Marvin Southard talks about his vision of mental health for the future…

I think the model that is coming out of this transformation is pretty close to the model that I would hope to end up with. So I think we're moving in exactly the right direction. And if it can happen in such a way that, as the budget turns around, we can increase so that we do those services and expand in the ways that they're needed to. And I think what I would like to do is to make sure that we do the expansion on the evidence-based side of the PEI, the early intervention. This may be heretical, but it's never been really clear to me exactly what prevention of mental illness [is] that isn't strengthening families and preventing substance abuse. The emphasis that I would carry differently from that model that we talked about earlier – one would be much more expansion on the early intervention side, particularly with anxiety disorders, because I think anxiety disorders are the threshold, particularly for young people, for a whole host of other things, including substance abuse, that then reinforces more major mental disorders. And I think we are beginning to understand some things we can do for anxiety disorders that we didn't know before. And I just think there's a lot in that area that can be addressed. So that's one part.

Another part is I think, in terms of social support, we don't have a clue yet about what the opportunities for social networking and all of that stuff is. Something in that area will probably be useful. So, for example, I'm thinking that one of the things I'd like to see is that case managers would do health tracking for people that maybe would involve readings from people's pedometers or their blood pressure reading. I have my blood pressure log on my iPhone. But it's a behavioral reinforcement mechanism, too, because since I know I need to keep this log, then it means I'd have to take my blood pressure. And if I'm going to take my blood pressure, I want to do okay on it, and if I want to do okay on it, then I need to get my exercise, because that's what keeps my blood pressure low. So that made me think [that] there's probably feedback loops that we could create that could be very helpful for people, in a support group kind of way. So I think that would need to be a part of what we do.

And then what we talked about, about the healthcare reform. I think becoming confident enough in what we offer as a specialty service that we can kind of merge it back into the whole person as part of the specialty care. Nobody really knew what to do with mental illnesses, so in some ways, that's why they got carved out aside. As the science and the practice improves so that we're able to get better results, I think, as a field, we'll get more confident of our place within the general array, and bring our gifts. As I'm in the dialogue about healthcare reform and the 1115 waver and stuff like that, it seems to me that what we have learned in the rehabilitation model and in the consumer engagement has some lessons for physical health, writ large.

I would close by saying what I say in the new employee orientation every month for new people coming into mental health. And one of the things I always say is that we're really lucky in the Mental Health Department and working in this field because everybody wants two things from their work – they want a paycheck that they can count on, and that's a good thing. But also, they want to have the sense that their work made a difference, that it had some sense of meaning to it that made life better for someone in some way. Everybody can do that in any job they do; but in some jobs, it's harder to make the connection. In mental health, it's been really easy for me to get the sense that working hard really has the chance, at least, of making the world a little bit better place for some people. And that's what I wanted to do with my life's work is to do something like that, so I feel very fortunate in the way that my work life has turned out, that I have at least had the chance to try to do things that have that effect.

READ THE FULL TRANSCRIPT BELOW.

INTERVIEWEE: MARVIN J. SOUTHARD

INTERVIEWER: Marcia Meldrum

SESSION I

DATE: October 30, 2009

I. Early Education and Training; Internship in Kern County; DSW at UCLA

MM: Good morning.

MS: Good morning. Marcia, how are you?

MM: I'm fine. I hope you are as well.

MS: I am.

MM: It's Friday, October 30th and we're starting our interview with Dr. Marvin Southard here at DMH. I'm the interviewer, my name is Marcia Meldrum. So I just would like to start by asking you to tell me a little bit about your early background, where you grew up, where you went to school, and some of the formative experiences that sort of shaped your future career, I guess.

MS: Okay, well, I was born in Santa Fe, New Mexico. My father was stationed during the war as a chemical engineer working on the Manhattan Project at Los Alamos [the 1942-46 project that developed the atomic bomb]. My mother was a secretary there; she went straight out of high school and had to give up a college scholarship to work to support her family. So she went from high school to working as a secretary on this Manhattan Project. My mom comes from a group of people who settled in northern New Mexico before it was a part of the US; and so they didn't immigrate but they were taken over. So my grandparents spoke – Spanish was their first language and at one time had a ranch in a small town in northern New Mexico. But the family lost the ranch in the Depression and there's some interesting stories about that, that we don't have time for.

So anyway, my mom and dad met. I was born in Santa Fe, because Los Alamos didn't have a hospital at the time. So I grew up in – We lived in New Mexico until I was four and my dad worked for UC Berkeley at Livermore Labs - that's what he was working for [Lawrence Livermore National Laboratory is a University of California research facility, primarily funded by Federal energy and weapons research grants]. He ended up leaving there, just after I was born, because he couldn't pass the security clearance, because his brother had been a rum runner [transported illegal alcohol during Prohibition] [he laughs]. So anyway, he became a manager for State Farm Insurance Company and we moved to Tucson when I was four. So I grew up in Tucson, Arizona. I'm the oldest of five.

MM: Wow.

MS: And so my mother is Mexican, my dad is American mix, English, German, whatever. But I ended up growing up being much closer to my mother's family, first because I knew them from New Mexico, and secondly because we went back to New Mexico every summer when I was growing up. So even though my name and my looks are pretty much as Anglo as you could probably wish, I actually consider myself and I identify as a Latino.

MM: Yeah, I was wondering about that, because you've had this consistent interest in Latino work throughout your career.

MS: Right.

MM: Yeah.

MS: So I went to Catholic schools in Tucson. When my parents got married, both families disapproved. So my mother's family wanted my mom to marry a Latino and my dad's mother in particular wanted – Well, nobody would have been good enough for her son, but certainly not a Mexican. So anyway there were some tensions with regard to that. The thing that both families had in common was that they were both very committed Catholics. And so, in terms of our family identity; probably religion was probably the strongest driver. So both sides of the family had that one piece in common and so kind of a religious, spiritual commitment or viewpoint of the world was something that I grew up with from my very earliest memories and has pretty much persisted throughout my life. So when I was in grade school – I was in seventh grade for the Cuban Missile Crisis [the October 1962 confrontation between the US and the USSR over Soviet missiles based in Cuba].

MM: Oh, okay.

MS: So and growing up in Tucson, there was a Strategic Air Command base five miles away from our house [the US Air Force command in charge of nuclear missiles and strategic bombers], so I fully expected Armageddon to happen any day. So with that mindset, it was like, well, what's worth doing in life? So it was like – I may as well make a commitment to this religious viewpoint, because everything is going to end anyway. That was my seventh grade view of things. So I went into the seminary to study to be a Catholic priest after 8th grade, because that's the way they did it back then.

MM: Goodness, so you were like thirteen or fourteen?

MS: Fourteen. So I left home when I was fourteen to go to a boarding school kind of place. Ironically only about five or six miles from my parents' house; but in the initial stages, it was pretty strict. So, for example, the first time I came home was at Thanksgiving and it was very odd coming home because living in a kind of an institution – it was dormitories, so there were 24 of us in a dormitory and coming home, it was like, all the rooms seemed so small [he laughs]. Anyway, so I did that for high school. I graduated – we started out with 38 in my freshman class. There were 12 of us who ended up graduating and the twelve of us, most of us are still in touch to this day. [Among the teachers I had there, one Fr. John Sauerhage, stood out as a brilliant teacher who opened numerous intellectual doors for me.]

MM: Oh, that's nice. Great.

MS: So we have periodic reunions; and it's been an interesting and useful thing to have a group of friends that have been friends for forty five years now, something like that [he laughs].

MM: Yeah, that's a long time. That's wonderful. Was your family all supportive of this decision?

MS: Yes, they were in a – it was an odd kind of arrangement because, and I'll skip ahead as I describe it. Nobody asked. It was entirely my initiative to do this and I think the template

had been set, because two of my uncles, my mom's brothers, had gone into seminary. Both had left, but two of them had gone in before high school; and two of my mother's sisters – my mom is the oldest of ten and two of my mom's sisters had gone into the convent and they also left. So I was like the next generation and then my brother, two years younger than I, also did the same thing. But in fact my dad had the talk with me about why I wanted to go, but it was the summer before, so I was fourteen and there were already some tensions between him and me about adolescent things. So I just gave him brief answers that I'm sure were pretty frustrating to him. Now having been on the other side of those kinds of transactions –

MM: You know better, yeah.

MS: But, at the time, I thought I knew what I wanted to do, so I just did it. So like leave me alone! So the way it worked at that point in time is after high school, you went to a college seminary. For us in Arizona, the place we went was St. John's Seminary in Camarillo.

MM: Oh.

MS: So that's how I ended up in southern California, so I came to Los Angeles in September of 1967 and it was somewhat overwhelming, because I remember still driving on the Conejo Grade [the Ventura Freeway's dramatically steep descent from the Santa Monica Mountains] in Ventura County, where there were oceans of cars. It was like a tidal wave of cars.

MM: Right, it's so different.

MS: Yeah, it was somewhat different. So trek back a little bit. One of the things that happened in high school is, during that four years I was in high school, '63-'67, the Catholic Church changed.

MM: Yes, right. Vatican II [The Second Ecumenical Council of the Vatican 1962-65, which instituted major reforms in the Catholic Church, in liturgy, Scriptural interpretation, and openness to other denominations].

MS: Vatican II took place. So, when I started there in '63, everything was in Latin and very strict. When I finished as a senior, four years later, Mass was in English and it was immensely more open. So, when I started as a freshman, besides only coming home on major holidays, we weren't allowed to watch TV, listen to the radio or read newspapers. And then four years later, we were debating other high schools and putting on plays.

MM: Amazing.

MS: It was a significant change. I think in some way, just as a personal thing, that transition was profoundly influential in my way of thinking about the world and how things operate. And it also probably saved my parents a lot of grief, because some of the adolescent rebellion stuff that ordinary kids have to take out on their families – I had an institution to take it out on. So my parents and I, as it turned out, didn't really have a very eventful adolescence.

MM: That's good.

MS: So anyway, the ten or twelve of us that came from Arizona came to California. California, at that time, in terms of religious politics, was very conservative, much more conservative then. So it was like for us, stepping back in time.

MM: Oh, wow.

MS: So we came from this ["updated"] high school into this environment, which was once again restrictive and as it happened, in Latin still, so it was quite –

MM: Yeah, wow.

MS: Quite surprising for everybody.

MM: Yeah, back to the Middle Ages.

MS: So there was a certain amount of tension involved in that and so I had been – Back in high school in Arizona, I was student body president and then when I came to California, for our sophomore year, I was elected class president and I was seen as, within the institution as kind of a Sixties rebellion leader kind of person, even though I'm really not very radical. But the Rector of the seminary called me in and said that, by calling me in and speaking to me, he was saving the Western Church, because I had an influence over my class and the Arizona people and we had an influence over the school and the school provided priests for the whole western US. Therefore, he was nipping it in the bud. So I took it as a great compliment really [he laughs]. [Still, I had some wonderful teachers at St. John's and a spiritual director John Keller, OSA, who helped me a great deal.]

So, anyway, I got my bachelor's degree in philosophy from that seminary, St. John's. Then the way that the studies go [is] you get your bachelors; then you go for graduate study and after four years of graduate study, that's when you're ordained, so that's the process. So I enrolled in graduate school, also at St. John's, [and] completed two years of the required four. At the end of those two years, I wasn't sure. It was as though I was engaged to be married, but I wanted the wedding date to be farther away rather than closer; and so that made me think, "Maybe I should pause and think about this."

MM: You were 22 then?

MS: I was 23 years old. Oh, in our class we graduated from college with 45 in our class; and then I'd say probably the number that was in our first year of graduate school was probably 30, because that's a big transition point.

MM: It is a big transition, yes.

MS: So a lot of people left at that point. So [there were] around 30 people in our class for our first year of graduate school. Meanwhile the Catholic Church reform stuff had caught up with St. John's [and] with California. [James] Cardinal McIntyre had left [in 1970] and [Timothy] Cardinal Manning [Archbishop of Los Angeles 1970-85] was in charge and it was more open than it had been. So, for example, for one of the years I did my – they have an internship program, so it's like for all four years of undergraduate, but especially in graduate school, you had an internship. And so one year it was working at the Catholic Student Center, in the Newman Club at UCLA [Newman Clubs, named after John Henry Cardinal Newman, are Catholic student groups at non-Catholic universities]. So I'd go there, spend a day, every week there doing whatever it was.

So let's see, as I was saying, I had some doubts about [the priesthood] – and this is the reason I had the doubts. I had worked a couple of summers – during the summers I would work various places, so one summer I worked at the Post Office and another summer I worked as a janitor at a nursing home. But the last two summers I was in the

seminary, for one summer, I worked in a parish in San Joaquin Valley and I was like a parochial assistant. I would take a census and it was during the UFW time [the United Farm Workers' efforts in the 1960s to win recognition as the bargaining unit for migrant farm workers]. And so the farm laborers were doing the march up the Valley and so we participated and helped arrange that and that sort of thing. [One of the pastors of that parish was Fr. David Duran who had been the accountant for the UFW.] Then the next summer, I worked in a small mining town in Arizona, Clifton, and I had three responsibilities: one was to write a history of the town for their centennial.

MM: Good for you.

MS: And I was also supposed to work for the parish, running their youth group, and then I was also running the city's neighborhood Youth Corps Program and so I had those three things I was supposed to do that summer. And the important thing about both of those experiences for me was that there was all of this positive energy coming to me from people, because I was young and energetic and I wanted to get engaged in things and people really responded positively. But I knew, somehow I was wise enough to know it wasn't me, it was the role. It wasn't me as a person, it was the role wearing the collar, I mean. And some of the things that happened were just touching; but still I knew they weren't about me as a human being and it was confusing. And I didn't understand exactly how – because you have to act a certain way in the role, but how do you take care of your own needs in that circumstance? So I decided to take a leave of absence.

So I took a leave of absence, applied to Social Work school as a way of taking the leave of absence, because I wanted to do something in the helping professions and I didn't want to have to repeat an undergraduate degree. So if I had chosen psychology or –

MM: Right, yeah, you would have had to start from the beginning.

MS: I would have had to start from the beginning. Social work you can get in with a degree in philosophy, so I applied to UCLA and UC Berkeley. I was accepted. I decided to go to Cal, so I went to Berkeley and studied community organization, administration and social planning was my focus there. [Neil Gilbert and Ralph Kramer were some of the professors who influenced me the most at Cal.]

MM: And what were you thinking then? Were you thinking that you might, after you sort of got in and spent some time you would then make a decision about returning to the priesthood?

MS: At that point in time I was planning on going back. The plan was I was going to go back and this was just kind of an orientation plan. I talked to my Bishop, I got permission, and when I went back to visit the seminary, it was though I were still a seminarian. So the program I was in was a block placement, so the first year was entirely academic and the second year was the field placement year and then you had to go back to campus like twice a quarter for seminars and write papers and send them in and that was the arrangement for the program at that time. So I did – to circle back a little bit, my parents weren't thrilled about my career change, nor were they particularly thrilled about me choosing to go to –

MM: Berkeley?

MS: Berkeley, with Berkeley's reputation at that time. So, and I handled it pretty much the same way I did entering the seminary, is I really didn't ask for their advice about taking the leave of absence or anything like that. I just did –

MM: Yeah, you did what you were going to do.

MS: What I was going to do. Still, I knew that somehow – it's funny, it wasn't an explicit thought, it was just a given that I wasn't going to ask my parents for financial help for this process. So I got a scholarship and then there were complications with the scholarship, because the Asian students at that time sued UC about equal access and so everybody's scholarship was held up in the meantime. So I actually didn't get my – I mean they paid the tuition, but I had to get the money for books.

MM: Not much to live on.

MS: Yeah, so I worked as a gardener and did some other things and anyway, I got through that year. But then I went back to Tucson for the summer and my mom tells me, "You know, son, whatever you want to do with your life, as long as you're happy it's fine with me, but your dad, he really wanted you to be a priest." And so a month or two goes by; and my dad says, "I really want you to be happy and do what you want, but your mom, she really wanted you to be a priest."

MM: She wants you to be a priest.

MS: So I just laughed. At that point, I said, "Mom said just the opposite!" So anyway, so there was some pressure with regard to that, so I needed an internship that paid well for that second year. So it ended up that the best internship I could get was working for Kern County Mental Health, Drug Abuse Division, which I had access to applying for because the administrator for Kern County Mental Health at that time was a priest, [Fr. Phil Foley,] who was on a leave of absence from the Diocese of Fresno. I didn't know him well, but I had friends who knew him and so we met and so he made the arrangements, I got the internship, it was a very interesting internship working in substance abuse administration. I learned –

MM: This was Kaleidoscope?

MS: Well, this was prior to Kaleidoscope

MM: Okay.

MS: This was just the internship and then I did whatever needed to be done. I made some important mistakes and learned from them – like, I didn't know County procedures. So I was frustrated that something was taking so long so I got a brochure that needed to be printed, printed –

MM: Some place else.

MS: Some place, and they took it from me and printed it, but all the authorizations weren't there. So it was like, "An intern did what!"

MM: [She laughs].

MS: So anyway, in February [or] March, I still wasn't sure what I was going to do the next year. And there was a job opening that came up for the director of a new program that was going to be started, Kaleidoscope, and I had no intention, I mean I didn't know what I was going to do. But somebody, a colleague at Kern County Mental Health, bugged me to apply. So I put in my application, not because I thought I would get the Director's job, but because I'd really never been on a job interview before. So I thought I should

get the experience of doing a job interview and then I still don't know what I'm going to do. I'm going to work and then go back? I don't know, but this will be an experience.

And then to my surprise, [the Director of Catholic Social Services for the Diocese of Fresno, Fr. Ralph Belluomini,] offered me the job. So that was in March of 1975; and then the program started April 1st, 1975, which we all thought was an appropriate day. And so that was when Kaleidoscope started, so there was April and May [when] I was working but also still a student. So then I graduated in May of '75, I guess it was probably June 3rd or something like that, and started the Kaleidoscope program, which started out [in] five small towns in the San Joaquin Valley. Originally it was Taft, Shafter, Wasco, McFarland, and Buttonwillow; and it turned out after six or eight months, Buttonwillow didn't really have enough business to keep us going. Delano had lots, so we switched out Buttonwillow for Delano.

MM: Was this a federally funded program?

MS: [It was a] Federal funded 410 Program [alcohol-impairment countermeasures are funded under this section of the Highway Safety Act of 1966]; so it was – we had to – [for] any enrollee, we had to get a physical [exam] for the chart and do all of the things on that. We had the 410 program and we also then opened up a PC1000 program associated with it.

MM: Yeah, I don't know what that is.

MS: PC 1000 is drug diversion [California program for first-time drug offenders].

MM: Okay.

