

Mark Ragins describes how the Village model was different:

At the Village we did it as a whole. It was the team together. We all know the clients together, our caseload was lower [than in the clinics] and still is, and we know them all, so we could be reassured as a group. Also, I had the resources to put into things. To me, the question wasn't, "So this person's suicidal, do you want to put him in the hospital or not?" The question was, "The hospital will cost four hundred and twenty-five dollars a night to put him there. (That came out of our budget originally; that's the way we were set up.) Can you think of anything else that costs less than four hundred and twenty-five dollars that might be less traumatic and might help him as well? Sure. Let's have a friend hang out with him, bring a pizza; let's rent a hotel and have someone with a cot in their place. Let's do extra visits." We reduced like ninety percent of the hospitalization costs, we could think of something else. The doctors over at the average clinic don't have access to divert those funds to other things. Their choice is hospitalization or nothing.

I had a huge advantage, not just in personality and in being with a team, but a huge advantage that I could actually move funds to do what the person needs. And this was one of the inventions of the Village, we were given capitated funding [that is, funding per patient served], and we came up with [something new]: There's three ways of doing care, from an administrative standpoint. I never made a study of mental health administration. One way is our standard way, is regulated care. We make a whole set of regulations. People with a certain diagnosis gets certain things, people with certain symptoms, or certain conditions, get certain things, or whatever. There's regulations that determine what you get.

The second way of doing it is managed care that says we've got a pot of money, and someone like Kaiser or an HMO decides we're going to have someone outside your team manage what you get, when you call to get approval for various things from a manager of the monies. The Village created something called designer care that said the actual clinicians who know the person, who have the relationship, design treatment plans and spend resources on what they think is individually best for that person, and have to stay within a budget and make rationing decisions themselves. That took a different kind of courage. There are very, very few clinicians who agree to make rationing decisions themselves. And of course it's much more fun when you have more money, than if you have less. That's not to say it's more ethical with more money, but there's more that you can do. Designer care has never been replicated [as far as I know]. And we stopped doing it to a fair degree, after the first half a dozen years of actually having clinicians make decisions....

And we went through that process together as a group. This was our original, totally at risk, capitated program, in the beginning. It was truly an experiment. Our number one thing is don't go broke. The first year we had like four hundred thousand dollars sitting waiting to pay for hospitalizations for people in case they fall apart. We spent like sixty. So the next year we bought all kinds of other things with that money.

But that experience of making treatment decisions in a fiscally responsible way – [Deciding that] this person I'm going to buy a drug rehab, this one I'm going to buy textbooks for, this one I'm going to pay rent for, this one I'm going to buy eye drops, this one I'm going to buy antibiotics for, this one I'm going to buy an extra person to hang out with them three times a week to show them how to use the buses. We decided what we'd spend the money for. Virtually no one in the system has the experience of getting to make decisions that look like that.

Read the full transcript below.

**LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
ORAL HISTORY PROJECT**

INTERVIEWEE: DR. MARK RAGINS

INTERVIEWERS: MARCIA MELDRUM and HOWARD PADWA

DATE; APRIL 14, 2010

I. Early Life and Education; Interest in People with Schizophrenia; Richard Lamb; Learning to take Risks

MARCIA MELDRUM: Good morning. This is Marcia Meldrum and Howard Padwa. We're interviewing Dr. Mark Ragins at The Village in Long Beach, and we're very happy to be here. Good morning.

MARK RAGINS: Good morning.

MM: It's Wednesday, April 14, 2010. We wanted to start out with talking a little bit about your background, where you went to school, where you grew up, and what exactly led you to medical school and then into psychiatry.

MR: I'm actually a native of Los Angeles. I grew up in Woodland Hills, out in the San Fernando Valley. A suburban, middle-class family. And when I was growing up, I wanted to be a biomedical engineer and make bionic people like in the *Six Million Dollar Man* [an American television series which aired from 1973 to 1978]. I was going to make all these bionic body parts. So I went to Cal Tech to college, and in the first physics lab, I couldn't make an electrical alarm clock that worked. It turned out I couldn't make anything.

So then I was going to cure cancer, but I failed at the chemistry lab too, because I couldn't keep my glasswork clean enough to actually accomplish any experiment correctly. Besides, research turned out to be a very isolating place to live and work. You work on very small subjects in labs that don't have a lot of other people around, and very painstaking experiments to get things done over long periods of time. It was just too lonely.

At about the same time, I started liking my psychology classes, and that seemed more interesting. I also started meeting my first people with serious mental illnesses, because my father was the Court Commissioner in Department 95, the mental health court here in Los Angeles back then. This was thirty years ago. So I got to meet people with real mental illnesses.

I remember one girl in particular because she was basically the same age I was. She was nineteen or twenty at the time. She was in the hospital, and they wanted to try the then brand new lithium on her. And she wanted to leave the hospital, she didn't want to be there anymore; so she was fighting hard to get out of the hospital. And her parents had been coached by the attorney to say she can't come home to live with us if she leaves against medical advice. So to prove she's not gravely disabled, she has to prove that she can support herself when she gets out of the hospital. She has to prove she could get an apartment and a job and money and do that after leaving the hospital *that day*. It occurred to me I couldn't have met that criteria. My parents were paying for my college and dorms, how could I have done that?

But what struck me most about this, she's fighting for this, is how much she needed someone to be going along with her on this. I know she has a lawyer, her public defender, and I grew up in the courts. Both of my parents are attorneys. So I know what the process is and all this language they're talking up and back to each other. But there's no reason *she* knew what was going on there. And she was awfully alone, and we don't have someone just to go through things for you in these darkest times, when you're being locked up, when you're fighting – you can't tell you're not a criminal in that court, even though it's not a criminal court. There's really no one –

It struck me that I could spend time sharing lives with people with serious mental illnesses, helping them be able to overcome things, being able to rebuild their lives and have things. And even if I couldn't help with some magical cure for something or other, at least I could walk alongside and help them through the tough times. So I went on to medical school, actually intending to be a psychiatrist. I went to Washington University in St. Louis. As my father says, "You could have been a real doctor." Of course, my father's idea of a real doctor is the doctor on the *Love Boat* [an American television series which aired from 1977 to 1986].

MM: Did you think about instead being a psychologist, for example?

MR: Strangely enough, since I was at Cal Tech, there weren't any psychiatrists or psychologists. I didn't even know what those were. I didn't have clearly in my head, except from reading something, what the difference was, what the jobs were. I had no idea what medical school was particularly like when I was signing up for it. If I had, I probably wouldn't have signed up in the first place. It was almost out of sheer ignorance that I ended up in that particular mental health career. I was good at math and science and had good MCAT [Medical College Admission Test] scores, and whatever, and they took me, so that's where I went. At the time, though, I think it was actually harder to get into PhD psychology programs than into MD programs.

At Wash U where I went, since I knew I wanted to be a psychiatrist, I spent all my elective time doing mental health things, so I never became a really very good well-rounded doctor. Although delivering babies was the best thing in the whole thing. So I spent time at a hospice; and I spent time in the substance abuse unit, at community mental health places, at the Maudsley Hospital, the center of the British Health Service and [their] Mental Health Service; at Masters and Johnson learning about sex therapy [William Masters and Virginia Johnson, pioneers in the field of human sexuality research, established a clinic in St. Louis in 1970]; [and] at the Menningers' [Clinic] learning about psychoanalytic treatments. I got a really much broader psychiatric background than most psychiatrists would. [The Menninger Clinic, the first group psychiatry practice, was started by Drs. Karl, Will and C.F. Menninger in 1919 in Topeka, Kansas. By 1966, it was a major psychoanalytic hospital. It is now in Texas]

Then I wanted to come back home, so I was looking at UCLA and USC [University of Southern California] for residency. I also applied to San Francisco, because the view is really amazing from the front porch at UCSF. So you go to an interview and then [each residency program has] you meet a resident who is there. But I wanted to meet some residents who weren't the ones they'd select to meet me. Let's find someone in the back someplace to see what it's really like.

So in the back, at the VA [U.S Department of Veterans Affairs Hospital] in Westwood, I find this guy. He said, "Oh, God, I'm so terribly busy here. We've got Lit Club tomorrow in the morning, I have this whole package of papers I have to read to keep up with these articles, and I'm supposed to present on this. I don't know how I'm ever going to get all this done." I went across town to the much less prestigious USC

and I find up there in the ward of the [LA] County Hospital that the earthquake has since knocked down, there's a guy up there in the back, he said, "Oh, my God, I'm so busy today. I've got seven more people I've got to see. I've got all these charts to do to catch up on things. I don't know how I'm ever going to get out of here tonight."

I decided I would rather learn from seeing patients and being with people than reading papers and preparing presentations about papers. So I went to USC for my residency; at Big County [LA County – USC Medical Center], back when there was actually a dorm for residents. There was even a little swimming pool out in the back. Where they put the clinic today was the dorm rooms. My dorm room is now a clinical office. So you could just like run down the stairs and you're on call where the hospital was. And like I said, there was even a swimming pool out back. I lived there for a couple of years.

My first experience at SC at the residency was being on call that first weekend, helping to write holds to lock people up longer. That's where they begin psychiatric training, is on inpatient, so it's learning how to lock people up, who don't want to be there.

There, when I spent my elective time, I knew I wanted to be in community mental health, because I really wanted to work with people with serious mental illnesses, and serious mental illnesses have a way of making you poor, if you weren't poor already. And making you uninsured, if you weren't uninsured already. So unlike a lot of medical illnesses – you can treat people with diabetes who are poor or rich, you can treat people with heart disease who are poor or rich. If you want to treat people with psychosis or schizophrenia or severe trauma or severe substance abuse, you've got to treat poor people, uninsured people. You have to be somewhere in the public sector, which is different than other medical specialties.

HOWARD PADWA: And why is that, that people with schizophrenia and psychosis tend to wind up having these socioeconomic problems?

MR: There are actually two theories about that. The ones that say, well, poverty must be the cause of these serious mental illnesses. It must have been that being poor makes you psychotic and have all these problems. But then they did careful research and said, you know what? People with schizophrenia don't actually start out poor, it's that there's something called social drift. They become poor after years of having schizophrenia.

The answer is probably somewhere in between those two things, because most of the people we see do not just have one serious mental illness. They have lots of other things get in the way of recovering from it, and many of those things do come from poverty. So you've got someone who was born a drug baby, who had very little educational opportunities, who was abandoned or put in foster care systems, who used drugs themselves, who ended up illiterate, who ended up spending time in jail, who's witnessed a lot of violence, and *then* they get schizophrenia.

We often say that the county system treats the sickest of the sick. I don't think so. I think we treat the poorest of the sick. Or to put it in another really weird way, we treat the sickest of the poor, because many people who are poor have huge amounts of problems that need lots of help, and we find our target group, those that we care about –

HP: The very sick among those.

MR: The ones who have symptoms of certain illnesses that we've chosen to count. You can be terribly sick with, say, crack addiction and we don't care about that. You can

be terribly sick with being a drug baby, and we don't care about that. But if you're terribly sick with manic depression, or if you can get your crack addiction re-diagnosed as manic depression, then we care about that.

It turns out it's a complex thing that a lot of things that are social problems end up in the mental health system. And one of the things I've learned over the years is that expecting the mental health system to be a pure medical system is doomed to failure because it's part of a social system of people that come with both sets of things [medical and social problems].

So my first exposure was – in residency I did my elective time in community mental health things. I went around and did electives where I visited – there's like hundreds and hundreds of places in this county. I went around and visited a bunch of them, from like youth camps and clinics and the jail system, over-crowded emergency rooms, drop-in centers, all kinds of stuff. There's way more things now than there was twenty years ago, at that point.

And I was at USC Alternatives [a residential treatment program on Adams Avenue in LA], where, as you may know, there's a residential program for people to, instead of staying in the hospital, they stay there for a few months to get their act together. I spent some time at Hollywood at the day treatment program that doesn't exist anymore. Spent time at Skid Row Mental Health, which was an award winning program at the time, now renamed Downtown Mental Health. And at LAMP down there when it was very first beginning [originally the Los Angeles Men's Place, LAMP strives to end homelessness, improve health and build self-sufficiency among people living with mental illness]. Those were my set of community electives. I could get about six months of elective time to prepare to come to work within the public mental health system, so I'd know something about the administration and the overall range of what the system looks like and the possibilities and things, before I started.

HP: What was it exactly about the community mental health that intrigued you? I mean, you mentioned that it was connected with socioeconomic. But was that something that drew you towards it?

MR: No. What drew me towards it was working with people with severe illnesses. I wanted to work with people who had psychosis, who had schizophrenia or manic depression, who had serious things wrong. I wasn't too interested in what we would at the time kind of disparaging call the worried well or anxious housewives. I'm not actually sure that that deserves the disparagement that it gets at this point, by the way. But at the time I bought into that. (he chuckles) And said, if I'm going to be a psychiatrist, [I should treat seriously ill people; working in private practice] would be a little like being an oncologist who only sees skin cancers or something. If you went into this, let's find people with serious conditions who need the help the most – so that drew me into the psychosocial stuff. I wasn't attached to psychosocial in the first place; I was attached to [the idea that] isn't it cool how people with psychosis think differently? What is hearing voices really like, or what's being paranoid really like, or what's it like to be in these different worlds or to think differently? That's what I thought was cool.

What I found, though, that I think separated me out from a number of people – I think psychosis draws a lot of people into psychiatry, but they don't end up actually working with people with severe mental illnesses, because there's a difference in liking the illnesses and liking being around the people who have the illnesses. I ended up liking spending time with people who have schizophrenia, or manic depression, or different things; liking having the relationships, liking the challenge of how can I connect to somebody that nobody else could. How can I be someone that they say, well, you

really understand me and hardly anybody does; or be able to untangle their thinking to make sense to help them work out things.

So I ended up liking not just the illness, but the people who have the illness. There's a lot more people that like the illness of schizophrenia than like people *with* schizophrenia.

HP: Right. Interesting.

