Department of Public Social Services], the Social Services people.

HP: Right, yeah.

IH: And [in education]. We'd go to [the schools], work with the teachers and various staff at the school level, the school nurses, teachers, the vice principal, really trying to help to alert them to the signs of emerging mental illness in students so that maybe they could then help steer the person to more professional help, the idea being that would prevent or keep things from getting worse.

HP: And this was happening in the early ‘70s?

IH: Early ‘70s, right.

HP: So that’s shortly after deinstitutionalization [the movement to close the state mental hospitals and move the patients into community treatment].

IH: Yeah. I remember working on the SAR Board, School Attendance Review Board, and that was the same thing. Kids who were missing school would come in front of the Board, and I was a consultant to the Board. We would try to develop a plan that would be helpful for the family, and again it was a preventative kind of approach.

HP: Right. And this was within the public system you were doing this sort of consulting.

IH: Right, and that’s the interesting part about it. It’s very different than today.

HP: How is it today? Because I know that there’s an interest in this sort of collaboration.

IH: Well, there’s a lot of interest. But the problem is the dollars now – I don’t know if it’s bad or good, I’m not going to put a value on it – but, where we had a very broad view and a very broad range of clients, the funding has narrowed. The funding has been restricted and reduced so much that the focus has had to narrow down. So now, at this point in time in the public sector, we really only deal with the most severe and persistent mentally ill adults. Again, the schizophrenics, the bipolar [patients], severe anxieties, severe depressions, and with children, we only deal with the severely emotionally disturbed kids. So, in terms of the whole spectrum, we’re talking about the most serious end of the spectrum, in terms of mental and emotional problems.

And so that whole other area, the preventive area, none of that is done today, because there’s no funding for it. And there’s no funding now for working with people who don’t have severe mental illness, in the public sector, the married couples or situational problems or the old what we called [the] psychoneurotic group. You have to have an Axis I diagnosis, if you’re an adult, to get treatment [in the public sector] today.

HP: And is that even the case with the Prevention and Early Intervention program under the MHSA [Mental Health Services Act of 2005]?

IH: Well, that’s just coming in now. We don’t know yet what’s going to happen there. And that money was deliberately developed to try to restore some funding for prevention and primary intervention. We’ll see if it’s effective or not.

HP: It hasn’t come down yet?

IH: No, it’s still brewing. Basically, what’s happened is we’ve identified – and I haven’t been a big part of that process – but the [LA County] Department [of Mental Health], working with stakeholders, has identified a number of types of program that they think would be desirable, and then those programs are generic. They’re going to be put out to bid at some point, and providers like ours and the private contract providers and DMH providers will all bid on those programs.

HP: Right, right. Now, you say that the pool of money has kind of narrowed. When did that happen? Were there any momentous times, or was it just a gradual chipping away?

IH: Well, it happened somewhat gradually, but I would have to say probably – I came here in ’81, to this [San Fernando Valley Community Mental Health] Center. And I’d say gradually, over the ’81 to ’87 [period], around in there, that it became clear that the dollars were really being re-prioritized. The dollars were shrinking to begin with, and then the focus was really shifting to the severe, persistent mentally ill. NAMI had a lot to do with that – the National Alliance for Mental Illness – understandably, because those are the parents of, and relatives of, severely mentally ill family members.

HP: Of the severe Axis I.

IH: Right, and they were saying, we just simply don’t even have enough money to treat this group. And this is a group that was filling the hospital beds, this is a group that was causing enormous problems in the community and at home, for families that were trying to maintain these folks at home, and of course, it was very disruptive. They [NAMI] had a good kind of political presence and some real strength and they were able to really begin to shift those dollars through the State Department of Mental Health, and the County Departments, so that the focus really became – As the money shrank, the focus became more on the psychiatric hospitalization folks, the people that were using the most costly types of service.

And of course, those were the severely mentally ill. The revolving door at that time was that people would come in, and they’d be in the hospital for a few days or longer, they’d get their medication, they’d stabilize somewhat, then they’d be out the front door. Generally speaking, they’d go out with some medication, and the usual picture was they’d go back to their board and care [home]. There was no continuity; there was no follow-through or after-care. They’d go back to their board and care with their medication and they’d stop taking the medication, and they’d relapse, and they’d go back to the hospital, so it was a real revolving door syndrome.

HP: Right, right.

IH: The question was “How can we stop that?” And at a cost – the majority of the money was going to that group.

HP: It was hospitalization, so it was extremely costly.

IH: The hospital would have taken all the money, had we not been able to interrupt that whole process.

HP: So what was the way to interrupt that process?

IH: The way to interrupt the process was to develop a system, and over time, it’s really involved developing not just the standards – [for] the psychotherapy and the medication, the case management – but building in real community supports, so that people don’t just leave the hospital and go back and decompensate. And the three levels of support that have evolved in this model are [first] housing –

In the old days, the doctor used to analyze and evaluate the patient and they used to say, "This is what you need to do. You need to get rid of those hallucinations, you need to get a brighter mood going and lose that depression;" and no one ever thought to ask the patient what they wanted. And even the word "patient" – the evolution, for me, has been "patient" 30 years ago, to "client," which has not the medical connotation, and today it's "consumer." And you can see that those [terms] really connote very different things.

HP: Well, what's the difference in connotation between "consumer" and "client"?

IH: Well, a client is somebody that you're serving. A client comes to the expert, like a client with a lawyer. The lawyer analyzes everything and then dispenses expert knowledge. A consumer is kind of someone who is kind of using the services of the system. And [the term] has less of a connotation of one being superior to the other. It's like the consumer is using our services. So, in a sense, we're serving the consumer, and what that one change in label [did was it] brought with it a sense of equality for the client. So what happened, as we were moving in that direction – and this is called the social rehabilitation model – again, it went from the clinical model, where the concept was "let's cure, we want to cure these folks" –

HP: Right.