MS: And then the odd thing was that in these small towns, we were – it was an interesting experience for me, because the part I was well equipped for was the community organization piece. So there was always, as we go into these small towns and it's substance abuse and you know there's – I had longer hair at that time – and so it was like, "Who are these hippies coming into our very conservative milieus?" But, on the other hand, the conservative milieus were concerned about the drug use among their kids and families. So we started these Technical Advisory Committees in each of the town to get a process of involving the community to support what we were doing; we engaged the civic groups and the churches and so we did that component. So that part I was pretty prepared for. Frankly, I didn't know jack about substance abuse treatment or clinical work at all, at that point in time. But luckily, and it wasn't my doing, because I didn't hire the initial staff. The board of directors of Catholic Social Services –

MM: They gave you the staff, sure.

MS: Gave me the staff and so luckily they had done a good job, [particularly in hiring a very gifted counselor, Carolyn Wade, and later Manuel Alva], and I had the good sense to listen to them and people who knew what they were doing, rather than pretend I knew what I was doing. So that was a useful experience for me managerially, because I think it set a template for me that I would expect to learn from my staff, rather than that they were just supposed to follow my orders. And so anyway we had a pretty successful program. But, as I was starting to say, we were the only human service agency in most of these towns, so we got all kinds of problems.

MM: Yeah, I can imagine.

MS: So I still remember the first clients in each of those towns. The first client we got in Delano was a young woman who had a substance abuse problem but was also schizophrenic, and she had a small child. So it was really complicated – she was very bright, but it was a very complicated issue. The first client we had in Taft wasn't really a client, she was a domestic violence victim who came because her husband had a problem; and her husband didn't want any help, but we ended up engineering her rescue so she and her daughter ended up leaving, moving to Arizona. And actually we heard from her maybe as recently as five years ago.

MM: My gosh!

MS: Yeah.

MM: She's doing okay?

MS: Yes, she remarried, she had other kids. Her daughter who we saw, so for treatment purposes we had to, I forget what it was. [We listed it as] nicotine abuse, I forget what we did to make it [eligible for services].

MM: Yeah, yeah, that's great. Amazing.

MS: So; but it made me know that if I was going to really do this, I needed to know a lot more than I knew at that point.

MM: Okay, so two questions.

MS: Sure.

MM: I mean you'd had this training as a priest, to be a priest and you'd gone through and got your MSW, but it sounds like it was your first exposure to real problems in the community.

MS: My first exposure to real problems from a clinical perspective, because like as I worked in these towns, there would be families with problems that we'd be trying to provide something concrete with help. But this would be the first time that it was like, not concrete things, it was more like the psychosocial stuff, which I didn't really have, I mean, because what was needed in Kaleidoscope and what we needed to do was something different from the spiritual comfort that would come from the religious viewpoint and something more also than just food and shelter.

MM: Yeah, basic needs.

MS: Basic needs issues, so it was that in between thing that some of my staff had that I did not. So I worked in Kaleidoscope for four years, approximately, and then decided to go back to school. I applied to the doctoral program at UCLA and I was admitted and started there in the fall of 1979, September '79.

And it was an interesting transition and, looking back on it, it was like wherever you are you think you know what you know and then – so I remember being a student again after not being a student and going through that, trying to find student housing and all that, and they [the university] were not helpful at that point in time.

MM: No.

MS: So anyway I found I loved school, in fact I wanted to – that's one of the things, I think I ended up liking every level of school more than the last. So I liked high school more than grade school, college more than high school, and then graduate school much more than undergraduate. So I really liked UCLA and my experience there.

MM: Was there anyone who was particularly influential at that point in your social work training or-?

MS: Well, I guess the three people that were most influential on me were Dr. Jeanne Giovannoni, who was a child welfare expert, but she ended up being my thesis advisor. She really helped me see things from a broader policy perspective. Then, another one was Doris Jacobson who was kind of like the clinical teacher and I really hadn't really had very much clinical training at that point even though I had the MSW. So that was very useful and then she was married to the Dr. [Gerald] Jacobson who started Didi Hirsch [Community Mental Health Centers, originally founded in 1942 as Los Angeles Psychiatric Service, in the area west of downtown LA].

MM: Okay, we can figure out his name!

MS: Yeah, and so she was very – his major contribution was in crisis intervention theory, because he did work coming out of the Cocoanut Grove Crisis fire [this tragic fire at a Boston nightclub in 1942 killed 492 people and injured hundreds of others].

MM: Oh right, wow.

MS: Then came West, taught at UCLA, started Didi Hirsch and I think it was LA Psychiatric – it had a different name at that point in time, initially, but it was very influential. And I got to know him, because my class ended up being the "party class," so we would be the social networking center. So I had this little tiny apartment in Palms and so when I'd had a party – it was a one bedroom apartment, but I would put my bed in the closet so that there was room for people to [squeeze in]. So I got to know both Dr. Jacobsons that way. And then the third person was Alex Norman, and Alex was kind of the management guy on the faculty at the School of Social Work at that time. So those were the three probably most influential ones for me. Influential in a different sort of way was Rosina Becerra [currently Professor of Social Welfare at UCLA; the other faculty named are Professors Emeritus].

MM: I don't think I know that person.

MS: Rosina Becerra was the research teacher for the first year doctoral students and she – I think there were seven of us in our PhD cohort and the first day of class, she said, "Every program has a course that is meant to wash out those who can't make it, and in this program it's me with this course." And so I don't know if it was her mood – anyway, [there was a] tension between our group and her. So anyway, we go through the first year. At the end of the first year, you have the qualifying exams and all of that and then normally what happens is the professor chooses somebody from that class who will be the TA [teaching assistant] for the next year. So, as the summer started, no one was chosen for that. Two of my high school classmates were working at El Centro in East LA [a Hispanic community center, known today as El Centro de Ayuda, or El Centro Human Services Corporation] and so one of them said –

MM: And these were guys that decided not to be priests, or they're working there –

MS: They were both guys who decided not to become priests. One of them had left after high school, but I stayed in touch with him, because we were good friends; and another

left at the exact same time I did. So they were working -- and actually, the second one I'm talking about had his MSW from Fresno State, so he left and worked. When I went to Berkeley, he went to Fresno State.

MM: Oh, okay.

MS: So they asked – they said there's an opening for a forensic specialist that you should interview for and so I said, "Great!" I didn't know what a forensic specialist meant in the context of mental health, because for me forensic work was debate; but it's really expert testimony on mental health. So I did my research at the library, found out what I needed to do, did the interview, did a good job on the interview, but then I had to –I think this was the key point in the interview, there was an ethnic authenticity test that took place. So, after the interview, the Medical Director, which was the guy who interviewed me, said, "Oh, let's go get something to eat;" so we went across the street from El Centro to a Mexican butcher shop and he ordered a burrito for me and he said – he didn't ask me what I wanted, he ordered me a *burrito de sesos*, which is [cow] brains. I do not eat organ meats of any kind in any ethnic context, but I knew this was a test, so I had to munch down those brains, which is the only time they ever – and I'm thinking of Mad Cow Disease [Creuzfeldt-Jakob Disease, the severe neurological disorder transmissible to humans who eat beef from infected animals]. That grosses me out in 25 years retrospect [he laughs], or whatever.

Anyway, so I passed the ethnic authenticity test. They hired me, it was supposed to be a summer job. But I can write, so I made myself very useful; I would go to a meeting and I'd do the memo after the meeting. It reminded me of [USSR dictator] Joseph Stalin [he laughs]; supposedly he gained power because he took the minutes for the meetings and then could shape what [was carried out]. So they asked me to stay on and so I became the assistant to the Clinical Director, so I was like the factotum for Dr. Baez, who was the clinical director, and I just did whatever he wanted. And it was very useful because I would go to the Quality Assurance Committee and I remember my first time at the Quality Assurance Committee, [when] they used to go through the medications. I didn't know anything – I didn't know psychiatric medications so it's like –

MM: Oh wow, on the job training.

MS: Yeah, it was on the job training, so I had to not look too stupid and learn about all the psychiatric medications and how to pronounce them in such a way as not to look like a total idiot and the same with the symptoms. At that point in time, I didn't know very much about the DSM [the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association], or symptomatology. So I had to learn that and I did and meanwhile I ended up making a connection with a social worker who was a supervisor there and she started supervising me on my clinical hours at the same time I was doing the administrator stuff for the medical director. So let's see then, that's my second year – and actually the good thing there is they let me adjust my schedule according to my class schedule. So I kept working during the school year, finished up the classes the second year.

Then [in the] third year, I started on the dissertation, which ended up being a comparison, a look at the market for forensic expertise and the competition between psychiatrists, psychologists, and social workers in five states. And then I developed a model from the sociology of professions because I took some classes in the Sociology Department and used that model, tested a model, for the professionalization project of social workers in each of those five states and to see how they got where they got. I got a little dissertation travel grant from UCLA, so it paid for some of the travel. Actually, it

was a great thing so I spent a couple weeks in Michigan, a couple weeks in – Rhode Island, Connecticut, New Mexico, and California were my states.

MM: How did you choose those?

MS: Well, it was a combination of things, California for obvious reasons, New Mexico for two reasons, one is I had relatives I could stay with and secondly because they had a forensic social work role in that state, which was unusual, because the professional status of social workers wasn't necessarily that high in New Mexico, but they still had a forensic role, so how did that come to pass? Michigan, because they had a very well developed forensic role, in fact that was the most well developed forensic role.

MM: That's really interesting.

MS: Yeah, and then Connecticut and Rhode Island also had roles, but I had a contact. Dr. Giovannoni had a friend who was the Director of Mental Health and Retardation or whatever they called in the state of Rhode Island. So it was opportunistic, really.

MM: Yeah, yeah, okay, makes sense.

MS: So then I finished up the thesis in, I think, February of '83 and then graduated that summer, that commencement, in the spring of '83 and so it was like, "now what?" And so I applied for several jobs and came in second in like three jobs in a row.

MM: Oh dear.

MS: Yeah, one of them was [at] Didi Hirsch and another one was – well, I'm getting in a little out of order because some of this came a bit later.

II. Clinical Director at El Centro; Labor Issues; Teaching at Cal State Long Beach; Learning from Clients; Cultural Competence

What happened first was I wasn't sure what was going to happen next and then the Medical Director [at El Centro] came to me and said, "I'm leaving, I want you to be the Clinical Director." And I go, "Me?" because I had gone from assistant to the Clinical Director to Assistant Clinical Director; now he wanted me to be the Clinical Director. I thought, because actually I had not contemplated that, because I didn't think, in an agency like El Centro, I would have been considered ethnic enough, but actually the surprising thing is that was never an issue.

MM: Oh, interesting.

MS: So I became the Clinical Director in, I think, around the summer of '83. The reason why I remember it was the summer of '83 is because my parents, for a graduation gift, took my sister and I to Italy.

MM: Oh, how lovely.

MS: Yeah, it was wonderful and when I got back; I was like, "How do I start planning for what comes next?" But as soon as I got back, he called me into the office and said he wanted me to be the Clinical Director. And so that's when I started that.

MM: Okay, let me just stop you here. So you'd kind of fallen into working in mental health.

MS: Right.

MM: And so at what point did this sort of come to you – did you see this as the career choice that you wanted? At what point did it sort of grab you, I guess, and what did you see yourself being able to bring to the Mental Health Center?

[Pause]

MS: Well, I'll go back to the MSW program. At Cal, one of the clinical classes I did take was on – actually, it wasn't a clinical class, but it was a cultural competency class or something like that that we were supposed to take. Anyway, the paper I wrote was on family therapy as the treatment of choice for Latino families and what I had in mind then was looking at some of the issues and dysfunctions in my family of origin. So going back on it, my mom is the oldest of ten; she had seven brothers. Of those seven brothers, now six of them are dead. Of those six brothers who are dead, five of them died from alcohol-related causes – some of them directly cirrhotic [cirrhosis is severe liver damage and loss of function] and others from esophageal cancer as a result. So some [died] at older ages, some at younger ages, but all really because of alcoholism. So that alcoholism has kind of been the family curse, which is certainly how the family lost the ranch in the Depression was probably related to that. It was presented to me as a gambling thing that somebody didn't use the money to pay the property taxes and gambled it away, and so anyway; but I'm sure they weren't sober when they did that.

MM: Yeah, probably not.

MS: So that family dynamic piece, particularly the work of Murray Bowen [1913-1990, Professor of Psychiatry at Georgetown], if you're familiar with that, was the thing that caught me and it started back in the Masters Degree program. And so that was the thing that "hooked" me so to speak, was that. So the forensic stuff was the door of opportunity. But the truth is, I never really – besides the PhD thing, I went to meetings about forensic programs, but my agency never actually opened any forensic programs. So I knew the literature and I knew the people; I didn't actually get involved in that work. So I guess you would probably say [that] like many people in the mental health field, it was an interest in issues within my own family that got me engaged. So one piece is that.

Second piece was my overall life goal was to be helpful in some fashion and the manner in which I made a contribution was maybe less important than the fact that I was doing something of service and so it was like a phrase they used to have in those days, "bloom where you're planted." So take advantage of what's there to be of service as you can, and so that was the second piece.

And for me, in the oddest sort of way, from one perspective, everything about my career was accidental. Looked at from another perspective, everything came together in such a way that it brought my talents and my interests together in a way that could look like it was plotted and planned. But so, for example, working at El Centro and it brought these mental health concerns, these addiction concerns and the ethnic stuff that I've always been interested in, I mean, at a very deep level, together in an opportunity. I didn't plan for it to happen but it was there for me to get engaged in.

MM: The right place at the right time.

MS: Yeah. So I was kind of in the right place in the right time, and I think that would probably be kind of how I would talk about my career, is being in the right place at the right time in a lot of instances. So, for example, I came in second in all of those job interviews. One was Didi Hirsch, one was La Frontera in Tucson, which is a Latino mental health center

that Nelba Chavez, who was later the SAMHSA director, was the executive of La Frontera. And so if I had gotten those jobs, then this job wouldn't have –

MM: Have never materialized.

MS: Have never materialized. Let's see. So then it's the 80's, I'm working at El Centro. Something I should talk about at El Centro that was really quite formative for me was [that] around 1985, there was a strike. The SEIU [Service Employees International Union], who are the [union] representatives of our agency, had a strike at El Centro when it first started and I wasn't working there at that time. And then they called a strike, a better estimate [would be] maybe [on] July 1st, 1986, when the contract expired and I, in my do-whatever-they-ask-you-to-do role, I was kind of one of the lead negotiators in the contract negotiations.

And this was the tension that was going on: El Centro was going very well as a clinical program, but the executive director, the CEO at that time, had a more grand ambition and so it became not El Centro Community Mental Health Center, but El Centro Human Services Corporation. The focus that he wanted to do was to make it a community development corporation with property development, kind of like TELACU [a local community development corporation], if you know of that entity. They wanted to make it a different power base TELACU and he had some connections to regard to that.

The problem was that in some ways mental health resources were being bled off to support these other endeavors and so there was some tension among staff at all levels and so that was one of the things that was going on. Anyway, there was a strike and the Executive Director went out on stress leave and so I was the guy! And so it was very intense; I'd arrive there early so that I could escort the workers who crossed the picket line through the picket line and so that they could go in there. Then clients that would show up would be cursed; and the most heartbreaking one was a woman who is coming in for therapy and had a bruise and the therapist asked, "What happened?" and she said, "Well, when I left last time, my husband was picking me up and the picketers were saying" – calling her "*puta*," "whore," and the husband said, "And that's your therapist! She would know what you're doing!" and so he hit her. Anyway, it was very terrible and tragic, so the strike went on pretty much throughout the summer.

So I'd be the first one there, the last one to leave, to try to make sure [people were safe] and we'd have – the managers were there because we had to do [three] things. We had to manage the media situation, we had to manage the County contract to produce enough units of services so we didn't go bankrupt in the interim and we needed to provide some level of care to those people. So the good thing is that psychiatrists weren't a part of the union so we had psychiatry mostly available, but we had to hire, because not that many people crossed the picket line; so we had to hire substitutes and make some kind of representations to them about what their future would be. So anyway, we did a good job and we got enough units of service and did what you needed to do to the contracts, so we outlasted the union. They needed to settle. For the last three or four weeks of the strike, the issue wasn't, were they going to prevail on the issues that led to the strike – which were wages. The issue was what was going to happen to the replacement workers.

MM: Yeah, sure.

MS: And so I was saying, "Well, we made a promise, a commitment to them, you know, and you guys – " So anyway the interim solution was that we would take back – we wouldn't lay anybody off. We would bring back anybody who wanted to come to work; but we

would continue all of the replacement workers who wanted to continue to work and we would meld the workforce. So that's what happened.

MM: So did people get their hours cut back though?

MS: No, no, we just – There was some attrition; [during] a three month strike, some people do get out of their jobs, they leave, they do other things. Some of the replacement workers didn't want the tension that would come from the melded workforce so they left. So I don't remember the exact number, but maybe we were over FTE'd by ten or twelve people and so over a year's attrition, you can make that work out, so we did. So anyway, the reason why I went into that for so long was that it was kind of a, "Oh my God, I didn't know I could do something like that," kind of experience, like I never would have expected to step into many of those roles. Particularly, the media role and something like that as being the spokesperson, except I had to; I was thrust [into it].

MM: There was no one else to do it.

MS: Yeah, it was thrust on me, and I did a decent job with it, so I got a certain amount of confidence from being able to do it in that way. So then, career wise, the next thing that happened after that period was that I had a friend, a classmate from UCLA, who was close friends with a guy named Dr. Jim Kelly, who was on the faculty at Cal State Long Beach and he wanted to start an MSW program there. So he is a master of academic wizardry, so he ended up creating the MSW program kind of out of – it started out as an extension program so that's how he got some of the funding. And he got Orange County to get some CALSWEC funding [from the California Social Work Education Center at UC Berkeley] and LA County – anyway, he ended up making it work. I knew him socially through my friend and so he hired me and my friend and a couple of other people as teachers. So there was one year when I was full time Clinical Director, and full time faculty member at Cal State Long Beach, so that has been –

MM: Quite a commute back and forth.

MS: Well, and I lived in Westchester.

MM: Oh, my gosh.

MS: So it was very intense; and that was probably the time in my life that I have saved the most money, not because I earned terrible [large] amounts, but because I didn't have time to spend anything [he laughs]. Particularly because this program was just starting so it was like, you're teaching a class on aging – do a syllabus. I mean, so it was like, "what!" and so I had to steal syllabi from other places and put it [together] and decide how I'm going to lecture it. Anyway, I really enjoyed teaching and I might have switched career directions at that point, but this is what happened: There was a civil war going on in the faculty at Cal State Long Beach; and the civil war was Jim and the people he brought in on one side and a guy named Dr. Isaiah Lee, who had run the BSW program for years and who was actually the department chair.

MM: Oh wow. Yes.