MM: Right. And we read in the recovery book [Ragins' book, *Road to Recovery*, is online at <http://www.mhavillage.org/writings.html>] that you were trained very much in the medical model, and at this time that you were mostly thinking that your role with these people would be structuring their lives, telling them what to do, giving them the medications that would make their lives bearable, but not allowing them much of a say in their own treatment. Did anything in your experiences in community mental health challenge that?

MR: There were a couple of things. One is, I mentioned I went to medical school at Washington University. They're the people who made up the Feighner criteria, which was the [partial] basis for DSM-III and DSM-IV. [The Feighner criteria were the first set of syndromic diagnoses made from observable signs and symptoms, named after John Feighner, who was the chief resident at Washington University at the time. They were first published in 1972. The Diagnostic and Statistical Manual of Mental Disorders (DSM) provides a common language and criteria for classifying mental disorders. The original DSM-I was published in 1950; DSM-III, in 1980, represented a major revision.] They're profoundly excellent psychiatric epidemiologists. They came up with these criteria to make us into real doctors, to have real syndromes of things. So I grew up having memorized those criteria, with a clipboard of what's the Feighner criteria and what's the treatment that goes with these criteria? I took it with me into the hospitals, and I was very good and very arrogant. I'm somewhat of both still. (he laughs)

I also made a little notebook of my outcomes and kept track, and I found when I was working in the inpatient ward, three-quarters of the people who left there, their illness was well treated, and they were doing well. But I also kept track a little longer, and noticed that two-thirds of them came back to the hospital within six months, back to where they started; that I wasn't actually accomplishing anything by making people take their medicine to get it together. They came back. I had to figure out what's going wrong here.

I'll tell you one story from back in those days that I think captures it for me. There was a guy on the ward, we called him Wolfman, because remember the old radio DJ Wolfman Jack [a gravelly-voiced DJ who became famous in the 1960s and 1970s] and he talked like this on the radio? This guy talked like that because he had mania and he was yelling and screaming at everybody all the time, and he got so hoarse by doing that. Usually at policemen. He was harassing policemen, and all of a sudden the police would drag him to the hospital. He had charts like this thick. Every resident had seen him. So it was my turn, the fourteenth resident. I was supposed to do an adult initial assessment. Yeah, right, initial assessment. He'd been there fourteen times. He'd done more assessments than I had.

So I said, "You know what? I'm a little lazy. I'm probably just going to copy the stuff from the resident before. I'm not going to actually do all this all over again, which was probably what the resident copied the one before that." I said, "But there is a couple of questions I'd actually like to know, if you don't mind." He said, "Sure. What do you want to know?" "I want to know, Why do you do this?" He said, "What?" I said,

"Why do you do this? You keep stopping your lithium, getting all manic, getting involved with the police and getting dragged back here. Why do you do this over and over again?"

And he said, "Do you really want to know?" I was young and naive at the time, so I didn't know that was a really important question. I just said, "Yes." But I think it is a crucial question that in most interviews comes up someplace, usually not out loud. *Do you really want to know what it's like to be paranoid, to have your kids taken away, to be living on the streets, going through trash cans, to be paranoid, to be manic and throw your wife out of a window? Do you really want to know this stuff? Or do you just want to treat me, while keeping at arm's distance and not really want to know?* But I was young and naive at the time, so I didn't know that was important. So I said, "Yeah."

He says, "Well, here's the story. My mom is very elderly and she's a Holocaust survivor, and she's a very angry, bitter, depressed old lady, and she takes it all out on me," which by the way, there's something – we know this business about people who are abused tend to do a cycle. Do we really want to know that Holocaust victims tend to abuse people? That's not something we want to know about, really, is it?

But that is what was going on. He was feeling just totally miserable, very depressed, being with her all the time, and every night when he went to bed, he just prayed he would die and not wake up the next morning. But since he too was devoutly Jewish, he knew he wasn't supposed to kill himself. So what he did is he stopped his pills on purpose, get manic, and then go find a policeman and hope he'd shoot him and put him out of his misery.

By the way, in this story, who's getting insight, me or him? So I'm getting insight, not into his illness; this isn't telling me anything about his manic depression or how he responds to lithium. This is talking about him and his life and how he deals with life. I said, "That makes sense. I've got a couple more questions, if you don't mind." He said, "Sure." "The first one is, do you think God's going to be fooled?" That was the most smartass thing I could say, but he said, "What?" I said, "Well, you say you're not going to kill yourself and you go out and find a policeman to kill you, do you think God's going to be fooled by that? Didn't you know that all you did was drag some poor policeman into this, who's now going to feel guilty? How is that better than killing yourself?" He said, "I never thought of it that way."

I said, "Well, while you're thinking about that, I've got another question for you. If we can make your life a little better and worth living and less miserable, would you stop trying to kill yourself like this? For instance, obviously your mom does not need you all the time, because you're in this hospital half the time. Besides, we could find her an in-home worker who might help out some. I think you live near LAMP; you could drop in there; you like being around other people, doing some other stuff in your life. Instead sending you over to some other mental health center, I'm going to the outpatient clinic next rotation, I'll just see you there in between things and hand out pills. Would you want to stay on your lithium that way and not keep trying to kill yourself? We'll work on making your life better instead." He said, "Yeah."

And that's what happened. The next year, when I was in the outpatient clinic, he never went back to the hospital, changed his pattern, because I'd made a shift in looking at what's going on in his life instead of what's going on with his illness. And that's what dragged me away from the medical model – those two things in the beginning. One that said treating people against their will and getting them better doesn't lead to them staying on the meds and staying any better. And two is that to figure out what's actually going on, you have to ask them about them and not about their illness. We say people stop their meds because of side effects, or it doesn't work, or something like that. It usually isn't a biological reason. If you set out with a set of questions that are biologic,

how would you ever find out about why this man stops his lithium? My Wolfman questions did that.

It was sheer practicality that said, "This isn't working at all." But do you realize there's a slanted thing about this story is that I, like virtually everyone else in training, started in the inpatient ward. The inpatient ward is selected for people who don't cooperate, don't want to take their meds, but do respond to meds or they wouldn't be sent out and back in again. It's a select set of people who do respond to meds but don't take them, and usually use a lot of drugs, too. Whereas the clinic is selected for people who stick around at the clinic, passively going along with what's going on, get some benefit out of things, but never enough benefit to get all the way well and aren't rebellious to leaving. It's entirely different.

Actually, there's not much overlap between the people who show up in our clinics and show up in our hospitals. There are two almost entirely different sets of people. And you'll see different sets of people in the drop-in centers. And the jail. It's different sets – and you can easily draw a whole set of conclusions about what works best for people, how services should be, on the basis of one of these subsets, without realizing that's only ten percent of the whole group. If you spend your life in a clinic, for instance, you could say what really works for people is coming in to group, staying on their meds, and staying on disability, since it works for them, without saying, "Well, what happened to the eighty percent of the people that dropped out who didn't show up here? Half of them didn't show up for their first appointment. What happened to all them?"

One other piece directly about your question. You asked about telling people what to do. One of my main mentors, who you should find to talk to sooner or later, you may have already, was Richard Lamb [Professor of Psychiatry] back at USC.

MM: Oh, yes, Dick Lamb.

MR: He'd been at SC probably ten or twenty years by the time I got there, already. He was the one who helped establish USC Alternatives. But he was also quite famous for having been the one to do the first research in the jail to find out who would have serious mental illness and who not. None of us walked into the jail before that and talked – he was the one that his work led to the business about the LA County Jail being the largest mental hospital in the world [see the news story at: <http://www.npr.org/templates/story/story.php?storyId=93581736>], which I think is kind of distorted, but nonetheless, that's a monumental piece of courageous work that he was doing.

He came from a tradition – he was trained as an analyst but hated it. But early in his life, he was a psych tech in the hospitals, and when they lined up people for shock therapy, in rows, for either treatment or punishment, or mixed together. He very much believed in the medical model that, when you see somebody it's not fair to blame them for not being able to get their lives together, and it's not ethical for us to say, well, they can't do it, let the policemen take care of it. We should be taking care of all the people, instead of the policemen. He was in favor of IMDs [Institutions for Mental Diseases; long term care facilities for persons with mental illness], and a law that says when people have illnesses, they can't use their broken brains to figure out what's wrong, we need to make decisions for them, we need to structure their life, we need to take care of their dependency needs, we need to be there for them to shelter them from life and to create some asylum away from the pressures of life.

Dr. Lamb presents a very compelling vision, that I've ended up very far from over time, because it turns out that that vision is almost self-reinforcing. The more you make decisions for someone, the more you drive them into compliance, the more you tell

them, "You can't make your own decisions, I will. Your brain doesn't work," the less they try to make decisions for themselves, the less they take risks, the less they take responsibilities.

I met a new person this last week, who came to us from a step-down unit. He was in a mental institution for a year and a half. The five years before that, he did really terrible, on the street, psychotic, and attacked his mom. He's pretty stable, he's on his meds and is stable now and he says, "I don't have any goals right now. I just want to make sure I'm stable. My conservator said I shouldn't try working, it would be too hard for me now. I want to make sure things are okay. And when I stay with my medicines, it helps me stay back together. I was doing a lot of group and structured activity there [at the step-down unit]. I need other activities like that to do during the day to keep together. I don't have any goals, but I don't want it to go back to the way it was before." He was carefully taught that passivity and obedience is the way that he can stay out of this terrible trouble.

But now I'm left with someone with no goals, and how do you build from there? The people who stay in that spot, and we reinforce that spot, stay in our clinics and stay obedient and passive and do okay and build up our caseloads. But most people aren't that obedient over time, and to get them that obedient, in effect, that approach is breaking their spirits. And then once they have broken spirits, we wonder why they're hard to get to do anything. We've added an extra issue to it. Their passivity is not because the meds make them so terribly sedated, or create negative symptoms or something, but because we've intentionally taken all their belief in themselves away, all of their belief that they can do things, that other people shouldn't make decisions for them, all their confidence away, through the kindness of taking care of them.

I ended up working with a set of people who were so disobedient there was no point in [trying to get them to be compliant or taking care of them]. Hanging out with homeless people, hanging out with people the system sent over to the Village here, or high utilizers [patients who make multiple return visits to the psychiatric emergency services and hospitals], various things that the system didn't want – mostly, they just didn't want to do what they were supposed to do. So I intentionally had to evolve a way of working with people [and for a while ended up] believing that nobody did what they were supposed to do. (he chuckles) Which in fact may be what the majority of the people do, but I don't know.

But as a result, I saw the strangest thing was that those people, by my helping them come to their own ways of doing things, by being their guide alongside them, by helping them find strength in themselves and building, they got further than the ones who were good patients and obedient in the first place. We were doing better with the bad patients than the clinic was doing with the good patients.

HP: And did you find that there were risks involved in that, though? If there were patients, clients, who you would push beyond where maybe the medical model would say it was okay, was that a risk in that it could lead to decompensation, or was the risk worth it for the opportunity to enhance?

MR: All of that is possible; there's massive risk to doing it any way. There are risks, somewhat, of different things. Like there's a risk of someone ending up, never finding any meaning in life and being depressed and saying I'm just existing, not living, and killing themselves. A really weird thing about the Village is that, despite the fact we hospitalize virtually no one for being suicidal, almost no one kills themselves here. The first ten years of the Village, nobody killed themselves, which is stunning for a program like this.

Actually, I had just, a month ago, the first person – since I've been here, I've been here twenty years now – the first person under my direction, who killed herself. But I just met her two days before she killed herself, so I'm going like, "What the hell happened here?" But it turns out we think that we're protecting people, but at the same time, we may be making them so miserable they're killing themselves more often. If someone ends up passive, with nothing to do, is that a really good way to get off drugs? If someone's protected from the difficulties of work, or the difficulties of raising their kids, does that make them so heartbroken and deadened that they don't do anything after that?

But your point is well taken anyway. One of the main difficulties to this is the willingness to take risks, to realize that I can't control you, I don't actually want to control you. If you [aren't willing to take risks, then] at each visit, you ask "Are you suicidal?" "Are you homicidal?" And if you say something that sounds risky, then I'll hospitalize you for a while. I may risk traumatizing you terribly by doing that, but at least I know you're not going to die. I remember, in the ER back at USC, when we saw someone in the ER who might commit suicide, they taught us, "First visualize this – if you don't send them on to the hospital, and you see them jumping off the freeway overpass there by USC with a sign on their neck that says 'Dr. Ragins wouldn't let me in the hospital,' if you can handle that, go ahead and send them out." [That's how they taught us to be unwilling to take risks.] It just doesn't strike me as a very client-centered way of making decisions.

HP: And it's also very – it's an interesting way to think about it as a practitioner then. What does that say about how you do it? You'd be operating out of fear then.

MR: And that's the whole thing, that's exactly the point. We can only work effectively if we're not in fear. Some of the fear comes from being around people with mental illness which frightens most people. We've been taught to fear [mentally ill] people, whether you're a doctor or not. We've been taught to fear, and with good reason at times. Bad things happen. A close friend of mine was murdered by someone with schizophrenia. So there's that kind of fear. It says, "Well, I'll keep you at a distance."

We can be fearful of how will I be able to handle all these emotions? Am I going to be able to keep separate my personal life and my home life. Is someone going to come to my house and attack my wife? What if I get these phone calls that disrupt my life? That can create a lot of fear. So most people try to create safety.

One of the things we fear is, what if something bad happens and I'm blamed for it? That is the single most important risk we worry about. We're not actually worried if a person kills himself, we're worried about if I'm going to be blamed for them killing themselves. In some way, we care if they kill themselves. But the fear – when they talk about people practicing protective medicine, they don't mean what Richard Lamb meant, they don't mean protecting the person from the stress. I don't think that's a good idea either, but he meant in a person-centered way, that this person deserves to be protected from the stresses of life. Now "protective medicine" means protecting *myself*, which isn't what he meant at all. He was much more courageous, in wandering into the jail in the first place to see people.