IH: To saying, "No, these folks have a very deep and profound psychobiological illness, and it's unlikely that folks with severe mental illness are ever going to be *cured*. But they have levels of independence and functioning that they can attain – their highest level of functioning that they can attain." So what it brought about was a perception of the client as a partner, rather than someone to be administered to, someone to be negotiated with. And so the whole idea of the client being empowered, the client having a big say in the treatment, and particularly a big say in the treatment plan, was really critical. So when we sit down now with the consumer, or the consumer and family, instead of saying, "This is what you need to do," the professionals are now saying, "Well, what would you like? What would enhance the quality of your life? What would make it better for you?"

HP: And learning how to live with the mental illness, instead of trying to just cure it, when it's something that may be impossible to cure.

IH: For many of them. What was surprising about that was that when you ask people those questions, you get three basic answers, which are not dissimilar to the way any of us would answer.

And the three things that you hear are, "I want a decent place to live." Well, mental health centers never thought about that before. And the second thing is, "I want something meaningful to do – work, or something." And the third one is, "I want meaningful friends and social interaction." Well, before, basically therapy was like the one hour [or the] fifty-minute hour. You'd come in once a week or once every two weeks or whatever, and it's all done in the office.

Well, [at] a Center like ours now, we house over 400 people a night. We have our own housing. We've developed – either we own [the housing site] or we've developed it jointly with other agencies or we master-lease buildings and then lease to clients. So housing has become a big area for us. And we have programs that are devoted to simply working with the client to get them prepared to live independently in their own apartment. So we provide over almost 100 Section 8 certificates [rental vouchers through HUD] a year, so clients get their own apartments.

HP: So they get their independence.

IH: Right, and then we have one of the largest vocational rehabilitation programs in the County, through the State Department of Rehabilitation. So we're working with our clients to help them find something meaningful to do. Now for some of them, it means going back to college. For some of them, it means really getting to a high level academically. Others, it means finding something that they find worthwhile and meaningful, so that they have that in their lives.

And then we've developed a program called our Clubhouse, or our Wellness Center, which is like a large social center, and as long as you have an Axis I diagnosis, you're welcome. And people can drop in and do nothing – just sit there and watch TV or shoot pool or whatever, or they can get involved in hundreds of activities. We've got a band –

HP: Oh, cool.

IH: – and they do dances. We have movie nights. We have a mini-college, so they can sign up for seminars and classes on a whole range of issues – and not always related to mental health, but just how to get along with your neighbor or how to cook a gourmet meal.

HP: So it sounds like the shift has kind of gone from trying to cure the mental illness to trying to improve the quality of life for the mentally ill.

IH: Exactly. Exactly.

II. Shift in Mental Health Care Administration: The Social Recovery Model and "Flexible Monies" for Integrated Services Agencies; Peer Advocacy Programs

HP: And when did – I mean, what you're talking about sounds very much like it would be the Recovery Model.

IH: That's right.

HP: And when did this shift start to take place?

IH: It was in the late '80s. I remember going to a meeting where they were presenting on the Social Recovery Model. And the shifting focus on the severe and persistent mentally ill and the Social Recovery Model all kind of came in about the same time – late '80s, maybe early '90s. Because, once you focus on that group, then you can see that the fifty-minute therapy hour is not designed to be helpful to the severely and persistently mentally ill.

HP: And it didn't really improve their lives outside of the clinic.

IH: No. No. And whereas with people [who were] more the psychoneurotic folks or the family therapy or conjoint therapy folks [who] might do well with that kind of counseling, the severely and persistently mentally ill generally did not. And so it had to be a new model that made sense, and this was the model that evolved – along with the shrinking dollars, and then a focus on that group – this was the model that made the most sense. And there were a lot of studies done on how effective that model was.

HP: Studies showing that it improved overall quality of life.

IH: Overall quality of life, exactly. And that people then used much less of the emergency rooms, much less of the hospitalizations, less drug use, less getting involved with law enforcement. There were a whole host of indicators to show that once people were successfully plugged in socially and had a place to stay, that these were really the keys.

HP: Now, before these studies came out, or as they were coming out, I guess the question would be, was there some cynicism about using mental health dollars not directly for what would be classified as traditional mental health services?

IH: Oh, absolutely. Yeah, definitely.

HP: What sort of challenges did you face in that respect?

IH: Well, I remember we got – The first real money that came out to support this model was the ISA money that came out [the Integrated Services Agency program, created by California Assembly Bill 3777, the Adult System of Care Act in 1988]

HP: ISA?

IH: Coming through the [Los Angeles County] Department of Mental Health [DMH]. This was the first time the Department really put money out, with the hope that, by providing more flexible money, that the whole system could be impacted, and that in the long run, you would save money. Up to that time, basically everything was done on a fee-for-service basis, so a client comes in, you see him for an hour, bill for an hour.

HP: It had to be MediCal billable.

IH: It had to be primarily MediCal billable. Not always, because there was some LPS money [the Lanterman-Petris-Short Act of 1968 stipulated how community mental health services in California would be funded] and there was some, what they called Short-Doyle money [the Short-Doyle Act of 1957 created the funding structure for community-based mental health in California], which was the non-MediCal side of it. But basically, you just billed.

There was no concept that, “Well, let’s put some additional money in and make it flexible. Let’s say sometimes you don’t have to bill for every dollar. Let’s just say you can spend some money on maybe helping a person find a place to spend the night. Let’s say you could buy them a meal, or maybe, let’s say if they needed transportation, you could buy them a bicycle if you needed to.” So you could do some things in people’s lives that would make it better, but you wouldn’t have an hour of therapy to show for it. So you would basically just have to have flexible funding. And so this concept of the ISA –

HP: And was this like [the] early ‘90’s?

