Ron Schraiber talks about the importance of client involvement in transformation…

Yeah, if you look at the Surgeon General's Report [*Mental Health: A Report of the Surgeon General*, 1999], it says, "Negative conceptions of fear of mental illness [were] perpetuated in textbooks for decades, by [German psychiatrist Emil] Kraepelin's original writings [which proposed diagnostic definitions for psychiatric disorders in the 1890s], [and affected] staff and consumers, families' expectations, leaving them without hope. A turn about in attitude came as a result of the Consumer Movement and self-help activity." And there was an article written by a client, [describing how, in mental illness] it was a social death sentence for us. It was like saying, "You forget your aspirations, your dreams; you can't handle stress." And as I said, stress is more about meaning. When they said, the first time I was in Camarillo, do you want to work in occupational therapy – it was putting cotton balls into a bottle. I felt so hopeless; I know my UC education was worth something [he laughs]!

But anyway, that [the change in thinking] comes from us, and I try to tell the Department. There's one out of sixteen people on the Executive Management Team. [Eduardo Vega is] only the one self-identified client, so it's going to be very tough, and that's not Transformation. Transformation is a fundamental change; it's like the Transformer toys going from a robot into an airplane. It's something different. I guess, it's like what consumers are talking about in – I say consumers, although I hated the term, "consumer," because I used to say, yeah, I'm a consumer of mental health in the sense that the system consumed me, and so there was a real debate, just as far as the history.

What do we call ourselves, the mental health clients, why did [we say] clients? Well, not all of us are "psychiatric inmates" – that's too radical, we know it might be stigmatizing for some; "survivors" is what a lot of us called [ourselves], of course that means you more survived the mental health system than survived your cancer. But for some, I tell people it means you sort of survived the system and/or your mental illness. It doesn't mean I don't think people can't have great distress. It means that you don't necessarily attribute it all to a Medical Model type of thing. I think it's a holistic approach and I think it relates to what people are asking for in the general field of physical health.

READ THE FULL TRANSCRIPT BELOW.

ORAL HISTORY INTERVIEW WITH RON SCHRAIBER

INTERVIEWERS: MARCIA MELDRUM AND HOWARD PADWA

DATE: OCTOBER 9, 2009

I. Early Life and Family Relationships; Experiences in the Mental Health System

MM: Good morning. It's October 9, 2009. And we're talking to Ron Schraiber, the Director of Consumer Affairs, is that right?

RS: Well now, I used to be the Director of the Office of Consumer Affairs, now that's called the Client Office of Recovery and Empowerment (CORE) [at the Los Angeles County Department of Mental Health (LAC-DMH)]. But I am now the Director of the Office of Policy and Research for the Empowerment and Advocacy Division. It sounds impressive, but I'm the only person I direct [he laughs].

MM: It's sufficient, one person – that counts.

RS: So there was, I have to admit, a certain marginalization process, I believe, but that's okay, for right now [he laughs].

MM: The interviewers are Marcia Meldrum and Howard Padwa and so we would just like you to start by telling us your story about how you got into the field of mental health.

RS: Okay, well, basically I was a graduate student in history at UC Irvine. I was going for a PhD, primarily interested in the acculturation process of minority groups and social history, more about people and their everyday life. When I was a kid, I used to hear that Napoleon built this, and I used to say, "God, how did he have the time when he was marching around Europe?" [all laugh] You know, and that there were actual people who did things, you know, and also it does relate to my Jewish background, as far as the dynamics of acculturation. My mom's from Poland - got out [of Europe] in the thirties; and understanding some of that dynamics and it's something of fitting in, not wanting to fit in exactly, and all that stuff, so it was something that I had a real interest in and that was something that also dealt – When I was starting college in '67, it was [the time of] the Vietnam Protest, the Civil Rights Movement, and the convergence of other movements, the Women's Movement, Gay Movement, that grew out of that and – Which, by the way, segues nicely that when I ended up at the psychiatric system, because my activism, even though I wasn't – what I call "B.C: Before Crazy" – I got arrested once at Cal State Northridge in a sit-down demonstration to establish Black and Chicano Studies. But anyway, what happened is, I went to UC Irvine for graduate school.

MM: Let me just ask, you were born in California?

RS: Yes. Born in Los Angeles. It's okay because sometimes [the way I jump around is called] flight of ideas, tangential thinking, I [like to] say it's [more like] the [Irish author] James Joyce stream of consciousness [he laughs], or whatever. It was the first time I had moved away. Even though it was only 70 miles, because I was raised in the Venice area, West LA, and then we moved to the Valley, when I went to high school. But I was very insecure and you don't know exactly how it is. But I didn't want to try to go to any other school besides Northridge and people used to think that I was actually sacrificing, because I had two younger brothers and the reason why I'm going into this is because I think – I don't know if you know [Austrian priest, philosopher and social critic] Ivan Illich?

MM: Yes, right.

RS: OK. Sometimes when people wanted to go into the priesthood or the sisterhood, he would want to see if they really – if it was something positive or if they were hiding from the world. And people used to think I was being sort of sacrificing and not going [to another school], because I had quite good grades in high school, by going to Northridge instead. But it allowed me to, in a sense, [deal with] my quote "neurotic" insecurities and then it make me like, "Ron's staying at home so he could take care of his two, ten and thirteen year old [younger] brothers," but I was very insecure. When I went to Irvine, I was living in a trailer. It was two bedrooms with two cousins and another friend and anyway, even though I was doing well, I ended up having a breakdown. Some [of the reason] was because I had high expectations. I was doing well in school, but I wasn't together and I think that when a lot of people come down with [what is] considered a psychiatric problem around these ages [in life], which they say most people [do], I think, [it reflects that fact that] we don't have rites of passage as much as more traditional societies. A lot of us don't make it. I'm very not too much Medical Model. Helen Hayes, the actress, said, "We're all born to a tragedy. I'm not talking about original sin, it's that we all have to grow up and some of us don't make it;" and I think I was one of the persons.

So I went into a real heavy depression and for about a year and a half, and I wasn't put in the hospital. I laid around in the trailer for a while. My parents, whom I don't blame, I mean, people don't need a diagnosis to blame their parents; everybody blames their parents. So retrospectively you can say if they weren't mean, then they were too nice because they taught me learned helplessness or whatever. So my mom was sort of stereotypically "Here, let me do this for you;" but I mean, I didn't have a bad childhood or whatever. So, even though I had a lot of problems with NAMI [National Alliance on Mental Illness, a family-based advocacy organization founded in 1979] and the family movement, I don't blame my parents. I'm a self made psychotic, as I say. Anyway, I became really depressed and went back to my parents, basically laid around. I had some outpatient therapy. My world seemed like it was like totally over, because I had these aspirations. I wanted to be teaching college. I can't say it was totally burning, but it was the only thing that I really knew how to do, besides doing some other impressions, which I can do actually quite well, without going into that, and have performed; I do it at conferences and all that stuff, but I was not together enough to do that. I'll do some afterwards.

MM: Yeah, fine, we'll do them afterwards.

RS: So, anyway, when I began to come out of my depression, which took a while; in fact, I never [regularly] listen to talk show hosts; but then that was safe and I could have some interaction. You feel ashamed of yourself. [Poet Elizabeth Barrett] Browning said, "How do I love thee, let me count the ways;" mine was, "How do I hate myself," because you look for yourself to blame, that you've done something to deserve this type of thing. So, after a while, and I think this is one of the things our society says, "Let's patch people up and get them back into the rat race," which isn't always the best thing, but I came out of it. My parents didn't really want to hear about it. My father was a salesman, sort of like [the Arthur Miller play] *Death of a Salesman,* didn't want to hear anything.

I really wanted to talk, because I didn't say anything, believe it or not, because you feel like you have nothing to say. Any of your education, any of your witticisms, anything is – what's the clinical term – shit [he laughs]. You don't feel like [you're worth anything], so anyway, I started expressing anger. I usually didn't previously express anger, I sort of internalized it. So I started expressing that and being sort of like here I've been a zombie, you don't want to talk to me. I can't encapsulate it. I know the way memory distorts things, and it can be very self-serving, but they didn't sit down and totally want to understand. They kept saying, "Well now, you're doing better, go back to graduate school; they'll accept you, you're doing okay and all this stuff." But I said, if I was doing badly, then you could say, "Well, let's study more;" but if you're doing well and you're miserable, then you definitely don't want to go back, you don't want to go back to some place when you're doing well and you're feeling [bad]. So I didn't know what to do.

MM: And at this point you hadn't seen any professional psychiatrist?

RS: No, I had seen somebody at UCLA. My sister referred me, and I had seen somebody from the public mental health. I'd just sort of sit there and look down, and I really didn't have that much to say. "What am I supposed to say? I'm pretty fucked up [he laughs], and I don't see any hope." I mean, this is one the [reasons] why clients talk so much about hope, [when] a lot of times the system just says, "Give up your dreams, you can't handle stress;" although the thing that makes something worth while, is not how hard it is, it's whether you have meaning from it. I don't know if I said this to you, [but] like the song, I won't sing it, but you know the song – "If you love somebody, there isn't an ocean too deep or a mountain too high to keep me away." [From "I Will Follow Him," classic 1960s song by Jacques Plant] If you fall out of love with somebody, in other words, you've been married for three or four years, then if somebody [your spouse] says, "Will you please go to the store and get me some aspirin?" you go, "God, you're asking me for so much." I mean, so it depends, so that's the thing. And then what they do is they give you meaningless work, a lot of times, like this is occupational therapy, like random stuffing cotton in a bottle.

Anyway, so when I came – I started expressing a lot of anger. I probably had a lot of anger anyway. I had an extremely low sense of self-esteem, like [when I was] trying to go out with somebody. [There is some] irony, since I was on the tennis team, I was on like the high school version of College Bowl [a '60s TV quiz show for students] and anyway, I was, I guess, not like a big shot [but had a lot of achievements]. But like, basically, the irony is that if you feel, for whatever reason, deep down that you're not really worth that much, the fact that you have something going for you makes it even more difficult to ask somebody out, because then if they say, "No," then you feel like it shows that it doesn't matter what you do. So I didn't do it. So I was very unfulfilled in a lot of different areas, and so I expressed some of the things that I had [internalized]. I think it also fit into a stereotype. I mean, if somebody changes, let's say that they are really a mean person and they suddenly start being nice to you, you'd say, "What's wrong with him?" But if you especially were considered like more of an ideal son, besides being somewhat of a slob, or something like that.

MM: So you didn't go back to school.

RS: No, and what happened is finally they started talking about hospitalizing me and I felt like – See, I would stay up sometimes two or three days and I used to say to my mom, "Look, before I just stayed in bed. Now I'm staying up because I have something I want to do." I mean, I started getting a little more confident listening to these right wing talk radios. I had an opportunity to go through an encyclopedia and I'd call them up and shut them down. [he laughs] So I started getting some confidence in that way, too; but it was a process, you know. And I did get some meds, I just didn't take them. I've never been into meds and some of that's a weakness. I never experimented with drugs. My cousin – except when he says, "You're so screwed up," he used to smoke marijuana all the time. And then you have to learn how to inhale like Clinton, and it hurts a little bit, so I've never smoked. I never drank, I just don't want to. I was reticent about anything new.

MM: So they were giving you some antidepressants and you weren't taking them?

RS: Yeah, meds. I've had every psychiatric drug; [but] I didn't take them, which upset my mom. I mean, she wasn't mean; she would sometimes try to help me run around the house. She was very nice, and sometimes I would just say, "Leave me alone," and I really felt guilty about that too, [because I thought] that shows how even more rotten I am. When they tried to say I had a cousin that was dying of cancer and if she can have such a good spirit, [and why don't you?] Then I guess again that proves that I am even more of a rotten person. It didn't motivate me, it just made me feel bad. So anyway I didn't feel my parents [understood], in particular my father, who, when you're a salesman, he said, when somebody pisses on you, you have to say it's rain, even though you sort of like the interaction. But it was alienating, like trying to close a sale; he sold major appliances. And so it hurt. And then one time I tried to talk to him about something, then he would suddenly change the subject. For instance, [he would talk] about his tires and I really felt totally, like I [was being ignored]. Again, he wasn't a bad guy; he has his own stuff. So they didn't know that I had done [something to frighten them, when] they fled the house.

Now, later on, I did get very good at frightening people. I mean, some of it was that you feel they're treating you this way and then you sort of fulfill it. I'm not taking away [anything, and] at one time, if I did – like [his parents would say] "What are you going to do?" [I'd respond] Like, [impersonates voice of character actor] Peter Lorre, "Don't be afraid, nothing is going to happen tonight." So sometimes they didn't know whether I was [going to do something destructive], because I had gone off the wall, and I was angry. I mean –

MM: They didn't know whether you were joking or serious, or how to take it.

RS: Right, they didn't know. It was like comedians on stage are normalized deviants because they're safer; but people like that are in real life and so they hadn't seen that. So anyway, I actually – when they started saying, "You should go to a mental hospital," and [when] they wanted to call [the hospital] – I said, "I'm feeling better, no I don't want to go," and I used to think it [the hospital] was like the roach motel. You can check in, but you never check out; that was the basic belief. I didn't know what they – and my parents once fled the house and that really hurt me. And that's when I really started doing this, like I really called up (repeats impersonated voice), "Don't be afraid tonight, I'm just coming.“ [he laughs] So they're really frightened of it and I would be angry too, so it was this combination of things. I could give you some of my records, which are sort of funny, for what the psychiatrist said.

MM: So they sent you to the hospital eventually?

RS: Right. Well, they sent me to – Now one thing I did and I have mixed feelings [about], when I've talked about it at a conference, you get big applause; but I dumped a bunch of fertilizer. They didn't know this, when they fled, when they [went] to my relatives, like my mom said – I said, "Why are you going over there?," she couldn't admit anything. "Oh, we just think we'll stay there." "Oh, you like sleeping on the floor? because I don't think they have like five bedrooms." And so that also sort of – come on, if you're frightened, but you could talk to me. I'm not really that – I know – and then I would just do it even more, like [repeats impersonated voice] "Oh, so, yes I am.".

MM: Right.

RS: So then I felt [angry] and I took a ten pound bag of fertilizer I happened to find in the garage and wrote, "This is only like one-tenth or one-hundredth of the amount of shit you've given me in the last twenty years" and I put it all over the place. So I feel [bad] because they had to clean [it up], like I see my poor mom – but they didn't know I did that. But then they went –

MM: They thought someone else did it?

RS: No, they didn't know I had done that when they committed me, because they had fled the house. And then I got committed.

MM: Oh, I see.

RS: And that's what brought me [into the system]. I was very active after that in the radical anti-psychiatry movement. I have a couple of articles I can give you, because I found that, having been involved in the sixties [movements] and things, [the same ideas] fit, like justice. You start to read about things that psychiatrists have no ability to predict, which they've even said in the *Tarasoff* Decision [1976 California Supreme Court decision, in which the Court held that mental health professionals have a duty to protect individuals threatened with bodily harm by a patient.] Of course, because he didn't want to be sued, but they take that onto themselves as long as they have the power; and I'm not demonizing them. But I'm just saying, "You don't know me;" there's a decontextualization of people's lives.