So the willingness to take risks is the beginning. My willingness to go in the hospital at the beginning and say, "I'm signing you out of here. I don't know what we're going to do next, but I'm not keeping you here." If you go to the state hospital and say, "You've been for three years, and they say you'll never get out, blah, blah, blah. Come on out, let's see what the hell happens." Something terrible happens, and you keep going anyway. The willingness to be with people while terrible things happen, without

stopping the action and learning from it, is a difficult trait for most people. That kind of courage.

MM: Did you have to learn that? Or did it sort of come naturally to you?

MR: Probably some of each. I'm a little more of a cowboy than most people. (he chuckles) And I was younger. (he laughs) I think we were all younger when we started. It also helped to be taking these risks as a group together. One of the huge problems – it seems like almost an administrative problem, but it ends up important, is that the largest responsibility for the risk in this system is placed on the psychiatrist, who usually has the least relationship and the least connection with people, because they have the biggest caseload. So we're asking about your comfort in taking risks, [which is usually going to be based on an] “I know this person is going to be okay” sort of thing. We're asking the psychiatrist to make the decision, and to bear most of the brunt of that risk, who has the least reassurance based upon relationships.

At the Village we did it as a whole. It was the team together. We all know the clients together, our caseload was lower [than in the clinics] and still is, and we know them all, so we could be reassured as a group. Also, I had the resources to put into things. To me, the question wasn't, “So this person's suicidal, do you want to put him in the hospital or not?” The question was, “The hospital will cost four hundred and twenty-five dollars a night to put him there. (That came out of our budget originally; that's the way we were set up.) Can you think of anything else that costs less than four hundred and twenty-five dollars that might be less traumatic and might help him as well? Sure. Let's have a friend hang out with him, bring a pizza; let's rent a hotel and have someone with a cot in their place. Let's do extra visits.” We reduced like ninety percent of the hospitalization costs, we could think of something else. The doctors over at the average clinic don't have access to divert those funds to other things. Their choice is hospitalization or nothing.

I had a huge advantage, not just in personality and in being with a team, but a huge advantage that I could actually move funds to do what the person needs. And this was one of the inventions of the Village, we were given capitated funding [that is, funding per patient served], and we came up with [something new]: There's three ways of doing care, from an administrative standpoint. I never made a study of mental health administration. One way is our standard way, is regulated care. We make a whole set of regulations. People with a certain diagnosis gets certain things, people with certain symptoms, or certain conditions, get certain things, or whatever. There's regulations that determine what you get.

The second way of doing it is managed care that says we've got a pot of money, and someone like Kaiser or an HMO decides we're going to have someone outside your team manage what you get, when you call to get approval for various things from a manager of the monies. The Village created something called designer care that said the actual clinicians who know the person, who have the relationship, design treatment plans and spend resources on what they think is individually best for that person, and have to stay within a budget and make rationing decisions themselves. That took a different kind of courage. There are very, very few clinicians who agree to make rationing decisions themselves. And of course it's much more fun when you have more money, than if you have less. That's not to say it's more ethical with more money, but there's more that you can do.

Designer care has never been replicated [as far as I know]. And we stopped doing it to a fair degree, after the first half a dozen years of actually having clinicians make decisions.

And when you hear the larger health care debate – I listened to Howard Dean at a conference a couple of weeks ago. His suggestion for health care *is* designer care. You put it in the hands of the doctors. And one of the things I don't think he realizes is, the vast majority of clinicians will refuse to make rationing, financial decisions if you didn't give them unlimited money. They'll say it's unethical. Even today, you go in a clinic and say, "All right, we don't have enough money just to keep giving all these people meds indefinitely. Which ones should we and which ones shouldn't we?" They'll say "If someone needs medicine, I have to give it to them." No, you don't have to. However much money we've got, what's the most ethical way to [divide it up, and then we're going to stick to] that. It's a real shift in the clinicians' thinking.

And we went through that process together as a group. This was our original, totally at risk, capitated program, in the beginning. It was truly an experiment. Our number one thing is don't go broke. The first year we had like four hundred thousand dollars sitting waiting to pay for hospitalizations for people in case they fall apart. We spent like sixty. So the next year we bought all kinds of other things with that money.

But that experience of making treatment decisions in a fiscally responsible way – [Deciding that] this person I'm going to buy a drug rehab, this one I'm going to buy textbooks for, this one I'm going to pay rent for, this one I'm going to buy eye drops, this one I'm going to buy antibiotics for, this one I'm going to buy an extra person to hang out with them three times a week to show them how to use the buses. We decided what we'd spend the money for. Virtually no one in the system has the experience of getting to make decisions that look like that. A little in the new FSPs [Full Service Partnership care, developed under the California Mental Health Services Act of 2005 (MHSA), provides all of the mental health services individuals with severe mental illness need to accelerate their recovery], but not a whole lot.

II. Working for LAC-DMH; Trauma and Financial Cutbacks; the Village; Stages of Recovery and other Visions

HP: Could we rewind a little bit and just get the story of how you came to the Village?

MR: How did I come here?

MM: Yeah.

MR: All right. I last left you after my senior year at USC, after doing all those electives. I went to work for a LA County clinic. There's a slight story there: So how do you find a job in a County clinic? At the time, there were vacancies for psychiatrists everywhere. They had terrible trouble filling the vacancies, and the administration was a wreck before – I assume you'll be talking to Rod Shaner [Medical Director of the Los Angeles Department of Mental Health (LAC-DMH)] sooner or later. He's responsible for filling up the psychiatrist slots, making sure we have adequate psychiatrists. I called up HR [Human Resources] at County Personnel and said, "I'm going to be graduating in another four months, I'd like to know where the vacancies are, so that I can interview around and see where I could get a job." They said, "We can't tell you where there are vacancies until after you graduate, because you can't be on the list to be told." I said, "Well, I'd like to arrange a job before I graduate, so I actually have a job when I graduate." "We're sorry. You're not eligible."

I said, "Is this like a state secret? I know we have a lot of trouble filling vacancies; is it a secret where they are? What if I said I was working for a newspaper

and I wanted to do an article on why there are vacancies?" "You'd have to talk to Public Relations then." (all laugh) Rod has made this much better, to his credit.

So I literally had to go through the book [that lists all the mental health programs] and call each one and say, "Do you have a psychiatrist vacancy?" I needed to get someone to go behind the red tape to advocate for me. And I chose a place called Coastal Community Mental Health, which you probably have not heard of since it doesn't exist anymore. Coastal Community Mental Health Center was a nice little community mental health center in Carson. Ironically enough, it took over the building where they made crash dummies before that. It had a small day treatment; it had a little homeless outreach program; it had some Spanish-speaking groups, including a men's Spanish-speaking group, which was fairly unusual; it had child and adult, outpatient therapy, and some med groups. It was a fairly solid clinic, and that's where I went to work right out of school. And I was there, I think, about a year and a half.

I got there in late '87. There was a massive recession and huge cuts that came in '88 and '89. Over that period, overall, I believe that the Department of Mental Health lost about a quarter or a third of all its employees. About a half of all the patients were discharged. There were huge cutbacks, but done by attrition. There were a few cascades of [staff involuntary transfers instead of firings], but it was done mostly by attrition. Our clinic was threatening to close, and then I was part of the court suit to keep it open.

It turns out that mental health care is not a right. Parity may change this somewhat, but mental health care was an option of the state, like running a state park or a library or something. The only thing you had to do was preserve public safety. You had to keep your ERs open and your emergency teams. You didn't have to have a clinic. You don't have to give someone mental health care, that's not a basic right. And we actually did work with the Poverty and Law Center [the Western Center on Law and Poverty, opened in 1967 as a joint project of the UCLA, USC, and Loyola Law Schools]. I remember this grungy office that we went to, to plan little demonstrations. That was when I first met Richard Van Horn [Chief Executive Officer of Mental Health America in Los Angeles (MHA-LA) from 1980 through 2009], who was running MHA. He was doing a demonstration to keep our clinic open.

By the time we were done with a year and a half of demonstrations and closings and openings and restraining orders and stuff like this, [because of staff leaving and not being replaced,] we were down to about seven employees left, like four managers, two psychiatrists, and three clerks, or something. Everyone, except me, under forty, was gone. And there was no plan at all of what to do with the patients. We were overwhelmed. And I said, "We gotta do something with these people." [One of the other psychiatrists said,] "The County will take care of them." I said, "Who's the County, if it isn't us?"

I threatened that I would bring a lawn chair and stay in the parking lot handing out prescriptions, until they figured out what to do. So they agreed to transfer me over to Harbor's Outpatient Clinic [at UCLA-Harbor Hospital in Torrance, CA], where, in one of my proudest accomplishments, a hundred and twenty-two of my hundred and twenty-six patients came with me, despite that most of them were terribly frightened of being on the hospital grounds. The rest of the clinic dissolved away. We don't know what happened to any of those people. It was a clinic with like 800 patients or so all lost to follow up.

Just before that happened, our homeless outreach worker was a lady named Robbyn Pannitch, who became a close friend of mine. She was originally on McKinney money. [The federal McKinney-Vento Homeless Assistance Act of 1986 provided funding for homeless shelter programs.] She'd go out in the streets and meet people and do outreach and stuff in the missions and stuff, try to get people housing. Kind of on

her own. She worked alongside me for about a year or so, and then she had a bad back so she transferred to Santa Monica Clinic, which was nearer where she lived.

A few months after that – you guys have probably heard this story from other people – she was working with this guy who had serious schizophrenia. He wouldn't take any meds. He was sleeping in people's garages and stuff. She went to court advocating for him, which was unusual in those days, and the judge ordered him into therapy with her, rather than any kind of drug treatment or medication or something like that. And he came in one day and thought that she was the devil and stabbed her, I think, twenty-four times. Her officemate was out at the time looking for a job somewhere else, because of the huge cutbacks. By the time the screams got to anyone there, she was already dead.

This was highly traumatic to the system as a whole. You'll probably hear a number of people of my age, or my era, remembering this. This is how we got the glass walls and metal detectors in all the clinics was in response to this event. This is how we got non-violent crisis intervention training, in all the clinics, in response to this event. There was a big funeral, there was a demonstration on the Palisades in Santa Monica, a candlelight vigil sort of thing. And a lot of people just quit after that. It was the next week or two, I think a hundred staffers said the hell with this. Because it wasn't like the depression today, where this job shortage is everywhere. It was just cuts in mental health. You could get a job in a lot of other things. (all laugh) I don't even know why. It was just us that was falling apart.

So she died, and everyone, including myself, was rather upset by this because it was the loss of a friend as well a loss to the system overall. I wrote a little piece – it was probably the first thing I wrote that had any impact – that said something to the effect of: You know what, if we don't have a program that's adequate to actually treat people in some kind of reasonable safety, we as staff should refuse to see them if we can't do it in a way that isn't safe. It's not a safe way to have a single person, without [another person to help, seeing a] homeless person by themselves, seeing someone who's dangerous and psychotic and no one's in the room to help them out. It's possible to help them safely, but that wasn't a program that could do it.

Now, I wrote and shared it with a few friends or something, and I guess this got picked up because it landed on some bulletin boards in other places, including over at Santa Monica Clinic. It's kind of just a basic civil disobedience sort of thing. Just say no. If it can't be fixed, then just say no.

That attracted the attention of [Roberto] Quiroz [LAC-DMH Mental Health Director, 1985-1991], who was running the Department at the time. He called me downtown to see who this troublemaker was who was telling people not to see people. And I still have the image in my mind, because he's going through massive cuts, and he's just absurdly overwhelmed. He has no chance of managing this stuff. He realizes rapidly that I'm not a danger to anything, that he doesn't need to worry about me destroying anything. He's got much bigger problems than me in the system.

I did tell him, which I still think is important, that "How come you have no idea who I am? I'm one of your bright young stars. I've been working for a year and a half doing things in a little rehab clinic, in extra groups, and things. I'm one of your bright young stars. You don't have many bright young stars around here. Everyone under forty has left. And how come my existence never came to your attention – I work right next to your District Chief!"

I also said, "So what's going to happen to our clinic? I'm worried about my patients if it closes." He said, "I don't know. Which clinic are you from again?" And he looks kind of absent-mindedly, bizarrely, through some papers on the floor. He has no idea which clinics are opening or closing, which one's which. It's just gotten too

overwhelming. He has no concept of what's happening anymore. And it's one of these Wizard of Oz moments when it's like there's nobody who has a handle on running this thing. And he was replaced, I don't know, six months later or something. Then that's when I decided to take my things in my own hands. My patients followed me to Harbor.

There was a huge crisis point for the overall system there, of a loss of monies, a loss of any kind of credibility, of administrative structure, of Robin dying and traumatizing us, why are we doing this? All the young energy and blood of these clinics gone because of attrition with these strange staffing patterns – it's sort of like you see in war-torn countries, where kind of everyone's starving and sort of picking on each other or attacking each other. That sort of thing evolved out of the crisis.

So I ended up over at Harbor General, which was a refugee camp for people who had gotten out of other places that had gotten closed and various things. An incredibly lonely place for me at the time, trying to do some of this stuff, but you really can't do community mental health alone, when you get right down to it. I think the moment that got me most was one day – I had a little bookshelf, like those that are hung on the wall, and it was all held up by brackets. And I don't know, I put too many books on it, and it fell down and crashed. And nobody came to see what it was. We're in this bizarre rundown trailer from World War II, or whatever, at Harbor. It's a bizarrely deteriorated physical plant, and all these rows of trailers and stuff. And nobody comes. And for somebody who's just had their friend get killed, because nobody came fast enough, that didn't work for me.

That would have been about the end of my career with public mental health, and we wouldn't be having this conversation at all. That's enough stuff in the first year and a half of working in mental health. Your clinic's closed, your friend gets killed. That's enough of this. Who needs this?