IH: I think so, yeah. And it came through the Department. Areta Crowell was the [LAC-DMH] Director at the time, and basically there were a number of programs and Centers selected, including ours. And it was a capitated rate-funding. [This was the PARTNERS program; with the acronym “People Achieving Rehabilitation Together Need Empowering Respectful Support.”] So at that time, the Department selected clients that had been costing the system roughly about 40 to 45,000 [dollars] a year. These were people that were in and out of the hospital constantly.

HP: Individuals.

IH: Right. Severely mentally ill. But hospitalization’s very expensive, so these were people that were in and out of the hospital, in and out of the emergency room. And we – the agencies – contracted with the Department, using this model – [the] psycho-social model [or] recovery model – for about, I think, our [capitation] rate was about 11 or 12,000 [dollars per year per person].

HP: OK.

IH: So we were taking a big risk. The [Community Mental Health] Centers took on a huge risk with this, because the deal was that we would have to pay for all of the person’s care out of that pot of money. So, if they went to a hospital, the hospital would bill us for it. So, where the system had been paying 45,000 a year, we only had 11,000.

HP: So you had to make sure that by getting them [into] the housing, that would prevent the hospitalization.

IH: Whatever we were doing, we had to [do it by] using this model. And it was more than that. This was the point at which we developed the outreach teams. The only way that we could actually cut those costs was to make sure that people were not using high-cost services when they didn’t need it. So we had to develop a system where everyone was notified. Like if we had 110 clients, we had to know where those people were every day. So our staff were in constant contact with those folks, and if it turned out that one was in a hospital, our staff would be in the hospital. We would go there the same day, or the next morning, just to make sure, to see – does the person really need to be here, or can we move them to a less restrictive environment? And that was the only way we could cost save.

So there was a tremendous lot of anxiety among myself and other Directors because, theoretically, we could have gone bankrupt by paying these bills.

HP: And also I’m sure the staffing issues had to be very different for these programs.

IH: Right. Exactly. They were much heavier. But it was really the flexible outreach. So it was no longer waiting for the client to come to the hospital or to the Center, it was our staff being out in the emergency rooms, in the hospitals, wherever the client was, making sure – or if they were having a big dispute with a landlord, our staff would be out there, working to negotiate that and to keep them in their apartment and keep things as quiet as possible.

And I remember, [the] first day or first week when we had this program, I was pretty nervous; and my [Adult Programs] Director called me and said one of the clients [was planning to] check herself into a hospital. And we had a feeling that a number of clients were basically just checking themselves in, when they didn't really need to be in a hospital, but this was a way to get some social interaction and a way to –

HP: Get some good meals.

IH: – be taken care of. And so she said she got a call from a client saying she was going to check herself in. And she said, "Well, I'm going to take her to lunch and talk to her about it." So she did and they went out, and I remember she bought her a croissant sandwich, and they talked. And now see, that was something that we could never have done before with the money. This was flexible money. Buy a sandwich. And by the end of the lunch – they chatted. First of all, the client was astonished that a staff member would actually go to lunch with her, because again it was that difference between the doctor being up here and the patient here [motions relative levels], or sitting across the table, talking to each other like people.

HP: Yeah, and doing it outside of a clinical setting.

IH: So afterwards, the client said, "Oh, I guess I'll go on the outing with the other clients today." So the whole issue of the hospital disappeared. It was that they had a nice talk.

HP: So a six dollar sandwich versus a $3,000 hospital stay.

IH: The six dollar sandwich stopped the hospitalization. And when I heard that story, I immediately knew, "OK, well that's going to work."

HP: That works.

IH: And then there was another day, [when] there was a client [who] checked himself in. And in the morning, our staff were there at the hospital. "OK, we gotta get you out of here." [he laughs] And so we really brought the cost down, and we actually did it for 10, $11,000 a year – on average.

HP: And how many clients did you have in this program?

IH: We had about 110, 120.

HP: OK, wow. Out of how many clients that your agency was serving at the time?

IH: I'd say – of course, we've grown over time, but that was probably about ten percent of our client load, fifteen percent, maybe.

HP: Interesting.

IH: But it proved to all of us that that model worked, and that you could keep people in the community and that if you give people a sense of responsibility, they'll take it.

HP: Now was this the idea of the agency's to try this new model, or was this –

IH: No, actually it was a model that had been developed back East [based on the work of Courtenay Harding in Vermont]. You'll hear more about it from other people you talk to.

HP: Like the ACT [Assertive Community Treatment] program model, or-

IH: Well, the ACT program came a little [later] - yeah, they're similar. The ACT program was a further embellishment of the sort of community treatment teams, but it was spawned by the outreach teams. I think the ISA was the first model that was really adopted here and the ACT, then, kind of grew out of that.

HP: Right, and then from ACT to AB2034 [in 2000, which provided for outreach and comprehensive services for mentally ill who were homeless or at risk of becoming homeless] to FSP [Full Service Partnership program, part of the 2005 Mental Health Services Act].

IH: Yeah, exactly, so you can see the trend. But we became convinced that this was the model that made the most sense. And of course, since then, in our Center, we've incorporated our consumers into every level. So all of our programs have a consumer representative that is available to the consumers in the program to talk about anything, any concerns they have, and then they meet with the managers of the programs to discuss concerns. And then they meet as a group every month, the Consumer [Advisory Committee], and if there are any problems or concerns, they relay [them] to myself or the Board of Directors.

So we do as much as we possibly can, just to erase that line between staff and consumers, and everybody here is a member, working hard to make things better. So we've really empowered the consumers to get involved and help us help other people. So a lot of our consumers now are in our Peer Counseling program. They get a certificate.

HP: To become Peer Advocates?

IH: Peer Advocates, and then Peer Counselors, and then they go on to train other people, or to take jobs in other organizations, and so that's been a huge change in the way clients have been perceived over the years.

HP: And that's a change like within the last 10 years, pretty much?

IH: Yeah. It's very exciting. It really creates a kind of an atmosphere of excitement and involvement and family; it has kind of a family feeling to it. Any consumer can walk through my door and chat with me if they want to.