MS: So I did not have time to go to all the faculty meetings and get involved in the politics. So it was like, I can be here to teach my classes and prepare the classes and I'll do a good job with that, but I don't have time for this other stuff. But all these tensions were there and as I was walking by the office one day, I heard Dr. Lee complaining about me to another teacher. I asked the other teacher about it and they were like "don't ask me." Then I went to Dr. Lee and said, "Well, I overheard this and is there something I should

know about my performance, is there something I am doing wrong?" He said, "Oh no, no, you're doing great. Think of me as your elder brother." So okay, no problem. Then Christmas break comes that year and I need to finish up doing the grading and all of that stuff. I take my parents who are visiting on a tour of the campus and I happen to go in and look at my mailbox. In my mailbox is a reprimand that has a two-week reply date on it. Had I not been there to pick it up, I wouldn't have gotten it in time to do [a response] – anyway, so I did get it, I appealed it to the Chancellor, the Dean, or whoever you appeal these things to. and I prevailed.

MM: Was it like a criticism of your teaching?

MS: No, it was [that] you have this other job and it was like, "yeah." [he laughs]. It was clear we knew that when he hired me on and because my scores were actually very good from the student ratings and all that kind of stuff [the problem was resolved]. But it kind of soured me on – there's agency politics, but they're not quite as bitter as academic politics and agencies pay better. So I ended up staying in the agency world and thereafter I just taught part-time, I taught part-time at Cal State Long Beach for about five years, but only that one year full-time.

So then the next thing that happened is that one of my staff at Kaleidoscope, Carolyn Wade, who I had stayed in some contact with, got a divorce. So we started dating and then we decided to get married. So we're fast forwarded here to 1990, so I started looking for a job in Bakersfield because she had two small children.

MM: And she wanted to stay in Bakersfield.

MS: It would be easier and better. Anyway, we got married in March of '91. But I couldn't find a job in Bakersfield because it was that recession at that time.

MM: Oh, right.

MS: Then I applied for – Program [Chief] was the job description, so I did the interview, the interview went well, but they were on a hiring freeze. Anyway, finally the hiring freeze was lifted and I was hired as program head for Kern County Mental Health in October of '91. There were six months where I was commuting. In fact, I sold the house, so I was living with friends when I was in L A and then commuting on weekends to Bakersfield.

MM: Okay, so as you're leaving El Centro what do you think, I mean, you talked about the strike a little bit, but was there anything in particular you think you accomplished there?

MS: Yeah, several things. One of them was on a managerial level. I built a really strong team with a group of talented people who were committed to community mental health. So for example, back then, we had a program called Los Compadres, which was a social model treatment of schizophrenia. It focused on the socialization and support activities that aren't too far different from the Full Service Partnership kinds of things that have developed more recently. We also had a very robust Crisis Response Service and actually that was the clinical thing I continued throughout my El Centro time is I was on the Crisis Response on call service. So I'd be on the on call list and respond to whatever was happening. So doing 5150s and going to hospitals and police things, because we had a geographic responsibility for East LA for that purpose at that time, so we did all the crisis response for East LA, Montebello, city of Commerce, that part of town.

We also started a vocational program there that was – actually I shouldn't say so much that I take credit for it as I learned from it. I think the good thing about me as a manager

is that I'm willing to try things. So we tried this vocational program and I wasn't really that convinced it would be useful. But there were a couple of patients that enrolled in that program as we first started it who I knew personally, because they had been in treatment for years. One was a schizophrenic and another one had really disabling OCD [obsessive-compulsive disorder]. As it turned out, we started initially with just a kind of a hinky janitorial program in which we hired clients to clean our building and clean some neighboring buildings; but we did a training and an orientation and it was so powerful that a job, even a job like that, did more for those two patients than years of psychotherapy and medication. I knew this OCD guy really well and it was like sometimes it would take him ten minutes to get through our front door because he would have to go through all these rituals to get through. And then, as it turned, out he didn't have time for that, he had to be there for his job and his mother was so – when they graduated from the training program and started the job, his mother was there and she was in tears. "It's the first thing my son has ever completed." Obviously, 25 years later, I still remember all that vividly.

So it was one of those things that changed my view of what mental health treatment ought to be and the capacities of mentally ill people. Paul Barry, I don't know if you know him; he runs the vocational program at the Village [Barry became Executive Director in 2009]. He was the guy that we hired to do that program at El Centro, so we got a lot of good people together there. So we had a housing program, we had a vocational program; I wanted us to be the best so we tried everything. We had an AIDS Program. That was another whole area I got involved in is I was – as the Clinical Director, I was the Latino Representative to the Ryan White AIDS Consortium thing back in the early days, when everything was a mess [Ryan White, an Indiana teen who died of AIDS in 1990, inspired many care and advocacy projects for people with the disease].

MM: Yes, I remember.

MS: So I participated in those – good thing I wasn't married, because I was working all the time [he laughs]. So I participated in those meetings and I learned a lot, met some wonderful people, some of the original AIDS treatment doctors, Alexander Levine, just really amazingly smart, but also dedicated, humanistic people. So I had the opportunity there to meet a lot of great people. So we had a homeless outreach program, we had an AIDS program, we had aftercare for graduating [from] foster care.

MM: Oh, good for you.

MS: Yeah, we had one of those programs. So I was entrepreneurial; that's one of the good things, and the bad things, about me as a leader and manager is that I'm entrepreneurial and I want people to do things and I let them do them. Sometimes managing all the horses going in all the directions is a problem.

MM: Yes [she laughs], they can sometimes try to run away with you.

MS: Yeah, or they – it's not so much they run away from me, is they have a sense that they're pulling against each other rather than together. So anyway, I'm very proud of what we were able to accomplish at El Centro. I developed a team that was very useful. Now, one of the things that happened there though was that my clinical team stood in opposition to the CEO and so this was another thing that was happening around the time that I left. The tensions were escalating and so we had a Board meeting in which we had rehearsed the clinical people getting up and telling the Board that there was a vote of no confidence in the CEO, and they needed to do something differently. So that was going to take place the day of the Board [meeting]; the Board meeting starts, everybody is prepared, they have their scripts, I have my role, everybody's [ready]. And the

chairman of the Board says, "I'm going to begin the meeting by saying that the Executive Director is resigning," so I was like –

MM: Oh shoot.

MS: We went to Steven's Steakhouse afterwards and had a quasi celebration. We won! Did we? It turns out we didn't really win. What happened was yes, he resigned, but the management of the organization went to a committee of the Board and the committee of the Board was headed by a guy who was the high school classmate of the ex-Executive Director; and the ex-CEO retained his spot on the Board and was on the committee that was doing the direction. So again I was kind of leading the [opposition] thing, but I was reporting to this committee and that's the point. When I left, that's what I left from.

MM: So they kind of did an end run around you.

MS: Yeah. And so it was like – it was a good thing for me probably to leave even apart from my marriage situation. And then what happened, however, was that so the board hired a new guy and the new guy didn't know anything about mental health. I think he had been an administrator of a health clinic. He thought the way to manage was to buy labor peace, so he agreed to whatever the Union wanted to do; so the El Centro employees, after I left, were earning more than County employees.

MM: Oh, my gosh.

MS: [They] had better benefits and lower productivity, because there were no standards for anything. Oh, that's another thing that I accomplished at El Centro. We put together a performance management system that included a productivity standard that increased – Actually, that's been one of the things I've done, every place I've gone, so we did it at El Centro first. When we did that, I took it to Kern County and we're still in the process of doing that here.

MM: Now that's a very management technique. Did you learn that? Did you just come up with that or did they teach you that somewhere along the way?

MS: I don't remember.

MM: Because it makes sense, you know, it's a hallmark of good management.

MS: Yeah, that's funny, I know it was my idea to implement it at El Centro and initially the Union hated it. But from my perspective, it was the only way to guarantee a revenue stream. And so I think that's the way I've changed – initially it was clear and simple. The initial program I had at El Centro had an incentive system built in, so if you met your own personal productivity goal, you got half a day's additional pay, so whatever. But if your team met their goal, you got a full day's pay. So there was an incentive not just to be, "I'm going to do it my way and get mine," and then it also gave a mechanism for rewarding the support staff. If the team met their goal, then that meant the secretary and all the people who aren't directly providing care all [benefited] – because their help is needed to really achieve [the goal], so I thought it was a good mechanism. So it lasted in that fashion for about two years; and then in lean negotiation times the Union said that the money that you put into that put into our salaries, so we did. I mean, why have a strike over something like that?

MM: Sure, sure.

MS: Anyway – let's see, I forget where I was in the narrative exactly.

MM: Well, we sort of got into Kern County, but I just wanted to ask one more question, which is again, you've alluded to this that your perspective on the mentally ill was changing and it sounds like it was changing because of direct experiences with clients. Could you expand on that a little bit? I mean, what have you thought about mental illness when you came into this program, [and] you hadn't had any "official training," did you think that the mentally ill could recover?

MS: You know, it's funny. I probably came into the mental health field with positive naiveté. So it was like since I didn't have a bunch of training, I was never indoctrinated into the, "this is a hopeless" [perspective]. And, unlike many people, my first introduction to people with mental illness wasn't on the inpatient side, so I didn't see [those patients] and I think that's one of the things that distorts psychiatrists views'. Their first introduction is to people who have the most severe problems, at the most severe point in their problem's trajectory, and my experience was the opposite of that.

My first involvement was from people in the community at Kaleidoscope who didn't even know that they had mental health problems. It was clear that they did, but that wasn't what we were dealing with, was their mental illness, per se. And then secondly, at El Centro when I initially started, it was in the community mental health center as an extension of [the] psychoanalytic therapy kind of viewpoint. So it was the schizophrenics and severe bi-polar disorder clients were the minority of our treatment population as I first started.

Actually the move towards the seriously and persistently mentally ill began to take place during my time at El Centro, and so the refocusing of the program through things like that Los Compadres program and so forth were part of the learning thing. In a certain way, I kind of learned with the field, so it's not so much I questioned things when I first started. I just picked up with how things were and then, but I wasn't stuck with any particular paradigm, so when I was able to see what worked for people, I didn't have any investment in a either a psychoanalytic or any other particular modality or theoretical paradigm. It was like that which helps people lead better lives, that's what we ought to be doing and so, in a certain way, I think [the fact] that my experience clinically was more practical than it was theoretical ended up, in my case at least, being a strength.

MM: Good, that's fascinating. And you had done this earlier paper on family therapy I mean, we talk a lot about cultural, what are we calling it now?

MS: Cultural competence, cultural awareness, cultural whatever, yes, you're right.

MM: Is there a sense in which you see the, I mean, if you look at the Latino mentally ill population, are there specific things that are more helpful to them than to Anglos or Asians or other groups or, I mean, what do we mean by cultural sensitivity or cultural competency, other than bilingualism, which is obviously, I mean that's a [given].

MS: That's a really good question and one that I grappled with when I was at Cal State Long Beach and I had to teach a course on cultural competence. And as a teacher then, the question was, what do I tell students that will be useful, that is not merely reinforcing cultural [stereotypes such as] Latinos are family oriented. So it was like, what is actually helpful? I'm not fully convinced I have any answers to that question even now. But I'll tell you two [starting] places. What helped me in the course was there was a guy named Joe Yamamoto, who was head of the emergency room at USC and he wrote a book on cultural competency and that book saved my butt in teaching that class, because it had things that would actually be useful, that weren't just a cultural stereotype B.S., frankly, so that's one thing.

The other thing is an approach in which I thought there would be a [degree of] usefulness, but there hasn't turned out to be yet. When I first started, actually my last years at Kern and my first years here, there was an effort to look at ethno-psychopharmacology and ethno-psychopharmacology is tracing the fact that different genetic groups metabolize medications differently. There was a researcher at Harbor UCLA named Michael Smith who was, like me, a Latino, and Dr. Smith was very persuasive – he was the best presenter on these cultural issues that I had seen. He talked about – he thought that within five years, and this was ten years ago now, that whatever [drugs were prescribed] would be specifically compounded for us and what our body would metabolize, so it wasn't just psychoactive drugs, but all [medications] would be that way and of course things have not progressed that rapidly.

So back to your original question, I think there are [pause] broad things that anybody who is doing a cultural intervention ought to be aware of about any other ethnic group. And some of those things are, for example, the role of the helping person. So, for example, ironically, generally speaking, Latinos prefer authority, so they would prefer – they wanted me to be an M.D., not just a [MSW] – and they would refer to their social worker as doctor because that's just how they saw it as being useful. And then there are some specific things about gifts and gestures and things like that, but they are those kinds of specifics I personally believe are relatively minor. I probably wouldn't say this in public, but my overall view is that cultural competence is really just a subset of the same kind of issues and relationship things that you would try to have with anybody. Everybody who is skilled in interpersonal relationships adjusts their approach given the race, gender, age, everything, of the person that they're engaging with and so that's what you need to learn to do and frankly the only way to do it is experience.

So for me, I knew without really having to think about it how to deal with Latino people, because I grew up doing that, which isn't to say I was familiar with every social class among Latinos because my family and their friends were pretty much working or middle class. So the aristocratic class of the Latino culture, which occasionally comes into practice, is a different way. I knew enough to know that things were different. But, for example, I had not known until I got this job very much about Asian cultures. But, as I've interacted with, dealt with groups, I've learned and I'm more adequately responsive than I was at a previous time. I don't know exactly if that is book content, or experience content, but I know I'm –

So culturally competent practice has been one of the primary issues of my whole career. On the other hand, I'm up to here in hearing the same things as I heard back in 1979 and it's like, please tell me something new, so it's like I am really tired of the rhetoric side of cultural competence and I'm really impassioned about the sensitivity and skill side of cultural competence. Anyway, you touched a nerve there [he laughs].

III. Program Chief in Kern County; Dealing with Deinstitutionalization

MM: Okay, so I guess we're ready then to talk a little bit about Kern County.

MS: Okay. So I was hired to go to Kern County as the "new guy." People were a little bit surprised that an outsider had been hired in to be the Program Chief and there were several people who were reporting to me who were thinking they should have had the job. Initially my job was to supervise the people who were in charge of the various programs, and that was pretty much it. And I didn't know until later [exactly how much opposition there was] – but when I came in I was appalled [about some aspects of the current practice there,] and I'll give you two examples of things that appalled me. One of

them was the clinical triage was done by an experienced clerk at the front desk. You call in for an appointment, the clerk would listen to your story, decide if you were immediate, long-term waiting list, refer out; whatever was going to happen with you got decided by this clerk on the phone.

MM: Wow.

MS: Second, Kern County Mental Health was in charge of both alcohol and drug, and mental health, but there was a very strong prejudice in both directions. When I first got there, somebody came to me and said, "You got to help me, I went for mental health treatment, I told them about my drug problem and they said, oh, we can't help you, you have to go across the hall because we can't treat you here, until you've been drug free for thirty days." He went across the hall and they said, "Oh I'm sorry, if you have a mental illness we can't help you until you've been stabilized on your medication," across the same lobby.

And I should say another thing that was happening at the same time was just as I was leaving El Centro, [it] was the beginning of the atypical anti-psychotics. Risperdal was just starting [risperdal, or risperidone, is used to treat schizophrenia in adults and adolescents, mania in persons with bipolar disorder, and irritability in autistic children]. We were starting a risperdal group, because we were trying to get as many people as we can to try it and back then you had to do the labs like every month. I mean, there were lots of labs that needed to be taken on that. It was very intensive, plus everybody was short on psychiatrists, so we had these things called Medication Groups where they would do the follow up in a group setting. So, when I got to Kern, they had some medication groups.

Well, as a way of – I should say this is probably my fault, as a way of dealing with this huge waiting list, with the triage happening, I ended up changing that triage process, changing the referral on the co-occurring, changing the wait list issue by starting these groups as a way to get people in to do something. I co-led the medication groups with the psychiatrist, just to learn how things were going on and learned a lot about how treatment was going and not going and the attitudes toward people. And I thought it was a very hostile attitude toward people with mental illness. So this is what had been happening. If you missed an appointment and had to reschedule, say for medication refill, what they would do is you would have to wait. You would be rescheduled for either 7:30 in the morning the next week, but you wouldn't necessarily be seen. What would happen is between 7:30 and 8:00, whoever was there, the triage nurse would see however many she could get to and you needed to come each morning at 7:30, until they got around to you. For an intake, for a first intake, if you missed an appointment, you would get your next appointment [scheduled for] a month away on the same time.

MM: Sounds very punitive.

MS: It was very – and that was the overall aspect; it was punitive and hostile. So there were – I mean, we had a crisis team that would say they were going to go out and shoot people up with [prolixin decanoate, a very potent phenothiazine] and they can't wait. And it was very not what I was used to, so I came in and I was Program Head. I wanted to change this stuff, and I angered people, and I didn't really know the full extent of it. In fact, I found out later that the Medical Director tried to convince the Department Head to fire me, to fail me on my probation, but anyway I got support from the Director. I started to make these changes, some people left, but we started to build, kind of in the way I did at El Centro. I put in productivity standards, we had more money, we used the money to expand services. They had not known much about EPSDT [Early Periodic Screening Diagnosis and Treatment] and the service opportunities out of EPSDT.

We really created the children's system there, because they didn't have – the children's system in Kern County was one agency and one part-time County staff when I started there; and so we started a children's system. [Deanna Cloud was the manager who accomplished that for me in Kern.] We went to a geographic team responsibility. I started mental health clinics in all of those outlying towns that I use to serve. We did, I think, a lot of good things.

[Another good thing that we did was to find community placements for most of the Kern residents who had been in State Hospitals. Fred Hawley and Phil Foley (Phil had been my supervisor when I worked at my MSW internship) were able to accomplish this task and we invested those savings in clinical programs. We did quality of life surveys of the clients we placed and found that they universally preferred their community placements.

Another important thing that I was involved with in Kern was the formation and growth of the Kern County Network for Children. It was a collaborative of agencies and entities that served kids and it brought together County Government, the schools, law enforcement, and ordinary people to knit together a better system. Kelly Blanton from the Kern County Superintendent of Schools, Joe Drew and Joel Heinrichs from the CAO, Don Dudley from DHS, and most of all Wendy Wayne were the leaders who made that work. The group did many great things, like start family resource centers, but the leadership training for community citizens was the thing I will remember the most.

We started a crisis stabilization center for clients in the Emergency – In fact, that was another interesting punitive kind of story. We started this crisis stabilization center, and the idea of a crisis stabilization center is where you interact with people so that they do not need to have to go to the emergency. They're stabilized, you can hold them for 23 hours, then you don't have to admit them for inpatient, you provide them whatever support [they need]. But so they're doing the remodeling and all of a sudden they're building a nurses' station in the middle of this. I told them I wanted it set up so they're not beds, so put like lounge chairs that can recline in case someone needs to sleep, but it's not like a bed, it's not an inpatient setting. So that's how they were supposed to reconfigure it, but then they started to build this nurses' station. And I said, "No, that's not the point, you should be with the people, not segregated," so they didn't build the nurses' station. I go back there in another couple of months; and, when it's operating the staff had placed furniture and plants to create a wall that's like a nurses' station, to keep them apart from those clients!