And then I got lucky. The AB3777 law [Wright-Bronzan-McCorquodale Act of 1988, which funded three demonstration Integrated Service Agency programs for the mentally ill] was going through the legislature, which basically was pushed by the same people who made up the original LPS law [California's Lanterman-Petris-Short Act of 1969 ended involuntary hospital commitments through the judicial system]. Those same legislators were getting old and they wanted to have a few models around for if we ever have the money how to actually make this work. Because they felt bad that the monies had never come to make it work. We'd at least have some models.

I don't know where I picked up on this. Maybe from Dick Elpers [J.R. Elpers, MD, Director of the LAC-DMH 1978-84]. I don't know if you're going to interview him eventually. Dick Elpers was mentoring me and he was over at Harbor General at the time. Both him and Milt Miller [former Chairman of the Psychiatry Department at Harbor-UCLA Medical Center, who died in 2005], they did sort of take me under their wing and I got to go to management meetings and see Milt's very unusual management style, that you'll probably hear about from other people. Both those people were powerful people in the Department [LAC-DMH]. I think I reminded Elpers of himself at my age, at 25 years younger. He told me about this legislation for this model program. I said, "You know what, I gotta get out of here. This would be a chance. It's a four-year project. It would be a hideout for a while until we see if the economy comes back." It was about the same tragedy for finances as at present, even worse than this present one for mental health, but it wasn't as global.

So I was paying attention. I thought the two leading contenders would be Pacific Clinics out in Pasadena and Didi Hirsch [Mental Health Center] over in Culver City. I was hoping for Didi Hirsch because I lived in Torrance at the time. And out of the blue, it ended up being MHA-LA [Mental Health America of Los Angeles], which the only thing I'd known about them is they did this demonstration when we were closing the clinic, and

that they were running a social center here, a drop-in center at the time, that I had sent a few people to from the clinic over in Carson. I had like their social calendar and stuff.

So when they got it, I was the first person to show up to say I'm interested in the job here to be one of your psychiatrists. They thought psychiatrist was the hardest job to fill with this program. I said, "I need to be rescued. I need a life-jacket." Martha [Martha Long, MHA Village's founding director] loves telling the story – which is another sign that I was young and stupid – that my letter to them she said was the single bizzarrest job letter she's ever seen, because I was using the analogy of Nazi rocket scientists. (all laugh) I said, "It was all these Nazi rocket scientists who weren't wanted [in Germany after World War II] and had to leave and flee. Wernher von Braun [German-American rocket scientist who was recruited into the US space program after the war] and whatever. And they came to America, and we decided to take them, and they made the foundation of our space program, NASA, and our moon stuff." I said, "The County is now shedding people with substantial talent all over the place. They don't want them. You just got this grant. There's a bunch of the equivalent to Nazi rocket scientists that you could bring in."

HP: I'm a Nazi rocket scientist! (all laugh)

MR: And looking back at it, I don't think I would send that letter again, but it did have some truth to it. This was a rescue for me that says let's hide away from the system as a whole, a system that I feel traumatized by and angry at. It's doing poorly. And before I give up on people with mental illnesses, can I figure out a better way to do it? Is this really the patients' fault or the system's fault? Should this be about, you know, never mind – now I get it why people don't want to work with schizophrenia. So forget this, it's a mess, the public sector; they kill people, they don't follow through, never mind this. Or should I say maybe it's still possible if we got to do things, if the system made sense from the ground up?

This was a true experiment. It was back in 1990. A small experiment of a hundred and twenty people here and a hundred and twenty in a control group that were just getting normal services. And we didn't have to do anything the way it had always been done. We could build everything from the ground up, figure out what would be the best way to do it. Whether it's a call system, whether we buy hospital days, whether we go to see them there, what kind of pills we give, what the teams look like. They just cared about the outcomes. No Medi-Cal paperwork, no formularies, no chart notes. What chart notes make sense? We decided a case manager making a note once a month to tell the story of what happens in the month and describe how many minutes they spent doing this, instead of writing a note every single time, made sense. So that's what we did.

Everything had to be built. Someone who did an evaluation early on said we were going to dive in, without principles only to practice on, because there isn't all this interference going on, which was an extraordinary opportunity for me. I had been doing some innovative stuff. I had created a little like rehab clinic where, instead of all the people sitting around waiting for their decanoate shots in the waiting room [many antipsychotic drugs are formulated with a decanoate, or fatty acid, base so the medication lasts 2-4 weeks from a single injection], I let them hang out in the day treatment room and play pool and stuff. We did relaxation exercises and went to the park, and they talked to each other and called to find out what happened if someone wasn't there. We were doing some stuff like that. I was doing some home visits a little; I was doing some kinds of these things. But this put a whole rocket engine underneath my career. Here's a bunch of researchers, a bunch of other people from everywhere –

and they were people, especially our professionals, who came from the County, most of them saying I don't want to do it the way it's been done. To build this experiment and say, what's the best we can do? How can we build a whole new thing?

And we did it very pragmatically. There was no such thing as a recovery movement at the time. The closest was psychosocial rehab that came from the rehab clubhouse [a model developed in New York in the 1950s, which involves persons with mental illness as partners in providing supportive services and activities for each other]. The only place I'd only seen this practiced at all was at LAMP, in Skid Row. About half of the cool ideas I brought here I brought from Skid Row, where the normal rules don't work. Things like med management or socialization or drop-in or outreach or group case management. The only place I ever saw that was Skid Row and at LAMP. Skid Row Mental Health [now Downtown Mental Health Center] was actually a very innovative place at the time, too.

So that's how I got to the Village overall. I thought it was going to be a nice place to spend three or four years to see how the experiment does – it'll be good for my career, and we'll see what happens with the economy.

MM: This comes from your book on recovery. You say in 1991, Bill Anthony [William Anthony, PhD, executive director of the Center for Psychiatric Rehabilitation at Boston University] came here and spoke and talked about recovery, and you said this sort of shocked you. But three years later, you were sort of talking in that vein yourself. So was there a process that sort of developed in your mind as a concept?

MR: The shock was the other way around. So we're here for like a year. One of the things about the Village being run by MHA is MHA is predominantly an advocacy group. They spend tons on advocacy. People with big mouths all over the place, the best PR group in the world changing all kinds of stuff, which had a great effect on little things like our homeless drop-in center. I said, "You know, none of those people who come here take meds, and they were all falling apart and having these problems." I said, "You know what? I learned something on Skid Row. They're not actually med-resistant, they're clinic-resistant. If I show up there with some meds, they'll actually take them there." They said, "Really? Okay." And they got a little money from the County and three hours a week at the drop-in clinic, and sure enough there's a line up to my desk to take meds; they just didn't want to go to the clinic to take meds. And that turned into the elaborate programs of today. And that got spread to other places. So there's great advocacy.

So we're out there doing presentations of our wondrous stuff. We're only six months into it, but the outcomes were already very positive. And we're noticing that we really are doing things differently. At the time I'd heard about psychosocial rehab and read some stuff about this, and I started thinking a little bit about recovery. I'd learned some stuff about moral treatment back in the 1800s [an approach to mental disorder based on humane psychosocial case or moral discipline]; that's one type of recovery.

Substance abuse has another kind of recovery. I ended up learning a ton about substance abuse, because I had learned to just throw them out. Here, you couldn't throw them out, because this is a no-fail program. So I had to learn a lot about substance abuse, which I mainly learned the first couple of years here. Substance abuse is really into recovery. I said, "Well, is there any way to apply this knowledge here?" And there's also some stuff about physical medicine rehab and recovery.

We had the CAMI journal, the California NAMI chapter. Their journal editor was Dan Weisburd, who's actually well worth talking to, but you'll get very unique opinions from him. He was one of the people that helped us get the Village done in the first

place. And he helped us publicize it in his journals. There's probably some sitting around here. So he was my first publisher of various things. He was publishing a whole journal about the Village to publicize us. So we were putting little articles in, and I put in mine about medication and collaboration. So he brings Bill Anthony up here to talk about leadership, and write a little article.

So we're having dinner at Martha's house. She's a terrific host. I'm like thirty-one at the time or something. So I'm sitting next to this giant who brought rehabilitation into mental health. I said, "You've spent a lot of time on rehab, written a lot about rehab. What do you think's coming next? What's the future hold?" And he says recovery. And I almost fall off my chair because I'd been thinking about recovery, but it just seemed way too out there of an idea. It's like there's no possibility of recovery being with schizophrenia? How's that going to work?

HP: What was your idea of what recovery meant at that time?

MR: What it was at the time – there is an article around which still gets passed around from one of these journals, and Martha still likes it. It's built on rehab and Twelve-Step [the action principles for recovery from addiction, originally developed by Alcoholics Anonymous] and moral treatment, that says you can recover three kinds of things. First, you can recover some kind of function, the ability to think clearly, the ability to tell what's real, the ability to sleep, the ability to have ideas in your head. You can recover in a functional way.

Second, you can recover actual stuff. You can recover a place to live, a wife, some money, an income. In some material way you can rebuild, you can recover the things that you lost. Like in a hurricane or something, you lost your whole house. You can recover by rebuilding your house.

And the third is you can recover – and this one turned out to ultimately be the most important one – you can recover self roles or feelings about yourself. You can recover self-esteem. You can recover that I am a competent person. I'm a good father. You can recover ideas about yourself, or roles about yourself.

So you could work on these three different goals. That became my initial recovery formulation: One was you can recover function from the rehab people, two, you can recover actual things in your life, and three, you can recover roles or self-images. I probably had a short word for that at the time, but I don't remember it at the moment. That was what I had written at that time. That's what I was thinking about.

But him saying that [recovery was the next thing made me think that] maybe I'm not so far off. I mean, I'm always in left field, the question is how deep in left field I am. But maybe I'm not quite as far left as I thought. After all, this guy, I mean he was mainstream and famous. If he thinks this is coming next – which I realized how far that is from Dick Lamb's approach. I mean, not to put either of them down, but they're not saying the same things at all.

That led me to my main breakthrough, the one that – if there's any contribution I made to this field, it would be – remember way back I said I spent some time in a hospice in medical school. Remember Elizabeth Kübler-Ross [Swiss-born psychiatrist], the physician who wrote *On Death and Dying*. Now, when she goes through that hospital asking people about their dying and stuff, she doesn't ask questions about their illness either. She doesn't say, how's your cancer going, is your hair falling out, are you nauseous, are you vomiting? It's perfectly valid to ask that, but that's not what she asks. She asks [person-centered questions] like I'm asking the Wolfman. She asks, how does it feel to be dying of cancer? What about your dad you haven't seen for twenty years? Are you going to do something about that? What about your kids, who are four and six,

are you going to leave them something to remember you by? What about your anger at God for giving you this cancer that you did nothing to deserve?

She asks questions like that. And when she did that, she came through with that set of stages. Remember the stuff with the denial and bargaining – anger and then depression and acceptance [The Kübler-Ross stages at end of life]. And we built a whole system of hospice based upon this. This isn't stages the illness goes through, this is stages the person goes through.

So I said, "Try to figure, are there stages here?" I've been watching people now for a couple years here, get their lives together and seemingly recover stuff. Are they going through a process like this? Can I make up some stages that look like Kübler-Ross', what happens to people along the way? When I did that I found that the bizarrest connection is that the values of the psychosocial rehab movement, and then the recovery movement, end up being the stages themselves. Or they're important because they mark the stages.

The stages I came up with were hope – you had to be hopeful first to believe something better is possible. Then empowerment. I wish actually I had used a simpler word at the time. It's believing in yourself, believing you can do it. Self responsibility. You can't be caretaken in recovery. Twelve-Step knows this. You have to actually do things and learn from mistakes, and that's where that risk-taking stuff comes in. And then obtaining meaningful roles in the community. You have to do something with your life. You have to be something.

Well, those are precisely the values I'd written little papers about, about what we were doing. Here's our empowerment – there's one lying around, called things like "The Empowerment Revolution Plan," or "Hope in Schizophrenia," or "Community Integration and Integration of Services." I had all these little papers on various things which then I put together in a little book that you guys have seen [*Road to Recovery*, cited on p. 4 above]. Because it turned out that the principles we were working on were the stages that people go through with recovery. And that's how it all melded for me.

Now, that remains pretty much my own vision. You don't hear the rest of the recovery world talking a lot about this analogy with hospice, and stages of a personal recovery, etc. When people hear me – first of all, I did this as a speech, I put it together. This was probably in like '94 or '95 or something like this. It was at Cal State Long Beach in the basement of the Pyramid [a sports center], a room in the bottom of the Pyramid. And it was for the field supervisors for the social work interns. Because I'd gone to talk to the social work interns a few weeks before. They'd invited me to their class, where the interns are all falling asleep because they were like studying hard or something, and they didn't even know I was there. But the teacher thought that was really cool, actually, so she invites me to talk to this big group.

I talked to this group, and the whole audience ends up capturing the whole thing. I'm on to something. A couple of people I even knew were like in tears. My God, this whole thing – that I'd stumbled upon something that really touched people and put it together; the whole room put it together. I can still, in various versions of that speech or that ended up in the book, putting it together, end up really touching people a fair bit, even though it's now sixteen years old. The shock wasn't that I was doing it wrong, the shock was that I wasn't as far out in left field as I thought I was. (he laughs) Strange thing.

HP: Now, what's interesting about this is, you know, talk about borrowing this idea of stages, that's kind of an emotional process that that describes. But we're referring to recovery as something that does have some biological bases, involving brain chemistry and things like that. So how does that translate?

MR: I don't do it that way, actually. I don't think illnesses recover. I think people recover. Your emotions can have biological things that change better or worse as you're having – like being terribly deprived can make your emotions, make you sort of sad and that can take your chemistry out of balance, or getting back together can make your chemistry better in balance. But the fundamental process for me is not firstly treat your illness, get your biochemistry together; then we use that as a foundation to rebuild your life and get more function and doing things. That's the standard medical model.

And even today, if you see the Southern California Psychiatric Newsletter [digital newsletter of the Southern California Psychiatric Society], they'll say it's obvious that medication stabilization is the first step of recovery, and we need to have more involuntary medications and things to get people on the right road. Not true. You can recover and *die* from your condition, just like the people in hospice. It's easier to recover if your symptoms are better, and I'm not against making symptoms better. But it's not the prerequisite.