And we've been able – at a lot of our events, we have consumers who have really evolved to a very high level now, and they make presentations to our Board, to our community, the members of the community, at our functions where we have community representation, our stakeholders. Our clients are out there; basically they're the face of the Center now. And they are as good at presenting, and as fluent at presenting, as any of our professional staff. And, of course, they have much more credibility.

HP: Because they've been there.

IH: They've been there.

HP: They're speaking from experience.

IH: Exactly.

III. Educational Background: Early Involvement in Community Mental Health; Cal Tech; Arcadia and San Gabriel Valley; Mental Health Center at La Puente; Public v. Private Sector

HP: Yeah. Great. So well, we've jumped ahead a lot. If we could go back a little bit, tell me about how you made the jump from – you were teaching at UCLA. How did you come to become involved in mental health and community mental health?

IH: Let me think about that for a second. Well, I finished up the post-doc, and then went to UCLA. I really thought I wanted to teach, be an academic psychologist and train, so when I went to UCLA, it was as an assistant professor. And basically, I was doing some research; but I was also supervising the graduate students. They had an outpatient clinic, and I was supervising their clinical work. And of course, in big universities, it's publish or perish.

And I found it was just like being in graduate school. So I loved UCLA – still root for the Bruins – but I thought it was kind of infantilizing, because the young, new professors did a lot of the work and were being judged by the older crop. Anyway, so I stayed there only for two years, and I thought, "Well, this is not quite right for me."

So then the question was what to do beyond that? And I liked the academic environment. So a job [opened up] at Cal Tech, [as an] Institute Psychologist. Cal Tech, as you probably know, is one of the premier science schools, but they had no psychologists. They didn't teach psychology. Well, they had [had] one. He had passed away, and so they were looking to replace him, and he worked in the Student Health Center.

HP: Like the counseling center.

IH: Right. Well, it was actually a Health Center, but it has counseling rooms, as part of it. And so it was a great job, and it's a very prestigious school. I got the job and went there and essentially did, gosh, seven, eight hours of counseling a day for a year or two, and that was really bone-crushing. But I eventually got them to hire another psychologist. Then we set up an internship program, so I brought some interns in. And then I got them to hire an academic psychologist. I taught a couple of classes, and then actually, we hired my old thesis advisor as an academic psychologist and a professor, in the school.

And I, because of the post-doc and because of my clinical work, I was always fascinated by clinical activity – but at some point, I recognized that I had a real penchant for organization. So, when I was there, I kind of noticed that there were a lot of things – a lot of processes, procedures, and policies and internal activity at the Center that I would have changed. I kind of set about just automatically redoing things. So before long – that's what happens when you volunteer – I was made the Director of the Health Center. So that was my first real administrative job, with them.

Turns out, later I found out – I'm digressing – My parents had divorced when I was young and I was born in Scotland, so [when] we came over here, I didn't know much about my family over there. Later I found out my grandfather was the second-in-command of the Glasgow Police Department and put in all the retirement plans, all their administrative policies and procedures. And my uncle was president of a large company over there, and he had a PhD in chemical engineering, but had become president of the company.

HP: Runs in the family.

IH: So that's kind of what I had done too, basically, at Cal Tech and then eventually, here. Of course, then I really got interested in administration, took a lot of academic preparation to try to get that balance. But Cal Tech was interesting, it was fun, it was a way of working with students, and the main contribution I think I made there was that I loosened the place up a bit.

HP: What do you mean?

IH: Well, it was an all-male school, to begin with, and these were all kids that were in the top one percent of their classes.

HP: Very high achieving.

IH: And when they brought them together, they graded them on the curve, and it was a tremendous workload. So [there] was a lot of depression and a lot of suicidal ideation.

[So I] developed an Encounter Group program. You wouldn't remember; you're too young. But [there] was a movement called the Encounter Groups, or Human Growth Movements. It was a whole series [of programs based on the work of humanistic psychologists Abraham] Maslow [1908-70] and Carl Rogers [1902-87] and [the] Esalen [Institute, a humanist retreat center founded in Big Sur, California, in 1962]. But the whole theory was that you bring people together and it was kind of low-level group therapy. You bring them together for a weekend and you just kind of loosen them up to talk about themselves, and what happens is there's a real bonding that takes place. So I trained a number of people to lead those groups and then also trained them to watch for signs [of depression and suicidal thoughts].

HP: So a meeting of the clinical and the administrative, in some respects.

IH: Yeah. So I felt really good about that. And also I started a student library, which I was very proud of. I had books on gay issues. There were a lot of gays on campus, but no one recognized it.

HP: No one was out.

IH: No one acknowledged it. It was total taboo. So by opening that up, and I had a gay discussion group night and gay and lesbian discussion group night and sexual counseling, [and] abortion counseling. [He laughs] I opened up a lot of stuff.

HP: A whole bunch of cans of worms there.

IH: A lot of stuff. So, at any rate, finally I decided that that was not really the place for me.

It’s a great school, but it really wanted to focus on the [top achievers], where my concern was the mental health of all the kids.

HP: Of everyone.

IH: Finally, I just said, “Well, I need to go somewhere else.” But I felt good about what I left behind. So at that point I moved on to the County, and worked for the LA County Mental Health Department.

HP: In one of the directly-operated clinics?

IH: Yeah, the Arcadia clinic. I was the senior psychologist in [the] San Gabriel Valley. And I stayed there [from] ’74 through ’79. So I was there for five years, and that was really good. I was clearly involved with – that was my first taste of public sector activity. And everything I told you about the consultation with the agencies and consultation with communities and working with a broad range of clients – that took place back in those days. And then, of course, I supervised staff also. I was basically Assistant Director for the Region.

HP: OK, for the Service Area?

IH: Well, we called them Regions then, the San Gabriel Valley Region. But it was a Service Area, the whole Valley. John Wells was the psychiatrist who was the Director and I was kind of his right-hand person.