So I guess my overall effort was to say, "It's not them versus us, it's all us;" we don't have a job or a responsibility without clients. So I formed very strong relationships with the NAMI groups [National Alliance on Mental Illness, a family support and advocacy organization], [especially Darlene Prettyman who later became a Statewide leader]. And actually I did a good job with the Board of Supervisors, so they were all very supportive of the mental health program, and we grew a lot and it was good. [Especially supportive were Supervisors Mary K. Shell, Roy Ashburn, Pete Parra and Barbara Patrick.]

MM: Was there something in particular that you wished you could have done and didn't manage to do, or something that-?

MS: Well, two things that I should have done that I didn't accomplish. One of them was to build a [more secure] succession plan so that whatever was going on didn't depend on me and my energy for things, that it was deeper in the organization, so that was one thing. The second thing is to - I never completed it, it got completed after I got there. It was some kind of training program for professionals in Kern County, because the

biggest problem [was that] mental health clinicians don't usually see Kern County as a place to move to.

MM: No [she laughs].

MS: So really the strategy needs to be pretty much, "grow your own" and the only program there at the time I was there was an MFT [Master's in Family Therapy] program and the MFT program at that point was pretty much geared towards a private practice model, producing private practitioners. So I started to lay the ground work for a creation of an MSW program, but it didn't actually get started until after I left and I laid the groundwork for the start of a psych residency program at Kern Medical Center and that got started, but again after I left. Since it got started after I left, what didn't happen is the connection of those programs to the mental health work in the Recovery Model didn't happen in the way that it needed to. So there is a MSW program there that does have mental health training taking place and there's a residency program; but they are not particularly, in my view, operating on a Recovery Model.

I wished I had completed something so that the ship could have stayed on course. Because after I left, some things moved forward and flourished and other things didn't, but in this last crisis, the whole program in the County has fallen apart and it was just terrible. I mean, layoffs and cutbacks – I'm luckily out of the loop in some ways. I don't know everything that is happening. Anyway, so those are the two things I would have done.

MM: Okay; and then kind of comparing these, LA County and Kern County, which are very different places. But I know that during this period in LA, they were suffering from a continuous series of cut backs and were you experiencing this same kind of thing and how were you dealing with them, or it sounds like you were sort of creating new clinics and making things happen?

MS: Well, yeah, during that period of time, I started – Oh, I should say that I was Program Head for only like a year and a couple of months; and then the Director [Ed Rous] retired and so then the Board chose me as the successor. During that time, it was pretty much a constant growth. In some ways it was because there were so many unrealized revenue opportunities. You start EPSDT and start getting more Medicaid match; that goes into your base [and] you can use that to grow. So that's kind of the trajectory we were on. The biggest thing that we did which is something that LA County did, but Kern did to a greater percentage – and one of the things I was proud of, one of the accomplishments that I did get support from staff to get done – was, when I started, we had 43 people in state hospital, and over a year or two, we were able to reduce that to two people in state hospital.

MM: Wow, that's good.

MS: And then we tracked the life satisfaction of the people we moved and it was a hundred percent [of the] people thought they were better off where they were now, compared to when they were in state hospital. So all of that state hospital money, of course, is unmatchable. So the money that we got from the state hospital is the capital I used to start the new programs and that capital you use, you can use it for drawing down federal match. So if we save 12 million, it can become 24 million and [with] EPSDT, it can become infinite, because you only have the 5% match to worry about. So that's really why we were growing at that time is we re-directed long term care to outpatient care and then invested that in services that could draw down federal participation, so it was a really good business model [he laughs].

MM: That's great. And what about, I mean, one of the key problems of the mentally ill is housing and finding places where they can live and community resistance often – so was that similar in Kern County?

MS: Yeah, it was a little bit different. One of the first things that I got involved with, actually as Program Head, but then later as Director, was finding housing from the NAMI perspective. And from the NAMI perspective at that time, it was "our kids that we're taking care of now with schizophrenia, what happens when we die?" And so NAMI created some "quality board and cares" was the word that was used at that time so they were board-and-care-like facilities in neighborhoods. In fact, one of them was in my neighborhood in Bakersfield and there was some degree of – It was a case by case issue. So, in one instance, one of the neighbors was an ex-sheriff of the County who also had family issues with mental illness and so in that case there was no problem. In another one, we were starting a program out on the edge of town. It was going to be a ranch program, and it was full NIMBY-mobilization [NIMBY="Not in My Back Yard"], public meetings, the whole ugly nine yards of things. So politically the brokered deal on that one was that we withdrew from that project, but found a substitute and the substitute was [country singer] Merle Haggard's [former] house in Kern Canyon; so we bought from Merle Haggard this facility with the biggest guitar shaped pool.

MM: That's lovely.

MS: And Anne Sippi from here in LA was the program that we got to run that program. So it was Anne Sippi Ranch. [The Anne Sippi Clinic was named after a young woman who made significant steps toward recovery after a long history of mental illness.] They started the program, and it was a very advanced psychosocial model with employment opportunities and they started a gift shop for client crafts and had a continuum of care for supported living places that people could move into. It was very good. [Susan Rajlal who currently works for us here in Los Angeles developed the programs at Anne Sippi..] Then we also had some grant writers that got us some [funds]; we built a couple of supported housing projects. We took over an old motel and turned that into a residential [facility], so we did a lot of housing things there. Actually, that was probably one of the more aggressive [areas] and things to be proud of that we did was the housing continuum. We got a couple of federal grants.

[My wife (Carolyn Wade Southard) after I left Kern] ran a really wonderful homeless outreach program so that the team that was doing that knew, literally, knew every homeless person in Bakersfield, and formed good partnerships with police and all the shelters and everything, so that we had the ability to respond to whatever was going on. Also, there was a grant for a rural homes program in which we taught living skills to mentally ill people, so they could keep their housing. That would involve the staff of that program cleaning houses, whatever it took, clean house, buy groceries, whatever. So I think the housing program was one of the more progressive things there.

MM: Great, so what else can you remember about Kern County?

MS: So let's see.

MM: Were there particular people that you found good to work with?

MS: Yes, actually, it was an interesting process. Initially, there were some tensions with the community agencies, as there often are at the board level. But, over time, we were able to build some partnerships with them, particularly as I started to expand services, then an expanding pie is easy to make friends with. So some of the agencies that we worked well with, one of them was Clinica Sierra Vista, which is a federally qualified FQHC, that

started out as the Farm Workers Health Clinic. [The Director there was Steve Schilling and I believe he is still running that program.] And so we had contracts with them, so they provided mental health services in some of our outlying communities. [Another really good partner was Henrietta Weil Child Guidance Clinic which was run (and still is) by David Camara and Linda Hoyle. One of the sad things that happened was that I had to close down the remnants of the Kaleidoscope program.]

One of my less successful efforts there was to integrate substance abuse and mental health services. Because they were both in my kingdom, I naively thought initially that the solution would be to hire mental health staff, put them on the substance abuse teams, [and] to hire substance abuse specialists, put them on the mental health teams and we're integrated. Wrong! And so what I often say is the immune systems of both organizations mobilize to expel the outsiders.

MM: [She laughs] I like that.

MS: And we really – I mean, it was important to me, so people pretended to do it. But again, that was put in the category of something – it really didn't work out in the way that I had hoped, in most cases. In some places, of course, it did, but in most cases it did not. So there was another interesting program called Desert Counseling that had a program called Kern Linkage, which was a very advanced, psychosocial model of intervention [that also did housing and school based programs. The program people, especially Bill Drakos and Gene St. Amand were excellent,] but towards the end of my tenure, the CEO ended up, and this I found out later, but they ended up owing the County money. So as I was leaving, we took over Kern Linkage [as] part of the program and those employees became County employees and the rest of the program continued to operate. My recommendation to the Board was that they end the contract as I left, but they ended up not [terminating]. The agency ended up growing. Then the guy ended up being convicted for embezzling money and being sentenced to jail, along with his wife. But that happened after I left. What else would be interesting about Kern? I could talk for days.

MM: Yeah, I can see that, so maybe we'll come back to that later.

MS: Okay.

IV. Director of Mental Health for Los Angeles County; Crisis Services; Co-Occurring Disorders; the Stats Project

MM: But then in 1998, you had the opportunity to move to Los Angeles County.

MS: Yeah, what happened was that my predecessor here, Dr. [Areta] Crowell [DMH Director 1992-98], asked me to put my resume in, even if I wasn't interested, because she wanted a pool that was qualified enough so that whoever was chosen would have been chosen from a decent pool of people.

MM: Yeah, and not by default.

MS: Yeah, so under that context, I put my resume in and I also had a conversation – I was still a smoker at the time so I was in Sacramento and I bummed a cigarette from Richard Van Horn and he told me, "Oh, you should apply for the job from LA." And I said, "No, my wife would never want to move to LA, and there's the kids and all that," and he said, "Don't presume, ask her." So I talked to my wife and she said, "Oh, it doesn't hurt to put your resume in," so I put my resume in, but I did not intend to take the job. So I didn't prepare for the interview and so I did really well on the interview since I was not at all

nervous. The first level interview was with a group that included providers and NAMI and clients and it was one of those community things and so they interviewed all the candidates and then sent a list of five to the Board of Supervisors. So then I made that next list. For the second interview, the one with the Board of Supervisors, the only preparation I did is that I didn't listen to the radio on the drive from Bakersfield to LA - you should know that for jobs I really wanted, I could be OCD, like I'll think of questions that they might ask and then write out and memorize the answers to those questions.

So – and I'll hike back. I was doing very well in Kern and we were very progressive, things were going well. They had a CAO [County Administrative Officer named Joel Heinrichs] that I worked really well with and he was leaving the job, because this was in the dot.com boom days and he was leaving to be a part of a dot.com start up business with one of his buddies. He recommended to the Board [of Supervisors] that they hire me as the County Administrative Officer and so they were doing the interviews. The only other candidate at that point in time was that CEO that was later arrested for embezzlement; and he was in the interview group because he had very, very close ties to one of the members of the Board.

So we did the interview; but I made a huge mistake in the interview process, which was I got a phone call one day from the local newspaper that said, "Oh, I understand that you're one of the finalists for the CAO position," and I said, "Yes, it's a great honor, blah, blah, blah." Then I found out it wasn't public knowledge. They had gone fishing and I had bit on the bait, so then I had to call the Board and say, "Well, this is what happened." Then there was an article about me being one of the candidates and the other candidates being mysteries. I think what happened was the Board thought that, well if he can't keep his mouth shut when he's the candidate, what's he going to do when he's the CAO?

Anyway, the process stalled forever. I mean, it took a really long time and in the end they appointed the assistant CAO who hadn't applied for the job as the CAO. All of this takes place in the newspaper, so it was mildly embarrassing and actually that's probably the reason my wife said, "Go put your resume in." Anyway, I put my resume in, I'm interviewed by the Board; a week later I get the call back saying we're offering you the job. I panic. I say, I have to call back and it happened to be on a Tuesday, because they make their decisions on Tuesdays. As it happened. I had a closed session with the Board that afternoon on another matter and [in] the context of closed a session, I tell the Kern County Board I've been offered the job in Los Angeles. A couple of them say, "Wait, wait, don't go we want to talk to you;" so I put the LA Board off and then it turns out they [Kern County] don't have anything to offer me. I ended up talking with my wife and I took the job. So that's how I got the job.

MM: And so here you are.

MS: So here I am, eleven years later.

MM: [She laughs]. Did you have any specific plans in mind? I mean, this is a huge job, even though you obviously have all these excellent experiences beforehand, this is a big job.

MS: No, I really didn't. Well, I have to say that since I worked at El Centro for ten years; I wasn't unaware of the LA County system. I knew many people in it, I knew County administrative staff, not well, but I knew them, because I'd been in contract negotiations with them, and other things. More to the point, I knew the CEOs of the major community agencies because they had been colleagues of mine. In fact, there was a statewide organization that I was the representative on that group for El Centro and we started an abortive self-insurance trust, one of those things; and I was on the Executive Committee

of that group, which I learned a whole lot of things from, about swindlers and such. Anyway, I got to know people pretty well. In fact, that's what my one o'clock meeting today is – we informally call it our dinosaur meeting. It's a meeting of people who have been CEOs of community agencies for a long time and they're basically the same people I've worked with fifteen years ago, or more than that, twenty years ago; and they were very supportive of me in my application process and probably had some fantasies that I would be really easy to deal with.

Meanwhile, the Department of Mental Health staff, I learned later on, had opposite fantasies. There were rumors going on that I was coming in with my team from outside and everybody was going to lose their jobs and there were huge – in fact, to this day, I'm sure I don't all of the rumors that were going around about [that], but from the executive staff perspective, it was a black day, when I was hired. Of course, I didn't know any of this. So coming in, I guess my first – I'm not sure, you'd have to probably ask other people. My own view was that my approach and my goal was to learn again this system because [once] again, it was so big and so huge and so diverse and so many things going on. I've heard some feedback, however, that I came in wanting to change everything and I didn't really know what was going on with things that I was wanting to change. So probably the truth is somewhere in the middle.

Some of the issues for me were the same as they had been at El Centro and at Kern County. One of them was, from the very beginning, access, and how we do access to care. I think one of the first things I did was write a White Paper for discussion discussing levels of care and some way of focusing care in certain – because this was still in the time when we imagined the capitation for Medicaid was coming sooner rather than later. Of course, it still hasn't arrived, but in a capitated system, then you're going to really be clearer about what bundle of services [you're providing]. So I developed in Kern a levels of care model in preparation for capitation that never came, and then I did an adaptation of that here.

Another thing I wanted to do is to integrate substance abuse into treatment services and – I'll loop back on that in just a second. A third thing I wanted to do was to reform crisis services because – and I'll work backwards on that. Crisis services first. Crisis Services was a mess here. Basically what was going on was that each hospital had their private PET teams that were delegated by the County and they would go out and hospitalize people for whatever reason. Literally, at boards and cares, they would have solicitation cards. And there were all of these hospitals that just churned MediCal inpatients. So it was hugely expensive.

MM: Yeah, no kidding.

MS: And wrong, and bad care, and I mean, everything about it was wrong. So that was my first area of things to get fixed, it was that crisis thing. As I tried to focus on it, initially from abuses that would come my way, this way, that way, or the other way, I was told literally: "Forget about it, you'll never change it, this is how it is in LA." So what I did was I hired the guy who ran my crisis services at El Centro, Dr. Beliz, who in the interim had been working for LAPD [Los Angeles Police Department] and some other places, to head up the crisis program. Then we worked steadily through the years at eliminating the private PET teams, along with [DMH Medical Director] Dr. [Roderick] Shaner, so the three of us kind of – because they were right, if we tried to take them all at once, it would have politically collapsed on us. But we developed a titrated course of starving them out, so we were careful and moved it forward and basically used our services and patient's rights and everything. So we ended up closing some of the abusive hospitals [which] just got closed down.

We still have a few residual private PET teams, but they are very limited in their scope of what they can do, and they probably, at this point, serve the system. And, as a part of that, we vastly increased the functionality of the county response crisis teams. So that was one of the things that we did. Then as I said, once again, integrated treatment of co-occurring disorders was one of my areas of focus from the very beginning. It started to have a personal element because just about that time, slightly before I started in LA, maybe a year or two before, our younger boy, Adam, started to have big problems.

MM: He was fourteen, fifteen, sixteen?

MS: He was fourteen; and the problems were of a co-occurring nature. So he had an anxiety disorder to start with and the anxiety disorder was social in nature, but also generalized. Substance use in that context serves several purposes; and he's a very smart guy, and so that's what he dedicated his life to. So things were getting more and more problematic and, since it was co-occurring, it was an odd mixture of things. It was adolescence, so there was the adolescent acting out, plus real mental health issues, and [these were] mixed up and you weren't sure what you could see. So it was like beginnings of some law enforcement [problems]. He and a friend were arrested for breaking into a vacant house to smoke marijuana there and so they got picked up, they were on probation; stuff was starting to go poorly. So issues about co-occurring; he was seeing a psychiatrist, but it wasn't really helping that much and we knew there were drug issues and trying to get him into the right kind of help was a problem. So all of that was going on during my last [months] at Kern, as well as [when] I started this job so I [had a] really heightened awareness of co-occurring issues and adolescent issues, so that was a second area of particular focus.

Then another one was the family engagement and relationship with NAMI, because I had had a really good relationship with NAMI in Kern County. I tried to kind of recreate that here and be more responsive to those kinds of needs. My predecessor, Areta, had developed a pretty robust client engagement process, so I continued to try to expand that. The other change thing is I began my first cut at trying to focus on what we called at that time productivity, and trying to focus on how we use our most valuable resource, which is the time and talents of our clinicians in the best possible way. So those were the areas, as I recollect, that I first started on and I thought at the time that I started slow and carefully, as opposed to the way I did it in Kern. If you asked other people, they may not see it the same way.

MM: OK. So I have several questions then about sort of how you did things in addition to trying to do them slowly and carefully. Did you have a strategy for working with the Board of Supervisors? I mean, you had worked with an earlier Board of Supervisors in Kern County. I've heard that these particular Boards can be quite challenging to work with.

MS: Yeah, I did not have a strategy and that was one of my biggest areas of learning that needed to take place. In Kern County, I ended up having a personal relationship with the Board members. So I was on a, "Let's go out to lunch, I'll treat this month, you treat next month," with three of the five Board members. We regularly went out to lunch and just discussed personal, as well as County-related, things. So, as much as you can be with your bosses in that way, we were friends. And the staff on the Board of Supervisors in Kern were important and to be treated with respect, but they were not policy makers by any means. Here, it's completely different. You don't really have an opportunity to form a relationship with Board members for the most part; and the relationships with their staff are crucial and the staff really should be treated as though they were the boss and I didn't know that. So I treated staff like staff, like, "No, I really don't think it really should go." I wasn't abusive or anything like that, but I was clear about my views on

things and I found out, that's not necessarily the way to be. So I had a couple run-ins that were very ego-dystonic and so I tried to learn from those.

MM: Okay, and one of the questions which keeps coming up in all our discussions is the advantages or disadvantages of having directly operated clinics versus contract clinics and you've seen this from different angles, obviously, having worked at El Centro as well. Suppose LA County suddenly got a whole new area of people to work with, I mean, would you want to, ideally seek to put a directly operated clinic in the new area? Are there advantages to having contract clinics in certain services, or what do you think?

MS: I guess I believe two different things on it. One is that from the beginning and this was a part of my initial interview with the Board, I believe in a mixed model and that the mixed model has certain strengths in it. The way I would articulate it today wasn't available then and probably I wouldn't articulate it publicly this way. But there are advantages of having a public option and the public option provides some – if the public option is well run and articulated, it can provide a standard against which to measure the issues of a contracted service. So that's one thing. A second thing is that being responsible for running directly operated services for a system like ours, I think, acquaints me and my administrative staff with the practical real difficulties and I think we can operate with our expectations of the contractors on a more realistic basis, because it's not theoretical. We know what it's like to try to get certain things done.