So I was really just there [in the hospital] for my 30 days. And one thing we used to do is this guy and me, we used to have psych techs and pat them on their backs and we would say, (singing) "Excuse us, while we kiss the sky," [from "Purple Haze," classic song by '60s rock star] Jimi Hendrix. And the psych tech would say, "What are you, crazy?" and I said, "If we ain't, we sure as hell are in the wrong place," and they used to say, "We want you to think of this place as your home;" and I said, "Okay, well, in that case, I want to sell it." But I mean, the thing is I wasn't a very good patient by the definition of being compliant.

MM: So you're talking about the sort of dehumanizing effect.

RS: Yeah, I felt like you have the master status of being a mental health client, but also they don't know me.

MM: Are there particular ways in which you felt that you were being treated as a child or not –

RS: Yeah, being treated like you don't know what's good for you. You have no insight. It doesn't mean that different inadequacies that you have at that time – I mean when I say that, if I had a lot of stuff pent up in me, rightly or wrongly, I mean, my parents – see I feel bad – didn't deserve [to be blamed]. They put their [due] diligence in, like thirty years on the day shift or just trying, were basically good people and to have me – I mean, there was this interaction because I would get angry about being put in the [dehumanizing and abusive mental] hospitals and I'd go, "Woe unto you." [he laughs] The way they treat you, you get put in seclusion or restraints, because I was very uppity; and the one thing that did change -- well, my father in particular couldn't deal with it and so I know I'm being committed –

MM: So you were committed more than once?

RS: I was committed – I was at Camarillo eight times, Metro three, and I did a tour in Napa for a short time [all State Hospitals; Camarillo closed in 1997]. But I had a few others, I mean like [run-ins] sometimes with the neighborhood too, and I know it had some of an adverse effect, because at first I was sort of maybe a role model for them [my brothers].

MM: And so most of these hospitalizations were a result of – you went home and then your parents got –

RS: Right; but later on, as my father – when I moved north by chance, I would either – in the north, I would either get more 415 [citations] which is disturbing the peace. [Here in the Los Angeles area,] I got more 5150s, which is [de facto] disturbing the peace [and representing a potential danger because of mental illness, allowing a 72-hour hold] – basically that's what. But I was also hospitalized there, because like one time I wanted to leave the country to visit a friend in Canada and my father – they had borrowed money for me, and you don't know how much your parents are scrimping by because they don't tell you exactly. But I wanted to go and then he said, "No," and he wouldn't give me anything, even though they were saying they were borrowing it, I mean, it was over the years. And it was more I just wanted to leave. I was fed up. I said there's only one way to get mental health in this country and that's by leaving it.

So one of the things I did was, [when] my father said, "No," I said, "Okay, let's do a test, like they do in commercials," and I poured some Wesson oil, we had Wesson and Crisco at home. I poured some Wesson on this side [of my head] and Crisco [on the other side] and I said, "Let's see which catches fire sooner," and I didn't plan to burn myself; but see, I would do [guerilla theater antics] – someone said I had a delayed adolescent rebellion. I don't know. I mean, it was my off the wall thing. I didn't burn [myself] and then I just said, "Well, maybe I should just burn [the house];" and threw a little bit of oil, and in the [medical] record, it says he tried to burn down the house. Believe me, if I wanted to try to burn down the house, I could have burned it – [I was just throwing oil around], so I never really [tried]; but it frightened people.

MM: I can see why, yes.

RS: And so people would even go on the roof [they were so frightened of me]. I mean, also, like I used to be terrified of these people [next door, who] were somewhat conservative people from the Midwest and then also prejudiced; although they interacted some with my father, but very anti-black. And I used to say, "You do anything to me," and I used to be terrified of them. "I'm going to have some of the brothers come over here, you know I've been involved in Civil Rights stuff, they'll come and kick your [ass];" and they were terrified of me. I would say here, I used to be like about a hundred and fifty pounds, or something like that; so it didn't mean that I was totally having fun about doing this, it was my way of trying to figure things out and I was getting involved and I was very deeply hurt and they didn't seem to understand. I even have an article called, "The Madman on the Car Hood," that I wrote and it's in the [CAMI Journal, the *Journal of the California Alliance for the Mentally Ill*]. It's like if you say, "Well, if you don't like who I am now, you can get a cardboard cutout of me, dad, a five foot ten and half cardboard cutout; and put my varsity letter, [my high school tennis team,] my magna cum laude [graduation honors] and whatever else [on it]." So I mean, one of my things is that people have motives for doing things. It's very easy to pathologize and for instance, you may even talk to Jim Preis [Executive Director of Mental Health Advocacy Services, a legal assistance program], do you know him?

MM: I know who he is, yeah.

RS: And you should probably talk to him. Are you going to talk to him? You should.

MM: Well, we have him on our list. It's a long list.

RS: Right. I've known him for thirty years, in fact I have seized, for lack of a better word, the podium [at a workshop] at the Hyatt Hotel [at LAX] in 1977, and he was there. [I seized the podium because this 504 conference was doing a workshop entitled "Mental Institutions: Laws and Practices" without any of the presenters having been what we called a "psychiatric inmate," or any clients being on the panel. It's like having a panel on women's issues with only men on the panel or a panel on African-Americans with all the panelists being white.]

But Jim knew how to deal with me, in that when I would come in [to Mental Health Advocacy Services], instead of just seeing me as a problem, he would relate to me that I had some reason. Now, even though sometimes I'd say, "He's so clever like a pitcher," he knows I'm going to pitch fastballs, or whatever, so therefore I'll pitch [him a curve, and he'll be ready for them]. But I didn't feel like that he was just treating me like, "Oh, here comes Ron, he's a problem." [Instead he saw] that I had some reason for my emotion, and people did talk about how the conditions at the hospitals were terrible. They were on the front page news when I was in.

MM: Right, right.

RS: So I became very involved. I mean, if there was a way I could get arrested at Merrill's Drugstore when I was living around San Rafael, I'd say, "The customer is always right. It doesn't seem like you're acting [that way];" and I used to say, "Oh, you're going to call the police?" and I said, "Well, here's the dime to call the police, here's a quarter for the National Guard, because I ain't leaving." That was one of the reasons that I got [committed or arrested so much]. It was sort of my thing having been basically a frightened person, even though I got arrested before, [in] my BC [Before Crazy days], as I call it, because it was just my way of not being intimidated.

MM: Yeah, yeah. Okay, a couple of things. One is – I mean it seems to me that every time you got arrested, they would look up your past record and you would be that much more likely to get sent away again. Is that right?

RS: Well, somewhat. Some of the cops – like there was an officer, John Mandler in San Rafael, when I moved up there. He understood me, he'd even say to me, "Look Ron, I'm going out with my wife tonight and you know I work this shift, please don't do anything. We got to be [at an event at a certain time]." He would also tell people, if you have Ron arrested, even if it's [serious]– and I got maximum sometimes, 90 days for disturbing the peace, then he will come back. It will just fan [his feelings], and that was sort of my thing. It wasn't like I went around doing things all the time. Sometimes I think the difference is like 99.99%; maybe I don't do anything [now]. Then I didn't do anything 91.0 [%]. But I still have some of this [anger] and I've gotten in trouble here at the Department [of Mental Health], because I got indignant about some of the stuff, about the entrenched attitudes. I became a major activist.

MM: Yeah, let's talk. Okay, a couple of questions. So you were essentially kind of moving around the state and how were you supporting yourself at this point?

RS: I got on – initially it was called ATD [Aid to the Totally Disabled]. My cousin Paul, who is now a professor, who was one of the persons I was living with at UC Irvine. He was on ATD because he had a spinal cord injury, so he knew all about that. So here I was – they just brought somebody over and they looked at me and I was not eating. At first I was whining and, "Oh, I don't know what's happening to me," and then I suddenly stopped talking, basically. And so then they just put me - I didn't have to try to have to do anything. I tell people the difference between a job interview and an SSI [Supplemental Security Income] interview is that in a job interview you lie about how good you are, on an SSI interview you lie about how bad you are. But I didn't have to, because they just came over and I had no history, [had been a] high achieving guy; and so then they just put me on it when they looked at me. And then [ATD] became SSI. So that was very important to me to allow me to do things, to move around especially. What really helped, too, was when they had direct deposit, because I didn't have to wait for my check. So I could move all over the place; I mean, that was one of the unintended consequences [he laughs].

MM: And at some point here did you start talking to other patients about –

RS: Yes. I looked for – one of the key things that changed my life was [psychiatrist and antipsychiatry critic] Thomas Szasz. What happened was, by chance I was sitting with my two brothers and I was in what I called my sort of neutralized [state]. I was denatured but I was able to function. But I didn't know what to do, etcetera, so I was still living at home. And that's part of the dynamics of that, if you have an adult living at home, especially if it's more of a white traditional type of home, the person wants the benefit of being the child [with the parents], but [of being an adult] in the sense [of not wanting to be] told what to do, even though they weren't that bad. But I happened just by chance to see, it was in like in a new book section [of the local library], it was *The Manufacture of Madness* [by Szasz] and it compared the Modern Mental Health Movement with the Inquisition [the medieval and early modern Catholic repression of heresy] and that really fed into my thing and that's actually what led to my being hospitalized. I mean, when I say that, he's [Szasz] gotten enough black marks among traditional [psychiatrists]. But it was something that gave me some basis that I wasn't just this nut or failure, that it related within a cultural context and so that really changed [my thinking]. I mean, I'm not a right wing libertarian like he is, I'm a libertarian, but in economic areas, I'm a typical leftie [he laughs].

MM: Good for you.

RS: So [my thinking] really changed and then I became more indignant and saw the system as a system of social control rather than human liberation, I would say. It stifles you, you're supposed to conform; you start to look at it that the diagnoses are highly subjective. I had two or three diagnoses, [actually probably closer to ten]. I'll just give you an example, that [shows] how strong the Medical Model is, if I can.

MM: Sure.

RS: I'm at Camarillo for – this may be the fourth or fifth time and this doctor – he decides that I'm paranoid schizophrenic and so then he says, "Well, it doesn't seem like he's on [the right] meds," or whatever. So he changed it to a manic depressive [diagnosis], because that's what they're called then, so I'm on the lithium line, and I spit it out [lithium is a medication for bipolar disorder]. But he doesn't know that; but a couple of days later he comes and says, "You know, Ron, since I put you on lithium, you're doing so much better." He doesn't know, I don't say anything; and then he's going to know that I am not on lithium because they take a lithium [blood] level. And then he comes over like a couple of days later and says, "How dare you Ron, you're not even taking that lithium!" and I said, "No, doctor, but I'm doing so much better!" [he laughs]

But it showed that it was more that I was going along with their regimen and what happens in the mental health system [is] they have this thing about you take your meds often or you don't get to stay in this program; and as we know, meds – I have to admit they help some folks, but for others, they're a disaster. But they say you have to take something. It's like, instead of it being a tool, it's become an end. And ironically, one of the bugaboos of the mental health system, I mean, especially among the – we used to call ourselves psychiatric inmates, because we were prisoners of psychiatry. If you're locked up, you're an inmate. I mean, they often say it's like turning the asylum over to the inmates and we said, "That wouldn't be any worse," if you look at how they treat people, especially in state hospitals. So, go ahead.

MM: But there was a consciousness, I mean, you sort of referred to it, among all the people who were in the hospital, the inmates, everyone had somewhat similar feelings that this was not working for them.

RS: See, you know what's interesting. Yes.

MM: And that their rights were being violated.

RS: Yes. So I mean a lot of people were [doing] what they often try to do, including people like me, [which] was [to say] you don't represent, like [Vice-President] Spiro Agnew, the silent majority [of persons with mental illness] and they used to say that [to me]. And after I spoke, [they would] say, I know what you're saying, you cited the research and have some good witticisms, you elucidate things, but who actually represents the silent psychotic majority? Do you really? But of people who have been in the system, there's nobody, even if they've had good treatment, [who] had not been condescended to, felt like their opinion hasn't mattered. It's always the thing.

And I even got something from Dr. [Marvin] Southard [Director of LAC-DMH 1998 -], in one of my PEs [performance evaluations] about you have to watch, instead of just representing your point of view, [your work] should represent [the] client's point of view. I said, number one, I am a client, that's why I'm in this thing. I don't see anybody and sometimes they try to delegitimate you. I know I've talked a little bit about this. The first part of being labeled as mentally ill is saying there is something fundamentally wrong. Later on then, they were saying, some people in NAMI and some professions, you don't really represent clients, because in part, you were never really mentally ill, you were misdiagnosed and then in fact, they say, you even denied you're mentally ill. But I say, that's what you say is one of the hallmarks of being severely mentally ill, that you don't know you're mentally ill. So I fit all your criteria in denying [my illness]. I can say that I know what it is – extreme depression, when I came out of it, even though I used to say, I don't hear voices, [or have] delusions. I say I have very few illusions [he laughs], I have some confusions, but I would be – Sometimes they put [as my] chief complaint, constantly railing against the psychiatric system.

MM: Oh, I see.

RS: When I was in college, I had a very strong dependency on getting good grades for my identity, or before. But, like when you go through high school, people say, "Oh, let's see your grades." "Oh, I don't want to show you." In college they mail it to you, you don't even show anybody. But even though I knew that even some of the brightest students, or the brightest people, didn't necessarily get good grades, because they weren't as interested in doing that stuff. Sometimes very alienating stuff, memorizing stuff that wasn't relevant. I mean, sometimes you need to memorize and going and playing the game; I still needed it and I think I had a lot of contradictions about that. So later on, I would just say to a judge what I felt like saying, I mean, it wasn't like – and when people started [listening] or getting entertained, then I didn't like it as much. I wasn't doing it as much for them. It didn't mean like I didn't [say], "Oh, thank you very much," but sometimes they would wait for it because it was sort of boring in court.

II. Becoming a Client Activist; Successful Treatment; The California Network and the Well-Being Project; Fatherhood

MM: So tell us a little bit, because I know eventually you became, let's see, I think your first job was as a patient advocate in the Bay Area, right, Contra Costa County?

RS: Yes.

MM: Tell us sort of how that came about.

RS: Well, as being an activist –

MM: And how you got from in the hospital to advocating for the people in the hospital.

RS: OK. I was really very active; that was my cause. Since I didn't drink, smoke, take any drugs, and sometimes I lived outside, it wasn't the worst thing in the world. For me, especially, sort of getting my sense of independence, and so I just said instead of being a nut, I'm a vagabond, [and] that I would be very active in the client movement. When I moved up to Mendocino County, I helped found an organization that I named CAPABLE, which stood for Citizens Against Psychiatric Abuse Bureaucratic Legal Entanglements.

MM: Oh, I like that, good for you.

RS: And it combined the standard names of a lot of, in particular, [the] anti-psychiatry [groups] like NAPA, which stood for Napa State Network Against Psychiatric Assault. There was a group in the south called STOMP, Stop the Torture of Mental Patients, and then there are other groups that deal with stigma and discrimination often [with names] like CAN, Client Action Now, Client Advocacy Now, or like there was a group in the Bay, TALLY, Take a Loving Look at Yourself. So I combined sort of the anti-psychiatry with also the saying that we can, that we're capable. So, among other things, that's where I got more of a reputation.