And then in ’79, the County got a large community mental health center grant for a new Mental Health Center in La Puente. So they were looking for a Director for that. I think they had a Director beforehand [and] he left. But it was one of the first grants; we had nothing. Basically, there was a mud puddle where the building was supposed to be. So I was hired as the Director, and basically, we designed the building; we hired every single [employee]; we had about 85 staff or so, mostly bilingual [and] bicultural because it was a Latino area. And I was very proud of that program. We put it together. But it was a tremendous learning process for me from the administrative side, because I had to learn every single aspect of what it takes to run a mental health center and really oversee it, structure it [and] design it.

HP: Yeah, everything from the utilities to –

IH: From the building, everything. Telecommunications. Every aspect of it. And that Center’s still going. I think it’s called La Puente Valley Mental Health Center.

HP: So when this opened, was this a directly operated [clinic]?

IH: It was directly operated, yes. And I was a District Chief at that point.

HP: OK.

IH: They had developed that District Chief classification, so I was a District Chief. And I was there for two years. And that was the showcase for DMH. Dick Elpers [J.R. Elpers, DMH Director 1978-82] was the Director at the time. Any time any dignitaries came in to the County to see programs, they always brought them to our program because it was a new building, and good staff, and it was a good process. But I decided to move on. Actually, '81 was when I decided to leave the County. I thought it just felt too restrictive.

HP: What were some of the things you had wanted to do at that point that you weren't able to?

IH: [Well, it could take months or years, for example, to get all the approvals to get new locks put in.] The private sector, here – if I wanted locks on the doors, I'd get it tomorrow. So that's a big difference in the system and also – For the most part, the directly-operated programs are the clinic model type program. And they're gradually changing now, and because the MHSA dollars have become so much more important, the directly operated programs are having to develop Wellness Centers and they're having to develop FSP [Full Services Partnerships] full-service programs and FCCS [Field Capable Clinical Services] programs and all the different categories of program. But the private sector has really taken the lead in all that. And almost all the children's programs are in the private sector, so if you want to develop an innovative children's program, it's primarily through the private agencies.

HP: And is it generally because of – this phenomenon you describe with the locks also applying to – if you want to start a new program, you have to approve it through so many levels of bureaucracy?

IH: Right. In the private sector, basically, we can move faster.

So both sides of the system have positives. The departmental side is stable, constant, and immobile. And there's a value to that. They tend to focus more on the safety net aspects of the system – psychiatric emergency team-type activity and hospital beds. And those are needed, and those are stable, and those don't fluctuate. But the private sector is much more mobile. So if we want to develop new programs, we can get a new program up and running in a month.

HP: Well, aren't you restricted because you need to get the County to fund it, though?

IH: Well, yeah, the County funds it. But let's say – a good example would be, let's say, if the County wanted to start a Wellness Center, they'd have to search for a building, which means they'd have to go through their Department of Buildings and Procurement, and it would probably take a long time. I can go out in the real estate market and find a building to lease tomorrow and sign a lease in a week. So, I mean, that's the difference. Once I have a contract that says I have a program and there's facility money, there's a line-item, a budget item, for facilities, then I can take that money and go out and I can find a building that fits our needs. I don't have to go through layers of bureaucracy and have different departments sign off on it.

HP: Exactly. So I guess that translates also to these innovative clinical practices you were talking about.

IH: Right. Exactly. Yeah.

HP: Does that level of bureaucracy infiltrate clinical practice as well?

IH: Well, I think not so much any more. Like I say, it's changing. In the old days, yes. It was basically [true that] you were locked into the system.

But with the new MHSA dollars, you can only spend it on a few categories of programs. You have to be an FSP or you have to be an FCCS or you have to be a Wellness Center. Basically, those are the categories of programs that you can spend it on. And those are all outreach-based, they're all innovative, they're all flexible. They're not the old fee-for-service, where the client comes in and you see him and you bill an hour for mental health services or you bill 30 minutes for crisis or 25 minutes for case management. These are programs where they're more "you-oriented" and the funding, like for FSP, means do whatever needs to be done.

So you need to get out into the community, you need to go talk to the person's landlord, you need to go talk to their family members, you need to talk to their doctor. You need to provide grocery money so the family can stay together, or rent money. It's a totally different structure. And now the directly-operated programs, because if they didn't get some of the MHSA money, basically, they'd be closing because their money is shrinking too. I mean, as you know, most of our money comes through realignment money [realignment is the revamped plan for funding mental health care in California beginning at the local level in the early 1990s], and the realignment money is made up of vehicle license fees and income tax, or sales tax.

HP: And those have been going through the floor.

IH: Well, yeah. I mean, no one's buying cars and no one's buying a lot of stuff, so that money is really shrinking. And the only real pot of money around now is the MHSA dollars. So the directly-operated programs are getting a good share of that money, but that means they have to be flexible; it means they have to develop these programs.

HP: And while the flexibility is good, is there some value lost in losing more of the traditional clinical model?

IH: Well, there definitely is, not so much a losing of the traditional clinical [model], what's lost is volume because the FSP, it's one to –

HP: It's like fifteen to one [caseload] I think.

IH: Fifteen [clients] to one [provider]. And right now our outpatient clinicians have a caseload of 18, so if we shift from an outpatient [base] funded by the Short-Doyle dollars to FSP, we're losing probably four clients [per provider] out there that we can't see anymore.

HP: Yeah, so the system can serve fewer people, but it serves them better.

IH: It serves them with a richer program, but not everybody needs a richer program. So is it better to serve a lot of people with a reasonable, helpful level, or is it better to serve a few with a real rich program and not serve these other folks at all?

HP: Right, what are your thoughts on that?

IH: Well, that's the dilemma. I frankly think that it's too restrictive now, that we should loosen up the definition for the MHSA. We should provide much more flexible funding.

Some people we give them whatever it takes, but for other people we give them what they need, which may be much less.

HP: Which may just be coming to the clinic and seeing a psychiatrist.