Third thing is that politically a balanced system protects the public mental health system, depending on the weather. There are some times where having directly operated staff who are union protected is a really good thing in terms of protecting our funding. There are other times where having community agencies that are entrepreneurial is helpful; so to have both cards in our deck, so to speak, is. I think, useful. Fourth, there are some services I would only do, personally, on a contracted basis and there are other services that only make sense operated by, I think, County employees.

So, for example, if we were going to do, as we're maybe going to be asked to do, a 24-hour treatment program for disturbed, criminal youth, I would contract that baby out. I would not want to have the responsibility of running such a program on a 24-hour basis, because, generally speaking in LA County, county employees don't do well on 24 hour shifts basis, because everybody wants the day shift. And making people do, in our civil service system – it wasn't that way in Kern necessarily, but in our civil service system, making people working a shift they don't want to necessarily work at and making sure you have a team that has all the members to do it, so that you don't have all scut workers on the evening shift and no psychiatrists and so forth [is unworkable]. I'd rather that be done in the private sector where they can just tell people what to do.

There are other services though, like the Crisis Response and our jail services that really make a lot more sense [as] directly operated, because we're partnering with other entities, like LAPD or the Sheriff; and it just works better if you're both kind of in the government mode of things, rather than having one set operating from a private practice mode and the other people working in the public service mode. So I think there are some programs that fit in the category I would say [that] ought to be contracted out. Others fit in [the category of] ought to be directly operated; and then a broad spectrum in between that can go either way and it's really that decision is political and opportunistic.

MM: I see.

MS: And I know there is some talk that goes back to re-inventing government and steering versus rowing and that Counties ought to be the steerers and not the rowers; and [pause] I don't think that fits the complexity of the situation as it exists here.

MM: Okay, and conversely there's some feeling expressed to us by some people that the contract clinics tend to cream the better patients and leave the jail patients, the homeless people, the co-occurring disorders, to try to push them into the directly operated system.

MS: Yeah, I guess that's what I was saying by trying to use the public option modality. You know, human beings are human beings and so there are incentives to try sometimes to make your work easier and human nature being such, unless you build some kind of checks and balances into a system, so that, particularly in LA, where the contractors are really often not competitive with one another in the true business sense. But I think it makes sense to have what I describe as a mixed economy.

MM: Okay. So we sort of got cut off with talking about co-occurring disorders. I mean, so what specifically - you tried to mix the teams and that didn't work too well. So was there a next step to that?

MS: Yeah, the next step has been to do what I didn't do in Kern, which is to prepare the process – to prepare each setting for the reception of the other. So the strategy [which], I have to say, was already operational to a certain degree here in Los Angeles was co-contracting. So we contracted with a number of substance abuse providers to do mental health services and we tried to make those services ones that focus on co-occurring disorders. Meanwhile, we've also tried to do education and skill building for our clinical teams, mostly within the directly operated, because I have better control there, and where the idea is that we would not merely have substance abuse specialist team members, although we've done that this time. So we have substance abuse specialists on most of our clinical teams, particularly on the Full Service Partnership teams that came out of the Mental Health Services Act.

But actually the background to that is one of the really good things we did in LA County was we were one of the first three pilot counties for the [AB]2034 Program and actually we were kind of the ones that made it work, and produced the outcomes. But some of the things we learned in the process of doing that were that programs that didn't attend to the substance abuse issues of their clients and didn't attend to the housing issues of their clients had much poorer outcomes and if they were going to get good outcomes, they needed to invest in substance abuse and housing stuff. I mean, it's a brute fact, and so for me that learning was dual. First, yeah, it confirmed what I thought I already believed, that substance abuse and housing were crucial to recovery, but secondly, the power of following outcomes. It's like if you can follow outcomes in real time, then you can adjust the programs in such a way to create [better] outcomes.

Jumping ahead, that's what I hope we're able to do in the next challenge phase of the integration of physical health and mental health, see if we could find a way to track the health outcomes as part of the things we're making a contribution to. That would be the thing that would drive the integration of [physical] health and mental health care in a productive way rather than in a "who can capture the other guy's money stream." So anyway, that's jumping ahead to future challenges.

MM: No, that's okay, there's a question about that too.

MS: So we've been working on training staff so that the ultimate goal is that every clinical team will have the expertise to deal with the addiction issues of the people who come to them. But it wouldn't necessarily [be] in a way where everybody gets referred to the substance abuse specialist, because I mean that's just another way of dumping. It's not my problem as a clinician, it's yours as the substance abuse specialist; and we have

some of that that's probably still going on. But the overall idea is that everybody should have the basic addiction intervention skills, not that there shouldn't be specialists, but everybody should know about stages of change, motivational interviewing, some of the basic things.

Our goal is that that becomes a part of everybody's basic clinical treatment bag, whether you are a children's, adolescent, or adult clinician. That's just something you know, just like you know the DSM. You can't be a clinician in our system and not know that. That's where we want to get to, and so we've been providing training. We have a co-occurring coordinator that's been working on that, we've used ISAP [Integrated Substance Abuse Programs] at UCLA to try to provide training in various ways, [and] we're training our children's providers on basic skills. But we're doing it not just in the sense of one-time training, but we're trying to [give] support so that people can get feedback after the training about what's working and what's not working in their interventions. So we're trying to use the principles of systems behavior – how do you get a system to change its behavior? We're trying to implement that with this as our focus.

MM: Oh, I see, that's cool. I like that.

MS: The latest iteration of what we're doing with that is we're using our Stats Project, which I don't know if you've heard about that.

MM: I don't think I know about this.

MS: Yeah, the Stats Project – it's got two intellectual sources. One source is what I was trying to do in Kern County with regard to the productivity, but we couldn't actually get done in exactly the same way here, because the unions objected to productivity. So you have to negotiate productivity, you can't – So I said, "Okay, we're not measuring productivity," because clinicians do a variety of productive things besides see patients. We're looking at – we're measuring direct service percentage and we're not setting an individual quota, because it depends on your caseload and your work and so forth, so there [are] no individual expectations. But the expectations for the Program Head is that every program will have a minimum of 65% of their clinical resource time invested in direct client care. That's the goal that we're going to measure on.

So I had some feedback from the union, some threats about some unfair labor practice; but ultimately this is a management right, telling people what to do, particularly my supervisors. I said, "If somebody believes they are being pushed too hard [that's wrong], but really the supervisor has a responsibility of telling the individual clinician what they ought to be doing with their time. Maybe in some cases 65% is way too low, maybe it should be 90% in some cases, [in] other cases maybe 15%, because of the nature of the work." It's individual, but overall that's the average and so we put that kind of into place, but it didn't really change things very much. We got a little bit [better], but not that much. So a few years back, we started this Stats Project in which we used an organized fashion of measuring progress, using data. The other intellectual source for this was Chief [William] Bratton's Stats Project back in – The Broken Windows [Chief Bratton as New York Police Commissioner, helped lead a project which developed better policing based on the concept that unaddressed random acts of disorder (broken windows) were part of an overall culture of crime tolerance and created outcome measures based on these incidents, as well as more serious crimes. Bratton became Chief of the LAPD in 2002.]

MM: Yeah, yeah.

MS: You know, where you can use data to measure the effectiveness of policing and the Captain had to answer for these precincts on a regular basis. So we set up a thing like that, where we have a monthly meeting and directly operated programs rotate through it. We started off with three metrics that had to do with direct service percentage, cycle time for data entry, and oh, I forget what the third one was, and then programs. The data is presented about where they are, the person talks about what their obstacles are, they make a commitment for improving over the next quarter and then the next quarter they come back and say where they've been and how things have gone, what the issues are. Out of that then there were also administrative – everybody would make commitments and some of the commitments weren't from the program, some of them were for administration, [that] administration needed to change certain things. Then we broadened it out so that we also measured some administrative functionality like, percentage of performance evaluations done on time.

Then more recently we've started to add clinical quality measures. One of them is, if in your program you have a client hospitalized, what percentage of those clients are seen for an outpatient visit in the week following their inpatient stay as a measure of follow-up, and so that's one of the metrics that we're using. *Now*, the metric we're using is what percentage of your cases have the co-occurring [or] substance abuse diagnosis field filled in, with the backup done. So that's one of the things – so we're trying to drive the program, as the first step is recognition of co-occurring illness and the second one is treatment of what you then recognize. So we're evolving that system to try to find important, but reliable [markers] – see, because the thing is, we can find important things, but unless you have a reliable data source, forget it. That's been a really powerful learning tool for the whole system and it started out pretty skeptical and people were pretty scared. This is a mental health adaptation of the Chief Bratton thing, so it's much kinder and gentler than the thing that police captains got.

So it's been very successful. I think we had – because we had an increase in direct service percentage, we had something like a four million dollar increase in MediCal revenue year upon year, based merely on the increases in direct service percentage. So it's been successful. Yeah, we just got a quality and productivity award for it from the County and we're going to be making a presentation on it probably, at a national convention in New York next spring.

MM: Good, let's end on a positive note. I think we're going to conclude this part of the interview now.

MS: Okay.

INTERVIEWEE; MARVIN J. SOUTHARD

INTERVIEWER: Marcia Meldrum

SESSION II

DATE: January 15, 2010

V. The Comprehensive Community Care Initiative; MHSA; the Planning Process and Stakeholder Involvement; Transformation of the System

MM: Good morning. It's Friday, January the 15th, and we're starting the second session of our interview with Dr. Marvin Southard. Good morning.

MS: Good morning.

MM: So we want to talk, before we talk about MHSA, about some earlier attempts to better address the needs of the mentally ill in Los Angeles and one of the things that was started [and there was] a lot of planning involved in, was the Comprehensive Community Care initiative, have I got that right? The CCC initiative?

MS: Yes.

MM: Could you tell me a little bit about that?

MS: Sure. The Comprehensive Community Care was kind of my effort, when I first became the Director [of Mental Health] in Los Angeles, at trying to bring about a mental health system that was responsive to all of the needs of the various [ethnic and interest] groups in Los Angeles. My observation of Los Angeles, at that time – which is probably still true today – was that we had really some outstanding world-class programs in our County, but no system that made any sense. So, if you happened to get into a good program, you could really get excellent services, but upon finishing that program, there may be no appropriate aftercare, or appropriate housing. So there would be like these little oases of excellence, but the system didn't really make very much sense.

MM: It wasn't integrated.

MS: Yes. So CCC was an attempt to look at LA County as an entire system. And so we did really a fairly remarkable community engagement process to develop what would be a strategic plan for refocusing LA County. So we started by getting a Steering group to do the planning and the Steering group included client and family members, leaders, community agency executives, and some of the executive team from the Department of Mental Health to try to develop, along with a consultation group, both a process and a vision for what we would do. So a consultation group devised a process about how we would go about getting the community engagement and we put together a plan by which we would do several things. The plan was that at one level, it would be a structural reform of the Department of Mental Health, and on the second level, it would be a expansion of services in ways that met the community needs as the community expressed those needs.

It was based on community meetings, and focus groups that took place in all of the Service Areas, and that [input] was then summed up in work groups. Just like we always do, there was a work group for every age group and problem, so there was a housing work group, there was an employment work group, there was an adult work group, there was an older adult work group. There were the multitude of things that we [in mental health and community support work] do. So there were literally thousands of people who participated in the planning process, both in the work groups and then [as] the work group material was synthesized into reporting groups that were wrestled with at community meetings that were held at Kedren Mental Health [Center]. The Steering Committee acted kind of like a board of commissioners and then got public input on various pieces of the plan, at meetings that were held in the auditorium in Kedren.

[Dr. Kenia Casarreal who had been a friend and colleague of mine when I was at El Centro Mental Health was the lead consultant in this effort and was immensely helpful. There were a lot of people who played key roles in this process, but the ones who come to mind particularly (and as I say, there were many others) were Yvette Townsend, Cora Fullmore and Robin Kay from my Department and Susan Mandel, Ian

Hunter and Richard Van Horn from among the community agencies, as well as Jim Preis, Bill Compton and Stella March from the advocacy communities.]

So [he laughs] one of the things I remember from the whole process is at the grand kickoff we had – I think we were using the auditorium at Good Samaritan Hospital at the time. It was full [to capacity and] this was the first kick off, with the community agencies, [the staff, the Board offices,] and everybody. And it was one of the first "speak to the world" public addresses that I gave as the Director. [The talk] I gave [was] a combination of the Saint Crispin's day speech [he laughs] because I'd say, "There will be people in their beds today…," because I'd had just seen *Henry V* [in Shakespeare's play, the King refers in this famous speech to "gentlemen in England now abed", who will regret "they were not here"]. And so it was part that, and part from [the WWII movie] *Patton*, the part where [General George] Patton says, "Your grandchildren are going to ask you what did you do in the war, and you want to be able to say that you did this, and you don't want to have to say, son, I was shoveling shit in Louisiana." So unfortunately, you know how things go at speeches, it was that use of the quote from *Patton* that drew [attention], "He used the word!" [he laughs]. So there was some level of upset that came up about that, [which over shadowed the message of the speech. On the other hand people remembered it.]

But anyway, [CCC] was a very good plan that got about one third implemented and it ran into implementation difficulties, because we [became mired in] budget issues. One of the budget issues we ran into was that the plan envisioned a greater degree of decentralization of mental health services in LA than it has been typical –

MM: So devolving authority more to the Service Areas?

MS: Yeah, that was the plan. So, it would be – my view of it was [that] the services in Antelope Valley [in Northern LA, near the Mojave Desert] have got to be different from the services in South LA.

MM: Sure.

MS: While it's true that there needed to be services that met the needs of all the different age groups, they needed to be tailored to that particular area. So the plan initially was that there would be District Chiefs that would really run the mental health services in their Districts, but that would mean that they would have to have the staff [to do so]. And what happened then was that there was resistance from community agencies that took the line of "We're going to have nine headquarters to deal with, not just one," and how do you deal –

MM: Right, yeah.

MS: Yeah, and then there were some real organizational issues like there are community agencies like Pacific Clinics, that serve like four or five different Service Areas; so they would deal with like four or five different administrators about the implementation; how would that work?

MM: Yeah.

MS: So there were real design problems, there were fiscal issues, but it became like – one of the storylines that was used politically was that DMH is just trying to feather its own administrative nest in this plan. So we, as I said, probably only implemented about a third of it –

MM: So a third geographically or a third of the plan?

MS: Probably about both. I think we did three Service Areas within – we called them geographic initiatives and we set those geographic initiatives which meant the District Chiefs in those areas got additional resources; so there was the Service Area 5 GI and so some of the geographic initiatives were set up, but they weren't set up everywhere. So that was part of the issue and then in terms of the milestones and goals, we met some of the goals [that] were about the expansion of crisis services and we met most of those milestones – we met some of the older adult milestones, but not all of them. We didn't meet the housing milestones that we had set out, because there were no resources in the end to do that, so, looking back, the plan was very good, the vision and values that underpinned the plan were quite strong. A client-centered family focused system was the vision for it. But it became politically not tenable to push it forward, so we kind of just let it sit for a period.

MM: A period of time. That was about 2001?

MS: Yeah, 2001 was when the planning – well, I think it was around 2000 [that the planning began]. I think the report has it.

MM: I have a copy of the report so I can –

MS: Yeah, I think it says around 2000-2001 is when the report was finalized. We were doing implementation until about 2003. Then there was a very strange dynamic that was happening originally, when I first became Director. I think I may have mentioned it before, is that, after I was hired, but before I started the job, I got some calls from County Counsel and the auditor, around the problem they were having with us, which was a very unusual problem. [It] was that we had something like a 70 million [dollar] fund balance that the CAO and the board determined was not appropriate, that we needed to spend. So we had like 70 million dollars that we needed to [spend] – but, so it's like, how do you spend one-time money in a way that makes programmatic sense?

So the plan we had was to invest in services like benefits establishment and expansion of EPSDT [the Federal Early Periodic Screening, Diagnosis, and Treatment program for children], where you invest the short-term money, but it creates the opportunity for long term revenues. So you invest short-term revenues of a million dollars to create an ongoing revenue stream of half a million dollars. So anyway, we did some of that, but as we started to go forward, all of the revenue expectations in such a plan didn't fully develop for a variety of reasons, as things don't; so it was like, "Oh my God, you're going to be short of money!" So the contractors were concerned. So that's the back story for why CCC got kind of put on the shelf, because it looked like a new and ambitious director is trying to do all this stuff, but he really doesn't have the money to get it done. There are times where you just have to wait for a better time, so that's what we did.

MM: And obviously, funding is a continual problem. There was an effort to start a new tax on the nickel-a-drink?

MS: Yes, actually that was preceding all of this. The nickel-a-drink tax was the first effort addressing two things. One thing, you'd say, is the chronic underfunding of mental health services that are needed to really get the job done for people. And the second thing is that realignment never ended up working the way everybody thought it would work for two reasons. One is that when it first started, it started off with us jumping into a recession, so from the very beginning it just didn't happen in the right way; and then the second thing is that the formula has some caseload-driven programs that people

didn't imagine would grow as fast as they grew. Particularly in the early days, it was foster care as well as in-home supportive services; now it's primarily in-home supportive services. [But the revenue growth over time that we had counted on for mental health ended up being unavailable, because the formula says the caseload-driven programs get first dibs for sales tax growth over the annual baseline.] And so there hasn't been money even to cover cost of living [increases] for most of the mental health programs and realignment was supposed to have solved that problem. It didn't.

So one of the things that advocates – and it was focused primarily here in LA at that time. I was the clinical director at El Centro in those days, and actually I think my first [project] working together with Richard Van Horn was on that campaign. Also, it wasn't my first [project] working together with Susan Mandel, but that was one of the areas that we worked on. But some of the players in the community agency world to this day were very significant workers in getting that nickel-a-drink initiative [on the ballot] and the polling was great until the last two weeks and then the liquor industry did a very strong campaign and [the initiative] failed by a significant margin. So that's the end of that story. But some of the same people involved in that effort later were some of the people that came together, particularly again here in LA, to think through an approach and do the work on the planning for the MHSA initiative.

MM: Okay, so let's talk a little bit about MHSA. My understanding is that it was initially put together by the California Council of Community Mental Health Agencies [CCCMHA]; that's where the initiative came from.

MS: Well, yes.

MM: That's what they told me [she laughs]. You tell me differently.