And here's the system design thing that's really weird, is that our present system says first you come in, we do a diagnosis, get your symptoms under control, then we help you rebuild your life. And then we'll do some wellness and recovery for your self-image. We'll do it in order like that. It's a system design and we've got a system set up like this.

But when I was forced to just follow people on their own path, that's a rare path. I'll give you an example, a story of this. One of the early members of the Village was this little lady, who was just up from Mexico. She had very severe schizophrenia, all these religious symptoms, but she didn't think she had any illness at all. She'd lived in a little town in Mexico, spoke only Spanish. She'd actually had a bunch of shock therapy down in Mexico, and was even going to have a lobotomy in our day and age, but she ran away and came here. Her family sort of rescued her, but she had no money. She was in our Spanish-speaking ward at Metro [Metropolitan State Hospital, the main Los Angeles state psychiatric institution]; she ran away from there repeatedly, and she's one of the Village's first members. No money, no benefits, with her stuff in these giant trash bags around the corner, right out there. Help her out. She won't take any medicine. I wanted to give her decanoate [antipsychotic drug] shots for two weeks, to relax her, because she's not too compliant with medications. She won't do that at all because a needle once broke off in her rear-end in the hospital, so she was afraid of needles.

So I had this person that's really stubborn, really religious, this giant mess, and what are we going to do with her? And we started working on practical stuff. All right, let's put the mess aside, let's get her inside one of these little apartments right around the corner here. We'd do these little home visits at the time. One day she took this huge refrigerator and she threw it down these giant stairs, and the refrigerator was like three times the size she was, because the devil was talking in the back of the refrigerator. You may have heard devils talking in the back of your refrigerator at that time. There was holy oil all over the place; she was cooking pages of the Bible in a frying pan.

So I did what anyone in their right mind would do; I put her back in the hospital to get her together. And she does terrible in the hospital. She was taking other people's clothing. She was making a mess of everything. It was well-intentioned, but – It was hard to get her to take any pills. She'd scream when you tied her down to give her shots. So finally I said, "You know what, the hell with it. This is going nowhere. I give up. Here's a board and care room she can stay in, and put her stuff in here, whatever she might like." We put her stuff in there, me and a Spanish-speaking case worker with me. And we watched together as she walked down the streets, away from where we'd set up. That in itself, there's some letting go to this model – just watching her. We cared a lot, but what the hell's going to happen next?

She reappeared within a week or two in the lobby of the apartment building that had the one that she threw the refrigerator out of, hanging out there, kind of camping out there, and getting food from the old lady who was the manager. I said, "Oh, she's there. OK, let's let her stay there. Let's buy her a little apartment." We tacked down the refrigerator and the stuff. (all laugh)

And we're going along and it gets a little better, kind of hanging in there. And then she says – she doesn't have any money, she wants to donate more money to the church, so she wants to wash dishes in our café to get money. Any program in their right mind would say, sure, we'd be happy to have you wash dishes, when you're *ready*. Cooperate a little bit. And by the way, ready means are you prepared and likely to succeed? The Village uses a different definition of ready. Our definition is, are you excited and motivated?

Think about it a second. By the definition of ready as prepared and likely to succeed, were you actually ready to do anything important for the first time in your life? The first time you had sex, were you prepared and likely to succeed, or motivated and excited? (all laugh) Think about it. How about the first time you had your own apartment? The first time you got married? The first date you were ever on? The first time you had kids? Nobody's ever been prepared and likely to succeed the first time they had kids. All these things you get ready in retrospect.

HP: What do you mean "ready in retrospect"?

MR: That you got ready by doing it. You've learned how to raise kids by raising kids, how to have sex by having sex, how to have an apartment [by having an apartment] – so the job of the caseworker shifts from getting someone ready, prepared to be able to do it successfully, to helping them learn while doing it unsuccessfully or increasingly successfully. That's the difference between job preparation and on-the-job coaching, and between housing preparation to being in the apartment, in supported housing. The entire shift is from "I'm getting you to the point where you're stable enough to do this," to "I'm going to help you learn *while* being unstable."

Going back to the lady with the washing dishes, I said, "Sure, go ahead and wash dishes." And she was really stubborn. But that's not really the point of the story. The point of the story is that she comes to me about a week or two later and says, "You're always trying to get me to take pills and stuff. I'm struggling at washing these dishes. I forget what I'm supposed to be doing when I walk in the room. Do you have any pills that will help me remember what I'm doing and help me focus?" I said, "Sure, Haldol [haloperidol, an antipsychotic medication], five milligrams at bedtime." So she agrees to the meds and eventually even agrees to take shots, but only from me and only in the arm, and she [prays to Jesus in Spanish] and swings her arm around like crazy, and I'm afraid I'm going to break a needle in her arm.

Far more often than treatment provided the stability to rebuild their life, rebuilding their life provides the motivation for treatment. And then we say we're going to design a system based on that. The first step isn't diagnosis and stabilization; the first step is engagement and welcoming, setting some goals, working on stuff that they mess up. That's why I work on the welcoming team now. Then while you're learning by rebuilding it, that's your motivation to take some responsibility for what's wrong whether it's some emotions or illness or stuff, that comes as part of rebuilding.

There's a number of huge advantages, but two of them right off the top of my head. One is this business of insight. "I don't believe I have an illness." "Yes, you do." "No, I don't." It's a non-starter. I don't care whether you have an illness or not. You've got a problem; you've got something you want to work on. We don't have to define it as

biochemistry; we don't have to define it as emotions. I don't care. However you define it is fine with me.

I'm working on your goals and your problems, and then I see if there's some way I can be useful. Maybe teaching you how to be sober, learning Twelve-Steps, would be helpful. Maybe learning cognitive behavior therapy would be helpful. Maybe learning how to do a job would be helpful. Maybe taking Haldol would be helpful. We're all helping as part of achieving your goals so it's not a prerequisite to believe you have an illness. In the normal system, half of our clients walk away because there's a prerequisite you have to believe you have a biochemical abnormality in your brain. There's a teeny number of people who don't think they have any barriers to achieving goals in their lives.

III. Funding Issues; MHSA and Consulting on Transformation; MORS; Staff Transformation

HP: Right. So I guess the question is to what degree then would this – it's a system that's a mental health system. It has mental health dollars to serve people with mental health problems. But I guess the question then comes up, isn't it part of a larger thing of just helping people achieve their goals, whatever they may be? That goes so much more beyond mental health and part of the social safety net in society as a whole.

MR: So you get into two big implications from that one, and you see how rapidly I'm changing after years in the clinical practice, I end up working on questions like Medicaid funding systems. It's like who the hell cares about Medicaid. Because to answer a question like that, you have to take some Medicaid funding.

So two things from that. One is, when we left the state hospitals and did the deinstitutionalization, which was before my time, and then we ran short of money. What they decided was, we will focus on just the mental illness – we're the Mental Health Department. There's already a Housing Department, there's already a Job Department, there's a Supportive Education Department, there's Welfare, there's already Departments for all these things. We shouldn't be spending our money on things that aren't mental health. There's a shortage of money. We need to focus on just our people.

And that worked terribly, because all these other systems don't serve people with mental illnesses well, hardly at all. At the very least, we have to set up collaborations to make them work for our people. At the most, we have to provide an integrated service like we do right here. So for instance, the job sites here are funded through our subcontract with Vocational Rehabilitation, so that they can serve people like this, using us as a contractor to do things. The homeless drop-in program is a contract with HUD [US Department of Housing and Urban Development]. Actually, it's four contracts with HUD, or six, so that we can make housing work with mental illnesses.

At the present time, since funding streams come from different pieces, you have to combine multiple funding streams to be able to provide an integrated service. Somewhere along there, you have the question of can this work, how would this work in County clinics versus contract clinics? This is a huge problem. It's very difficult to combine multiple funding streams in a directly-run program. Contractors can do that incredibly better. So that's one thing. It doesn't work to say you've got all these sources scattered around. That doesn't work. It has to be integrated, or at least collaborative in a very strong, tightly done way. Not "here's my collaborative agreement" with somebody.

The second thing is that on a day-to-day basis, Medi-Cal, and to an even more extreme, Medicare, are illness-centered funding sources. They pay you for treating illnesses, not for helping people have better lives. So you go through a bunch of rigmarole, explaining how what you're doing to help them have a better life has to do with treating their illness. Putting it all in illness-centered language. Now, they fixed that eventually for hospice, so presumably they could do it eventually for us as well. But I think that's a ways off. And I'm sure the guys that created hospice fought against this for ten years or something.

But that is a huge problem all over the place – funding things. And that's where you get to the Mental Health Services Act [MHSA, passed by California voters as Prop 63 in 2004 and signed into law in 2005, creates a new permanent revenue source for the transformation of mental health services provided by the state]. It says that this normal set of funding of Medi-Cal can just do this one piece, but it isn't person-centered funding, it isn't integrative funding. It says let's actually pass some funding that would be integrative, so we can get out of this problem. And it was an amazing job. We succeeded in doing that.

And then we had a huge crash in the economy, and we said, you know what, any money we've got around here we've got to pick for a federal match, and the vast majority of the Mental Health Services Act was turned back into Medi-Cal rules to make it eligible for the match. Because we ended up with this interesting decision that said, "I can have one dollar to do whatever people need, or I can have two dollars to do medically oriented things that I can bill Medi-Cal for, and I've always been doing already anyway." Most people chose like a dollar ninety-two ratio. (he laughs) But different Counties and different programs choose different ways along that way. The "correct" answer, by the way, isn't one dollar. It's somewhere in between because some of the services are legitimately illness services, without even a whole lot of twisting.

This place, I think, runs on, you have to do five hours a day of legitimately Medi-Cal funded things and then three hours a day of [other integrated services], to be able to match the services to get the funding, to put it together with other funding sources. My image for this one is, today we have our TV, it's got this one plug in the back, and it's a digital thing that's got all the stations and HBO and radio and Spanish-speaking and Korean-speaking, and it's got a link to my computer, and it can tell me who's calling on the phone. I don't know how it does that, but it all comes through one giant cable. But that isn't what a TV used to look like. A TV used to have all these plugs, a UHF and a VHF and the HBO and each had its own box. There's all these different cords and giant dust bunnies in the back, and it's a giant mess, so you could get it all on the front side of everything you wanted.

It would be nice some day if we had a giant plug that just did one thing for everything. The Mental Health Service Act is not that plug. It's not sufficient money to run the entire mental health system on. It's another one of these plugs – Medi-Cal's one, Medicare's one, HUD's one, Voc Rehab's one. So right now the job of an administrator who wants to run a recovery-based person-centered program like this is to manage those twenty plugs in the back. I think we have two separate audits going on today from two different plugs. One for SSI being people's payees, they're demanding to know how are we doing that, and one from the State or something. And it's an incredible mess managing all these plugs. But from the front side of the TV, the people say, I came here, you helped me, I got the service I need. They don't know that my time sheet's got six different lines on it.

HP: All they see is basically their HBO in Spanish.

MR: Exactly. So that's the answer to the administrative question – how you do person-centered services with illness-centered funding streams? and why that's a huge obstacle. Once you get to a certain level of administration, that is the number one question people ask, about the mismatch between the funding source and the services.

MM: All right. So I'm going to try and put two questions into one question. You're developing the recovery concept. Can you tell me how staff adjust to this? I mean, was it hard to – did people have to come here with it sort of already integrated into their mindset, or was it something you needed to train people through? I mean, after a certain point you had this sort of static group of clients, and then you realized you had to start graduating some of them out of the system. And was that something that was hard for staff to adjust to? Not to mention the members themselves.

MR: Those are both key things with long answers, but they're both separate things, so we actually can't put them together. The Village is not a good example of how to create a program like this because we had such an unusual birth, between this being a state thing and this extra demonstration status, and we were working for [Mental Health America], and [we had capitation] rules. That's not going to work at Long Beach Mental Health [a DMH-operated clinic near the Village], because someone will say, "You can't do that."

The Village's way of doing things was fairly clear; we're an experiment, we don't have to do things that they always have, we build it from an experiment. And we together learned as an experimental group – we were comfortable with being an experimental program and a model and doing things new, and we'd learn it together. There's still a bunch of us who came from the very first experimental period. We think of it as the good old days when we had the experimental program.

After a good five or six years of that, then it becomes inculcating people into the culture the place already has. And culture is the key thing you're building. So we have huge orientations, we have the immersion trainings here; we have our own staff do that, we have orientation trainings, we have a buddy system. We tell people this is going to be different and you're not going to get used to it for like six or nine months. We spent a lot of time training new people – and that's like just getting somebody into a cult or a religion or to become part of the cult. It started out with a shared experiment and then it's become a way of bringing in newcomers into the fold. We have lots of rituals and stories and stuff in order to emphasize the culture we've built here. But that doesn't work when you leave this place and try to do it someplace else.

Since the Mental Health Services Act passed five years ago, I've been to forty-three of the fifty-eight counties in California. The prettiest place for a presentation was South Lake Tahoe, with the lake right there – although close is Santa Cruz, with redwoods in their parking lot. (he chuckles)

But I also got – I guess it's been like five years now – a job being a consultant to the LA County Department of Mental Health, which is how Marv [Marvin Southard, Director of LAC-DMH from 1998 through the date of the interview] met me.

I'll do a little digression on this one because it goes with your overall project here. When the Mental Services Act came through, we're supposed to do things that are recovery-based sort of things. They had in their own backyard us as one of the premier accepted models of recovery things, and Jim Allen [retired Deputy Director of LAC-DMH] came by, who I assume you'll talk to sooner or later -- Jim Allen comes by and hears me doing the presentation of the four stages. He's kind of an impulsive person. But he says, "That's the person I want to go out there and tell people, so they'll make the changes." So I was at the first meetings of Program Directors as to how we're going to

do that. I was included as a presenter to the group - here's what recovery is about, and then as a consultant. So when Debbie Innes-Gomberg [LAC-DMH District Chief who oversees MHSA funds] does the first set of clinics, the big six and the big seven, me and Bruce Anderson [consultant from Community Activators in Seattle] were included as consultants, a job I've done to various degrees ever since.