IH: Right, it may be meds only. It may be a med clinic, it may be meds and a therapist once a month, or it may be meds and a case manager, whatever they need. And we don't have that flexibility. If they're in FSP, then [it has to be] fifteen to one, instead of taking that pot of money and giving the providers the flexibility to develop plans that can be at variable levels. We talk about that: Tier 1, Tier 2, or three different levels of clients. It's in the works, but right now it's still too restrictive.

HP: Right, is that something that might come down the road with the Integrative Plan [under the Mental Health Services Act]?

IH: I think it's going to have to come. Yeah, the Integrative Plan is really going to be the key. It's going to have to come down the road, because otherwise we're going to lose – If all the money is converted to MHSA dollars, we probably won't be able to serve many of the clients we're seeing now.

HP: Right. I guess the other side of that too is if things have to be sort of in this new model, the clients who are just meds only, do they get lost in the shuffle then?

IH: Well, there are several people that get lost in the shuffle. One is indigent clients. Almost all the indigent clients get lost because the first priority will be to see the most people we can and if you have a Short-Doyle dollar to spend, if you spend it on an indigent client, then you have spent your dollar. If you spend it on a MediCal client, then you've got two dollars [because MediCal matches MHSA dollars spent on eligible clients]. So you can see twice as many people. So you can see right away that, with shrinking dollars, you want to see all MediCal, which means that the indigent dollars that are left are being very, very sparingly used. So that's the first one.

And meds only is not a good model in my mind. Meds only is not enough. I mean, the whole idea of the models we've been talking about, the Recovery Model, is that you have to have supports built in. So if all you're going to do is offer medication – someone walks in every month and gets their medication, they don't get anything else, your housing, your social centers, your case managers. I mean, not too many people are going to be able to make it on that.

IV. Evolution of San Fernando Valley Mental Health Center; Evolution of Mental Health Services Act; Financial Issues in Mental Health Care

HP: Right, right. OK, interesting. So tell me a little bit about what this center [San Fernando Valley Mental Health Center] was like when you first came and how it's evolved?

IH: Oh, there have been tremendous changes here.

[Break]

HP: All right, we're back. So tell me about how this agency has evolved? So you came here in '81. What's changed?

IH: Well, this Center was developed through a Mental Health Centers grant from the Federal Government. Back in '66, I think it was, the Federal Mental Health Centers law, Public Law [88-164], was passed and it allowed the Federal Government to give grants directly to community groups bypassing the State and the County [this was the Community Mental Health Centers Construction Act of 1963]. And so this initial grant was for about 2.5 million dollars.

The concept was that the Centers would offer 15 services. So it was a full range – basically the ones I mentioned before, all the way from community consultation, community organization, working with the walking wounded, the psychoneurotic groups and situational adjustment groups, and the psychotic. So there was a full range of services required. The grant was given actually to five different agencies because none of the agencies offered all 15 services, but together they did. So they formed a consortium and they got the grant. And the Board of Directors was made up of members of those five agencies. And then when I came, that model was not working because basically this Center was beginning to develop its own programs and many of them were in competition with the funding –

HP: With the other programs within the agency?

IH: The ones that founded the agency and so there was a big tug-of-war going on. So when I came here, it was after I was at La Puente, and I had learned the ropes at La Puente, from designing the building on up.

The Center here was in bad financial shape; in fact it was three months away from being closed by the Feds. But anyway, it looked like a challenge. I thought I was only going to stay for a year maybe. I was actually thinking of going into financial planning. I had gotten all my licenses in that area and I was going to do half time private practice and half time financial planning.

But then I got caught up in the Center. There were so many interesting aspects to it. And I pulled together a really good team. I got some people from my previous [job at] La Puente. I really got lucky with the employment department. I found a comptroller through EDD [Employment Development Department], which is unbelievable. I mean, he was a great, very, very, very talented guy. Anyway, we pulled together a good team and we just really started. The Center owed a lot of money to people and we were able to kind of just get some allowances on that from various governmental entities. Anyway, we corrected all the problems and then we set about developing the Center, growing it. So that was in '81. We were 2.5 million [dollars budget]. Today we're about 37 million a year.

HP: Wow.

IH: So it's a big, big jump.

HP: Is it mostly County contracts?

IH: Almost all government contracts, right. We do some fundraising, but nothing – that's dwarfed by our governmental [funding]. And of course all the new programs that have developed over the years, we've gotten really good at developing grants and proposals.

But also we deliver a quality product. We really pride ourselves in the work that we do and the programs we have and almost all of them have been recognized as top quality programs.

HP: Are there any that stick out in particular?

IH: Any programs? Well, we have a lot of them [he laughs]. We have a program called Cornerstone which is for the homeless mentally ill and it's a clustering of programs all the way from outreach staff [that] will go out and search for homeless mentally ill people on the street. It's a drop-in center, it has showers and lockers and we provide food, serve three meals a day.

HP: Wow.

IH: It's got a recreational area; we provide them with of course all the basic life support systems. Then we help find the person a place to live and then continue them in the Center. So it's our homeless housing continuum. We take people right off the street.

Our latest program we just got out is called Street to Home, where our staff go out and we find the really resistant people, the ones that have been resistant to coming in off the street and going into a house, and our staff work with them specifically to move them immediately into housing. It's an experimental program, but it's designed after one that was implemented in Times Square in New York and it was very successful in getting these really chronic resistant folks off the street. They're folks that have tri-morbid conditions; they're mentally ill, they have substance abuse and they have medical problems. And the findings are that if we don't get them off the street, they will probably die within six months. So it's a real challenge and our staff has been really effective in getting a lot of these folks. We have housing available, we move them right in. Usually we don't do that with our homeless folks. Usually there's a time when they're in a shelter and we're working with them to give them the basic skills to get back into housing.

HP: In order to maintain a home once they have one.