Although we've had our interlacing things in the movement, believe me. So I was, from my activism – Fortunately Jay Mahler, who was one of the major founding activists, he got a contract from Contra Costa County [a longtime client activist and cofounder of the California Network of Mental Health Clients, Mahler was Program Director of Mental Health for Contra Costa and is now Consumer Relations Manager for Alameda County Behavioral Healthcare Services.]. He originally tried for Alameda, and they had a director, who was a Marxist leftist and was open to it. I mean, he actually said he was on the left. Anyway, he contracted with him, so that gave me an opportunity because I did apply for jobs. But I said I'm against involuntary treatment and it doesn't mean that. Elyn Saks [a USC law professor and mental health client activist], when I used to do her class, she would say, "What would you do if your son wanted to jump off a building, would you [commit him]?" and I said, "Well, it depends on how much he pissed me off that day." [he laughs] But anyway, no, he's [Schraiber's son Joshua] a graduate student at Berkeley now, but he even came to the class sometimes. But what was the question?

HP: I guess we could backtrack. Tell us a little bit about what the client activism was like back then, with these organizations that you were working with.

RS: Well, let's – we were very outraged by our treatment, in particular the mental health system, because it's a sense of betrayal that we found our basic humanity discounted.

MM: Forgive me, I mean, you were involved in various parts of the state; so you found this pretty consistent throughout, no matter what institution you were in?

RS: Right. I was going to say to you when I cut myself off – The way I got to the Bay Area is that I had this friend who subsequently became a psychiatrist, but he's had a lot of [different] jobs, he went to Guadalajara [for medical school], and he sort of liked hanging around. He went to high school with me, he liked hanging around with people that were having problems, not to say that he didn't have some. So I used to say, "What?" and he kept on saying – I had another break, I just think this one was due to [exhaustion]. I was worn down by the system. I mean I was constantly battling and finally, like erosion, you just suddenly [give way].

MM: Yeah, yeah.

RS: So it was my second. I was just again lying around after I've been like a bucking bronco and he took me to Synanon [California drug rehabilitation program and alternative community founded in 1958 by Charles Dederich; it collapsed due to legal problems in 1989], if you may remember.

MM: Yes.

RS: And see, there was a difference between me [then] and now. I don't have a drug problem, but they took people they called "life-stylers" and they had some pejorative name like "nut cases." Their primary things were like alcohol -

MM: And drug abuse, sure.

RS: Yeah, they called them, I forget, something worse than that. But you know a lot of groups like Gays [were called] queers, and all that stuff. So he took me there and the difference between me and before was, if anything bad was happening, I would say, just take me home. Now, [this time,] things are so screwed up, I'll go in. [I'll try something else.] I mean, they say, "You want to go in?" and I was really depressed. I didn't say that much. They shave your head. It's like going into the [Army]. And they got me up there and they said, "Have you ever been out of LA?" and [I said] "No, really." It didn't work out there because I was just really depressed.

They took me to this hospital where I met Dr. Knepfer. Dr. Knepfer understood me; he was sort of a hippie-ish type of guy. I would never call myself a hippie, I was a disaffiliated something, but [he laughs] he – but then, I wasn't taking that many meds. I tried some, I would just read whatever thing they had to try to fill my head, even though I couldn't retain it, whether it was *Reader's Digest*, this or that. And then he suggested ECT [electroconvulsive shock therapy, traditionally a standard treatment for severe depression], and for me, ECT actually did do something, which is a bugaboo of the [client] movement. But I trusted him. See, he told me, things aren't working; he understood my feelings about the system, even though I rarely talked and I even said, "I think everything I've ever believed in is screwed up," because you feel like everything is. And so that [ECT] is one of the bugaboos of the movement. But I was willing – and this is one thing about choice – because I trusted him and if you're obsessively depressed and somebody knocks you on the head really hard, then you forget why you're depressed. I don't know what the reason is. And then I got kicked out for trying to organize the patients, although he didn't have a real problem with that. And then I just stayed up there, which was the best thing.

I was originally in the Bay Area and somebody told me about – I used to go around, and again, including with my Judaism, I have pride and I also have some shame in the sense that when I was a kid, [if] you wanted to insult somebody, they'd just say, "You Jew!" I couldn't go back, "Oh yeah, you Christian," that's considered an honorific title. So I would wear sometimes my yarmulke [the traditional Jewish skullcap]. I still have this thing. But I was very more proud of – I have faith – part of me is traditional; the other part is in outer space, even though I'm a secularist.

MM: But let's – we need to get back to the Client Movement.

RS: OK, the Client Movement.

MM: And we sort of want to know what the thrust of that movement was.

RS: Well, the thrust was against forced treatment. People found that the meds were worse than the disease, generally. They'd been forced into electric shock, like [writer, activist, and NAPA cofounder] Leonard Frank and [attorney and leading campaigner against ECT] Ted Chabasinski, when he was 6, in 1943, and it was something about regaining a sense of identity. One of the things that the professionals don't realize is that after you have a major break or whatever, you lose who you are, and you have to reconstruct who you are.

MM: That's a nice way of putting it.

RS: And so people are trying to find that sense, but there was a tremendous sense of outrage. Also, now you were definitely in a pariah class, like mental patients. I mean, you listen to talk radio. "You left wing loon, you right wing crazy," and all this stuff, and it's used so much. And that's why I say, "No, it's not like it's like SNAFU which is from World War II, situation normal, all fucked up." But anyway, what we tried to be was very non-hierarchical usually. And there was this article, "The Tyranny of Structurelessness," because people will emerge who are strong leaders, who are into that role and people look to them and there's no protection if you're on the outside. ["The Tyranny of Structurelessness", by Jo Freeman, was first published as a booklet by women's liberation activists in 1970. It is available at this link: http://flag.blackened.net/revolt/hist_texts/structurelessness.html] Believe me, I know what it's like to be on the out and the in. And so it was like most organizations; you have maybe one or two real strong advocates and the other people will live more vicariously and sort of do, or sometimes you have to cajole them. I led a boycott – I have an article I could give you – of the mental health system in Mendocino County.

MM: Now, how do you boycott the mental health system, by all the patients not going in to see their therapists?

RS: It wasn't of the whole system. This is an example, OK? And I know that [radical community organizer] Saul Alinsky is a bad name amongst some right wing [groups], like when they tried to tie [Presidential candidate Barack] Obama with the community organizer. But there was this program, CSS, Community Supports and Systems Project that was considered progressive; what happened was that after a while, the clients dropped out, because it's being dominated by professionals. The only ones that were left were me, and this sort of like my lieutenant, because if I weren't there she wouldn't be, she didn't want to [be there on her own]. And then they had this one person that they used for every photo-op, the very compliant sort of guy, and I wanted to try to get him to drop out, but I didn't want to force him, but we would talk about it. Then finally, and it's in this article, I could get it from the Mendocino County Newspaper, when he dropped out, instead of saying it was due to apathy, I declared it a boycott! [he laughs]

MM: Good for you.

RS: And I learned some of that from Saul Alinsky type of strategizing, and we had started to get some credibility. Fortunately it was a smaller area. But they didn't listen to us, until after a while CAPABLE started getting some credibility.

MM: Was there an element of self-help also between the patients?

RS: Yeah, there was always self-help. I mean, within the client movement I'm talking about, especially on a local level, there was always some tension between some of us who were [primarily political-type] activists and I have no way of discounting [that], of just saying, "I'll show you." The way I show you that I'm not incompetent, that we're not incompetent, is that we set up self-help. That's one of the reasons why [client activist] Sally Zinman did [set up the] Berkeley Drop-in Center, because a lot of us said, we're anti-psychiatry, we don't like the way we are treated. But throughout, of course, there was always this thing of somebody said, like the way somebody treated me, or my parents, or I wanted to go out with somebody and once they found out I was a mental patient, they said, "No." Sometimes it was just "Oh, don't go to that person at DPSS [Department of Public Social Services], see if you can get an appointment with this [other] person." But sometimes it would just be sort of like the difference between a traditional group therapy, there [at self-help] you weren't a mental patient, to use the old terms, you were just another person. Sort of like with an ethnic group, they go, like Joe, the Filipino guy, but when he's among Filipinos, it's just Joe. And people in the movement, which is different from like twelve-step programs [AA-model principles for recovery for addiction or other behavioral problems], we never really talked about what our diagnosis is. You just know that the person came there and they were feeling this way.

I mean, for some clients, a lot of people, just like in any movement, they're not that politicized. Some [of us] were trying to politicize them. Of course, a lot of times what that means is that they become enlightened when they agree with me, and when you become brainwashed, that's when they agree with somebody else, so that, like the system, don't you see. But a lot of things, like including especially consciousness raising, was associated with all groups, but especially the women's movement, where people had this sense of dissatisfaction that they weren't fulfilled; but they didn't connect the dots, for some reasons. So basically when I got this job, I had already – Jay helped, he was the primary mover of getting the California Network of Mental Health Clients started, and I was one of the original board members. And speaking, if I'm focused, is one of my strengths; so I would get to be known some. I'd be asked to speak and so I got to be known around the place because of that.

So, when there was a job opening, and I never would have gotten a job without that position being opened by [the Department of] Mental Health – what they called "mental health consumer concerns." Because I did apply for a job; they would say, "You are the experts;" after a while it got to be, and I said, "Well, then pay us," [he laughs] since we are the experts; and even now, they don't pay people [or generally, pay them at the bottom of the pay scale].. I mean, I have a good paying job.

MM: Yeah, but it's not true for a lot of people.

RS: Yeah, right, I mean it's basically because the challenge is, you [the clients] have experiential knowledge, and then you have people who got degrees, advanced degrees. And a lot of times it's more – I can honestly say and I've actually, since I had Dr. Knepfer, even though most of my experiences were negative with professionals, is that it comes from having an empathy, a good heart, I mean, where you feel [that] somebody listens to you. I'll just give you an example, which I think is real important, is that one time I got into an argument [with Dr. Knepfer] and he goes and says, "You are obnoxious," and I felt so good because it was honorific, because he wasn't saying, "You're manifesting schizo-effective disorder." He was just saying I was a person and that is one of the key things is going from patienthood to personhood. We do the Annual Hope and Recovery [Conference] and the biggest reward, I can honestly say, I'm not trying to BS, is when somebody says they felt more like a person, because a lot of people in society anyway don't feel that much like they are persons. And to gain that sense of self and even talking about being like in jail, and sometimes people say, "Oh, you know, I'm glad you brought that up because I felt double whammied." So that's the most important. That's what it's all about.

MM: Yeah, that's cool, I like that. I'd like to start talking about the Well-Being Project.

RS: Okay.

MM: Do you want to –

HP: Well, if you could just tell us a little bit more about the start of the California Network of Mental Health Clients? How did it start?

RS: Well, I guess it was the California Council of Mental Health, which is the state advisory board; it used to be the CAC, the California Advisory Council, I think. But now it's like the equivalent of the state advisory board; every County has one, we call it the Mental Health Commission. OK, so they started having "Consumer Speaks." People started speaking up. They called these meetings "Consumer Speaks." At the start, people did start speaking up about their treatment. What's interesting is – I'll try to stay on topic. The Mental Health Association had their slogan, "We speak for those who can't speak for themselves," and we started speaking. A lot of them didn't like that.

HP: When was this roughly?

RS: Oh it was around the early eighties; and the Network I believe was founded in, let's see it was just the 25th anniversary, so it was either '82, [or] around '84, it might have been started, or - I can find that out. Anyway, yeah, so some of them didn't like it, because also the ones that really started speaking up were people like me who were indignant and often were middle class and often pretty halfway decently educated.

MM: Right, articulate.

RS: Yeah, and so that was also used against us, you can't really [represent people with serious mental illness if you are articulate] and stuff. So you [practically] have to almost go through a degradation ceremony, [showing and talking about how totally screwed up and wiped out you were – like I was so wiped out I didn't get up and even try] to go to the bathroom sometimes; this shows whatever, and these types of things; and it's hurtful too.

Oh, the Well-Being Project. I have to give Jay credit. I've had different things with Jay [he laughs]. He sometimes says we are like brothers. I say, "Yeah, like [Biblical brothers] Cain and Abel at times" [he laughs], because when certain things got heavy, I felt that he sort of took a neutral position and then I would quote, which didn't help me, I used to say, "You know, [Italian poet] Dante [Alighieri, author of *The Divine Comedy*] says that the lowest rung of hell should be reserved for those people who do nothing in a time [of moral crisis] and won't take a side." So I was trying to motivate them, but they'd just say, "How dare you!"

But Jay was out there. I give him credit. Sometimes he was slighted by the more radical [clients] for not doing [things], but he was there. So they called it like the California Client Council, or something like that initially [he coughs], under the California Advisory Council, I guess you would say, whatever the equivalent was. And then they [the CAC] would help us get a non-profit status through the state of California. Most of the funding was through that. Now, initially –

MM: From the State?

RS: From the State and it still has a predominant – recently they've had somewhat of a meltdown, the Network. But they've done a lot of good stuff, especially under Sally [Zinman, a mental health survivor and long-time activist, who was one of the founding members of the California Network and served as its Executive Director from 1997 to 2007]. With the Well-Being Project, we had a lot of issues internally, which I can go into. So that started the Network and a lot of people were very critical. We had some conservative people. There was a real great debate [about] who should we have [as] our membership, because some people said, "Okay, you have to have been hospitalized," but we know some people that were never hospitalized for various reasons. They said you have to be on SSI, but some people never applied or were afraid to and like we know one person that just had a family [that], for good or bad reasons, they could have been practically dead and wouldn't have taken them to the doctor for physical reasons, or [any] other reasons [he laughs].

We were afraid that neurotics would try to take over our psychotic organization [he laughs]. I came up with a definition; it was something [about] people whose lives have been dramatically affected by psychiatric labeling or treatment. Because some people – There was one major activist, she'd only been hospitalized once, but she strongly identified with mental health clients as well as lesbians; even though she was straight. She had an identity with people that were marginalized, but she had been hospitalized very briefly.

But so this money came out – the State did it. I mean, some of it was a mixed blessing because here we are out on the street. People were caught; it was embarrassing to the system, [our] complaining. And I was initially doing the promotion, PR, and I would – it's not as easy now. You just put [out a notice], "Ex-mental patients to meet at the Holiday Inn" and we would get people, because it seemed so novel [he laughs], and we'd get newspaper coverage. But they funded us and within the initial group, there weren't people that were totally [critical of the system], but most of us were critical. Otherwise, you wouldn't be involved as much, and it was the sixties. But I remember Lou Williamson, he's still somewhat conservative. But anyway, there was still more of this radical tinge, and there's this thing about trying to maintain this bylaw against involuntary treatment, even though we want choice. And that's the key thing: it's about choice. If you take that away, [that's a critical loss]. Let me just focus on this.