I'll tell a little of this story along the way here. One is, this was not easy for me, because I'm going back to the very same system that I escaped from and was so traumatized by fifteen years before. Not only that, Jim Allen was the administrator who closed our clinic, and was in charge of things, and "let this happen to Robbyn [Pannitch]" in some ways, although that's not a fair criticism of a high level administrator, but in my emotions, that's where it was at. For me to go back to the very same place that had been so traumatic and now asks me to come and tell them what I've been doing and that they care about it now, fifteen years later, was difficult.

That was the emotional piece. The practical piece, which I think was one of your questions is, can this be done in the County culture? Can this be done in direct services [that is, directly-operated programs]? This isn't the County mode. This risk taking, will that work? What about Civil Service? I didn't have any great motive one way or the other of does everything have to be contract or not contract. I mean, I don't care particularly one way or the other. So that was an open, just a more intellectual question. But the emotional reaction sort of moved me against [direct County work].

The emotional part helped at the beginning, because as I went to these other clinics, many of their staff were traumatized in a variety of ways, or beaten down, or felt destroyed or mistreated in a variety of ways, and they could sense the same thing in me, that even though I was coming to them, being brought in by high administrators -- but they knew I wasn't really one of the administrators. I don't talk like them. I'm different. I would spend time with them; I'd crab on their behalf on various things. I related more to the clinicians than to the administrators that I was actually working for. So that gave me some ability to work in clinics, or work with clinics, on these transformation things.

What became clear along the way was that – and this is not just true of LA County Department of Mental Health. I've worked now in a variety of other places - the vast majority of mental health programs are in far too bad emotional states to transform into anything. They're barely hanging on, treading water. They're all beaten down and traumatized and burned out in a variety of ways. And we spent a lot of time asking, how can we get the morale around here a little better? How can we get them more invested? There's a lot of burnt out people who were innovators earlier in their careers and they're just burned out; "I'm not doing this any more." They're heartbroken people that wanted to believe in something again, but it's like, never mind, I've been betrayed too many times.

That consultation job was heavily into the trust and betrayal and trauma [that staff were feeling]. And there wasn't a whole lot of motivation of staff wanting to transform into this anyway. We did this for a couple of years, with some modest success, and then the bottom fell out of the finances and the whole thing had to move to Mental Health Services Act funding, which gives this huge economic push – It was supposed to be just a fifteen percent add-on to the system, not a replacement for the whole system. Which made it happen incredibly faster than it ever would have, but in an incredibly more tragic way than it ever would have.

So I've been part of that process since, and – I've figured out a few things from this: One is that, until we have a time where we have a recovery-based system, recovery practice will be based on individual staff making personal transformations. The core shift of the thing is this difference between illness-centered and person-centered: that my job isn't treating mental illness, my job is helping them have better lives, that I'm

relating to them emotionally as a person, and to what they're going through, not relating to them as a diagnostician fixing their illness.

Which no one was taught. We were trying to do this in San Bernardino. The staff said it's unethical to do this or that. You've got to create boundaries, you've got to keep distant from the people you're supposed to be helping. Some people will make a shift, and you probably will meet people along the line who will describe when they sort of got it, or when they shifted along the way. And at this point there's a scattering, way more than there were five years ago, but not enough to run a whole system, and by no means a majority of anything.

We have succeeded with some individuals transforming, getting things, and we have succeeded in changing the structure of the thing, to this welcoming and engagement thing, integrative services and FSPs and some clinicians are leaving their offices now. A lot of actual structural changes have been made.

At this point, I'm a fan of Ken Wilber who says that there are four pieces to change – which if you want to be asleep or have your head spin, try reading – but his point overall is right. [American author Kenneth Wilber has written extensively about his theories of psychology, philosophy, and ecology.]

So there's: 1) what are my internal values, 2) what is my practice, 3) what is the culture, and 4) what's the system? For anything to truly transform, it has to change all four, and it has to change all four simultaneously no less, because the one you don't change drags you back. I mean, the Village just built all four differently. So for any other program, we try to go and say, "So which are the ones that drag you down the worst here? Is it the values of the staff here, is it their practices, is it the culture of the place, is it the systems and these kinds of payment things, so they can't even paint their own walls?"

My present consultation keeps spinning around those four things, which we work on all at once, but it's a long process. I mean, if we told someone we're going to transform and make a whole giant revolution, and it'll take a generation to do this, say thirty years to do it, that makes sense. But since none of us have ever watched a thirty-year transformation, how do we know that we're ahead of schedule or behind schedule, doing it right or doing it wrong? So we're five years into it. Are we ahead or behind? Have we done a little transforming, or a lot of transforming? Are we ahead or behind? Are we doing well or poorly?

Bruce [Anderson] had a quote a couple years ago, when we were talking about trying to stick with this. "As the months go by, I get more and more hopeful that we're actually going to make it and more and more frustrated by the obstacles of any given day." It's very hard for me to tell whether this transformation process is on schedule or not.

HP: What would you say here in LA have been a few of the successes in the transformation process, and a few of the real challenges that you've had, things where you were hoping to see change and it hasn't come about yet?

MR: There's been huge successes structurally. They've literally transformed the structure of many of the clinics, from having these welcoming teams and programs, to thinking of services flowing through, to building FSPs – There were no ACT teams [Assertive Community Treatment, a team treatment approach designed to provide comprehensive, community-based psychiatric treatment] in Los Angeles ten years ago, or fifteen years ago – to having Wellness Centers for people to move to. This whole idea of a structure of flow [that is, of patient flow through stages of treatment to wellness] – That structure is now the way people talk about things, and no one had any of those

ideas in their head ten years ago. So when you see them at a meeting now and they're thinking, "What are we going to do about these people? We have too many cases", they're thinking in those terms, not in the terms they would have discussed the same problem ten years ago.

HP: Which would have been get me more funding so I can get?

MR: Well, they would have said here's my clinic thing. I need ER beds for this, I need step down units, all [determined] by the acuity of the illness. I need day treatment. The pieces were illness-acuity-centered pieces, and now they're [seen in terms of] phase of recovery pieces. And I think the administrative structural language has been the substantial success in many places.

I think the MORS [Milestones of Recovery Scale] is well on its way to being a success. Do you want me to digress and tell a story about the MORS?

MM: Yeah, we wondered about the MORS.

MR: So the Milestones of Recovery Scale. In about, I think, '97 or so, CASRA, the California Association of Social Rehab Agencies, puts together a two-day retreat. We thought managed care was going to take over all of mental health at the time. It was getting big. Iowa had just switched [its state program to managed care], Massachusetts too; it was all going to be about managed care. We wanted to come up with some rehab categories for managed care groupings and contracts and outcomes, before they got all clinical, that could inform managed care. So we sit there in this group, and it's like a hundred people, they have a grant to do this, of some line staff and consumers, people that ran programs, family members, and administrator people working together, and we, tried to figure out what's the tool going to be for these managed care groups.

The MORS was our outcome for that, of here's a way of tracking people through their levels, and then you could theoretically [also use their level as an outcome] – there's one interesting thing that happened like halfway through. We realized, wait a minute. Those aren't just the input categories. They're also the outcome categories, because you don't have to track changes like housing separately, because they move MORS levels. Sure, important things happen in the middle, but a really important thing will move you levels.

So the same one-page, two-second tool could not only be the groupings for your service packages. They could be the outcomes. So you could theoretically write a contract that said I'm giving you a hundred MORS "fours". By the end of the year I want no more than twenty of them to have gone back to "one", "two", or "three"; no more than twenty still in "four", twenty to have gone up to "five", and [twenty to be at "six", "seven", or eight,] whatever the benchmark is. You could write a contract that looked like that.

We did that as a product, and nobody cared about it except David [David Pilon, Executive Vice President of MHALA] and me and a lady named Shelly Levine, for years. Because managed care died and nobody cared about it. I would show it to people on napkins. They'd say that's pretty cool and it would go no place. (all laugh) Occasionally, David or Shelly would find a little money to do a little validity study or something, and put it together.

And then the Mental Health Services Act made it take off, because now this is a way of saying, how could we track people? Well, use this tool. We got bunches of connections for doing the studies that show it's a valid scale and people move through it. We had partners in Massachusetts. The entire state of Massachusetts is shifting to using the MORS on everybody. There are people from Texas interested, Montana's

interested. We're doing this in San Diego and San Bernardino and all over the place. LA is going to put it in all its clinics. It's become this concrete tool. It's a replacement for the GAF score.

MM: Global Assessment of Functioning.

MR: Right. The Global Assessment of Functioning score has an interesting incorrect assumption in it. It assumes that symptoms and function are inversely related, that everyone, as your symptoms go down, that's what determines your functioning going up. It's based on the biochemistry model. Except that's not actually true, because what do you do with someone who has a lot of symptoms and a lot of function? Is that a thirty or a seventy? How about someone with almost no symptoms but almost no function? They're doing nothing, but they're stable. Is that a forty or a sixty? The MORS tried to go through getting rid of the risk, engaging, connecting, [building skills and supports, moving people on to self reliance and community integration]. And it's not a linear scale, it's like a set of gates that moves them along.

So we're doing massive MORS trainings. We're building stuff for e-learning stuff to spread this around. But this has been a way for many people to concretely – even if you don't get the emotional transformation of recovery, you can get moving people along and moving through services, and design services to move people through that. And that has been about two-thirds of the way that transformation] gets embedded in practice. It's a language people are talking.

There has also been striking success in including consumer staff in at least an affirmative action, separate but equal, sort of way, which is a step in the right direction. And that took enormous work through HR [human resources] for various things. That varies from our Jump Start program that does these trainings – I was doing a presentation on listening to a set of people down at 8300 [South Vermont, LAC-DMH's Women's Reintegration Services Center] for Model Homes, an employment program for people with mental illness. Consumers have been included in ways that I didn't think would happen nearly this fast.

HP: Such as?

MR: There's now consumer staff at work – I can walk in the place and they'll say I'm the consumer peer advocate. And when we first started, staff would say "I'm never working alongside someone I used to have in my caseload. I don't want to damage our relationship; I want to take care of them." I went to these meetings there to try to help staff get used to this in places. And there's still some of that, I'm sure.

HP: But you said it was kind of separate but equal. In what ways?

MR: There's two ways of looking at peer services. It doesn't have to be one or the other. One way is to say the highest kind of service is peer-provided services. If you can get everything peer provided, it would be better. If you'd have a psychiatrist that had experienced a mental illness, that would be better. To have the consumers run things, that's the ultimate; try to head toward that direction. So then you try to set up consumer-run, drop-in programs, Project Return programs [Project Return Peer Support Network, a program run by and for people with mental illness], a variety of programs that look like this. And we have some, which didn't exist before either, except our Project Return.

The other way is to say people with lived experience in mental illnesses bring a value added to any job. Like speaking Spanish, or being from here, or being a parent

brings a value added. They know things, they can connect in ways, they can do outreach in ways, they can help people rebuild their lives and give hope. They can do a variety of things that the people who don't have mental illnesses just can't.

So what you really want is as much of that value added in every position you can come up with, but it's not the goal to get everybody to be consumers. The goal is to have as much of that enriching your program as possible. And the goal from that point of view is two things. One is that people with mental illnesses will be accepted as our colleagues. And two is, the people already working with us who have serious mental illnesses feel safe enough to come out of the closet. Because right now people don't. And there's a lot of pain to that. It's like talking about being an undercover agent and betraying yourself sort of thing.

Right now, you can come out if you're a peer advocate, but it's still not safe to come out if you're a psychiatrist. And there isn't a job path that goes between peer advocate, social worker, and program director, and things like this. That's what I mean by it's there, but it's got a ways to go, and I'm more in favor of the integrated version rather than let's build a consumer-run system here and then you go to your doctor outside, which is like Fountain House [a self-help program in New York City operated by people recovering from mental illness in collaboration with a professional staff] doesn't let psychiatrists work there because "They'll ruin our clubhouse environment. We have consumer things here and nothing else." I think integration is more important than purity of consumer-run things. I think people need integrated things, whether it's employment or meds or whatever it is, everything ought to be integrated, including self-help and peer advocacy and this sort of thing.

HP: So just with the transformations, what are some of the things they haven't done so well?

MR: The overall morale is still poor. In most places they are still struggling to do anything, to get a better energy level. There still is always this effort, "how do I get my staff to do anything?" Overall energy level and morale – of course, it's not fair to say we've done a bad job, because we've gone over a cliff while we're doing this. (he laughs) But the overall emotional health and energy and life blood in most of these programs is still much lower than you would really like. They're still not pleasant places to work or to come to or energizing, or places of healing or asylum or acceptance or sanctuary, or whatever. They can't provide that emotional core. The Village is much more emotionally healthy than most clinics.

The other thing is, the vast majority of staff still haven't made the fundamental shift from illness-centered to person-centered. For example, I saw this paper [one of the clinics in] the Department of Mental Health was making up about when you're ready to go to the Wellness Center: "You're ready to go when your illness has been stabilized and your symptoms are controlled; then you're ready to go to the Wellness Center." I'd say, "You're ready to go to the Wellness Center when you become self-responsible, whether your symptoms are controlled or not, whether you're hospitalized or not." If you're stabilized and irresponsible, you're not ready to go to a Wellness Center, and you don't have to be symptom-free to be in a Wellness Center. But they're still looking at an illness variable rather than a person variable. To me, the vast majority of clinicians have not made that fundamental shift.

The second disappointment is the vast majority of clinicians have not built new rehabilitation skills. They still don't do welcoming very well, home visits very well, apartment finding, supporting services, very well. There's a set of skills – and this is both with the existing staff, or new staff – when you start to change your staffing

patterns. This is so heavily civil service and unionized and stuff that to change to a staffing pattern that would include a financial – there is no payee program anywhere in the County. And there's nobody who's qualified to be a payee.