IH: Right, because otherwise if you're been on the street for three or four years, you lose those skills. So it calls for a lot more monitoring, but that whole cluster of programs [is in the] Corner Stone Program. We have our health component, we've got the drop-in center, the food center, we've got our psychiatric staff for medication, we've got a vocational aspect to it. We try to provide WRAP [Wellness Recovery Action Plan] services around each person and move them back into the community. We do our big Wraparound Program – that's another one for children. That has worked out very well.

Our Wellness Center, I've talked a little bit about that, but that's now paired with a client-run center and they're in contiguous buildings. The client-run center is totally run by clients, by consumers, and then [at] the Wellness Center, the consumers have a large voice on what goes on there, too.

HP: But there's still clinical staff, right?

IH: Still clinical staff [are] available to provide medication and some of the mental health services, but a lot of the social programming is done by the clients there.

HP: It has a major client-run component.

IH: Right, and I've been very proud of that program because it just shows you that if you give people respect and dignity and expect them to rise to the occasion, they do, and our consumers have consistently done that. And yet they're not really prepared to go out into the world and deal with all the stresses and strains out there. But they can really function well in that kind of family unit where they provide each other with support and closeness.

HP: Right, right. OK, so one thing I'm curious about is tell me a little bit about how you saw the evolution of the MHSA, what you expected from it and what its strengths have been, what its shortcomings have been.

IH: Well, it was born with great promise. Do you know which group developed and spawned the MHSA?

HP: No.

IH: You see, most people don't. It was done very specifically by the California Council of Community Mental Health Agencies [CCCMHA], which is a trade association for all the non-profit mental health providers in California, and we're one of the founding members of that group. We meet regularly, we have an executive director in Sacramento [Rusty Selix] and he does a lot of lobbying work, he's a very effective lobbyist with the California legislature. But that actual legislation was written by that California Council, nobody else.

HP: What prompted it?

IH: Well, we were seeing shrinking dollars coming in, but that wasn't really the – this is before the [2008] recession. The real impetus was that we had a system that had a lot of gaps in it. The basic system was in place and it was being funded by realignment funding. But there were a lot of groups that were not being served and there were a lot of gaps, so that we didn't have the flexible funding that we needed to really reach out and provide adequate services. And [MHSA] was really a brainchild of Rusty Selix, the executive director of that organization [California Council of Community Mental Health Agencies] and Darrell Steinberg, who is now the President pro Tem [of the California State Senate, from 2008], but at that time he was in the [State] Assembly [1998-2004]. And Darrell got interested in mental illness because everyday, when he went to work, he'd have to step over the homeless mentally ill people in the street. So he said, "This is wrong." He developed the AB 2034 [legislation]; that was his baby, with Rusty. So they had before worked together on developing that program.

And then they started thinking, "Well, how about an initiative [on the ballot] where we could really generate some dollars for mental health?" And we saw from all the surveys that mental health had high priority and that people were very sympathetic, concerned about the mental health system, and had very open attitudes towards providing more funds. So he really came up with the idea of a millionaires' tax, this is Rusty and probably Darrell too, and presented it to our group. [The MHSA is funded by a 1% tax surcharge on California incomes above one million dollars] And we were all very skeptical about it, you know, would the voters really vote it in? And what kind of opposition would there be to it? But I remember sitting around the table, about ten of us, and we were actually working with Rusty, writing a lot of the language in that bill. There was nobody else in the room, it was only the [community] providers like ourselves; and I'm emphasizing that for a reason.

And once it was written, of course, then we did some polling and surveys and it looked like there was some support for a millionaires' tax to finance some of the mental health programs. But it was meant as an overlay on the system, not to replace anything. So there was a very specific language in there that there would be no superseding. Any money that was currently in the system had to stay in the system.

HP: No supplantation.

IH: No supplantation at all. And the money was meant as an overlay and to fill in the gaps and really give us for once an adequate system.

HP: And what gaps were you thinking of in particular?

IH: Well, it was mainly the kind of gaps that were filled by the FSPs and the FCCS. More of the outreach and flexible dollars, flexible spending, so that we're not contained to these little tight niches.

HP: Billable services.

IH: Federal services, right. So basically the language was developed. [And much of the funding for the campaign was contributed by CCCMHA and the community agencies.

HP: Right. And I suppose from the investment was the belief that, when it passed, this would lead to services that you would be able to provide?

IH: Right, more services; and that a lot of the money would come back to the agencies that we would grow and develop. And so, as the campaign went on and it became clear that maybe we were going to win, then some other people did step up.

There was a whole myriad of issues. I don't think it was well understood at the moment. But my point is that it was pushed by the non-profit providers. They haven't gotten nearly enough credit for that, because they were the total driving force. Eventually towards the end, other people and organizations came in with some money, but that was way down the line.

Then when it went through, it was filled with all kinds of promises. It was going to be great. Well, in the first two years, no money trickled out.

HP: It was passed in '04 and no money was seen until '06?

IH: Something like that, yeah. I mean [the State was] writing the rules and then the rules became restrictive. So right now we have this tight FSP and all these tight definitions of these programs; but we're dismantling our outpatient programs, because the other money is drying up. So our realignment money is drying up and so here we are. We're stuck with these big [client to provider] ratios, because we can't see the people now that are being pushed out of the outpatient system. So a lot more people are getting less. Instead of the dream of the overlay, what we're getting is that the basic structure and system is being eroded tremendously.

HP: And that kind of money is to transform AOP [Adult Outpatient Program] clients into FCCS clients?

IH: Right, exactly. And [for] FCCS the ratio is [not] much different, maybe one to – maybe even one to twenty-five maybe. But right now our people are seeing eighty in a caseload. Unless we can loosen up those rules and requirements and restrictions and make it more flexible, there are a lot of people – It's already been happening.

HP: And what would you do to make [the MHSA dollars] more flexible?