So what happened with the Well-Being Project.– so we'd get some funding from some other sources periodically and from SAMHSA grants [SAMHSA is the Federal Substance Abuse and Mental Health Services Administration]. It's ironic, because a lot of the money is from the system; but it takes us away from – you're filling out MIS forms, rather than maybe putting out Xeroxing saying [that the mental health system] messed up, and that thing about maintaining the integrity, even if you're funded, has been a major issue. Anyway, so they used to have this Office of Prevention in DMH, the State DMH

[Department of Mental Health], and they had like forty thousand dollars they were going to give to the clients and forty thousand [for] NAMI. And it was [for research] about what factors promote or deter the well-being of the emotionally disabled and what we did – Well, they're just going to give it to us. We had like, which is usual, a lot of teleconferences and who's going to do it? And I decided we can't lose this opportunity, even though we felt that what they wanted us [to say was] like make sure you comb your hair enough and you get dressed and all this stuff; [we had] to try to really make a research project out of it and so we advertised and initially we had like one director and a co-director. Well, we ended up hiring [sociologist] Jean Campbell – do you know Jean? Maybe?

MM: No, I only learned about her through this project.

RS: Okay. Well, she's now a major researcher at the Missouri Institute of Mental Health [part of the University of Missouri School of Medicine, based in St. Louis]. She got her PhD, and then we had, for a short time [another researcher]. We advertised, I put in [that] past and present mental health clients [were] especially encouraged to apply, and ethnic minorities, but all of us ended up being white folks. The movement has been primarily [white], but I can honestly say there has been a real effort to outreach into the community. And [the other researcher], I don't know if I should have even said his name, because he worked part time at UC Berkeley, I think, doing our statistics, and I'd appreciate that you not mention his name because [he may not want it known]

MM: It wasn't in the published report [Campbell J and Schraiber R, *The Well-Being Project: Mental Health Clients Speak for Themselves. A Report of a Survey conducted for the California Department of Mental Health Office of Prevention.* Sacramento CA: California Network of Mental Health Clients, 1989]?

RS: No, actually just in the interim report.

MM: OK.

RS: He was a statistician and had a history. It wasn't the greatest paying [job], but it was 1986, it was like $12.50 or $15.00 an hour, and that was not the worst in the world. People, if you pay them, we just said, were willing to talk about that they have a history, but don't tell anybody else. I mean sometimes you need to; otherwise it's like being gay in a gay organization, being in the closet takes away the purpose.

MM: Right.

RS: So, anyway, I wrote that [proposal] and there was a thing, since they knew my strengths and weaknesses, whether they were going to hire me [he laughs]. But even though I'm saying, here, [without me] you wouldn't have had this; and especially for Jean, I mean I had a lot of contacts in the state organizations and I came from the movement. Jean had not –

MM: She was a post-doc then?

RS: No, right then, she was like a lot of people, she was ABD and she had originally done a dissertation, when she was married to her first husband, on machinists. But she was caught in this thing where she couldn't do it anymore, because she didn't have access [to the machinists]; and then if she didn't continue paying her graduate fee, then all of her money [student loans] was going to be due. So she subsequently did her doctorate and she got her own [dissertation] committee together, from people all over the nation and based it on the Well-Being Project, which I give her a lot of credit for.

MM: Yeah, good for her.

RS: Yeah, she was. So anyway, Jean had some background about doing some survey research. I had some minimal [research experience], but I knew about the movement issues. We also created because [we wanted] this thing about being non-hierarchical. When I say that, we appointed a supervisory board. A lot of times what you need to do is give staff an assignment and let them do it, and you trust them. But I wanted to be non-hierarchical [in regards to the employees] and that was a nightmare. Because what happened is, even though [the study has] been validated all over the place, I mean, with every one of its shortcomings, about being a ground-breaking study, which I think it was as far as clients analyzing.

One of the things is that after we collected all this data, [the California Department of Mental Health] wanted non-clients to write it. We said, "No way;" it's like feminist research. We said, "We want to do it," and they finally gave in. And we had clients do the interviews. We tried to get a random sample from NAMI, but they wouldn't give it to us because they said we didn't use the word mental illness [in the study], we only used schizophrenia; we duplicated a question; we used [the term], "diagnosed psychological-emotional problems." I wrote them back something that 91% of our sample said that they were hospitalized, so that sort of says we're dealing with this population. The word "mental illness" was a Medical Model thing. Some people didn't want it. I also wrote that we get involved in your [NAMI] surveys, when you survey clients; but they didn't want to give us legitimacy. We did get some local NAMI [chapter]s to do it and so we also interviewed – because they wanted us to, and I'm glad that they did, the State -- some family [members] as well. We interviewed 331 mental health clients, approximately 150 or 160 mental health professionals, and about fifty or so family members. And the big problem we had with the thing – we also did a video which won an American Psychiatric Association Award.

MM: *People Say I'm Crazy*.

RS: Yes, you've seen that?

MM: Yeah, I have.

RS: Okay [he laughs]. Yeah, I did a little stand-up in that. But anyway, that one won an award. So we said, "Where did we go wrong?" But what we tried to do is not just make it for the converted, that [all kinds of] people could listen to it, and that they gave it an award, I guess, was validation that they saw what we were trying to do. But what happened is, and this created a major divisive issue, and it was a nightmare for Jean and I. We had originally contracted with Richard Cohen to [make] this movie called *Hurry Tomorrow*, about the Metropolitan State Hospital. Somehow they let him in there, around 1973 or 1974. [Cohen did make the film, which came out in 1975 and was widely acclaimed; his other films deal with issues such as poverty, homelessness, police accountability, and special education.]

MM: When you say “we” contracted, you mean the [Client] Network?

RS: Yeah, the Network and everybody was so happy. I mean, I even raised money for Richard. He was one of these stereotypical dedicated documentary makers. We don’t know where he had his other money, but he did some stuff about the police. But this was not unusual – he wanted to do his own vision. We were supposed to also be the executive producers; but also, he’s not a client and we should have some control and we have deadlines. Well, we went way beyond [deadline], because we felt after a while we had to let him go because he’s taking all this time, he’s got his *auteur* Vision. I mean, [we knew] it’s going to be somewhat abstract. I don’t know. I mean we wanted something creative, but we felt we had to say, “That’s it,” so we discontinued [the film project].

We thought we were doing okay, that people would recognize that our preliminary research that we had published was good, and had something – Whatever, and that caused Sally, and [Oakland client activist Howard Geld, known as] Howie the Harp [for his harmonica playing], you may know of – No, Howie wasn’t as strong, but he got his own thing because he wanted to be the grand negotiator that brought everybody together and in the meantime he [Howie] had to go to Egypt to be in some big [world mental health conference]. But it was all these different things and four or five people [were involved], and I’m not just trying to marginalize them, because even – if Steven Spielberg didn’t get a job, there would be thousands of people in the street. And it really hurt because we didn’t want to get – it’s one of those command decisions you make.

[Brief interruption]

RS: Oh, they gave us hell, like we were on a power trip. It was the most difficult decision and we didn’t want to do it. We once went with Richard, I mean, I was one of the few other clients, to the American Psychiatric Association, where he was doing a documentary. We all slept on the floor together and we said, “Oh God, we can [work together].” I mean. like we felt we had a fair process, that he would really understand us.

MM: But it didn’t work.

RS: Yeah, sometimes it doesn’t. You hear about all this all the time whether it’s a multi-million dollar [film], or it’s a small documentary. We had a $120,000 [budget], which wasn’t that bad, and then a few people, like Ted Chabasinski and Sally, felt we were terrible, and it took up a tremendous amount of time. It was around the film, that they even said, for the sake of our friendship, let’s give that up. This was our baby, we wanted to see it go and then one of the persons who didn’t like us getting [the project funding]– she didn’t like some of the data. Like about half the people said that medications were helpful, somewhat helpful, very helpful. About 25% said it was helpful in some ways, harmful in others; about 20% said it was somewhat harmful, very harmful; and some said neither helpful or harmful. And I said, “Well, that’s what our data is.” And I understand, because I’m afraid to ask some questions, what if they don’t go with my views [he laughs]? But, if you have a product that especially only about one third say it’s very helpful and you’re forcing it down people, that’s a major concern too.

MM: Yes.

RS: It's not like it's a universal thing that, and then when a significant amount, like one in four or so, are saying it's very harmful, that's a [negative]. If you try to sell a car that way, that wouldn't be a major selling point. So that was the basic thing about how that [the Well-Being Project] happened, but we had a vision about making it more than combing your hair.

MM: Well, I thought the study was quite fascinating.

RS: Did you?

MM: Yeah, and that the major finding was what mental health patients wanted was a job and money and independence! Sounds like a pretty normal goal.

HP: Yeah, that's what everyone wants.

MM: Yeah, exactly.

RS: Yeah, see, that's one of the things that comes back. Even if they would say, "Well, they're not well enough to do that," is that it's like just saying we're people like any other group. And I'll give you this picture. When [civil rights leader] Martin Luther King went down to Memphis [in 1968, to assist the striking] sanitation workers, you know what their sign was; it didn't say, "We demand better wages, better working conditions;" it just simply said that "I am a man." That's all. And I use that sometimes, because I'm a person and as I said, we have enough problems thinking about being a person anyway in society, whether you have a diagnosis or not, often. But that's the major thing, to feel like you're a worthy human being and that's why [it's the same in] any civil rights [movement], whether it's, "I am somebody," like the Black Community, and of course now we also have, "Mad Pride" [like Black Pride or Gay Pride].

So it's been interesting. I mean, because of this, I've had some very interesting life experiences. It's like taking some of the stuff I've either read about in school or my subsequent reading about the sociology of knowledge or just how vested interests [work]. Because it's very obvious the way that NAMI, as well as clients – I'm not exempting myself – how we gravitate to certain belief systems and how entrenched certain belief systems are and how you move things. I've been marginalized to some extent. Sometimes my mouth – like Dennis Murata [Deputy Director of the DMH Program Support Bureau], who you might know, one time he said – [though] we get along real well – "Ron, how dare you do research?" because usually - well, you saw I had some papers out. It's more like I try to say, "I'm not holding you up against the wall, I'm holding you up against your word," that you take empirical evidence-based [research], even though there's a problem with that, because it's based on traditional assumptions, but you don't necessarily do that. And there's a tremendous resistance. They talk about transformation. That means something fundamental and I could go more into that, I guess.

MM: What was the immediate impact of the Well-Being Project?

RS: I have to give Jean credit. It was more that she made sure it didn't stay on the shelf. Because you can have a good study and it just stays there; and of course she was interested in getting her PhD. But we started sending it around ourselves and making [it available] free if we could get some money, saying here's a donation. The biggest question, which I would have to admit was mine because it was my thing, [was], has the fear of involuntary commitment ever kept you from seeking treatment? And they started to do some research, like [University of Virginia law professor John A.] Monahan and some of these people, and one of their [studies] says 35% percent said the fear has [prevented them from seeking treatment], and ours said 47%. We didn't do regressions and all that stuff, I have to admit, at that time. My son could do that for us. That was the major thing, but it was also something that said clients could do something. I think that it gave us increased legitimacy. I've gone around and even where people know of the research, that's nice, I guess [he laughs]. But I think it was one of the cutting edge things around client research.

Also with the statistical project, I forget what they call it, but it started to open up questions that weren't really asked. I mean, we asked people even about their sexual life, which a lot of times – I could [give] you a little insight into [sexuality in the hospital], if you want to spice this up. I've even got to the point where I talk about it to [DMH] employees. When you check into a hospital, your desire for intimacy, libido, sexuality, doesn't check out, but they don't allow you to do anything. In fact, they infantilize you. And so you have what you call "bathroom therapy." What you do is one person goes in and then the next person, whether you're straight [or gay]; if you're a straight couple, you pick either one bathroom [or the other]. And people used to say, "Where do you have sex in the mental hospital?" I said, "Well, you find an empty room, you close it, and you hope nobody comes in; or if you're an exhibitionist, you hope they do." But anyway, it was more like you go into a stall and if they found you, they would go, "Ohhh!" And then you already feel degraded anyway. They'd say, "What are you doing there?" and I'd say, "If you can't figure that out, you need at least five more years of post-graduate work." And they said, "You don't know what you're doing." I said, "Believe me, we know what we're doing, and for such a small area, we do it pretty well." And then one time – this is true, the guy says, "You should be ashamed of yourself, Ron, you've gone to college and she hasn't graduated from high school." So I just said, "Wait a minute, she's only on a fourteen day hold, I'm on a temporary conservatorship; therefore, she's taking advantage of me [he laughs]."

But you're taken outside the sphere of humanity, in a certain sense, and what you do is ludicrous, I mean, even sometimes about holding hands; people need a sense of support. A lot of times, you know the expression, "hugs not drugs," which was something in the movement. I can tell you because I'm actually going with somebody who's a lawyer by training, [who] came down with a breakdown later on in her life. I met her at a conference and meds helped her, and I have to believe that. But her first experience was where a psychiatrist was extremely condescending [to her], I mean, like saying, "Oh you're nobody basically, now." But when her brother, who she really loves and they were close, had her committed, probably very well intentioned, she wouldn't talk to him for two years.

And so this is a major area; and here they don't want to admit that there are different perspectives. I mean, they have stakeholders, but whether you've been locked up – In fact, it was published in 1984, in *Newsweek*. I wrote this longer letter. They did this stereotypical article on homelessness and Szasz – who I've just one time met, but he wouldn't even remember me; I met him at the Bay Area when he spoke at a junior college – but he reprinted part of it, because I just said, "Many of us so-called homeless mentally ill have preferred the chill of the night to the cold reality of our treatment," so we stay outside. And some people – I worked at LAMP [Los Angeles Men's Project, founded on Skid Row in 1985] for four years, and [with founder] Mollie [Lowery], when she was there. It has changed, no matter what the big promo with Nathaniel Ayres [Ayres, a homeless musician and mental health client, was featured in several columns written by *LA Times* journalist Steve Lopez; these became the basis for the 2009 film *The Soloist*.]. Have you seen that movie?

MM: Yes.

RS: But I think it's stigmatizing for this reason. Nathaniel Ayres never attacked Steve Lopez [as is shown in a scene in the film]. And some people, whether it's Hollywood effect now – it's like, let's do a thing about Jaime Escalante, with the guy who taught kids that are Latino and let's have a gratuitous drive-by shooting. They didn't need to do it in particular [a reference to the 1988 movie about math teacher Escalante, *Stand and Deliver*]. And also you wouldn't know this from the movie, because I read the book. And I know Steve Lopez and he once talked to me for three hours, but he was going to do something about somebody who said they didn't like hospitals, and then another who said they did. He's learned more, he was buying the total NAMI line at one time. And he [Ayres] had very bad experiences; he had a terrible experience with [drugs and] electric shock, and I have to tell you. People that I know, not just in the movement, even though there's some research that says that it's helpful, most people that I know, including [people] not in the movement, who tell me that they have had it [ECT], tell me that it wasn't helpful to them.

MM: Yeah, I know that. It's not considered to be helpful for a lot of people.