HP: Oh, in the directly operated.

MR: Right. But the contractors do it. So their staffing patterns haven't shifted, and the skills of their staff have not changed substantially. But that, to some degree, goes along a little with morale, because it picks up on a thread I told you back a long time ago. Remember I said when I first started to be a psychiatrist, there was a vacancy of psychiatrists everywhere in the County. And I said Rod [Shaner] fixed that.

Well, doing that came at an enormous cost. I'm not saying he should or shouldn't have done it, but doing it came at an enormous cost, in that Rod massively increased the salaries of psychiatrists, massively increased the recruitment, increased retention, and then psychiatrist slots routinely were filled everywhere. He has a little trouble out in Antelope Valley, or in the jail or something. But by and large he's got all the slots filled.

As a result, virtually every other service has been gutted, because paying psychiatrists is very expensive. And the pills are very expensive. So that the average clinic is an elaborate medication support service. Example story is, I was in – I think it was in Hollywood [Hollywood Mental Health Center], and we were trying to talk about flow, about people moving on. Debbie [Innes-Gomberg] was there as a consultant. Debbie gives an example, "Say someone comes in, they were in the clinic before a little bit and they came back, and they've got some modest depression and they're off their meds, and they want to get back on. You're seeing them now. Can you visualize some kind of plan that would maybe in say six months or a year they'd be able to go on to wellness and leave?"

Now, since it's Debbie, she likes pushing CBT [cognitive-behavioral therapy], which is supposed to be the answer to this, but they didn't figure that out. They said, "Well, you said she was off meds. We'll get her back on her meds." "Okay, you get her back on her meds, what else do you do differently?" And the room went dead. A few minutes later I said, "You know what? Let me go back for a second. Here's a bread-and-butter case, not terribly difficult, just the depression, before we add weird street drugs, and then psychosis and some psychosocial bizarre thing. Even for depression, you don't have faith in anything, besides meds as the way to get this together."

It's not that they don't have a faith in psychosocial rehab or recovery. There isn't a faith in anything besides medications. They'll use therapy to maintain relationships; they'll use case management to get paperwork done and to get them various things. But the idea that they have faith in "if I see you for twelve weeks you're going to get over this trauma, you're going to learn some skills and stop using drugs to stay clean. You're going to learn how to talk back to your voices, so that you can cope with them and go back to work. You're going to learn how to have less negative thinking and less depression, so you can get up and do things, so you're not stuck housebound in your panic attacks."

All of those, they're retained by a few – the most successful staff in the County system (this is how the problem is generated) who have learned how to keep the system away from them, how to work by themselves, make a little world for themselves and for their clients, help them do stuff on their own, so they can thrive on their own. Recovery is a group team thing, culture thing.

HP: Yeah, so it's a real paradox.

MR: Right. To tell the people who've been successful by staying away from everyone else, "Come join these jerks that you can't even fire." Because every clinic, because of Civil Service, has like a quarter of the people who aren't doing anything. "That's going to be your teammate with whom you're going to share your clients" – "They're mean to me." "That's your teammate with whom you're going to share your clients" – "I don't like that person." "That's your teammate with whom you are going to share, who you're going to build a culture with." "I don't want them talking to my people." That's absolutely what we've not been able to get around – to get most clinic staff to like each other and trust each other, to work together as a team, to support each other emotionally, to go through these risks together, to help them learn new skills, to transform, to be in this together, to create an emotionally healing place together.

Because, unlike here [at the Village], they didn't get to hire their teammates, they don't get to fire their teammates, they don't get to choose, or hold each other accountable for anything. If you find someone who doesn't do anything, sorry, there's nothing I can do. The Village's number one reason for firing people is being disrespectful to members. I don't think anybody in the County's ever been fired for that.

Building new cultures that sort of get recovery the best – the places that have done the best is if you have a very charismatic leader who is devoted to things, and the culture flows from their personality, and they do know how to manipulate the rules; if they have to get rid of this person, and get that person in. They've got administrative strength and they'll stand up to things and hold it together and make it. We now have enough support from administration that if you have a leader like that, who's terribly devoted to making things work, and you leave him in the same place for three years, which is unlikely – the leaders keep bouncing around all over the place – they could make substantial inroads. It disappears when they walk off. Len Tower made inroads at Arcadia [Mental Health Center, where Tower served as Director] that disappeared when he walked off. Wendi [Wendi Tovi, Director of the San Fernando Community Mental Health Center] has made inroads up at San Fernando Valley. It's still there. She's still there. There are some other people too that can do it for awhile, but –

You said, how did the Village transform? As far as I know, that's the model: Enough administrative support, enough lip service, enough control of things, and enough individual autonomy to manipulate things. If you have enough administrative skills, if you've got a leader – you usually need two or three in your place to make this work so you don't burn yourself out – you could do this. And some places are somewhere along the line of doing it. But that's a tough model, especially when the leaders get moved around at the whim of people above them.

HP: Interesting.

IV. Client Flow; Stigma; Closing Comments

MR: Do you want to hear the flow answer?

MM: Yeah, give me the flow answer.

MR: Creating flow was the single hardest thing we ever had to do; that's what I think. This is – how many years ago? Six, seven, eight, somewhere in there. The program had already been in existence for ten, fifteen years – good culture, strong, and all this stuff – before we started really trying to move them on their way. And the problem was the Village was doing very well, and people were doing well, and we had a waiting list that took about one new person every two months, because there's no dropouts in

programs like this. That's a huge difference – one of the things about recovery programs is people don't drop out. They just stay. That's how you normally create openings is dropouts. In the normal clinic, most of the flow is spillage, not flow. (all laugh)

Now, most programs would say, "Fine. Well, I guess the Village is doing fine, we have an opening; we'll take someone." One of the things about the Village working for MHA is that we think our job is to change the system through advocacy and try experiments even that are financially detrimental to us, to lead the system and show it how to do things. So we said, "How can we torture ourselves and change focus? You're going to need it some day."

The Mental Health Services Act came a couple of years later and they didn't think about flow at all. Remember those first elaborate stakeholders meetings? Some of the questions you were supposed to fill out were, "Tell me what the needs are in this community and what services you need to meet those needs." That is not a flow question, that's a capacity question. The flow question is, "Tell me what the needs are in this community and what services you need so those people are no longer in need." That's a flow question.

As a result, [throughout the State,] we built capacities, huge FSPs, and [several years later,] they are all filled. So the Village had the advantage that we were working on this question two years before they even started. So we had been working on it for seven years, or something like this. And it is hard on both sides. First, there's huge administrative reasons not to. And one of the true sadnesses here is that our contract negotiations have been so disrupted over those seven years that our flow experiments have gotten always disrupted, and we can't tell what would have happened.

For instance, we had a freeze on admissions for *nine months* last year. That doesn't help us do a flow experiment. Then suddenly we'll have to end this and bring in lots of people. Our flow has been determined virtually entirely administratively, which is to some degree financial, but not entirely. One of your questions said, "What do you think has been a huge obstacle?" The inability of DMH to manage contracts. I said it's hard to do recovery transformation in directly run clinics, but [if they're going to try recovery with contracted programs], then they have to have this extraordinary ability to manage contracts, using outcomes, using flows, using culture. DMH has no inherent ability to do that. The people who run contracts for the County don't do client-driven contracts, they don't think about the clients at all. So if you say they're not going to [be able to run recovery programs] directly, then they have to build client-driven contracting ability.

HP: And that's difficult, especially if you have people drawing up the contracts who aren't providers, who don't speak the same language.

MR: Exactly. So before we even ask "Could it be done by a contractor?" you'd have to create that ability. I've never had the job of being a consultant to the DMH contractors. Occasionally I'd run into people like that, but that would be a whole new challenge – I don't believe anyone's even started that job. I may be one of the only people who've even thought of that job. (laughs)

Part of [the problem with the Village and flow] is that the experiments have always gone awry because we're contractors. The second thing is, all the incentives go against flow. So any given program is not going to do it for their own good – you're looking puzzled.

HP: Why would there be an incentive against it?

MR: If someone's doing better and it's easier, it's less work than moving them on, the person you like and says they like you.

HP: And the person that you only see once a month to give them their meds.

MR: All to take the new person, who's a troublemaker at the beginning and all these problems. This is true whether you're running an IMD or a hospital, every program works like this. We've got it set up, so if people don't move out, you don't have to take any new ones.

So you're always fighting against a natural self-interest. The only way to do this is to make a huge cultural shift that values "flow," to be able to push this, to make this really part of the clinic, and how they structured it. So the Village spent years doing this culture shift. We had someone who had a full-time job of doing this at one point. We said, "Your job is to help make a culture shift, to talk to staff about what problems they're going through and help people find other referrals to go to the outside and do various things that connect to the outside."

And we do it, and a bunch of clients do well; and one does terrible, and everyone keeps telling the story about the one who does terrible. "I'm never going to do it again; it's not going to work." And we don't trust any of those services out there, and besides, the services *were* crappy. What is a community Medi-Cal provider? It barely exists, and certainly they're not going to continue this philosophy. Because – I mean, there is a way of doing this philosophy, once you're doing better and self-responsible. But that isn't what anyone's practicing, are they?

So that's when we built the Wellness Center. You can date that. So pushing flow started a year before the Wellness Center was built, whatever year the Wellness Center started. MHA built the Wellness Center and said, "We're going to create a low-expense place that people can go to, just to get meds, and community integration and self-help things and peer advocacy, a place you graduate to." But there's a little of a copout to that, because you didn't actually make it out of the system.

HP: You're still in it.

MR: We just made a step down, instead. That can be more and more of a copout until you can't even tell the difference between the [standard services and the Wellness Center]. And in some clinics, it's very hard to tell what's a Wellness Center and what isn't. But it did make us also think of what are the services at that level. And it isn't rehab any more. It's community integration, it's self-reliance, it's self-help. It isn't wraparound. It isn't job coaching and supportive housing and money management and med management. It's a whole different set of services that we didn't even notice we weren't providing the people who were still here. So they've graduated to wellness, but their needs are actually different. And that's still in the process of evolving, really, what a true Wellness Center looks like at that level.

My scheme, which I don't know if you're familiar with or not, says let's simplify things a bit from the MORS eight stages and have three. One is for unengaged people. What's welcoming and engaging for people who are disconnected: What's drop-in? What's first steps? What's connecting for people who don't really show up much for crises or various things? Second is the middle spot for people who were engaged but poorly self-coordinating: What's their learning to deal with their illness, learning to get off of drugs, learning how to have housing, this kind of rehab? And third, self-responsible people: What's community integration, self-reliance, doing without us, leaning on natural

supports instead? Notice how different that is from let's get your illness stabilized. I'm working on a different set of stages, or different levels.

HP: Right. Different question.

MR: So we put "the graduates" over at the Wellness Center. And every time they had one crisis over there, they'd say, 'Oh, the Wellness Center's no good!' Even though it was our own staff over there, so the criticism was a little blunted, and people wouldn't let more clients move. The first crisis is always caused by just moving over there itself. And then the Wellness Center says, "Oh, you come and rescue them." And this and that and they don't want to go and all these problems, and it's a terrible mess. And people don't want to move. But over the years, each year about twenty or thirty people of the four hundred or so graduate and move on.

HP: From the Village into wellness.

MR: You can say, "Well, that doesn't sound like very much." Except it's enough to never have a waiting list. If the County didn't put freezes, we would have been able to take people throughout.

And also, the other thing that's happened – The Village has gotten to be this weird place because since, over the years that's added up, the core Village members that have been here ten or twenty years are the hardest ones – There's some people that don't move on. But there are the ones that do move on. So I think we actually have achieved flow, but, because we've had a freeze for so long, we're trying to apply the knowledge to those people least likely to be able to benefit from it, the ones who are stuck here [and struggling for a long time].

And there still is a lot to be learned, I think, on the edges, of what does it take for someone in Wellness to be able to move on to the community itself? Some of it, I think, we got a huge break just now with the National Health Reform, because a good deal of the reason why people can't move on is because they're uninsured. If there actually is insurance to get things paid for, that may – maybe it's not as big as I think it is, but that may be a way to move out of the system that, for a lot of people, no matter how well you get, if you still need meds that cost hundreds of dollars, how do you do that? You're stuck anyway. A lot of people are stuck at that place.

But a bunch of people have moved on and done amazing things over the years. One of the really cool things about spending twenty years of your career in one place is I know the stories of where we came from and I can hear someone say, yeah, I remember when this was this way or where they came from. I really can see that recovery isn't a vague concept. I've shared lives with hundreds and hundreds of people who've recovered. I have seen them go through the process, and that's been a huge gift to me back of seeing that this isn't "let's sell people some theoretical notion."

In the same way if you work in a hospice, people do die with dignity. It is possible to have [a mental health program where people do live with dignity]. Hospices are not depressing places. Hospices are stunningly alive, caring, generative, with volunteers and people doing holistic things. I think if they can do it with end of life care, we can do it with people with severe mental illnesses. And we've been working hard on it.

A good deal of my attention the last few years has been not on questions like "How do we help people the most?" It's on questions like "How do we transform other systems?" which is an entirely different kind of question, far from my original training.

I guess the best thing I've learned from that is that one of the things we've learned about recovery is that if you want the staff to treat the clients in a certain way, you have to treat the staff in that way, which is based on the administrative structure and the program director, and how many steps it goes up. Because if you want a system that's based upon individualization, taking risks, empowerment, looking at your strengths, people getting more resilient, building things about their lives, being involved in their activities, getting emotionally connected, that's the same thing your administrators have to do and your structure has to do, which of your leaders are using recovery principles in their leadership, your program directors, administrators, and all the way up.

And that gets to the original thing about if you're working in different systems – civil service leaders work in a certain way, jail leaders work in a certain way, the VA leaders work in a certain way, non-profits and for-profits work in certain ways. I mean, I happen to prefer the non-profit out of these groups, but that's just my personality. That says, "How do you get recovery transformation within this administrative culture?" No one's got a recovery-based administration culture. How do you make that work? It's become an interesting question: How do you get your administrators to be more and more recovery based? Even the people in the contract office, even if they don't know clients, are they writing recovery-based empowerment contracts?