IH: I would take the restrictions off. I would have a whole menu of services that could be delivered all the way from meds only to the FSP-type programs. And I would let the agencies evaluate the clients as they came to the Center and use their money wisely, under monitoring from the County government. But use the money wisely to develop different levels of care, different levels of care plans, coordination plans for each client, so some clients may need a little bit, [while] other clients may need a lot.

HP: Well, doesn't that already exist to an extent the fact that you have Wellness for some, FCCS for others, FSP for others?

IH: Yeah, but there's a whole group in between Wellness and FCCS, which is – most of them are our current outpatients. They need more than Wellness, they don't need as much as the FCCS.

HP: And that's the core of the system.

IH: Yes. Because most of our clients were in the outpatient center, and most need more. The Wellness is really minimal; it's like medication and some case management, but it's not real intensive work. And the FCCS is a lot more intensive. It involves a high staff to patient ratio.

HP: And it involves doing all of this field work that some clients might not need.

IH: That's exactly right. And you've got this group that can come to the clinic, needs medication, needs some ongoing counseling and therapy, needs some case management to keep them stable and to keep them in their housing. And that's the group that's losing it.

HP: So basically it would be good if the MHSA could really help offset the cuts to AOP [Adult Outpatient] programs?

IH: Definitely. And the reason it was designed the way it is was because we assumed that the outpatient [program] would [still] be there. These [MHSA programs] were meant to be supplemental to that and instead are replacing it. [The community agencies were already developing those types of programs and were experienced in using the Social Recovery Model.] And those are the clients we've been working with.

[In] the directly operated programs, by and large, there are some exceptions, but by and large, they have been working more in the Clinical Model with these folks. And it's been the fifty minute hour. Of course, they do the Psychiatric Emergency Teams and the hospitals, but it's more of a traditional model. And so the providers have a lot to share, in terms of the kind of work that we have been doing. [The community providers developed MHSA to support that work, but much of it has been diverted to County programs, and now the money is actually disappearing, because there is less revenue coming in.]

So at this point, I think it's survival time. I think we have to use the MHSA dollars to shore up the outpatient system. And right now, if we're limited to FCCS and FSP, we're not doing that. But in the other sense, it's sad that we have to do that, because the concept was an overlay.

HP: The concept was to complete the system.

IH: Right, and now we're shoring it up or trying to shore it up.

HP: Filling up holes in the dike, basically.

IH: Right, exactly. So that's unfortunate. We work pretty well with the County. Actually, for a County, for our Department, I'd say we work very well. They involve us in decisions and we have our trade association here at the table. I'm at the table.

HP: ACHSA [Association of Community Human Service Agencies]?

IH: ACHSA. I'm at the table at most of the [DMH] Stakeholders Meetings, so we have representatives at those. I think that this County here is probably a little less arbitrary than a lot of them.

HP: OK. Well, I know we need to wrap up, so one final question. How would you like to see the public mental health system develop in the future? Where do you see it going?

IH: It's definitely going in the wrong direction. Right now, it's shrinking and it's getting more and more narrow, as the funds are shrinking. So I think the next few years are going to be a horrific challenge. I've seen a lot of challenges. But this seems, to me, this is probably the worst situation we've ever had. Because the realignment funds [are] at a low ebb and they're probably going to shrink further because of the recession and the fact that people aren't buying cars, and they're not buying a lot of goods. The millionaires are now, I think, less than half the number of millionaires that were existing prior to the MHSA.

And because these are all tax revenues, there's about a one to two year lag before you feel the impact. So right now we're getting like about a billion and half dollars a year from MHSA. They're projecting it's going to be about 800 million in two years.

IH: So that's almost cut in half in two years. And that money is the money that's being used to shore up the system. In addition to that, I mentioned the FMAP money which is the Federal Participation in MediCal. I mean, it used to be 50/50 and then the Feds now are given 60 and the County is giving 40; but in two years, that comes down to 50 again, so you can see we've lost a full 10% – actually 5% of the overall funding, which is huge. So those three things are going to happen all at the same time.

HP: Now in a perfect world, where would you like to see it go?

IH: Well, in a perfect world, I would like to see it go where it's supposed to go. With the MHSA funding, I'd like to see us have adequate funding, to provide services to the full, like we used to. The full range. I'd like to see prevention and early intervention. I'd like to see community organization, community consultation, which would really serve a lot of that purpose. Innovative preventive projects that really focus on the prime causes of mental illness and how we can either prevent or intervene at very early stages. Adequate funding to serve the broad range of people that have emotional and mental problems, not just the most severely mentally ill, *and* the severely mentally ill. And adequate funding to fund the models that are effective, like the Social Recovery Model. We know that works, and we know that that's effective.

And we know, if we did adequate preventive programs, [that] a lot of people would not have to get to that level, even if there's a strong genetic, metabolic component. [We know] that there are many, many steps that could be taken to at least lessen or cushion the possibility of a full-blown mental illness. I'd like to see all of that. I think we need it. And the costs to society, if there was someone who had the vision to say, "Let's put out enough money now to create this vision, this system [that] has all different levels and treats all the people that have strong emotional problems. Let's put out enough money now so that we can prevent a lot of these illnesses and reactions from developing, so that we can reap the rewards on the other end." And the rewards are that there would be much less hospitalization, much less incarceration, much less emergency room usage, much less crime. There are so many social areas that would benefit that the money would be paid back to society many times over.

HP: In what it doesn't have to spend.

IH: That's right, exactly.

HP: With the consequences [of mental health problems].

IH: But the State and Federal governments don't work that way. They don't look at the big vision and say, "OK, let's put more money out right now than we're putting in," so five to ten years later, when the system is in place, society will reap the benefit. Because the political system we're in takes small, short-sighted steps. Legislators have term limits. People are looking at how they're going to be judged [in] the next two years, not the next ten years, and that's what happens.

HP: All right, great. Well, I know you need to go, but thank you so much for this. It's really appreciated.

IH: Sure.

Interview Duration: 1 hour and 41 minutes