RS: Right, and as I said, some people say. "I know it's helpful because I've had it thirty times or forty or fifty." [When] some people say, "How many times did you have it?" I say, "I don't remember;" but it was only about three times. And that just helped break [the cycle], it did, and then I felt sort of good. But then I started getting committed again for my other things, doing my thing for a while. He [Ayres] had a very bad experience, so it wasn't like out of no place that he didn't want to have these treatments. Even his sister, I've read some of the interviews. Imperatives change. I mean, I have some very interesting court records where I say certain things to the judge, when he takes away my right to represent myself. He says, "You have all types of mental problems," and I said, "Yeah, just like you;" and then he says, "Take him out," and I say, "Be there or be square, hotshot." I might get 90 days, or at first, they would just say, "Get him out of here;" but then when it didn't work, "Put him in for psychiatric counseling;" and they tried to sock it to me. But after a while, there's only so much that they can do, when they say, "Get out or learn from this;" and then there were things with getting involved with the movement.

MM: What do you think made the biggest difference to you? I mean, at one point, you were having a hard time sort of functioning, what we would call functioning and clearly that changed and you became an active member of the movement and you started doing things. What do you think made this possible?

RS: Well, I have to – you know, it's hard to say because naturally, like everybody else, I'm trying to write a memoir. It's called *God and Other People I Know,* because I know this guy who said he was God and he had his name officially changed to God [he laughs].

MM: Oh good, now we know who we can appeal to if we need divine help [she laughs].

RS: That's right! I think reading Szasz's book [helped me], because it also fit in [with] my Master's degree, when I was going for a PhD; and my consolation prize is history, social history. I'm very interested in, as I said, the acculturation process, marginalization, but [also] the history of ideas. And [it made sense to me] when he compared like *Malleus Maleficarum* ["The Witches' Hammer", a 1486 manual on the detection and prosecution of witches], where they used to pinprick witches, to the DSM [the *Diagnostic and Statistical Manual of Mental Disorders*; the last major revision was published in 1994]. And I have to admit, naturally, when I feel delegitimized, if I could delegitimize what they've done and [view] everything that's theirs is real crap, rather than me, even though you internalize and you get some legitimacy from this – whether you agree with Szasz [or not]. He's a brilliant polemicist, and like one of the things [he said was] when people say, "Well, mental illness is biological;" well, so is eating, but look at how many different customs and cultures we have around eating, let alone sex. It's not like something that automatically means one thing.

But so I think that helped give me a sense of looking beyond. Otherwise, I was just sort of a failed person. I mean, sometimes when I'm feeling bad now, I can say, well. maybe I'm a successful mental patient. When I'm feeling good, I mean, which is most [of the time], I'm a civil rights person; but so that really helped. As I said, I had a second break, I almost had a third; I mean, it was a brief thing. But see, I had my son and I was primarily a single father with him, which, when I think about how they say you shouldn't haven't had kids – you could say he must be really screwed up – but he really made me a much better person.

MM: No, but I was wondering about that, because I think that probably did make a big difference. And he's what now, twenty?

RS: He's 22. Yeah, I have a picture including from, when he was in the *LA Times*, it was a terrible article. It wasn't just about me, but it shows him sitting next to me, you can see that he's sort of contented, which hopefully, [if] people didn't read the article, they just see that. His mom was also a mental health client and she was saying, "You're like NAMI, you're taking him," [he laughs] guilt tripping me. We get along quite well, but for a while she was very embittered. She would go through what we called her episodes and it's not about psychiatrically labeling her, which they would. It's about what her behavior – she would go into somewhat of another dimension and put candles on the floor, and sometimes feel like she was talking to Dylan, Bob Dylan, and ['60s folksinger] Donovan.

MM: Well, good people to talk to.

RS: And she wasn't as much watching him, so he might be covered in the bassinet; so she finally did something that got the attention. I said, "Look, I'm working as a patient rights advocate now. I have a business card and you don't. They're not going to believe you as much, plus you're sort of out there." She could calm herself, but she would get pretty wild, but it wasn't her getting custody or me; we weren't married. It was either me, or it was going to be somebody else, but it took her a while. But [with him, it was very personal that transcended me; I really became much more focused and a better more caring and thoughtful human being.]

I mean, we have a very excellent relationship. In Yiddish, they'd call him a *mensch.* He's a real good guy. I'm not a vegetarian. He does it for idealistic reasons; and he didn't rebel against me like in the Michael J. Fox television show [*Family Ties]*; he's in the Green Party. And he was Phi Beta Kappa and he got accepted into [UC Berkeley] and he studied genetics, not because he was concerned about if he's going to get mental illness, although I took him to a lecture about disputing the genetics of mental illness once. He said he likes to ask these big questions. He's into evolutionary biology and so it's not like, "How am I not going to get mental illness?" It's something [that interests him]. And so it bothers me when I hear like, "Don't have kids because number one, you couldn't deal with it; number two, they may have a mental illness." Normal parents screw up kids just as badly; it depends of course on the individual.

And for me, if I have some things that can say I'm proud of, but without taking credit for him exactly, I used to say that if he turns out well, I'll take the [credit], but if he doesn't, I'll blame genetics. But he's been a real joy in my life. I mean, [fatherhood is] very grounding and I try to take some of the things. My father used to – one thing, he would overly jab. He had a good sense of humor, and if you're already feeling insecure, it can really diminish you. So I made a point, even though I kid around, never, like if you had pimples, I wouldn't make a joke about pimples. I would be encouraging, so it's been really important to me.

III. Patient Advocacy at LAMP and at Metro State; Working at LAC-DMH; Hope and Recovery Conferences; Issues with NAMI and with DMH; Thoughts on Recovery, Stigma, and the Medical Model

MM: Okay, so I want to ask you briefly, we were talking about LAMP. You were a patient advocate then for a number of years. You worked at LAMP, and I know at one point you were at Metro State as well?

RS: I was a patient's rights advocate; I was there as a patient three times, too.

MM: Three times, so as a patient advocate, how did you try to apply your own experiences to help other people?

RS: Well, the first thing that I would do – I've always been pretty out – it doesn't mean where I live, I go and tell my neighbor I'm a mental health client; but it has influenced me about even dating in general. I think the closest analogy is like being gay, where you know, like [Erving] Goffman [1922-82, one of the leading sociologists of the 20th century] says, "You're discreditable if you go and say [you're gay]" for some people, or you might be the wrong religion, or something. It's not something obvious like a physical disability, but in my work, I'm very open about it. And if somebody's going to be intimate, I'm talking about as a close friend, then they have to know about that, because this is my cause and my passion, in a sense. And so I would tell clients that – overwhelmingly [the reaction] was positive. Some people would say, "I don't want a crazy person representing me," [he laughs] but that was very rare. It's more a problem with the staff, although some staff, including at Metro – When I was in the Bay Area, I went to a private hospital where they declared me *persona non grata*; there was a state investigator. They said, after the clients talked to me, they would elope, you know that term for going AWOL, and break windows? I said, "God, you should hire me if I have that much influence on the patients."

I just talked to them more; it was ridiculous [he laughs], and at Metro I would tell people, look, I know how you feel and I would tell them, if you want to get out sometimes, you may have to do certain things. I'd say, are you on a conservatorship? And often people had public guardians. The family didn't have that much to do with them. Sometimes you try to talk to people, it depends – with clients, with rare exceptions, I would just tell them right off that I was a client. I could also tell them, I don't want you to be dishonest. The way I would say it is, "I know truth is stranger than fiction;" but if you repeat some of these things, they're going to consider it delusional, and that's not going to help you get out. And so there were some probable cause hearings when I was a client, called Gallinot Hearings*,* after this case [certification and review hearings to determine if a 5150 hold should be extended, based on *Doe v. Gallinot* 1981]. You had to file for a writ and I would have to figure out what I was there for. Was I there to prove that I was right, or was I trying to get out? Because sometimes when you try to explain yourself, then this happened, I put Crisco [on my head], but it was just a joke – [he laughs].

HP: That doesn't sound good.

RS: Yeah, or I'm just angry; and you have somebody else speaking against you, so it's like you try to focus on the grounds, in particular. I mean, when I was in the state hospitals, they took people on 72 hour hold, so it wasn't like now where it's more a longer term thing. Now, most of them are forensic [committed through the justice system], even at Metro. So, I mean, in that sense, I would try to tell them [the clients] and give them advice.

I'll give you an example; this was in the Bay Area. This is one of the things you get satisfaction from. There was this one guy who was mute. He could hear and he wouldn't talk; and we would see people twice before their hearing. This was a probable cause hearing, where you could recertify them for fourteen days, and I'm trying to talk and he just acted like [he couldn't speak]. And I said, "Look, you know, I've been locked up myself. If you want to get out of here, you better start speaking. If you don't, they're going to hold you; I mean, there's very little chance that they're not. They know you can hear, but you're not responding. " And then he started talking. Then, when we went to the hearing, the doctor said, he's mute; and when he started talking afterwards, I said, "Yes, the psychotic patients right advocate [got him to talk] [he laughs]!" I didn't say that, but it was sort of like that type of thing. But then, when he got out, I said, "Here, I'll drive you to the BART [Bay Area Rapid Transit]," and I gave him a pack of cigarettes. He smoked one and I felt pretty good. I said, "So how are things going?" Then he looked at me with the same look and he wouldn't talk to me anymore [he laughs]. I said, "Whoa!" It was like he was the devil.

So some staff were good folks. I think there's sort of a death culture there. It's just the institutional arrangement; but there were some caring staff and some that weren't. One thing that they told me. I don't mean everybody [all staff] did that, but have you ever heard what a military tap is? It's like they're saying this one psych tech, when they have a needle to inject you –

MM: Right.

RS: That they were pounding it against the thing [syringe] to make it flat so that when they'd inject it, it would really hurt. So that was called the Military Tap. So I just went and reported that. But there were different things, and believe me, I have some sympathy about that if you're dealing with it. There's the context of why people do things. I mean, I tell people, if you're locked up, what do we say? We say somebody is getting cabin fever; it means you're getting anxious. Then you even say you're going stir crazy, if you're locked up in a hospital all the time, or any place. And there's enough movies about people suddenly being thrown together, how they get on each other's nerves, then you should expect that. But there's a tendency to pathologize their behavior.

Once they were doing an article on me for like the [local] weekly, the Marin County version. This guy worked at Radio Shack and I used to hang around there sometimes, but like a lot of writers, he had a day job, and he would interview big rock stars, but then he did some other stuff. But he was doing something about me that was sort of like an amusing, admirable, freak show. This one thing about seizing the podium at Hyatt Hotel in 1977, just as an example, and I'd recently gotten out of jail where I had had ammonia thrown at my eyes. And it was funny, people would say, "What did you say when they did that?" and I said, "Ahhh!" [he laughs] But they were having a panel [at the Hyatt] on Mental Institutions Rights and Practices and Jim Preis was there, as well as Barbara Lurie, who used to be the chief patients rights advocate [at DMH]. I said, "It's like having a panel on women and they are all men," and I got pretty upset and it ended up with me being attacked by this man [he laughs]. But it was related to [the issue] that we [the clients] could speak for ourselves. I mean, even though I was actually [speaking] on another panel, but I was just indignant that they were talking about it, with nobody even being there.

MM: No patient representation.

RS: Yeah, how do you know what happens when nobody's around? I knew the reporter, because she was then working for the [Los Angeles] *Herald Examiner*, and she had talked to some of us in NAPA. There was a NAPA LA Network Against Psychiatric Assault. So my poor mother, sometimes she would see like some people who could be somewhat weird, someone we would say, that in other groups could pass [as not ill]. In her dreams. My father, at the end, because I started getting a job, I just was [doing better]; and I recently got to Hawaii where I spoke, and then I drove down in some rented car that one of the clients who has money from her family [loaned me]; I mean, she got a trust fund. So a lot of things happened around 1984 – and it's funny, *1984*, like the movie or the book. I think it was [1984] or 1985, where at the APA [American Psychiatric Association meeting], we always demonstrated against it and they let us in. We hardly had anybody who listened to us; there's like twenty psychiatrists [in the audience].

MM: But they let you in.

RS: Yeah, to actually speak, because before they weren't letting us. And if you do it long enough, they don't look too good. And as we would gain more people, and they have certain values that they are supposedly supposed to manifest, and I don't see them all being like rotten people. I'm more subscribed to the banality of evil type of thing.

MM: Oh, that's good. Howard, do you want to sort of take over?

HP: Well, can you tell us the story about how you became to be an employee of DMH here?

RS: I sold out [he laughs]. Now, I mean, that's not quite it, because I think about – that's one effect of my son too, about having to help support him and still trying to maintain my basic [ideals], to compromise without basically compromising myself. Well, it was simple. OK, when actually I moved from the Bay Area and Jean Campbell and I started living together, the mother of Josh, our son, she was very embittered. We had gone from [being] lovers to more like friends with periodic incest, if you know what I mean. So we were more friends and at that time we weren't living together. Sometimes they say, "Watch out; you get what you wish for." She wanted to make things pretty miserable [and] we were having that dispute around the film maker, so I moved from Northern California to Southern California. At that time, I was still working as a patients rights [advocate]. There was a lot of literally incestuous relationships between – one of the staff members was having an affair with the film director.

MM: Oh, my goodness.

RS: And there were other things that I was involved with, and with Jean, and of course – Anyway, it was like this great [drama], so it got to be pretty bad between certain things. In fact, [Mental Health Consumer Concerns] didn't hire Jean to do some survey research, which I knew was a mockery. I mean, they didn't know as much about survey research. They hired somebody, who was a very nice person but didn't know a lot about [it], so I had a dispute about that and I said it's not [fair, just] because I'm living with Jean. I mean, Jean is a researcher; but anyway, there was a lot of – So we moved. OK.

So I got involved with LAMP. I was looking for a job and I won't take any job, but I had to eat. One of my proudest times was when I was throwing newspapers at night for the *Daily News* in the Valley, like at two am, and then I was looking for a job. I had a part-time job very briefly with the MHA and then we were living in Santa Clarita [at the northern edge of LA County], because we were living with Jean's older kids, and then I got a job at LAMP [after the newspaper delivery job]. I wrote a very strong letter, saying [and underscoring] what my points of view were because it was so far away. And Mollie was open to it. And fortunately, Jim Preis said I had mellowed [he laughs], and said, "Yeah, he's cool." And she [Mollie] used to even tell people [potential clients], "We're not part of the Mental Health Department," because a lot of people wouldn't go [to a public mental health program, due to bad experiences]. So anyway, I worked there and then for almost four years and I was pretty popular among the clients and found it an interesting thing.

I applied for a job here [at DMH]. Even though Barbara Lurie knew me, she wouldn't hire me, because she thought I was a loose cannon, I think. I used to say, "I'm not a loose cannon, I have a definite way of shooting, you may not like it or something." But she was a person who wanted to be in control. And [the DMH job] was twice the money; I had Josh. And then, during that time, I wrote a Minority Report about the jails, which I could give you.

MM: Right.

RS: Did you know about that?

MM: Yes, right. You got yourself – I don't want to get too off the track here, but you got onto the Task Force for the Incarcerated Mentally Ill; and they issued the Final Report, which I have read, but you wrote a Minority Report, is that right?