MS: Well, the impetus was really – there's a group in Sacramento that call themselves the Mental Health Irregulars, and the Mental Health Irregulars include the mental health agencies, but [also other] people who care about mental health. So putting together the initiative included the community agencies, but wasn't specifically limited to them, although it's certainly true that Rusty Selix, who is the executive of the statewide mental health agency consortium [the Executive Director and legislative advocate for CCCMHA], and his relationship with [State Assemblyman] Darrell Steinberg [now a State Senator] that ended up being [crucial]. Because Darrell was interested in mental health, going back to his days on the Sacramento City Council, I believe, where the Loaves and Fishes thing [a private agency that works to feed and find housing for the homeless] was in his District. So it became – there's opposition to all those kinds of things and then after a while he got involved, saw its usefulness, the real issue of homelessness, became an advocate for that on the City Council, continued that in the [State] Assembly, [and] as an Assemblyman worked with [State Director of Mental Health] Steve Mayberg to do the [AB]2034 program [1999 legislation which offered state grants for demonstration programs for the homeless] with three pilot counties that included Los Angeles, Stanislaus, and what was the third one? Ventura.

So the three Directors kind of met with Dr. Mayberg and kind of penciled out a plan over lunch and I'm sure you've heard that story a number of times.
[And the work with 2034 was based on the experience with MHA's work at the Village, which was possible because of the advocacy of [Mental Health America Executive Director Richard Van Horn and Areta Crowell who was my predecessor at LAC-DMH.]

MM: Yeah.

MS: And then that ended up working so well and the outcomes of that seemed so dramatic that the program was expanded from the three pilot programs to I think, in the end there were like 30-some counties [that] were participating in 2034 and that became the starting point for MHSA. How do we get the resources to do 2034 statewide and get it out of the budget process? Because the first – I guess it was the third year of the program, it was remarkable because the 2034 program expanded even though it was a budget cut year, but you can't count on that. I mean, any program like that that is based on a year-to-year funding is problematic. So that was the starting point.

What the community agencies absolutely did on this that government entities could not do is fund the political research and all of that so that funding came, I think, primarily through the large agencies in Los Angeles. There were some others that probably contributed statewide, but it was primarily Pacific Clinics, Mental Health Association, some places like that that put in their discretionary funds as they were allowed to do, to fund the polling to see what would work and what wouldn't. And then they did the polling about what people were interested in, starting with the idea that they would do something like a 2034 expansion and they found out other things that other people were interested in, like children's mental health and suicide prevention and those sorts of things. Then, when they got the polling information, there was an intense period where this "Irregulars" group kind of tried to work out the language. So that included the Darrell Steinberg staff and Rusty Selix and his staff, and [in] LA County, our legislative analyst at that time, whose name was Steve Fox, was a participant in that group, and the Mental Health Directors Association was represented.

Anyway, there was a long sausage-making episode of trying to craft the language and the plan and I think the feedback that I got from that process was that Steve Fox, the LA guy, believed that the community agencies ended up getting their way too much in the way that it was drafted. I think that really had to do primarily with things about the set up and the powers in the approval process through the Oversight and Accountability Commission [a 16-member commission established by MHSA to oversee and evaluate the implementation of the Act] and all of that kind of stuff. I really didn't know exactly what Steve was so upset about, but he thought it was moving authority away from local government. But anyway, they came to a compromise, everybody – all the stakeholders bought off on the compromise; and then the process was, "Well, how do we make this passable?" In Los Angeles what we did was we had a Steering Group that I was one of the members of, but met – where did we meet? Couldn't be at County Headquarters, so we'd meet at like 6 o'clock at somebody else's building and the Steering group included Richard Van Horn, Areta Crowell, and Susan Mandel and Bruce Saltzer and the Union, SEIU [Service Employees International Union].

MM: Okay, so the Union was involved in it fairly early?

MS: Yeah, so – yeah, the Union was very much involved – I think they were probably involved in that drafting [done by] the Irregulars Group. I just wasn't part of that at all, so I don't know any of the details. In the campaign group here in LA, the Union was very much involved and they were involved mostly in mobilizing manpower and volunteers – that's their strength. The community agencies did contributions to the money. I would provide my colleagues in other counties with the work products of our Steering Group, I mean, of what we did here in LA, but this was all after hours.

MM: So what were your expectations? I mean, first, did you think this was going to pass, and then second, if it did pass, what did you think this would – I mean, did you have high hopes for it, what did you think was going to happen?

MS: Well, that's a good question. The polling numbers that were reported to the group were always very favorable, but having been through the nickel-a-drink tax [experience] too, it was [uncertain]. But the good thing about this was that it was relatively good economic times and the billionaires don't have an explicit lobby [he laughs], and at least at that time they didn't care so much. So the opposition was not – I mean, it was like the Howard Jarvis people [the grassroots organization which opposes most tax increases] and things like that, but nobody was giving them money. So there wasn't really a broad [opposing coalition], though the Republican Party was against it.

MM: Sure.

MS: But not even all Republicans were against it, so it was not as hard as we thought it might be. But it was – we were kind of trying to wait – everyone was optimistic, but we've been there before, too. So I thought it would have a significant chance of being passed. I was optimistic.

MM: And so then, I mean, in anticipation of that, this would involve a major change in all the directly operated clinics, wouldn't it? A lot extra, I mean, a lot of new initiatives? Or what do you think?

MS: Well, probably we didn't really understand the complexity of it, so in the first instance, I was probably thinking of it as being an expansion of the 2034 model so that we can bring that 2034 model to scale, provide that on a broader basis, so we could do not only offer intensive services and aggressive outreach, but also housing and those kinds [of things] to a broader population; and that we would be able to do early intervention and prevention services, so we could reach a population that we kind of in the mental health community gave up in the early 80s. So that was probably as much as I thought of it, in terms of the complexity. Then, after it passed, then it was – because I don't think I actually read the detailed provisions until after it had passed and then looking at the complexity of the planning process was pretty daunting. But, having done CCC and having had the successful experience of a planning and Stakeholder process for our budget crisis that turned out not to be a crisis after all – I think we talked about that before – we thought we would be in a good position to meet the demands of the planning process.

MM: Okay, so then there are two questions. I guess the one that I wanted to talk about first was the planning process. I mean do you want to talk about that a little more, what are the potential problems about working through a process that involves Stakeholders? And what are some of the advantages at the same time? I mean, it always sounds like it's really, really complex and I hear about meetings and it sounds like NATO, "No action, talk only." [she laughs].

MS: Well, it actually isn't – it really is an art form, because you need both things, you need to be patient and broadly inclusive, but you need to structure towards action. So I'll talk about it from the point of view of the advantages first. So the first, and to my mind and in some ways the biggest, advantage in the planning process that was developed for this purpose was that the extensive engagement and inclusion of persons with mental illness in their families as a significant and even central voice in the process meant that the power dynamic that had characterized and been the main problem in the CCC planning process didn't go away, but there were ways to move beyond it. The typical stalemate in the previous planning processes would be – is this idea plan, implementation, whatever it is – does it advantage the community agencies more? Or does it advantage the County directly operated programs more? And so you could –

whether it really had an impact on either side of the system, making that argument could raise issues that can block progress.

But in this planning process, the decisive voice then goes to clients and family members and so it's like, well, who cares if it's a disadvantage or advantage, what matters is, does it really help us achieve our goals? So, as that slowly started to become the ethos of the group, then some of the traditional blockages got reduced, not eliminated, but reduced. So what then happened was the people who stood in the way of the group process – and actually, John Ott was our consultant on this process, who was a very gifted facilitator and he was able to get the trust of the group as a facilitator. The way that he structured it was, at least at the time, that we didn't move forward unless there was a complete consensus.

So that meant some very long and frustrating meetings; but ultimately in a group process, the holdouts feel really intense group pressure to get over themselves and let the group move on. So in the end that group process ended up finally working and so some of the people who were holding on for their own purpose ended up compromising in some fashion and moving forward, so that kind of process worked. Another thing that worked in the process is, if somebody had a significant objection on a policy matter, they were usually rewarded by being made the chair of a work group that was supposed to come up with a solution to that policy.

MM: Yeah, that's good.

MS: So raising an issue just to slow the process was not a very rewarding tactic, because then you were expected [to be a part of the solution] – and [this dynamic] really worked remarkably well. Because there would be people who are advocates for a particular issue, [for example,] older adults, and this allocation formula didn't represent older adults. Well, what is a fair allocation formula? So we had the allocation work group. So then this person was on the allocation work group and then that work group had to come up with a solution that they [needed to] endorse by a certain time and present to the larger group. The elements of the opposition to compromise have to be the ones themselves that come up with the compromise and present it to the group. So it was cumbersome, difficult, time-consuming, but in the end, very rewarding.

We slogged through and I believe we ended up being the second County to submit a plan to the State. It was a huge plan, I mean a thousand some pages. It was kind of overwhelming to the review process, but, because of the way that we did it, and because we tried to take all of the mandates of the planning process seriously, it was a very complex plan, but actually, worthwhile. Because its complexity ended up allowing us a certain amount of flexibility in the long-term implementation, and there were some things that got put into the plan because people insisted on it, that didn't work. So they haven't worked and we haven't been able to implement them. [I think the bottom line for the Stakeholder process was that it forced everyone – myself included – to re-examine initial presuppositions and consider what really matters.]

MM: There also seemed to be a whole lot of players involved in this. I mean, you mentioned the Oversight and Accountability Commission, there's the Planning Council, there's the Community Partners. I know at one point they had to put a Memorandum of Understanding in place to make sure that everybody knew what exactly they were doing. Is this essentially – I mean, does this mean things are working better, or is this kind of putting additional road blocks into the implementation of reform – to have all these different players involved? Is everybody clear on what their role is?

MS: No, it's still to this day it's unclear and changes. So, I think realistically speaking, the Planning Council has not been an obstacle or road block, they have some oversight role, but it's really not – they haven't been a difficulty. The main issues have been the three corner tug-of-war between the State Department of Mental Health, the Oversight and Accountability Commission, and the Counties. And then there are groups like the Community Partners that would try to play one group off the other group or do various things. Because that was the other thing, we had our local stakeholder processes, but then the State had its stakeholder process for the MHSA and no one really quite figured out – or I never figured out anyway, what the relationship was between those processes was supposed to be. So sometimes, on occasion, somebody who was either unsuccessful in getting their way in the local LA process, or who didn't bother to participate in the process, would try to get their bite of the apple by doing something in the statewide process. So it happened, oh, I can remember three or four different ways.

The one that irked me the most was a judge saying that the courts have gotten nothing out of MHSA and they needed to get something out of MHSA, even though we made a special accommodation for that judge to put something – to bend the plan to get something in. But he didn't get what he really wanted, [which] was judicial officers funding. It's like the plan does not have a mechanism by which I can hire more judges or probation officers, things like that, [nor should it]. I can provide mental health services for people who have mental illness associated with the court, but I can't get you more staff, and that was the fantasy. So I think that was one of the problems with MHSA at a certain point in time, and still to a certain degree now, is that people can read into it as the fulfillment of whatever their particular desire is, not understanding the true purpose and limitations of it.

That being said, also one of the strengths of the process has been to have new partners in a new kind of way participate in the planning process, so having the probation department sit and participate in the planning process for our children in transition-age youth services – our understanding of their perspective on the needs has been really actually helpful to a lot of us, to implement services in ways that we didn't know [and] that we wouldn't have been able to do.

Let's see what else – There's a part of the planning process that I would say is a good in itself and it's a positive change, even absent the money, that it gave us an excuse and a reason to have a robust community input process and so we now have structures through the Systems Leadership Team and all of that stuff that they developed that I – I mean, I don't know what my successor will do, but I will continue, independent of whatever the requirements of MHSA may be, because it's a way to monitor service quality. It's a way to gather information about things that are going well and things that aren't going well, it's a way to vent steam in the system when things get difficult, where there's a place where people could go about issues without necessarily going to the Board [of Supervisors], so it gives a focused place for community input and engagement. So I know some Counties have kind of suspended their community process after the planning has been completed, but we're going to continue ours here.

MM: Good. OK, that seems reasonable. So many questions [she laughs]. Well, let's go back to sort of the implementation of what we call transformation and I've seen a number of the documents that came out of the clinics – the directly operated clinics that were planning what was called "Transformation." So can you talk a little bit about how that was implemented and what problems occurred in transforming the clinics. I guess we should start with the question, "What does that mean, transformation, exactly?"

MS: Yeah, transformation is probably a double, or maybe triple, entendre. It means on the one hand, that what we're trying to do is create a system in which, like CCC, where people get the best possible services and they don't just get what they get because that's what we do. They get what works or what they want and need rather than – well, we have social workers that do supportive therapy, so that's what you get, is supportive therapy and medication. If you want something different, go get a job and get Blue Cross. And so that's one thing that it meant.

I'll give you a specific aspect of transformation that we were working on from the day I started, that continued and accelerated with MHSA, but wasn't really dependent on MHSA. Two areas. [The] first of those areas is dealing with co-occurring substance abuse disorders. That's an issue that, because of my educational background and because of my experience at El Centro and in Kern [County], and then later confirmed by personal experiences within my family, that really segregating out addiction issues from mental health issues just makes no sense in terms of effective treatment. So I've been trying to transform our clinics in such a way that they all become co-occurring capable; that if somebody comes in there, their addiction, as well as their mental illness, can be dealt with. So that's one meaning of transformation.

Another meaning related to that is we've known – I mean, I knew for a long time that for some people, a meaningful way of using time, like a job or volunteer experience, was more powerful as a therapeutic agent than therapy. So focusing on transforming our clinics, so that's the kind of change we supported in the lives of our patients, not merely talking about their dreams or problems. So that kind of focus on strength and practical life improvements were the sort of things we were trying to do just across the board. Then, in that sense, MHSA gave us the resources to try to carry forward transformations like that, that we were attempting to do in any case.

[The] second meaning then of transformation was adding the specific things that MHSA called for. And the third meaning is the probably the meaning that sticks in most people's mind, as we ran into financial difficulties in the directly operated programs, or within the system, transformation meant that staff would be asked to stop doing the generic outpatient work that they used to do and start doing one of the things that was funded through MHSA, whether that was Full Service Partnership [FSP], or Field-Capable Clinical Services [FCCS], or whatever the plan was [service programs established under MHSA]. And so the difficulty for transformation, both practically and intellectually for our directly operated programs, is which of these things did we really need to do? And in some cases the emphasis was felt to be primarily, "Oh, this is just a way of saving money, and not really a way of changing services," or "This is a way of watering down services so people don't really get what they need. Instead, they get this things that MHSA pays for." So, in the initial iteration in some places, for example, the Wellness Center probably looked like underfunded outpatient clinics rather than a new way of supporting people with mental illness.

Now, the good thing was that from the very beginning we started and got support for a "Change Group," and the Change Group, I think they started with what they called the "Big 7" or something like that and those were the clinics in which the expansion of MHSA was going to occur and what did that mean? How did they go about the change? [The original clinics slated for transformation were Arcadia, Compton in South LA, Edelman in West LA, San Fernando, and South Bay.]

And so we had the program heads of those clinics and some of the staff and some consultants and some central administration people meeting on a regular basis to think through and plan that. And much of it worked, part of it didn't, but they set the agenda

about how to go about implementing a change. Then, in a place like LA, sometimes those good plans get slowed down on the rocks of implementation. So, if you have a really good plan for a Wellness Center, but the building doesn't get leased for a year and a half, so people are trying to do something in space where there's no place to do the Wellness things that they are supposed to do; and the FSP program is supposed to start, but the caseloads are still high and so how do you do FSP work, or etc., etc. But I would say, for MHSA implementation within the directly operated clinics, the range would probably be from A- to C- across the group, but I think probably overall, we get a B, given the magnitude of the change and the obstacles involved. I think we did okay.

MM: And so, but there's still work ongoing.

MS: Oh, absolutely. Yeah, the transformation is, actually as we speak, entering it's newest phase and the newest phase will be related to both of these things. Once again, there will be an expansion of evidence-based practices through PEI [Prevention and Early Intervention] and a need to deal with a realignment shortfall of a significant amount. Some say 43 million, I say 23 million, but anyway, a significant amount of money. And the likely outcome of that is that we are going to say that almost all of the services provided in the directly operated clinics will be MHSA reimbursable, so it's like, what do we offer in our directly operated clinics? We offer FSP services, Field Capable Clinical Services, Wellness services, assessment services that are fundable through MHSA, short-term crisis services that are evidence-based and fundable through PEI, and other evidence-based services, like first-break services [that is, provided at the client's first psychotic break]. So, if you come in and you quality for public mental health services in an adult clinic, the menu of things you may receive fit into one of those MHSA reimbursable categories.

So the change, once again, if we do it correctly, and it will take us some time to do it, will be a good one because it's actually in the line with kind of the literature and the research that's coming out now which is that generic-we-can-help you therapy is much less effective than evidence-based therapy that uses a particular methodology for a particular purpose for a particular period of time. And so we have been, for the last several years, training our clinical staff in short term [models] like CBITS, cognitive-behavioral interventions for trauma, and other short-term models of care. So we're thinking we may be, not prepared, but almost prepared to deliver a clearer and better quality of service through this change in the long run. So that's kind of where we are expecting to be through this transformation process that we're living through right now.

MM: Okay, now I'm sure you've heard this too. Multiple people have said to me that they're afraid that clients are falling through the cracks, that some people are just not fitting into the FSP and not fitting in the FCCS, and some clients are somehow getting lost through the system, because we can't fit them into these slots.

MS: Well then, they're not thinking hard enough.

MM: [She laughs] Okay.

MS: I mean, I'm being serious about that. What does that mean? Does it mean that – When that comes up to me, I say, well, give me an example of who wouldn't fit and then they give me an example and then I tell them where they would fit.

MM: Oh, I see.

MS: Because, and really so, as an example, somebody who meets [the criteria for] medical necessity because they have an acute depression and so they may need treatment for longer than six sessions, so they wouldn't show up in the short-term model, but they are still employed, so they don't need the FSP. So of course, the question could be, well, why wouldn't they fit in either the Wellness or the Field Capable? And the answer to that is, well, they would prefer to be seen in the clinic. Well, the idea of Field Capable is not [that] everybody needs to be seen in the field, 40% can still be seen in the clinic; so this could be part of the 40% that's seen in the clinic. Or, if they need – what are they getting for their depression? Medication and case management and self-help? All of that could take place in the context of a Wellness center, if that was the appropriate [setting]. So it's like, I don't believe that people need to fall into any cracks. I believe that the assessor just needs to make the judgment about what of those things best serves the client's real needs, rather than saying, "Oh, you're in, you go to this clinician, who knows what this clinician may or may not do for you, but you're in."

On top of that, the modal number of times somebody comes in to our service is three. So it's like most people vote with their feet that they don't need what we're offering. So maybe we can do a better job of offering something that is more effective and meets their needs better, because people don't usually take the energy to go to mental health treatment on a whim. There's something significant going on in their lives and so either we're miracle workers or we're really not meeting the need in the best sort of way and probably it's the latter.