HP: A recovery-based contract.

MR: That is a big problem.

[short pause]

MM: Stigma?

HP: Yeah, stigma.

MM: I mean, you've worked with the community here in Long Beach now for a considerable number of years. Do you see shifts in the way the community regards the Village or its members?

MR: Yes and no. To start with, my view of stigma is different than many people's. [all laugh] The normal response about stigma says, people just don't understand mental illness and we need to do more education; then they'll understand and then they'll be less stigmatized. And the problem is out there that landlords and policemen and others treat them badly.

I maintain that that is not actually what the problem is, that knowing more about mental illnesses doesn't make you more or less stigmatizing. Stigma has to do with, are they different than me, are we separate? It has to do with segregation and that you're a different kind of person – that we're not the same fundamentally. That the illness has made you fundamentally a different kind of person. My approaches to stigma go back to Ken Wilbur's four things. It has to do with compassion, inclusion, acceptance, and connection.

To make this much more concrete, I'd much rather, to help with stigma, instead of me going out and making a speech to the Lions Club about the nature of schizophrenia, to have an internship program at the Wal-Mart where someone with schizophrenia works and say, "Aren't you surprised about what people with

schizophrenia are like?" It's an emotional connection that creates the shift that we're actually humans.

So there's going to be a twist. If I say that in order to break down stigma, what I actually need is emotional connectiveness, not education, then I have to say, so why don't we emotionally connect to people? And instead of starting out there, let's start in here. We have a whole bunch of rules that say you're not allowed to emotionally connect to people. Those rules are incredibly strong in fortifying stigma.

My second best speech in my whole life was – besides the first one with the four stages – was about maybe ten years ago. It was in Anaheim. It was the Mental Health Association of Orange County. They asked me to be the keynote speaker, and it was about stigma. And they were doing brown eyes, blue eyes. Do you know what this is?

MM: Oh, yeah. The brown-eyed people are discriminated against.

MR: Right. Brown eyes are the wannabes. It was maybe like in the seventies, or maybe the sixties. Brown eyes, blue eyes. You took it in the classroom and you said, all right, the people with blue eyes, you're the special ones who get the good stuff, and the brown-eyed people, you get less in some ways. And then you just let this go for awhile, and what happens is all kinds of subtle and not so subtle, rather amazing processes of "I'm better than you;" and you start feeling worse. And actually, people started suing because these were such powerful things. You can do a few days of this sort of thing.

So they said we're going to do a "brown eyes, blue eyes" in this whole conference. So the brown eyed people got to sit in better spots, and they got the better stuff, shorter lines. They got their picture taken with Snow White. Then my job is to be the lunchtime speaker to process this three hours of "brown eyes, blue eyes" with a group of four hundred people, while I'm up here on the podium and they're eating lunch.

[So I began the speech by saying that] I was in the planning group and we were deciding how mean to be to the brown eyes people who are doing this. I wanted them all to help me decide; we have to these decisions right or this won't work. One of the things we said was, well, we can be mean, we can make the brown-eyed people park really far away. (all laugh) And we decided that was kind of too mean. What do you guys think, was that too mean? We decided we could make the brown eyed people not get to go to the bathroom here. They'd have to go down to the other side of the lobby to go to the bathroom. Is that kind of too mean? We said you couldn't have food at all here, that only the blue eyes could have food and the brown eyes couldn't. Would that be too mean? Or there'd be certain sessions you're not even allowed to come to if you're brown-eyed – and I went through this whole set of things. And pretty much people thought these were all too mean.

All right, now let me go back to your own program, tell me – We said the main reason they're too mean is because there's some consumer people at this conference and they wouldn't be able to handle it. That's why it was too mean, because they couldn't handle it. But when they go back to your clinic, how many of them get to park in the parking lot here and how many who have to park someplace in a different place? How many have the bathroom that you share and how many have to use the bathroom somewhere else? How many can't eat in the clinic – and you can't in certain places. Can't share the coffee pot, can't come to certain lectures – the whole list of things were things that every day we discriminate against them, in our own programs. And yet you all think those are too mean, that for three hours they couldn't handle it.

HP: Well, is that discrimination, or is that the workplace? When I go to Target, I can't use the staff bathroom, I can't eat in their break room.

MR: Whose workplace is it? Is this their place or the employees' place?

HP: So the ownership of the clinic space is taken up.

MR: Right. Whose place is it? Are you coming to a place owned by the staff, or is this a shared space to help your life get better? Target is there to sell you stuff, not to serve you. Target isn't there for your benefit, it's for their benefit to sell you things. They will make whatever concessions they need to make it nicer than K-Mart. But their point isn't to have you have a better life, their point is to make money. It's a for-profit enterprise.

Versus a local park, do the staff at a local park have a different bathroom that you don't get to go into, or should they have the same one in the park? Would that be fair? If the staff want to play basketball at lunchtime, they get to use this court and you don't get to, it's a staff-only court in your park? (all laugh) The park is supposed to be a social service. Whereas, if you're at a [LA] Laker [basketball] game, yes, the staff has their own bathroom, because that's not a social service. You're paying money to the Lakers.

What I said was, so, if we're doing this every day without even thinking about it, we've got a whole bunch of things that are discriminatory and putting down [our clients] at our own sites, that when we think about them, we think it's too mean to even do for three hours, why are we doing this? I maintain we're doing it not because we're uneducated, but because we're not making enough emotional connections [to their experiences]. We're refusing to connect to people emotionally. And why are we doing that?

And that gets down to, we're doing it because we think there's professional rules about connections, we don't think we'll be able to handle it. And the very first question I started you guys out with was, do I really want to know? We're doing it because we don't think we could handle it without the rules. Because we're scared to do it without the rules. Or because we've been traumatized, had friends killed. Why do we have the barrier? Because Robbyn got killed. That's not a nothing; it scared people.

If we're going to have less stigma, we have to have more emotional connection. If we're going to have more emotional connection, we have to figure out how to work safely and ethically without so many emotional boundaries. And that's what the Village has figured out how to do, how to be a team, how to be connected, how to do ethical work and safe work without having – you didn't notice any big boundaries and walls here.

MM: We had some difficulty getting up in the elevator. (all laugh)

HP: Yeah, but so did everybody else.

MR: But that goes back to it has to be a team and it has to be a culture, which the County doesn't manage to make the employees feel safe from each other, let alone safe from clients. Attention to basic safety in most clinics hasn't occurred. Even though Civil Service is designed to build safety and security, it doesn't actually succeed. And if we don't hire people with mental illnesses, how can we expect anyone else to? If we say they're so dangerous in our waiting room that we won't let them walk around and won't share bathrooms, but we expect you to give them an apartment in your building? We're in no way a shining example of the ability to live and work alongside people with mental illness without building walls and barriers. [Outside employers could] say, "You guys are

the experts and you seem to think you need all these barriers. Why should I be any different?"

So that's half the answer to stigma, that it has to do with emotional connection, it's not an education. It has to start with us, not with someone else's problem. Well, how about someone else's problem? There is a community out there, we don't have to wait until we're cured to fix them.

Long Beach, in some ways, has made enormous strides over the years, especially in the police side of things. This was one of the worse police departments in existence. They were like number two for unsolved murders. They murdered, or killed, a person with mental illness virtually every year. It wasn't just that they were bad for people with mental illnesses, they were kind of bad for everything. Now, there are special teams where special policemen ride together [with a social worker] and answer most mental health calls. There's a quality-of-life police team that helps out and helps people with problems. They don't just arrest them or try to shoo them away. I know you, you need to go over to the Village and follow up on this, and then they come by and visit people. There's a connection. They're represented in our jail and connections, and we have a connection to them. The police have become much more supportive.

There are also individual agencies out there, individual property management companies, individual employers, and individual schools. We have a pretty good connection with Long Beach City College. We've done it by community development of individuals. That has not been a global stigma reduction campaign, because I don't know how you'd do a global stigma reduction campaign, and make it an emotional thing. But it has been, "Can we get some more people connected to you here?" We'll get you into this thing. We'll come along – even an AA meeting needs to be made to accept people with mental illnesses. What kind of place where our people want to go, and can we come along to make it a more welcoming place?

So that kind of thing we've done some of. There's a huge funding problem involved with that. That kind of work, which is essential, is not what Medi-Cal thinks is their job to do. There's not a funding stream – Well, actually, the Mental Health Services Act has some funding stream which the State took half of, and then the Counties took some, to do a statewide education campaign, which I think is community development.

But when you get down to it, I don't think this has to do with mental illness at all; it has to do with tolerance. Our society [is very intolerant in many ways]. They say all those people with mental illnesses in jail are there because we closed the state hospitals and don't help them. That isn't true, actually. The number of people in jail is going up since 1980, when the hospitals were already closed, and the number of people in jail keeps going up all the time because of two – well, there's three things. One is the war on drugs.

Two is because when they switched from the housing projects to scattered Section 8 [housing; Federal assistance provided by the United States Department of Housing and Urban Development dedicated to sponsoring subsidized housing for low-income families and individuals], they took ninety percent of the money out of it. Eighty-five percent of the women in the county jail are homeless. The people who are in the jail now, they didn't used to be in the state hospital, they used to live in the projects. If you look at these people, they're not [the stereotypical cases of] mental illnesses, like "I was going to college and I got schizophrenia." They were from foster care, from special ed, from juvenile justice, from third grade dropouts, and stuff like this. This is not the charge of the mental hospitals. It's because of the failure of childhood programs. The number one factor that predicts relapse from parole is illiteracy. The two largest factors that predict homelessness are foster care and being a veteran.

The third factor is growing intolerance. Long Beach used to have a lot of slums when I showed up here twenty years ago. There was a terribly messed up mall across the street. There were empty buildings. There were homeless people all over the place. There was no giant movie theaters, no million dollar condos, no all this stuff. It was a poor place with a lot of people rambling around. There were some buildings we were frightened to go into, because there were guys around doing drugs and kids around being mistreated, and all this shit all over the place.

Now, that's largely gone. Taking two hundred and fifty thousand people in California and putting them in prison has made California a nicer place. That's not a very good liberal idea now, is it? (he laughs) It's easier to walk around now, and there's not as much crime, not as much drug addicts, not as much deteriorating buildings, not as much people screaming stuff on the street.

And we like it better this way. The vast majority of people with mental illnesses who get caught up in stigma are doing something annoying. Just like the vast majority of people who get caught up, who *don't* have mental illnesses, are doing something annoying. Now, people with mental illnesses, I don't know if they're percentage-wise more or less annoying than everybody else. It doesn't actually matter. All that matters is our tolerance for annoying. We figured out a terrific solution here. Get rid of them all. Lock them all up.

The last item on this one is that our normal approach to advocacy and services is to say, you know what, people with mental illnesses have a lot of serious problems. They can be distressed. So they need a lot of help. They used to be in the hospitals, that we don't have anymore to take care of them. We have a burned-out social system. They can be dangerous and stuff. You need to have us around to take care of them, to make sure it's safe for them. That's our normal advocacy approach. That is selling out our clients, because most communities say, "I've got a better idea. I'm getting rid of them and you both." The Village has a good chance of not being here twenty years from now, not because something will happen to mental illness, or because [someone takes over our] building, but because there won't be any poor people in Long Beach anymore. Remember we treat the sickest of the poor. There are no Villages in Palos Verdes. (he laughs)

The alternative is to say, You want us around to help with that homeless person, not to get them out of your sight, not because you don't want to have to see them on the street. It's because they could write the next *Harry Potter*. They're worth saving. They are someone that could make a contribution, they could be somebody. Now we're standing with them both on the same side. And not only are we no longer selling them out. As often as not, thirty or forty percent of the time the person you're talking to has a family member with serious mental illnesses, or homelessness, or some disease or something. And when they think, "How would I like my brother treated, or my wife, or my mom?" They say, "Let's look at that funding again. The way that guy was talking, that *is* what I would like."

The recovery movement says, instead of being a fear-based, a deficit-based, an illness-based program for people who are too ill to live alongside you, they're scary. We feed into that all the time. Instead, we say these people can recover – they struggle, they're different, they do things that are annoying, but they can recover, they can become part of things. And often times we love them, because they're some of our family members. We don't want to throw them away or put them away someplace. We want to figure out how they can make it along with us. We're going to help them meet their responsibilities, not help them avoid their responsibilities. We're not going to help them get out of responsibilities anymore. We're going to help them hold together so they *can* meet their responsibilities.

Because there's very, very, very few mentally ill people who are actually not guilty by reason of insanity. There's a lot of people who are mentally ill who do things that are irresponsible and socially disruptive, and then blame it on their illness. Then they ask me, "Can you write me a note to get them off?" "No. Can they stop stealing and using drugs? (he laughs) Or prostituting themselves?" "My voices told me to use drugs." "So? My best friend told me to use drugs too, how's that? You don't have to listen to the voices, how's that?"

I think that stigma has to do with inclusion and tolerance, both internally and then ultimately externally, and that, as a political movement, we have to stop seeing us as an isolated piece that all we care about has to do with mental illness. Help people who have mental illness out of the jail. What about the people who don't have mental illness in the jail? Is it good for them?

What about allying with all the people that we're being intolerant of? Maybe we've got political allies out there, people who help immigrants, poverty lawyers, women's rights, racial things, drug addicts. I mean, the list of people that our society's intolerant of is rather lengthy. We could get a whole number of potential allies. (all laugh)

This approach says the goal in reducing stigma is actually to reduce intolerance and exclusion. You don't have to be more educated to be inclusive. You just have to be less scared. And education doesn't make you less scared particularly. It has to be an emotional approach. So that's my thinking.

HP: Interesting. Well, thank you so much.

MM: Thank you. We're going to conclude this interview now because it's twelve-thirty.

END OF INTERVIEW