RS: Yeah, I wrote it because they –

MM: That was about 1993?

RS: Yeah, that's right. So Mollie [Lowery] got a little upset, because I'd be in the back, trying to write it, when I'm supposed to be working for her. But it was a fine experience. I mean, I could really relate to a lot of the people. I never stayed on Skid Row, on any Skid Row. When I slept out, wherever I was traveling – I still look at bushes, even now; bushes, if you ever need to sleep [outside], they have them right against buildings. The roots sort of sprout out so there's this little area.

HP: A little hole you could go in.

RS: Yeah, there's a little area, and so when I go by, I still look to see; it's very ingrained. And the big problem was that sometimes they put sprinklers on at three or four in the morning. So that was pretty good. Sometimes I would get into about not totally being more – I never counseled people against taking meds. What I've said is because see, what we were doing in the Client Movement was saying, "Oh, don't take them;" [but] it's like you're imposing your own ideology on other people. It's more around choice. And I could say I've had quite bad experiences with medications, including being paralyzed from the neck down by having severe Parkinsonism [tremors, rigidity, and instability resembling Parkinson's disease]. And then the irony is that I was afraid to call the psychiatrist for medical [help], because what were they doing to do?

MM: Sure, sure.

RS: All I needed was a bunch of Cogentin [an anticholinergic drug used to treat side-effects of antipsychotic medication]. So anyway, it was a good experience, actually being able to stay down there [at LAMP], and what can I say, people are somewhat – I wrote an article, in fact I'll give it to you, that's gotten a lot of distribution. It's called *The "C" Word* and it's about Josh and me.

MM: It's online, I think. [http://www.recoveryxchange.org/RonSchraiber.html]

RS: Yeah, and it's about when he would go down there with me at times. Although I know quite a lot of times he wasn't totally interested because he would rather go to the toy store. But they were all friendly and they were always happy to see him and I never said anything about who they were per se. And that was an issue about what I talked to him about this and all that. But anyway, so, after being there, I was looking also for a better check, because we started off at seventeen eight [$17,800 a year]; this was 1990; so [I was now paid] one thousand eight hundred and we went up to twenty two eight [a year] by. One year we had to take [a pay cut], because of bad funding; so I had to pay his insurance. It wasn't the worst in the world, but I mean, it wasn't a lot. Then there was a job opening at Metropolitan State Hospital because I guess [the lobbying group] was PAI, Protection Advocacy, now Disability Rights California. They got the contract to do the patient rights advocacy, maybe because probably of the legacy of abuse [and neglect in the state hospital system], and Teresa Nelson, who [was now the boss of] Patient Rights Advocates [for PAI], [already knew me] from [when she was Chief Patients Rights Advocate for] San Mateo [County]. We got along real well and she was very pro-client. Besides, like I said, we got along real well and that's helpful when you want a job; and so even though she was based in Oakland, she hired me. So I was there from 1993 to 1997.

Then, with this job, I [also advocated for] having an Office of Consumer Affairs [at LAC-DMH]. I wasn't as involved [at LAC-DMH, however]. I was known, because I speak [and advocate] around, and [I was very interested about] the job, when I found out about it, and I applied. I mean, Areta Crowell [LAC-DMH Director 1992-98] – I had written something. It wasn't just about me getting a job, because I have a saying that, "Radicals make the world safe for liberals to get jobs," and since I was agitating around – But I had the support of clients in the community. And the thing is that I learned from the Well-Being Project, because I would get indignant, "How could you?" and it's more that somebody said, "Ron, how could you do this?" And then I would give my moral, like the ancient [prophet, very condemnatory], and that would just alienate people, like how could you do this? Like, for instance, well, I won't go into it. I just learned to mellow out as far as being indicting, even if there was some validity or a lot of validity because, if it's true, people don't want to hear it; if it's false, they don't want to hear it [he laughs]. So I had stayed away from that, because of Josh. This job that I had at Metro was only funded initially for two years, because it was a pilot to see how it worked. When they had a job that was opened as a peer advocate, which was the same money at PAI, I tried to transfer. They said, "Whoever, if you work here, you have first shot at it," and it was stable federal funding; but this other client who was in charge didn't want me to have the job, that was the bottom line.

So, anyway, where was I? So I learned one of the persons was on the hiring panel, I got to know her and I never brought it up; I am just saying who was important in the Client Coalition. I just learned that from Jean. So I had the [basic] support [of the clients], so DMH hired me; but they asked me questions which I even [answered by saying], you're asking me questions; but I've worked with all of you in one way or another. I've been on this Task Force for the Incarcerated Mentally Il; I'm unusually well documented. In fact, some people have said my minority opinion was more on [target] than the majority, because they didn't want to deal with some of the issues because the Sheriffs Department is the thousand pound gorilla. And so they asked me questions, which were similar, and I said, "It's like asking when did I stop beating my wife." They said, "Are you going to write another Minority Report, are you going to do this, or how are you going to get along?" I said, Well, you've gotten along with me. I'm an advocate." They also had the legitimate concern that I'm more of an advocate than a manager, and they try to sometimes hold that against me. I'm not a paragon of virtue, but we got things done with underfunding.

So, anyway, what happened is that they hired me, but there was definitely – see the positions of both the [Office of Consumer Affairs and the Family Advocate] were to satiate [or placate their respective client and family constituents]; I don't mean [that] like totally cynically, but [he coughs] [to satisfy the demands] of the client community. So, if they had somebody that was known and they [the clients] were backing it, they might cause some problems and when they dealt with me, they knew that I was quote "reasonable" about what I [advocated for]; and that I said, "Well, if I disagree enough, then it would be up to me to resign," if I found it [untenable] or whatever. So that's how I got [here]; but I've got a lot of real issues here at times.

HP: Well, tell us about some of what's been good and what hasn't been so good about working within DMH?

RS: OK. Well, you have access where you didn't have access before. I mean, the biggest thing, and I realize it's just the one day event but we do it with three [languages], is the Hope and Recovery Conference. The first year I was here, I started that and it was in English and now we get like 600 people. If we'd planned better, we'd get a lot more, but we can't get a bigger venue [he laughs] – which came out of the Client Movement. And then we expanded it to Spanish because I went to a conference in Baltimore [and met] David Gonzales, who subsequently moved out here, [and] now is married to one of the staffers, who's also a client, who has the Recovery Exchange, and Cinemania, it's about stigma. ["The Stigma of Cinemania" is a website/blog discussing how popular movies help to perpetuate stigmatization of persons with mental illness. (http://www.iaapa.org.il/image/users/46024/ftp/my_files/text-files/cinemania/7.htm)] It was this anti-stigma conference and so I said, "Do you speak Spanish also?" He's from Brooklyn. He said, "Yes," so I started that.

And then particularly, with the help of Gwen Lewis-Reid, who now you're going to be interviewing – we started in Asian [languages], where we had simultaneous translation. All the speakers except – I help MC it and so does Gwen, but [the speakers] are basically all from Asian backgrounds; and since there are so many people that are monolingual in an Asian language, we have a simultaneous translation. Although interestingly some of the professional translators don't know a lot of mental health terms, so that was a problem.

MM: Yes, I could see that would be true.

RS: So from that some, as Gwen would say, "A lot of people have an Ah-ha moment," sort of like at the National Alternatives [conference], that they see that clients can do things and I think there's something about educating some of the staff, [as] Dennis [Murata] said. Although a lot of times they don't [bridge the gap] between implementing things and doing things. I've helped a lot with getting peer advocates, and raising some consciousness about the Recovery Model. Once [Mark] Ridley-Thomas, he's now a [County] Supervisor [representing the 2nd District since 2008]. He had this forum called, "The Mentally Ill Among Us: A Danger to Self, A Danger to Others," and I was the galvanizing force [behind taking action], which I think was made possible, although there are disadvantages, which I will go into. He has this regular forum, Ridley-Thomas.

HP: Yeah.

RS: He was a [LA City] Councilperson, now he's on the [LA County] Board of Supervisors. And even the title like "among us," like we're not really you, like it's the us and them and that we're a danger to self and danger to others, that's all we are. The Network would do this and I took their strategy. We asked them to send down a bunch of yellow shirts that have something that says that it's with the Network or some type of mental health [client] slogan [on the shirt] or sometimes [the famous quotation from Spanish-American philosopher George] Santayana, those who forget the lessons of the history [are condemned to repeat it]. But it identifies us as being clients and we changed the tenor of it [the forum]. It was almost like it was being put on by NAMI and I've got more about like "let's get outpatient commitment."

I understand a lot of the connections. I have, quote, "family members;" I can understand the sympathy and I can sympathize with my parents, although they were never active in that. But having some abilities to move certain things, I've done things about trying to get rid of segregated bathrooms, which they apparently re-instituted back in Long Beach [Long Beach Mental Health Center, a directly operated LAC-DMH clinic]. I mean, you have to watch it – how can you be partners in treatment if you can't share the same bathroom? I know it's very reminiscent [of racial segregation]. I can give you some of that stuff. It's probably – maybe it's better if I send it to you, because it's all – and so you can influence policy. You also know how much you're not [able to influence].

If I were out there as more of an activist type, I would be doing more; I would definitely probably be approaching certain things differently, in a much stronger way. As I said, there are tradeoffs and I think about [the fact that] I want my life to have meaning and not to think that after being involved, that I'm just here to do nothing. I'll give you an example, one of the things that's happening, which I would talk to you about the MHSA, is that around stigma and discrimination. The literature clearly shows that [the] "it's an illness like any other illness" [approach actually] increases social distance, even though that's the mantra of what mental health professionals [tend to do], especially NAMI, which I understand, families don't want to be blamed, especially with a schizophrenogenic mother. So it's genetics, it's a no-fault brain disease, which is not no-fault. What they're saying is [that] you're not doing it on purpose, but if it's lodged in your skull, then it's your problem still. It's still your fault, and it makes you qualitatively different. For some clients, it does take away blame, too. I'm not weak, or bad, I'm ill.

MM: Right.

RS: And sometimes you got to get people over the sick role, too, because then they buy into that. A lot of this stuff from the Client Movement was about responsibility because we were forced to look; logically, if they say we are irresponsible, then we have to claim responsibility. But a lot of it was like saying, I know something about it, I can do something. And so with the stigma and discrimination, they want to give a certain amount of money just almost like in the old days, some to NAMI, some to clients, and there is this part about family education. There's $90,000 for educational material. I'm looking at this and their overwhelming thing is about brain disease, and I remember one NAMI person wearing [a button saying] "Have Pity for the Brave Brain Disordered." I'd go, "Wow, they think that's anti-stigmatizing?" But again, I think that explains a lot in life, people are not so much against you, they are for themselves and they don't like being stigmatized. Sometimes, I think a lot of them are very – Of course, whenever you say people are well intentioned, that means you feel they're wrong; but they're not mean and evil, how can I torture my kid? But they're trying to also protect their sense of self, just like I'm trying – I don't find that saying I have a defective brain [is] helpful; and also, for the general public, it tends to say, if you have a chronic condition, it's irreversible because it's like genetic or it's innate.

And so [that theory is not supported by] studies [by] even people who want to believe it. Patrick Corrigan's also a client [and] he does a lot of stuff [Corrigan is Distinguished Professor of Psychology at the Illinois Institute of Technology and Director of the National Consortium on Stigma and Experience]. He agrees that – well, they're saying, we're finding out more about the brain, but there's no pathognomonic thing that shows that there's a specific [brain disorder], because they don't do brain scans really, and there's no blood test. They say it's like diabetes, but there's no test. It's very subjective and it's sort of like what the Supreme Court says about pornography, I don't know what it is, but I know what mental illness is. But if you understand it, then maybe it's not such a mystery or whatever. But so I just said, "[I'm speaking] truth to power;" I mean, like I said, "Look, I have a certain belief system." I said, "Fortunately in this area, the empirical research backs it up that it [stigma] increases social distance." People who hear genetic attributions or brain [disorder], they tend to believe that [[the solution is] let's hospitalize more and make sure [to give] medication, because you hear, "They [the mentally ill who commit violent acts] were off medication." It's always the way it is. Sometimes when I speak, I say, it's so ingrained that if I did something [or] hurt somebody badly, they would say, "I knew this was going to happen because Ron went off of his medications 30 years ago."

It's that type of thing, and so I guess that – We're supposed to think outside of the boxes to be transformative. You talk about evidence-based or what the research says and you can't be just NAMI giving out their standard [information that] it's the brain, it's an illness like any other. And I said I have to take my stand here if you're going to do that, when it's so overwhelming. And I do pass out [informational] things. What I try to do with one page, no more than two, I take quotes from the literature and I know authority isn't supposed to be a way of doing it; [but] sometimes if it says [from the office of] the Surgeon General, or I especially try to get quotes from mainline publications. I always say it's not one of the radical anti-psychiatrists, including about discrimination. This is one thing I got them to do and I do have a problem, and people go into this. I mean, it's even when you talk about the MHSA, somebody that you may talk to [may want to be critical of the status quo and] may want to get a consulting position, so if they talk badly about somebody [or something], it's a problem [and they may not get hired]. And I don't really want to knock anybody individually, but there are some problems with leadership in my area.

MM: Can you state a specific problem? I mean, you don't have to name names if you don't want to.

RS: Well, who else if you have a leader? It's that we are the change agent of this Department, if there is going to be any. And you have to be willing to, you know, to be on the cutting edge and if you are, you should expect to bleed, baby; and the old saying is that, "He or she who rocks the boat shouldn't expect smooth sailing," and there's not strong enough backing about that. I mean, even just, you know, about being more assertive because it undercuts. If you have the main person in the office and I don't want this to be an individual kvetch or complaint, although the personal is political sometimes. We have to shake up things some; and if the person at the top isn't willing to do that, then they undercut you; and we have to do it especially.

All out groups appeal to a higher truth. African-Americans appeal to the Constitution about equality; all out groups, whatever, gays, you name it, women, like the Seneca Falls Conference [women's rights convention in 1848], I think they redid the Constitution just putting all men and women are equal, and building on the basic thing about the higher context. One of them is about research and about our dignity and that's why you try to pick issues, whether it's the bathrooms, which I can tie in with the larger Civil Rights Movement. And, if we don't make a stand, for instance, around this issue, around stigma and discrimination then it becomes [worse]. I didn't hear any real [support], except Catherine Bond [Vice Chair of the LA County Client Coalition], who sort of chimed in. You worry about if you want to get some possible position, and it becomes a problem. I mean, there's also something where discretion is the better part of valor. Like when they read this 400 years from now – and even whether there's further things, when I'm around, at least I can say that I spoke up, that I didn't go gently into that good night, although I don't just want to indict people. But there is the thing about speaking truth to power, not just in this, but in your job; and one of the things here is even though we have Civil Service, people are very uptight about being out there.