So, my view, fairly strongly, I think, is beyond optimism. It's that we need to be more accountable for what we offer our clients and making sure it's something that's really helpful and desirable from their point of view. And I think having a clearer assessment and linking the people through the assessment to the right service, rather than to a generic service that may or may not be what they need, is a better option in the long run.

MM: Okay.

MS: All may not agree, but that's fine.

MM: Okay, and just one other comment. I think at least four contract clinic people have said to me is that they were already doing the transformed model, they were already into Wellness before MHSA came along. Do you think the contract clinics had already sort of moved ahead in this area? Or to put in another way, who has the most to teach whom?

MS: Well, to me it's probably program and professional specific, rather than system by system. In other words, as I started this particular interview, the problem with LA is not that we don't have excellent programs, because we have really wonderful programs, we just don't have a system that makes very much sense. Same thing with the directly operated and the providers. There are some providers that have really stellar programs – and frankly, if by community providers, is meant the Village, the Village is the group that invented the Wellness Center that we got it from. So from that point of view, yes, absolutely. Was that the common way of providing services across adult providers? Absolutely not.

Is it now? Actually, it's an interesting experience, because some community agencies are very well-run and very nimble, and so they have been able to procure the places and do the things, subsequent to MHSA, to do Wellness. Aside from the Village, and maybe one other place, I can't think of people who were doing Wellness, and it

depends what you mean by contractors too. So, for example, SHARE! [the Self-Help and Recovery Exchange, a consortium of self-help groups] became a contractor through the MHSA process. So they existed and [were] doing Wellness kinds of things, but they weren't so much a mental health contractor. I mean, they had a small contract. So it depends what you mean by that statement.

MM: No, I was talking more about along the lines of established contract clinics.

MS: Yeah, more established clinics, I think it's episodic. Some of them were doing – many of them were doing good things. Were they the kind of Wellness model that is currently operating? I don't think so. Some of them were hiring peers, like the County was hiring peers. Was it systematic? Probably not.

VI. Thinking about the Future; PEI; Jail Mental Health; Learning from Staff and Clients

MM: So, I want to talk a little bit about – did you want to talk more about MHSA? You know, what you think it might develop into from here? I mean, we're facing some budget shortfalls in the next couple of years.

MS: Well, I'll tell you what I think and hope will happen, and I'll tell you what might happen. So what I think and hope will happen is that the budget crisis of now is forcing a transformation of the system in the Counties that would have taken place anyway. The transformation that we're talking about now that would have taken place, must have taken place, but has taken place more rapidly is one in which MHSA ceases to be a categorical program type and instead becomes a funding stream for a system that has been changed into a system that does the things that MHSA envisioned.

So we wouldn't – I mean like what I'm talking about here, for the directly operated portion of the program, everything would be MHSA in terms of program. But, if realignment comes back up again and there's more money, it all continues, so we don't have to worry about what programs are Core or Realignment or MHSA. The County runs one program. That program we run has been transformed by the infusion of MHSA – its resources, its ideology and its community planning process – and the thing that will keep that happening is if there remains a focus on outcomes in a realistic way. So we continue to look at what are the outcomes that are looked for in the various sub-components of our programs, as we're running them, and then we change them if we're not getting the [right] outcomes. I think that's one of the things that social service agencies, social service entities, public and private, need to do is adjust, I don't know how to say it exactly, but adjust to what works and doesn't work in the market without considering it a failure and disgrace.

So it's like we have a service that really isn't producing the results that we want. People get dug into trying to defend, "Well, you don't really understand, our clients are so much harder than their clients," and all of that stuff. Rather, it's like, well, how do we adjust to get the outcomes we're looking for? This variant over here seems to have done marginally better than this one so let's look at the difference, add this difference over here and see if that makes – so that we can evolve. I think, through MHSA and the data collection and what we're doing, we have the opportunity – we, as Counties, have the opportunity to collect the data and change the programs according to what works, if we're given the freedom to do so. So that's what I think and hope will happen.

What could happen of course is that we get reversion back towards – from her English major, my wife used to say, "Everything slides to schwa" – so everything ends up sounding the same. ["Schwa" is the ubiquitous unstressed vowel sound represented by "ə".] So it's like I hope we don't end up getting back to generic undifferentiated programs that are supposed to work for everyone, but in fact work for no one, or not no one, but aren't particularly effective. And that would happen if the funding pressures get so much that all of the energy that is required to maintain quality programs, and the feedback loops and training and all of those things, just withers away, and that could happen. But I don't think it will.

MM: Okay, good enough. So I'd like to talk a little bit about PEI, I mean, because this – it's seems to me that effective early intervention would have the potential to change the whole system. And so could you talk a little bit about what you think might be happening? I know there's a PEI plan that has been worked on, but I don't think we've even had a chance to look at it or see what it's about, so maybe you could talk a little bit about that and what you think might happen. I mean, it seems to me this could really be a second step in changing the system to a completely different level.

MS: Yeah, usually what I say on this is that this is in the long-run the essential step, because whatever good things we've been able to do in CSS, and Full Service Partnerships and all of that, in the long-run, will be overwhelmed by the need, unless we could do something to slow down the stream of people who need those intensive services. Because, if there are so many people, pretty soon it will be so diluted that you'll only serve a few and it won't make a difference, or everybody will get so little that it won't make a difference. So I think your comments are exactly correct, that pretty quickly we need to use the early intervention strategies to slow down the stream of people being disabled by mental illness so that a system for those that are disabled can actually work.

So PEI implementation in LA ended up being very, again, even more complex than the planning process for CSS. Purposely we made the plan SPA-based as well as age-based, so that each SPA [Service Planning Area] did plans for each of the age [group]s and so you could imagine the way that the planning cells multiply in that. Then there had to be evidence-based practices that were chosen, so what we have now – and then there's lots of controversy on that, that I can speak to specific issues related to those pieces of controversy, if you're interested in them.

MM: Yes.

MS: But where we are now with it is that we have a plan that has a number of evidence-based practices that have been approved or recommended for each of the Service Areas, so implementation will be driven by agreements that were made in the stakeholder planning process. One of the agreements was that this PEI Plan would be one for involving new entities into the mental health service capacity, beyond those who had historically done so. So 30% of the PEI funding is, in some way that's not exactly clear yet, to be set aside for new agencies, new entities. 30% of the money is to be set aside for directly operated clinics and that was done, so that we didn't end up having a controversial bidding process. I mean, we would submit proposals and then who evaluates the proposal to say which is best? So anyway, rather than go through that, we'll just get an agreement that this will be it. And then that left 40% for the existing provider network to expand into prevention and early intervention activities.

So what we're looking at now is the 70%, that is directly operated and existing entities, will be the source of whatever we need to do in the transformation to make things more survivable and we'll probably end up using between a third and a half of the

money for transformation. So this would be my guess, that pot is 70 million [dollars], so we'll probably use 20 million for transformation; 50 million would be available then for actually new programs, a new staff to do EPBs [evidence-based practices]; 20 million would be for staff who are currently doing something else to do the EPBs. So that would be the mixture and then the 30 million for new entities would be put out to bid for new entities, because they can't really transform, because they haven't got anything to transform.

MM: Right.

MS: So that's probably – that's the plan that is being discussed with the community agencies today. So we'll see how it turns out. So the plan has been discussed with [the] health deputies, so the Board [of Supervisors] is aware that this is the proposal that we're going to make towards the budget issues, talk about it to the community agencies today, and then we're hoping we get a consensus by the end of January so that we can move forward. Paradoxically it will do two things. It will accelerate the implementation of PEI to the existing provider network, because the existing provider network will get some proportion. So it will be a closed bidding process; you get some of your money taken, it gets replaced plus with whatever the increment is, and out of that, you need to amend your contract to do these EPBs that are in the list for that service area and you have this amount of time to train your staff, so that we're sure that they can do the EPBs that are in place. All of that takes place before the end of the fiscal year. So that's the move that we're contemplating.

MM: That's a big plan.

MS: Yeah. So, and the reason we're thinking that that may go through is that the alternative is horrendous; because if we're taking 20 million dollars out, almost all of the money we have available is currently being used to match Medicaid in the community agencies. So a 15 million cut to community agencies would be probably a 70 million dollar cut to program, because EPSTD is matched by 4 to 1 and even the adult programs are matched to 1 to 1, so any cut that touches match is exponentially larger and that's – Since the community agencies currently see very few indigents, that means the curtailment would be in the Medicaid side, which means it would be huge, number one. And secondly, how do you implement curtailment to a program to which people have an entitlement , a federal entitlement? So it does dilute the controversy somewhat, when the alternatives are so Draconian. So it's like, well, do you want to jump off of the skyscraper or climb down these stairs? I don't like stairs; well, these are the choices, the elevators don't work.

MM: [She laughs]. Good solution, and so you said there were some controversies.

MS: Oh no, the controversies had to do with like – One of them was there were groups who thought, "Prevention and early intervention mean all that money should go to us;" and there are various groups who thought that. One of them were community health clinics, like free clinics and so forth who said, "Oh, we see people with mental illness, and we see people with mental illness who are not yet disabled by their mental illness, so just give us the money and that will allow us to keep on doing what we're doing." So our answer to that was, "That would be great, but it has to be an increment onto what you're already doing, not replacing the money that funds you to do what you're already doing, and it needs to be one of these evidence-based practices that you do, not whatever it is that you happen to be doing [now]." So that became one of the sources of controversy. So we did a plan and then there would be members of that group that would then say the plan is too something and then go to the Board offices, saying that they did this, they should have done that. So then we would have to go to

the Board offices and say, “Well, yes, we had that discussion, but this is what the stakeholders as a whole decided.”

So that happened like 3 different times with the same group; and the last and most serious time it happened, it happened after the Mental Health Commission had approved the plan. So there was from one of the Board offices a desire for us to re-do the plan and it was like, it’s really hard to re-do the plan unless that means just starting over from scratch, which would be another year and we can’t wait. So then we got to the politics of that, the plan was submitted, and so forth. So what we learned from that was that we would brief the Board offices before the final decisions were made, so that we could adjust to whatever the political realities may be, rather than have something derailed from a political perspective.
So that’s why, in this instance, we let the health deputies know what this PEI plan was in advance before we started talking to the providers because if they had said, “There’s no way we’ll let you do this,” then we would have gone to Plan X, whatever that plan would have been. So that was one of the [controversies]. And then there were controversies about particular subgroups, so we had the hearing impaired as a part of the stakeholder process that participated in the delegates and in the planning. So, after the plan was approved, the Junior Blind [a California-based organization that helps the blind to become independent] came to us with the complaint, “Why have you left out the blind?”

MM: Oh, my goodness.

MS: So it was like, “Well, we didn’t really leave you out so much as that you weren’t explicitly represented.” And then we have the UREP Groups, Underrepresented Ethnic Populations, so that’s easy. The Asians stick together so that’s good, so you have the Asian group, the African American group, the Latino group. But then we have the, I don’t know what – they call them Middle Eastern, but in LA, it’s really a broad definition of the Mideast, but it includes Russians, Persians, Armenians.

MM: Probably the Ukrainians?

MS: So, like all of those Caucasianish groups and then are people from the [Indian] subcontinent really Asians? Or are they – so all of those things plagued us at one time or another. We ended up finding solutions for them, and then we had also similar subgroup issues that we managed, but with the gay-lesbian-transgender [groups] and with the Veterans. So we had a special planning for – we called them countywide groups, and the countywide groups included people like the disabled and the Veterans, juvenile justice, things like that, where assigning the planning to a particular Service Planning Area didn’t really make sense. So like juvenile justice – the Juvenile Halls happen to be in particular SPAs, but the money shouldn’t really be taken from that SPA’s planning, because a Juvenile Hall happens to be there. It really needs to be applied countywide. American Indians are similar – the American Indians need to be addressed, but they’re not really geographically focused, as it happens in LA. So we had that countywide functionality to address those issues.

MM: So now the other end of the spectrum would be, I guess, the efforts to try to provide better service to the jails. And could you sort of define the objectives here? From what I read, it seems as if, in some senses, you’ve almost got a revolving door, and what we’d like to do is stop that door from revolving and try to move people with mental illness out of the criminal justice process. And how effectively are we able to do that? What are the major issues involved in this?

MS: It's very complicated, and I don't understand, even from the Sheriff's perspective, how it happens that we have low-level charges [filed against] people with mental illness, so many of them. But, one way or another, we do. I know some of the things they do in different jurisdictions to prevent that from happening. And it happens best at the level about whether they will determine whether charges will be made. So, if you could have a diversion from the Justice System at that very first place, rather than later down the road, because once people get processed, then it's harder. Anyway, so we have long had – and it's not well-known – but we have long had mental health court personnel in LA County. So we have a pretty impressive array of mental health folks that act as kind of advisor to the judiciary, and they can help re-direct, with the permission of the public defender and the prosecutor and the judge, some people out of the prosecutorial system into a treatment system. But it's not in every court – it's at many courts, but not every court. And it's really at the sufferance of the judges who are involved.

Then we have some specialty courts – like we have a co-occurring disorders court and we have some involvement with some of the drug courts, and there's a homeless court, and we have special Veterans' pods at the jail, and things like that. But I think all of that fits into [the idea that] some of these are really good ideas, some of them are great programs, [but] they're not a system. And so that's kind of where we are. And as a system, what I'd like to find is a way of diverting all or most of the non-violent mental health clients out of the prosecutorial system.

And here's the big problem with that, is that even though we say, or the Sheriff will say, "We're the largest mental health treatment facility in the world," or whatever it is – It would probably be more accurate to say, "We're the largest drug treatment facility in the world," because most of the mentally ill people who get arrested get arrested in combination [with] not just a mental illness, but also a substance abuse issue that's going on in their life, and really it's the substance abuse issue that got them arrested, not so much the mental health issue. And for many people, the jail is the detox facility.

Not that you can't necessarily get what [drugs] you want to get in jail, but it's harder, and so some people use the opportunity to detox. So it's complicated once people get charged. And then worse with the Three Strikes [Law] – if they get charged in a way that strikes are called – and then to avoid strikes being called, sometimes people plead things [admit guilt to lesser charges]. So the whole system doesn't really work very well, but it's an instance of the whole California Justice System not working so well right now – related to all of those things – the strike system, the substance abuse, and the revolving door.

So right now what we have in the jail is actually a very much improved situation than what it was 10 years ago. Well, even beyond that [time]. When was I there? I don't know if I mentioned this in our previous interview, but I visited the Men's Central Jail as a part of my dissertation research. It actually wasn't my dissertation, but it was part of my graduate studies. I was doing research on forensics, and so I did a tour of the jail. The guy in charge of the jail at that time for DMH was a social worker named Dr. Peter Chen, and he gave me a very thorough view. It was shocking because it was pretty much – Men's Central was pretty much stacked cages, and you just yelled at the person over there for the therapy, because you didn't get too close.

MM: Oh, my God.

MS: And it was just pandemonium of noise and banging, no privacy. It was really amazing. So now Twin Towers [Correctional Facility] has been opened, so the program there – they have an inpatient [mental health] unit. It wasn't always that way – But I've been to

the forensic units of some of the California prisons on occasion. Compared to those, at least, people are clothed [and] it doesn't smell terrible. So anyway, it's a small but pretty well-run inpatient unit, and the level of services that we provide are pretty robust, and then we actually have been able to recruit and keep a talented group of psychiatrists and mental health professionals there. So it's doing pretty well. On the other hand, one of the reasons it's doing well is [that] the Department of Justice has been doing quarterly visits since before I started 11 years ago, and I got a report yesterday that the Department of Justice visit went very well. They were very appreciative of the work that we're doing.

So we provide a mental health screening of all prisoners as they're processed, as they say. And then, based on that screening process, we do a more thorough assessment of those who meet the screening criteria in the Inmate Reception Center, so that's a big part of the component. Then people are classified as having serious mental illness or less serious mental illness. Those with serious mental illness are in the Twin Towers, insofar as there's room in the Twin Towers. Some people with less serious mental illness, or if there's no room, are part of the Men's Central population, but followed by therapists and doctors there. And then we have a group called the JMET team [Jail Medical Emergency Team], and the JMET team are like crisis response people for the general population, to assess and respond to situations where people didn't have a mental illness when they came into the jail, but under the stress of that circumstance, start to develop [a disorder]. So we have a response team available. So it's not ideal, but it's a pretty high-quality program.

And the main issues that they face are really the ones related to the overcrowding of the Men's Central, [which is] the biggest problem. And so every month or so, there's a suicide, and sometimes there's somebody who has been in mental health treatment, or sometimes it's somebody who wasn't in mental health treatment, and sometimes there's a question that the suicide was really a murder or – so all of those things go on.

So within the status quo, I think we're doing an excellent job. I think everybody recognizes the status quo isn't satisfactory. One of the things we've been trying to do – I should mention we have a special program for the women, because one of the things that we found out is that the level of mental illness is much higher among the women prisoners than it is among the men prisoners. And the level of abuse in the history of the men prisoners is high, but among the women prisoners, it's universal. So you almost cannot find a woman prisoner who has not been the subject of child or domestic abuse.

MM: That's horrendous.

MS: It really is horrendous. So we have a special MHSA-funded reentry program for women, recognizing that problem, that's been focusing on women as they're discharged with mental illness – making sure that they're getting that support and housing and medication, with a special interest in seeing if there's a way to reunify them with their kids. So that's a program that we're proud of. Also, we're trying to use peers as an in-reach program, so we're experimenting with a program that you're probably aware of, that Kathy Daly [Dr. Kathleen Daly, Director of Adult Justice, Housing, Employment, and Education Services at DMH] runs – to have peers doing the in-reach work.

We're looking at an expansion of our 1421 program – you know [AB] 1421? 1421 is Laura's Law – the involuntary outpatient commitment program [AB1421, which went into effect in 2003, mandates treatment, including medication, for mentally ill persons referred by family or law enforcement. It has been implemented in LA County, but not

statewide, as counties must provide funding]. We did an adaptation of that program some years ago where we used it as kind of a diversion program, that people could use it as a way of not facing charges. They could agree to this, rather than go to jail or go [to trial]. So [the] program used that way was successful, but not fully enrolled. The reason it wasn't fully enrolled was because with the time limits and early release – if people were serving 10% of their [sentenced] time, then why would you agree to a defined outpatient commitment to a program when your PD [public defender] is telling you, "Yeah, you're at six months, but the likelihood is you'll serve 20 days. And your alternative is to enroll in this mandatory program for a year." It's like, "I think I'll do the [20] days." [MM laughs]

MM: Yeah, I can do that.

MS: So we didn't get as many enrolled. So now we're looking at an adaptation of the program, where we use it both for that original purpose, but also use it kind of as a[n] early release from IMDs [Institutions for Mental Disease, defined as inpatient facilities of more than 16 beds whose patient roster is more than 51% severe brain disorders] and other mandated treatment programs like that. So that's what we're trying to do, especially for 1370s and 1370.1s [sections of the penal code covering defendants who are mentally incompetent to stand trial].

MM: Was there any major thing of your time as Director – major area –that you think I should have touched on that I didn't? We talked last time about the PET teams, and about co-occurring disorders.

MS: Well, I think one of the things that had started before, but I think has greatly accelerated, that should be highlighted anyway, is the Housing First models of care. I think one of the things that I learned in Kern and then tried to advance here, and actually, here there were some community models for creating permanent, supportive housing already in existence [like] Community of Friends. But [there were] some existing agencies that were already there that we tried to use to expand, and then MHSA has given us a great impetus to do that. And so I'm thinking that one of the themes that is important for community mental health, that has blossomed somewhat in LA over the time I've been here, has been the expansion of Permanent Supportive Housing Models as a way of providing better care. And that was also one of the things we learned out of the [AB] 2034 program, that if people are living under the bridge, there's not much in terms of outcomes that we're going to improve for them. So I think that's one of the important things.

I think we touched on, before, the cultural competence and the efforts at trying to make sure we understood what different communities needed, in terms of help with managing their illness in their communities. I think that's been one of the important things we've tried to wrestle with. One of the emerging themes that will probably be the focus of the rest of the time that I have is the integration of mental health care with physical health care in some model, both for the formation of the next 1115 [Medicaid] waiver [the waiver programs allow use of federal Medicaid funds for programs for the uninsured and other initiatives], but also for what will become of mental health [and] behavioral health in the health care reform environment.

MM: Really a crucial area.

MS: Yeah. Trying to understand what integrating mechanism will really help people with serious mental illness, and how would that be developed? And so my current talking points include [the fact that, as] everybody has experience in their own family, that just because all of the money is under one roof doesn't mean the care is integrated.

MM: [she laughs] Very good metaphor. Yeah.

MS: And then I see – nine times out of ten, I tell that to people – I see in people's eyes, they've had an experience with their family like I've had with my mom and with my son, trying to get specialty care connected in such a way that the various specialists understand the whole person is really a challenge.

MM: Yeah, I can imagine.

MS: And that's not even with mental illness. So exactly what mechanism are we going to use? And then second is exactly what outcomes are we going to measure? So those two things are – rather than "Don't take our money – we're too important," I'm trying to say, well, how do you imagine integrating care for people with these kinds of problems? And what, precisely, would be the care integrating mechanism? Because just giving you the money won't do it. Second, how will we know that it's working? What kind of outcomes would we propose to measure? And so that's kind of where I'm trying to drive the conversation, on those two arenas, so that it's not merely, "Don't take my money."

MM: Certainly the first line of defense.

MS: Yeah, and [it] probably won't work. The real important thing is, after all – from a patient's perspective – one of the horrendous things now is the longevity gap between persons with serious mental illness and the general population. The 20-some years' difference is real; so something about the current system is not working on behalf of these people. So pretending that what we're doing right now is OK is just not one of the options. We've got to do better at integrating care. Now, what does that mean? How will it happen? How do we make sure it's not [that] they receive even less care? And so that's why we need to focus on outcomes and the integrating mechanisms. So I really think we will approach it from a principled perspective, and I think behavioral health has learned some things.

So, for example – for homeless folks who have serious cardiovascular or diabetic conditions, finding them shelter, permanent, supportive housing, is the first step. We know that from the mental health side, but it also has to take place on the physical health side if they're going to save the money to do it. So it's like some kinds of investments that we've learned are necessary on the behavioral health side are also necessary on the physical health side. Then how do you do it, so that healthcare reform doesn't turn into a housing program? Because the last thing it needs is another mandate [both laugh]. So it's like, how do you define the sub-populations – it's a complex issue.

MM: And there are so many factors involved. From working in health care myself from a long [period], it's housing, it's also sometimes transportation for many people so they can get to the specialized health facility that's going to offer them the care they need.

MS: Right. Or to have the specialized health facility come there, like in Field-Capable Clinical Services. And maybe there [will] end up being cell phone and texting solutions to some of these problems [MM laughs].

MM: Or Skype. I can see that really getting a boost forward. I may have asked this before, but can you say something you've learned, specifically from working with consumers, about mental illness? Over the course of your career, have you understood something

about mental illness, just from working with the people themselves, that changed your views?

MS: Yeah, I think – let me see how to articulate it – I guess one phrase I would say is that nobody should be defined by their worst day, whoever we are, because everybody has good days and bad days. And just because somebody has a really bad day doesn't mean that that's the totality of who they are and what they're capable of. So I'm thinking back to some of the very first people that I was involved in the treatment of, to some of the client advocates that I'm working with now, and the truth is that, as a group, they are human beings. Some of them are – on the spectrum of saints and sinners, they fall all along the distribution just like everybody else does. So that's one thing. Another thing is that [a pause] giving patients respect [is] always the best course. So even if somebody is upset and getting into it with somebody -- It actually was a good learning [experience] that started with upset patients on the phone, but really is generalizable to everybody, to general behavior – [I've learned] that there is usually a nugget of truth in what anybody is saying. And if you can ignore the rest and look for and identify that nugget of truth, there is a chance for progress.

MM: That's great. I like that.

MS: And so I learned that starting with patients, where it didn't do any good to argue. Then I applied it to family situations [he chuckles], and then lately, I've been trying to apply it more generally to political situations [they both laugh].

MM: I think it would be harder there.

MS: Yeah. I'm not saying I'm successful, but the principle is [solid] – because usually there's some nugget of something.

MM: OK. Something to build on.

MS: What else? I guess this is more specifically about clients, is most clients want the opportunity to give something, as well as receive something.

MM: Yeah, it's important to their self-respect.

MS: Yeah. So if you can structure things in which there is an opportunity to contribute and give, then they're better off, you're better off. [pause] And then – what else? [pause] I was going to say – this is an elementary one, but it's hard to – that is, they're the absolute world's expert on how they feel, and so if a treatment or approach should be working but it's not working, it's not their fault [they chuckle].

MM: OK, good. And in terms of – you could ask the same question – is there anyone in particular who you work with here, within DMH, that's taught you something valuable or has done something really outstanding?

MS: Yeah, I think I've had the opportunity through the years to work with some really outstanding people here at DMH. Going back, I'd have to say that I have a great deal of respect for Areta Crowell, my predecessor [Director of DMH 1992-98]. I think she put some things into place – I hope I mentioned them earlier, but I don't know if I did – that were really a very great foundation for me to move forward on. For example, the work that she did with the client and family movements, that it was *very* well established and a part of the culture when I got here. So unlike co-occurring disorders or some other things, where I felt like I was plowing new ground, that was already accepted that clients and families had an important role to play in the system. In fact,

in some ways, I learned from some of the things that she had done and put in place with regard to client engagement. I think she had taken it more seriously than I had in Kern. I had done it, but probably not as systematically as she had done, so I really appreciate that.

[Another legacy that Areta left me with was a truly great Medical Director. Dr. Rod Shaner was the new medical Director at DMH when I was first appointed and he is still Medical Director eleven years later. None of the progress that we have made in Los Angeles would have been possible without him. The quality of the psychiatrists in the department these days is very high and that is completely his doing. He has also been completely supportive of our move towards hope, wellness and recovery as the focus of our work and the emphasis on treatment of co-occurring disorders.]

Another group – I was just thinking about this in another context today – I worked in other places with African-Americans as individuals. So there would be an African-American or two on the staff, and I would know and be friends with them, but LA County DMH was the first place where I really encountered African-Americans in sufficient number that there was a cultural thing. I think the African-American culture is very rich in a variety of ways that I have found extremely congenial to the kind of work that I'm trying to do here. So I think the kind of engagement with and the support of the African-American community and staff in this job has been something that I never would have expected.

MM: Can you expand on that a little bit?

MS: Well, one of them is in the area of spirituality, where, in a lot of government and academic circles, the default position is polite agnosticism, and so if anybody brings up anything other than that, it's kind of a roll of an eye kind of thing. But, because of the influence of the African-American community in LA County in general, but for sure in mental health – there's a variety of views on things like that – but it's as though the option for a spiritual perspective is not foreclosed from the beginning. It remains at least an option, because of the depth of that feeling in that particular community. Another part of it is there's a certain directness in addressing kinds of issues in the African-American community that can be refreshing in a bureaucratic context. So that's general.

More specifically, Yvette Townsend, Jim Allen, [and] Cora Fullmore were three of the Deputies [Deputy Directors of DMH] that I worked closely with, all of whom are now retired, but each of them, in different ways I think, taught me a great deal about this work that we're doing, and how to do the work in the context of a system like LA County – because, I think I mentioned before, my biggest deficit was that even though I knew LA as a mental health system, I did not know LA County as a bureaucratic culture. And so, to this day, there are parts of it that I still feel, eleven years later, like I'm a beginner. So there were parts of that system, that each of them, in their different ways, knew, understood, and went out of their way to help me navigate and survive. So they're people that have played a particular role in my development and survival.

And Dr. [Tony] Beliz [Deputy Director of the DMH Emergency Outreach Bureau], on this crisis emergency stuff, I've been working with him since the '80s because we worked together at El Centro. So really my entire understanding of that crisis work – the 5150s, all that, which I understand pretty well for a mental health director [MM laughs], is due to his work. Also, he used to work with LAPD as a behavioral consultant, and so he has a good match with the law enforcement world view. I don't necessarily. So he could help me navigate that sort of thing. And then Robin has just been magnificent.

MM: Robin Kay?

MS: Robin Kay, as a Chief Deputy [Director]. I mean, I didn't really know that I had a problem delegating [MM laughs], it's just that I didn't do as much of it as I thought I did, and as a result, a lot of things collected with me. But, having full confidence in her judgment on a variety of issues, there's things I just don't worry about as much, and it's remarkable. Like many times, she'll be called on to make some decision. And then she'll check with me – "Well, this is what I did. I hope it's OK" – and it's exactly what I would have done. So we're well-matched in terms of our vision of how the system ought to develop and where [the system] will go.

[My other Chief Deputies have also had a great influence and been a huge help to me. Dave Meyer gave me an understanding of the jail and forensic work that is so critical to DMH and he still helps today. Susan Kerr came in at a crucial time to help put the Department on a stronger administrative footing and was extremely helpful to me on a personal level. And then Sheila Shima, although she was only Chief Deputy for a short while, has been immensely helpful and supportive.]

Then persons you've heard about that have also been influential to me - Pearl Johnson, from the client side, was *very* special and influential, and I learned a lot from her; and then Stella [March], on the family side, has also been a really important person that I've learned from. On a different perspective on the family side, Carla Jacobs, who has, because of crises in her family, been very interested in involuntary treatment and the options for involuntary treatment, but, understanding the issues and the motives and the reality of that point of view, has also been very helpful to me. I could go on, but those are some of the people.

[I also need to say that my wife's work and knowledge in the public mental health system, particularly her work in homeless outreach and on-site school mental health, done in another County, gave me an edge of knowing how things really worked or at least could work.]

VII. Closing Comments

MM: So I'm sort of summing up at this point. So what do you think, looking back over [these] last 12 years, what do you feel most proud of having done?

MS: [pause] I'll start with three things.

MM: OK, three things are fine.

MS: First thing – I'm proud that I think we have really made the sea change on the integration of addiction treatment into the world view of our mental health treatment. I think my efforts in Kern really didn't produce what I hoped they would. [But,] because I've been more patient here, but persistent, [that has] meant that, apart from any funding or administrative merger, politics, or everything, I think the world view of this Department is different with regard to that at most levels. So I think that is probably a really good thing that has a decent chance of staying. So I'm proud of that.

A second thing is I think the community engagement process that we put together and the model of really engaging and taking seriously the input from people outside the system, whether it's community agencies who are outside the County system, or clients and families who are outside the professional system, or other County entities that aren't part of the mental health world, taking those into our decision-making

process. I think that has shown to most of our staff and our system to have been successful. So both, because [with] CCC, people liked the document but didn't think it was successful as an implementation. But then we had the budget crisis, and we used the same kind of process for the budget crisis, and that worked. And then MHSA people have a sense that [the process] worked.

Now we're trying to develop something that is more streamlined and therefore more permanent. But I think the principle that community engagement is the way to success has been established, and I think if that has worked its way, in some small degree, into the cultural DNA of the Department, I think that's something to be proud of as well. Because that's what I'm thinking now, rather than programs and things like that, funding dries up and some things just go away. But, in looking at what I'm hoping to have changed as a Director, I'm looking at things that may have a chance of being there 10 years after I'm gone.

Another thing – this is less developed, and I don't know if it will stay – but I'm really proud of the beginning attempts we are [making] to manage our system, using data and outcomes to guide our policy decisions. So the stats program that we're using, trying to use MHSA and things like that as the way things get done, rather than by the back-door deals. And then the final thing I'll add is I'm proud of the team that I have currently assembled. It's taken a long time to have a group that can both speak up and say what's on their mind, but also work together when called upon to do that. So that's been the product of both people who are a part of the group learning and me learning how to work with people in a different kind of way, because there are some things that apparently I did as a manager, I didn't know I did [he chuckles].

MM: Yeah, it happens to us all, I think. OK, and then conversely – what do you find the most frustrating or feel the worst about, that somehow hasn't happened?

MS: Well, let's see. [pause] I'm not saying it won't happen, but it hasn't happened yet – that we've found an adequate way of providing ongoing support to our peer employees. It's a challenge that's complex, because you don't want to therapeuticize people. On the other hand, you don't want to exploit them. So it's trying to find the right mix and the right supports and the right personnel to do those things has been an elusive task for me. I'm not giving up on it – so [I'm not] saying it won't be done or it can't be done, but so far, it hasn't been done, to find [the best way]. So that's one thing.

Another thing is that [pause] I haven't been able to engage or create a Latino agency to take the place where El Centro once existed, as the focal point for Latino mental health services now. Latinos are so ubiquitous in LA County that it's going to be *the* system, not a minority piece of the system, and that should be understood as well. Nonetheless, there are Asian agencies and African-American agencies that, though they serve everybody, the cultural focus is on the particular groups. But not Latino. It's been my goal all these years to try to redo an El Centro, but I haven't found a way to get that done.

In the 2034 programs, we measured all of those outcomes. The outcome we talked least about is employment, because that's the one that we've made probably the least progress on. Now, this is not the right time to be focusing on employment as a goal, but in the long run –

MM: But I think it is important to the clients.

MS: Oh, it is very important to the clients, but to have non-mental health system employment for the clients – so that piece is underdeveloped. We're having a conference on that in a couple weeks, and it's something that we have some degree of focus on, but it's [true that] supported employment, voc[ational] rehab, in this state has been historically kind of a mess. So exactly how we go about, as the recession wanes and opportunities open up, how we do it better than we did last time around – is another challenge that I'm not – so [with] all of these areas, I'm not say I'm giving up on them. I'm just saying there's not a clear path.

MM: OK, and the last question, you've actually already addressed in several ways. But feel free to expand further. Do you have a vision for what mental health care in LA should be? If you got a sizeable budget increase, what would you want to do?

MS: Well, actually, I think the model that is coming out of this transformation is pretty close to the model that I would hope to end up with. So I think we're moving in exactly the right direction. And if it can happen in such a way that we can increase – as the budget turns around – we can increase so that we do those services and expand in the ways that they're needed to. And I think what I would like to do is to make sure that we do the expansion on the evidence-based side of the PEI, the early intervention. This may be heretical, but it's never been really clear to me exactly what prevention of mental illness [is] that isn't strengthening families and preventing substance abuse. It's always been not clear exactly what we would be doing and what that is exactly. So the prevention side of it is – I don't like to be a skeptic, but I'm not sure exactly what, so probably that would be my vision for heavy investment in prevention.

So the vision that is – the emphasis that I would carry differently from that model that we talked about earlier – one would be much more expansion on the early intervention side, particularly with anxiety disorders, because I think anxiety disorders are the threshold, particularly for young people, for a whole host of other things, including substance abuse, that then reinforces more major mental disorders. And I think we are beginning to understand some things we can do for anxiety disorders that we didn't know before. And I just think there's a lot in that area that can be addressed. So that's one part.

Another part is I think, in terms of social support, we don't have a clue yet about what the opportunities for social networking and all of that stuff is. Something in that area will probably be useful. So, for example, I'm thinking that one of the things I'd like to see is that case managers would do health tracking for people that maybe would involve readings from people's pedometers or their blood pressure reading. A couple years ago, my blood pressure went all crazy, so I had to start taking medications, and I'd go see the doctor about it. So I'd take my blood pressure a couple, three times a week, keep a log, and email it to him on a quarterly basis. So I had my blood pressure log on my iPhone. But it's a behavioral reinforcement mechanism, too, because since I know I need to keep this log, then it means I'd have to take my blood pressure. And if I'm going to take my blood pressure, I want to do okay on it, and if I want to do okay on it, then I need to get my exercise, because that's what keeps my blood pressure low.

So that made me think [that] there's probably feedback loops that we could create that could be very helpful for people, in a support group kind of way. And we just really haven't figured out how to do it, and probably, there are easy ways to do it – [he chuckles] like an iPod application that will be "my support group dot [com]." So I don't know exactly what would work or what would be helpful, but it seems like there are some opportunities in that regard. I am not a techie person, so somebody young and

adventuresome should investigate that. So I think that would need to be a part of what we do.

And then what we talked about, about the healthcare reform. I think becoming confident enough in what we offer as a specialty service that we can kind of merge it back into the whole person as part of the specialty care. Nobody really knew what to do with mental illnesses, so in some ways, that's why they got carved out aside. As the science and the practice improves so that we're able to get better results, I think, as a field, we'll get more confident of our place within the general array, and bring our gifts. As I'm in the dialogue about healthcare reform and the 1115 waver and stuff like that, it seems to me that what we have learned in the rehabilitation model and in the consumer engagement has some lessons for physical health, writ large, that we have some lessons that we can bring to the table as well, I think.

MM: Definitely. Is there anything else you'd like to add?

MS: Let's see. I think if I was going to close, I would close by saying what I say in the new employee orientation. I do a new employee orientation every month for new people coming into mental health. And one of the things I always say is that we're really lucky in the Mental Health Department and working in this field because everybody wants two things from their work – they want a paycheck that they can count on, and that's a good thing. But also, they want to have the sense that their work made a difference, that it had some sense of meaning to it that made life better for someone in some way, and for a lot of jobs – everybody can do that in any job they do – but in some jobs, it's harder to make the connection. If you're an executive at Wal-Mart, maybe it's harder to make that connection with what you do. But in mental health, it's been really easy for me to get the sense that working hard really has the chance, at least, of making the world a little bit better place for some people. And that's what I wanted to do with my life's work is to do something like that, so I feel very fortunate in the way that my work life has turned out, that I have at least had the chance to try to do things that have that effect.

MM: Well, thank you very much. It's been a very good interview.

MS: Thank you. I enjoyed this.

MM: So did I. So we'll conclude.

END OF INTERVIEW