They say that you have to kill somebody to lose your job [in the County], but even though on a couple of instances – Sometimes I have to admit I could get pissed off – but one time I was so pathologized [for my objections]. I mean, they pathologized [my behavior as needing] anger management and I had some real reasons. I mean, I could go into this the way – I win advocacy awards; they take me out of the stakeholder process. Sometimes I do say something personal, like I said in public, when Dr. Southard says, "Can't you understand, I'm speaking in code" about something. I said, "I don't want a director who speaks in code;" I want somebody who is direct about what's happening, among other things. I've said things in private, but Dennis Murata I can say things to, he's somebody you can say things to and they're not going to kill you for it. That was very hurtful, because there's usually context; that's why we have the saying, "I'm not mad, I'm angry." And there is one thing, if I ever passed out anything [shuffling of papers], this is a poem, which you may have seen by Debbie Sesula. ["You and Me"; see http://acaciaward.0catch.com/leunig/youandme.htm.] One of the things – here's [Schraiber's essay] "The C Word.".

MM: OK, I like that. Oh yeah, I think I have seen this.

RS: And she's from Canada. Like a lot of things that endure, it only won third place in this writing thing, maybe because people say it's due to the [mentally ill] people's behavior. I'm not going to – when you're in anti-stigma or discrimination, you have to watch about where you want to homogenize everything, like saying, "Oh, we're not all that different;" it's sort of like the straight looking gay person who can't stand the flaming queen because they distract [attention with their behavior].

But usually people [express] NIMBYism [Not in My Back Yard opposition to housing facilities for the mentally ill], when we say we want a place [to live], including independent living apartments, when there's outrage about it, even if people have been screened heavily, [the] neighbors don't want you. That's not based upon your behavior; it's based upon stereotypical conceptions. It doesn't mean that [there aren't] some people that act that way. I'm very pleased that it doesn't mean that there aren't [financial fraudster] Bernie Madoffs, or whatever, who are Jewish, that, believe me, where the people hate him the most are Jews, because you really bring that stereotype [to life]. And I know of Latinos, that if they say "gang banger," they go, "Oh God, don't" – like on TV, you have what [German-American social psychologist] Kurt Lewin, I think, called the Commonality of Fate.

If you're in a group, you don't fail as an individual, you fail as a group. And so that's one of the things that whenever I hear about – without taking away that people can act bizarre and this and that, but it's not just because of their behavior, it's the "us and them" dichotomy. It's like I am firm; the group you don't like much, they're stubborn; the one you really hate, they are pig-headed. It's the same concept. I'm thrifty, you're cheap, if you save money. And so I really think a lot of things are this "us and them" dichotomy, because it makes things very easy for people to dismiss the other person; and I try not to do that even [with] what I say when I'm with NAMI. I mean, there's a lot of agreement on certain things; but they start off as a family [member movement], they're overwhelmingly family.

They sometimes – and this is one thing I really dislike, and Dr. Southard has done it – it's very commonly used. It's what we call the "violence card," and the "violence card" is where you say, "If we don't get money for our program, somebody is going to do something [violent].” That type of thing increases stigma and discrimination, because the most salient thing is the one of dangerousness. And [New York psychiatrist] E. Fuller Torrey, who you may know – he once was sort of Szasz-y and now he’s the worst right wing reactionary, who plays up violence.

He’s a psychiatrist. He has the Treatment Advocacy [Center], TAC [founded in 1998 to promote the reform of mental health laws and improve treatment services, TAC advocates outpatient commitment], and he gets a bunch of money from a family member [of a mental health client] named Stanley. His son also goes along, who’s a lawyer, who said yeah, this is all true. And he goes around with pictures of, here’s a schizophrenic brain, and here’s twins, but again, it’s not pathognomic. There’s too much discordance between diagnoses and what people have in their brain.

And Elyn Saks, whom I know halfway decently, she believes very strongly, in a lot of ways, in the Medical Model, because some of that’s been very close to her. She said she has tried to give up meds, but she says it’s what belief gets you through the night, and it relates to your own experience. But she’s also extremely strong about rights, because she knows what it is to be in seclusion and restraints. She also lived in a country, England, where they didn’t have any, and [speaks out] about dignity issues. So that’s what I think that a lot of things come down to, is when you feel a sense of humanity and dignity. Whenever you see your group is splattered with [headlines like] “Ex-mental patient kills two,” I just want to point out, why don’t they ever say, “Ex-normal person kills two.” And there are certain groups, as I also said, that – like with race, and we call this sanism, the prejudice and discrimination against mental health clients; some people originally, like Judi Chamberlin called it mentalism [in *On Our Own* (1978)]. That sounds like [entertainer The Amazing] Kreskin.

MM: Right, right, brain waves.

RS: Generally, there’s a guy named [Michael] Perlin [Professor of Law and Director of the Mental Disability Law Program at New York Law School]; he’s a mental health attorney who talks about [sanism] a lot; because it should be used instead of stigma and discrimination and it’s not to explain everything that – people have to take responsibility. But it’s also the internaliz[ation] – they call it internalized stigma; among ethnic groups, you call it self-hate, and that’s what it is. I mean, you hate the aspects, because of the way people often will treat you, or you internalize it. A lot of battles around marginalized people are to get them to feel they are worthy of things.

And so with the Department, it helps me [to support Joshua]; even though he got a good fellowship to Berkeley, it’s not enough, although he never applied for [undergraduate scholarships], and I couldn’t [put it together] because I was screwed up, when he was going. He said ”Dad, I’m sorry, I should have applied for scholarships, but I didn’t.” So he apologized! [he laughs] But anyway, that’s helpful. I would wonder, I don’t know, my world’s changed around him too. Would I leave [the Department]? I mean, I’m terrible. I have to admit sometimes it gets in [the way of the] job, but, if it weren’t for the last minute, I wouldn’t do anything. I like to read things, I like to read other things, like when I had an assignment in school, other things that I don’t have to read, and do things – because writing a book, even though because I’m strongly encouraged, and I have some chapters [completed], is that you have to do this at a certain time. The time’s running out, as my gray hair is [he laughs].

HP: So I guess we need to wrap up soon. So one final question as we wrap this up, is how do you see – what's your vision for how the mental health system should look and function?

RS: Yeah, that's a real difficult question, because I see things more holistically, and I'm more also [emphasizing] a rights and dignity type of thing. It's not as much service delivery and I also know the vagaries of human nature and what people do and not do. And sometimes, like they say about involuntary treatment, well, we have a saying that like, you can take a horse to water, but you can't make them drink. That must mean people don't always do things in general, let along if they have a mental issue. I'd want it to be voluntary and it doesn't mean I see everything totally black and white; but, for instance, I believe, just like a very significant amount of people avoid treatment because of the fear of involuntary treatment and I've seen it; that's the reason we've come up with this question. And even people who say treatment has been very helpful to them, a lot of them still say that the fear of involuntary treatment may keep them away. Like if you are very depressed, you say, "What if they keep me?"

Oh, and also, I'll give you an example is that some people don't tell you; that it's like they have a maid service, but you want to clean up your house a little bit more, so they [the maids] won't tell or see how much of a slob you are, so they clean up what's really bothering them. And sometimes I've known somebody who said she heard voices; [she was] afraid if [she] told them [the psychiatrists], that they might definitely commit [her]. But she would've [gone for treatment] if there wasn't that risk. So it would be voluntary just like the issue of somebody can be smoking four packs a day; they have chronic bronchitis, teetering on other bronchial [conditions]; we don't commit them and they're medical questions, but they are more ethical questions. And if you force people, if there were some criteria, let's say three packs a day, and you have this minimal condition, we'll commit you to try to get you off of cigarettes. You'd have some people saying, "Thank you," the "Thank You Theory;" and then you'd have a lot of people protesting in front of [the facility], and that's similar.

It's not because we're, quote, "crazy," – it's the forced treatment. And let me just give you – this is very important to what I see as a model. Sally Zinman, who was the director, who was a long time activist and was the executive director of the California Network – She has cancer, and she's public about it and she knows the pain; and she's having some real aggressive therapies around it. She knows that it's going to be very painful, could be very painful, the chances aren't great, but she has informed consent and the right to make that decision. It's a life and death type of thing. Her experience – actually, she was not ever in the mental health system, public or private, in a sense. Her father was wealthy. They had some psychiatrist take her to a farmyard and they put her in the basement and stripped down to her underwear and just a bucket for waste, and she was very indignant around this. I'm just giving you a brief overview. She used to consider - I never knew this until later, because we didn't ask people, we just knew you come there [to the Network]. She used to think she was Svetlana Stalin. I never knew that; I said, "Sally, I didn't know that about you," [he laughs]. And then she even agreed that she wasn't when she still believed it, because she realized how to get out. But it was the sense of humiliation, that is more sometimes far worse than other pain, but it's that she has choice even in a very painful procedure. And again, I think people will feel betrayed and hurt and between families and clients, it [involuntary treatment] creates a tremendous animosity.

It did with my family. So that's why I think that it doesn't mean like when Elyn asked [about] Joshua, "What I would do if he wanted to jump from the building?" But I did say, I mean, he [was] young. She has a theory about you commit someone just once to give them a shot; then don't do that. But of course if you have good treatment, it's different than bad treatment; and maybe you could see then this whole thing's about coercion, scales, and all that. But I would be doing it for myself [stopping Joshua from jumping]. I don't want to lose him, his opinion [is less important] - that's more of the reason why I'm doing it. I don't want to lose him. It's like you cry for yourself at somebody's funeral, maybe more for that. But that's why I think it's very important and it doesn't mean just like some people would not be – there's no perfect solution. Sometimes when people say, "Well, what do you think?" I say, "Philosophers both east and west haven't figured out a perfect thing, so I'm not that grandiose."

I think that – like if you look at homelessness, and I'll give you an example. It's primarily that we don't have affordable housing. There's this person I know who's a professional also, a lawyer, who had a break and lost everything, although there were a lot of bad stressors in this person's life, but [she] ends up hearing voices. Whatever they mean, or not, that's an issue, and also it's not [essential] to cure voices. If you have what we call distressing voices that you may want to get rid of, but if they're nice, and some people will even hear, "You're great." Some people say, "Get rid of [the voices] because they're not natural," and we say, "No, they're happy voices, so that's okay." And she was saying, "I became homeless because of my mental illness;" and then she was trying to get on a Section 8 [HUD program of housing assistance for people with low incomes]. She was more than able to do that; she was ending up staying at PATH, this homeless place, a shelter [a West Los Angeles facility run by People Assisting the Homeless], and finally she qualified. Well, I said, it doesn't mean you didn't have a breakdown and that didn't contribute, but if you had housing, you would have gone and done well, it's just that there isn't real affordable housing. [Note: the average rent for a one bedroom apartment in the LA area is more than a monthly SSI check; when you add to that the usual substantial deposit, people on SSI are priced out of the housing market for descent affordable housing].

Most people on Skid Row, believe me, when it rained, they had enough sense to get out of the rain. We would see, at the start of the month when people got their checks, we didn't have a lot of people at LAMP, but a few days later – There were some people [getting into] sex, drugs, and rock and roll because in part, they see no future so why not just go "hog wild." And you have to have some reason to have deferred gratification.

So what I'm saying, I'm looking more at the total person and I don't know if we have to label people as much. You say, "How can I help you?" I don't know; I mean when I say that, because the existential problems of living are very tough. There can be a lot of reasons, even when they say you have endogenous depression because we don't see any reason to live; to be sensitive, you can be depressed. So it would be voluntary, you'd have to have resources of course, and it would be holistic, looking at people as human beings, and you get rid of [coercion].

HP: Treating the person and not just the illness, the Recovery mantra?

RS: Right. Yeah, if you look at the Recovery, if you look at the Surgeon General's Report [*Mental Health: A Report of the Surgeon General*, 1999, at http://mentalhealth.samhsa.gov/features/surgeongeneralreport/home.asp], which just had our study [cited], yay! [he laughs], it says, ”Negative conceptions of fear of mental illness [were] perpetuated in textbooks for decades, by [German psychiatrist Emil] Kraepelin's original writings [which proposed diagnostic definitions for psychiatric disorders in the 1890s], [and affected] staff and consumers, families' expectations, leaving them without hope. A turn about in attitude came as a result of the Consumer Movement and self-help activity because" – and there was an article written by a client, [describing how, in mental illness] it was a social death sentence for us. It was like saying, "You forget your aspirations, your dreams; you can't handle stress." And as I said, stress is more about meaning. When they said, the first time I was in Camarillo, do you want to work in occupational therapy – it was putting cotton balls into a bottle. I felt so hopeless; I know my UC education was worth something [he laughs]!

But anyway, that [the change in thinking] comes from us, and I try to tell the Department – They have Eduardo [Vega] who's got a lot of – it's tough being in his position [Vega is Director of the Division of Empowerment and Advocacy at LAC-DMH]. There's one out of sixteen people on the Executive Management Team [and] he's only the one self-identified client, so it's going to be very tough, you know, and that's not Transformation. Transformation is a fundamental change; it's like the Transformer toys going from a robot into an airplane. It's something different. I guess, it's like what consumers are talking about in – I say consumers, although I hated the term, "consumer," because I used to say, yeah, I'm a consumer of mental health in the sense that the system consumed me, and so there was a real debate, just as far as the history.

What do we call ourselves, the mental health clients, why did [we say] clients? Well, not all of us are "psychiatric inmates" – that's too radical, we know it might be stigmatizing for some; "survivors" is what a lot of us called [ourselves], of course that means you more survived the mental health system than survived your cancer. But for some, I tell people it means you sort of survived the system and/or your mental illness. It doesn't mean I don't think people can't have great distress. It means that you don't necessarily attribute it all to a Medical Model type of thing. I think it's a holistic approach and I think it relates to what people are asking for in the general field of physical health. Of course, you have to have certain resources, but like the Full Service Partnership. I'll give you an example, and I think it's a real good example. You've heard of perhaps ACT, or PACT, [program for] assertive community treatment?

MM: Yes.

RS: Okay, what did that start off as? And it's a favorite of NAMI. It's Hospital Without Walls. That shows a certain attitude that you will always be a patient. Now, we're going to give you more freedom, but you're always a patient and –

MM: You're still in the hospital. The walls just aren't there.

RS: Yeah, so it shows a certain belief system about what you're capable of doing. Now, there's a Peer Bridger concept, that was started by peers in New York, that says, "We get people out of the hospital, keep them out of the hospital, and get the hospital out of them," and it's a different thing. [The Peer Bridger Program is run by the New York Association of Psychiatric Rehabilitation Services (NYAPRS), under contract from the New York State Office of Mental Health.] So you can have very traditional attitudes and that trumps clinical attitudes; and a lot of the times clinical attitudes are reifications of popular prejudices. I mean, whether they are gender issues, or whatever in society, like being gay until 1973 was a mental illness and what really changed that was gay activism. And what we need to do is walk into the Executive Management Team and have an ACT-UP sometime, to get more of their attention, to change some of the things [the ACT-UP model is demonstrative, street theater protest, based on the activities of the AIDS Coalition to Unleash Power, founded in 1987 in New York]. I don't know all the stuff that's happening in the Department because I don't know – I should go out more, but even a one-day thing – that's why I recommended Gerald Minsk [Client Advocate at LAC-DMH] to be interviewed, who knows more. Yes, I have to admit I don't want people just to be critical, but he is critical. He doesn't necessarily – we don't agree about some key things. He's very much more into that it's an illness thing, but I mean, he's been around and he can give you his opinion and what he's seen at the clinic level, as well as working at LAMP. He came to LAMP after I did, and was there for ten years.

So I don't think a lot of issues – when I think about the World Health Organization studies and I know there's some critique by Alex Cohen [Assistant Professor of Social Medicine at Yale] about [how] people recover more in the Third World, where there's less actually of these treatments that we have here. Now Alex Cohen used to do [field] research [at LAMP], along with Paul Koegel [Associate Director of the] RAND [Health Division], when I was there, and they both have PhDs. I worked sometimes with Paul. He's made a career, Alex Cohen, about disputing the data from the World Health Organization and still some back it; and I have to read more. It's one of those research [findings] that, if Alex Cohen is correct, I don't [want to agree], because I like the fact which says that people don't recover better, because I have to admit I do have grudges. Like a lot of people that are activists, whether I think it's based on ethnicity or something, it's a way of treating hurt and anger into something positive. It's something that's transcendent so that when you do see that you do bring some[thing], it's sort of like yes, I'm saying, "So there, we can do this;" but when you see somebody have some hope, it makes your life feel validated, honestly.

Even if I know a lot of it is going, "Nyah," and I know there's a lot of good professionals. But a lot of the attitudes of condescension which sometimes happen, even with the well intentioned stuff, like a lot of things that we know are lifestyle things. That's one of the ironies, while they're trying to medicalize psychiatric issues, on the physical side, they're more demedicalizing them in the sense of saying we have - The sick role was that you're not responsible. Now there's more things about being responsible, about whether it's not getting enough exercise, eating too much of the wrong foods, whatever, and that there is some sense of responsibility that we can have. And people have to – the system valued being a passive recipient rather than an active participant, as we say now; and people need to also make efforts. I have to admit I need to have a dental appointment which I haven't gone to, just out of inertia [he laughs]. But I mean we need to be more active in our own care.

MM: I think – let's wrap it up right there. That sounds like a good exit line.

HP: Yes.

RS: OK.

SECOND SESSION OF RON SCHRAIBER INTERVIEW

INTERVIEWER: HOWARD PADWA

DATE: November 6, 2009

IV. Thoughts on the Medical Model, Stigma, and Sanism; Impact of MHSA; Peer Advocates at DMH

HP: All right, this is Howard Padwa here on November 6, 2009, doing a follow-up interview with Ron Schraiber from DMH Department of Consumer Affairs for the DMH Archive. So we were talking a little bit about your thoughts on mental health policy in general.

RS: Well, just as a correction, now I'm the head of the Office of Public Policy.

HP: Oh, OK.

RS: And I direct that; the only person I direct is myself, which is a real management problem [they both laugh].

HP: Well, hey, it's great to be your own boss.

RS: Yeah, that's true in a lot of ways. I mean, I do have – that's why I was moved from [the] Office of Consumer Affairs. That's now called CORE, the Client Office of Recovery and Empowerment. But without getting into that – the personal is political – at the same time, this is not, as we say in my culture, a kvetch session – [not] just about that. So [what] I was just saying is that mental health politics are really impacted – it's not just, quote, what the research is – they say they want "evidence-based," and even though many in the client movement are concerned about what evidence-based is, it's because [the research is] based upon the old paradigm.

HP: What's the old paradigm?

RS: Well, it's more about symptom control and sometimes it's like [cases in surgery in which] the operation was a success but the patient died; and there are more intangibles. Of course, for instance, having contact with your family is important, and I don't blame my parents for my condition. I mean, you can always do "Monday morning quarterbacking." That's why I like to say I was a self-made psychotic. My parents used to say – like Art Linkletter [a popular TV host of the 1950s], do you remember him?

HP: No, I don't.

RS: He's too much before your time. He used to do "Kids Say the Darndest [Things]," and then [African-American comedian] Bill Cosby [took over the show] for a while. But his daughter [Linkletter's] had jumped out the window [allegedly due to an LSD flashback], and then he became an anti-drug [activist]. But I didn't drink, smoke, take any drugs – I had no excuse for it, in that sense [they laugh]. But, for instance, in the realm of stigma and discrimination – I use the word "clients" [for] people that have been diagnosed or identified with mental illness or whatever. In one of their key courses, NAMI – [the] National Alliance on Mental Illness – says that their number one, the single most devastating [thing] – this is [a] pretty accurate paraphrase – that can happen to a family,

[to] the family members of the person with mental illness, is the blame. Their primary focus is really on – as [child psychiatrist Leon] Eisenberg [1922-2009], this Harvard psychiatrist, said, it's more like exculpation – the medical model that they totally embrace almost to the point of biological reductionism – that they [the family members] don't ever cause anything. It's a way of saying "it's not us, it's biological." And their big thing [is] that it's a brain disease.

Now one of the things is [that] within the general mental health community – and that includes the Mental Health Association, the Department of Mental Health, NIMH – they say it's a brain disease. And of course, that has generally conservative implications, like the reason that people are like a certain way is that they have an intrinsic condition, and you don't have to look as much at the sociocultural parameters and interactions; because, even though they call it a no-fault brain disease, it's like they're saying, parents aren't at fault. That's the most important thing for them. It doesn't mean a lot of them [the family members] don't care. They want hope. I'm not trying to caricature them, but that is a major driving thing. Where was I now?

HP: Talking about the brain disease.

RS: About no-fault. They say it's a no-fault – if they have any deviant behaviors, "it's not your doing," it's no fault in the sense that they're not doing it volitionally.

[Pause to move to another room]

HP: OK, so we're back. So we were talking [about] NAMI, the establishment view of the biological [nature] of brain disease.

RS: So one of the key things is that within the American – I mean, this thing about parity, too, is that Americans accept reimbursement if it's biological. So there's a vested interest, as far as getting full reimbursement, that relates to mental health parity. And yet, at the same time, when they talk about a recovery model, the funding streams are still based upon the old deficit model, like "What's wrong with you?" – medical necessity – so it's not conducive to – It's not how good the programs are, it's whether there's a funding stream, and it fits in. Now, the MHSA [Mental Health Services Act of 2005] –

[interruption]

RS: [resuming] See – I never like to say on the level – I'm on the same level. I deferred, one time, about an office. I'm so status-conscious that I try not to be status [conscious] [he laughs]. You know what I mean? And so I ended up there, 'cause there's a nice [setup with] each having an office. Now they want to use that, and I said, "It's OK to use that for a library." So I'm over here, but at least I have some view here.

HP: Yeah, you have a great view here. It's not bad.

RS: I have to realize that I have all this stuff [pause].

HP: So anyway, we were talking about the deficit model.

RS: Yeah. A lot of the funding, traditionally, has been based on what they call medical necessity, and that's something [where] they have to have certain symptomatology, etc., and it's not based upon a strength model, which is more of the recovery. But there's other dynamics [in] that psychiatry wants to show that it's a real medical specialty, and what makes them different from psychologists? And psychologists also want to start saying that they should be able to prescribe. So there's these turf battles. And clients, who have often been denigrated – I mean, there's a mixed thing. Part of the medical model is that you are not bad or weak, you're sick, so you're absolved of that. It also means you're supposed to follow medical authority. For a lot of us – I mean, some clients definitely subscribe [to the medical model]. I think it's fair to say there's a hegemonic belief system around the medical model, and so some people will also say – just like gays used to, even around aversive therapy [to modify gay behavior] – "Yes, it definitely worked." Of course, some of them were afraid not to say that it worked. That's one thing you learn when you're hospitalized – if you want to get out, you tell the doctor how much you realize what he's doing for you is correct.

HP: You tell them what they want to hear.

RS: Yeah. I mean, it's just like any other place. And one thing is that there's no definitive findings. They study the brain – they say [mental illness is] like diabetes. I may have said that; and if you want to refocus me, go ahead.

HP: Oh, no, this is fine.

RS: There's no blood test for any mental illness. They sometimes say they've had [a test], but they can't replicate it, that it's unreliable [he chuckles dryly]. And when they say it's a brain disorder – if they think you have a tumor, they give you a CAT scan. If they think you have a mental illness, unless they're doing studies, they don't do [a scan] because there's nothing [no image] what they call pathognomonic – specific to any disease entity. There's always a lot of overlap [in the test results]. So when they say it's a brain disease, it's like show me the money. It's not up for me to disprove it; it's [up] to them –

HP: To prove it.

RS: To prove it. But that's one of the things – as somebody said, it's ideology masquerading as science. I mean, there's no objective biological markers, per se, that can stand up. They say, "There's greater ventricular enlargement [in the brain]" – but they can't use that.

HP: So I guess my question, then, would be – if it's not biological, what is it?

RS: Well, within the client stuff – and I've had my issues with the organized client movement, because they have their orthodoxy. I mean, there isn't like it's as established as much. [he laughs]. I think the mind – without getting into all this Cartesian mind dualism or whatever. [Rene Descartes (1596-1650) introduced the concept of the rational mind divided from the mechanist body.] I don't know. As I said about my family, I can do Monday morning quarterbacking, saying my mother, if anything was a somewhat stereotypical Jewish mother; [she] was overly caring, not the "Refrigerator Mom'" and I had a lot of learned helplessness. A lot of people have a psychiatric breakdown, or psychiatric issues, when they go away to college. I mean, Helen Hayes – did I quote her?

HP: I think you mentioned her last time, but I'm not sure.

RS: Yeah, I think I did, when she said that – I just happened to see it – "we're all born to a tragedy." She was a great actress. And she said, "I'm not talking about original sin – [but] that we all have to grow up, and some of us don't make it." And we don't have these rites of passage, and some of us just aren't prepared, and you don't have the supports. And some research shows – or suggests – like in Canada, [that] the most important thing is natural social supports. [See for example, Bonnie Pape and Jean-Pierre Galipeault, "Mental Health Promotion for People with Mental Illness," at http://www.phac-aspc.gc.ca/publicat/mh-sm/mhp02-psm02/index-eng.php .]

And that's why they say [the World Health Organization] – although I know there's some controversy around some of the findings – that people actually recover from schizophrenia at a much higher rate [in the developing world – China, Nigeria, and India] than they do here. Have you ever heard about that?

HP: Why is that? What do they say?

RS: Well, there's been some challenge by this guy named Alex Cohen about saying it's not as clear – they don't know for sure, but they tend to believe – because [even though] there's stigma there, too, there's greater social support. It may be that they're not as much into a post-industrial society, [and that] people tend to have a more cohesive, even collectivist, type of thing [social relationships]. And they don't have all of these other supposedly miraculous technologies that we have.

HP: I see. So it's almost framing mental illness as a condition of modernity.

RS: Well, if we live in an area of 10 million people plus, it's very atomized. There's no real cohesion. I mean, if it's more of an agrarian society, people may have a role to do – even if it's minimally. If there is something about saying maybe it's related to a group phenomenon, that people may pull more together. I don't know. And what I'm saying, too – and that has shown up, and I will give you – I'm writing this longer thing about the anti-stigma campaign. And this is the key thing. The Surgeon General has said, in their famous [publication in] 1999 [link above on p. 36], that the greatest barrier to mental health in the arena [of] advancement of mental health is stigma. Then the New Freedom Commission – they're just saying that it could be the elimination of that [stigma] – which makes sense. [President George Bush established the New Freedom Commission on Mental Health, which met from 2002-2003; the Final Report is available at: http://www.mentalhealthcommission.gov/reports/reports.htm]

If you have overt racism – we call it sanism. Even if you achieve certain things – like [African-American baseball player] Jackie Robinson's brother, who also went to UCLA – he, I think, worked as a janitor all his life, because there was a limited opportunity, so it wasn't just what your skills were. And then people internalize a lot of these things. But the prevailing belief system is that the biological model is the best way – saying it's like any other illness, it's not due to weakness of character. Different groups, as I've said, have a vested interest, for various reasons, in that, including some clients. And some of us, as I said, didn't like it, because you're saying I'm inherently defective, and also that, whether I'm doing something volitionally or not, they can dismiss me because it's a product of a sick mind.

So you're delegitimized, so we [the clients] didn't like that. So that predisposes me, even though I don't think there's any overwhelming evidence. But the bottom line is that they say that using that technique will decrease stigma, but the overwhelming literature shows that the illness, like any other illness, actually increases stigma. The Surgeon General acknowledged this, that [stigma] has gone up over the last 50 years since this landmark study around 1950. [Shirley Star, "What the Public Thinks about Mental Health and Mental Illness," published by the National Opinion Research Center in 1952] People believe more in the dangerous stereotype, social distance has increased, and it makes sense to me. I mean, if you have a brain disease – it's not like the pancreas in diabetes – this is the organ that deals with your actions, your thoughts, and if you're not in control of that, then that means you're unpredictable.

People want reliability in their life – normative things. You can act out, supposedly, and you could be dangerous because you're not in control. Everybody knows that we learn very early to suppress a lot of our feelings and what we think, obviously, whether it's sexuality or aggression or whatever. So people that are like that can be a danger anyway, and then there is the actual dangerous stereotype, like what happened at Fort Hood [a mass 2009 shooting in which 13 people were killed at a Texas military base by an Army psychiatrist]. Of course, some people say, "Well, psychiatrists are a little crazy." [they both chuckle]

HP: Yeah, a lot of psychiatrists, that's right.

RS: But a lot of times it's a person who has no psych history, and they say, "You know, he was such a quiet man." People can't believe. People want to think that if they just could identify certain people, these things wouldn't happen. And obviously since there are two million people, or three million, because they say it's one percent that could be diagnosed with schizophrenia – you don't have three million shootings every day, or even one percent. What would that be, about 30,000. Of course, they say there are these quiet tragedies. And I know there is what they call a burden of care and I realize – and I have empathy with my parents about that they didn't deserve [to have to deal with a son with mental illness]. I mean, we got into a vicious cycle – you get committed, you're pissed off about it, there's a sense of betrayal. And if the conditions are not nice, then you are pissed off, they don't want to hear it, and then you get committed again, so sometimes the best thing is about moving away. But anyway, I presented them with a lot of this evidence.

HP: Who are "them"?

RS: The Adult System of Care [Office] at the Department [of Mental Health].

HP: And when was this?

RS: Oh, recently. And I'll get some of that stuff [for you]. I mean, some was just brief, but it was like it didn't matter because they want to go on. I understand in part because they have deadlines, but the evidence was that, yes, for families, you can, quote, "destigmatize" them [using a brain disorder model] because then they don't feel guilt or it helps mediate it a lot. But the larger thing, as far as society – it [the medical model] increases it [stigma]. And even NAMI, that did a study through the Harris poll, [found] that most people believe it's a medical [issue] – that propaganda's got[ten] through, including from pharmaceutical companies that advertise all the time. But the stigma and discrimination in general psych has gone up.

And also, even the genetics. She used to be at UCLA, I think – [sociologist] Jo Phelan – she is now at Columbia [Mailman School of Public Health] [and] she's doing stuff at how the genome is going to affect stigma and discrimination, which would, according to their survey – attribution theory, I think it's called – [show] that it's not your fault. But what it is, it says "your condition is pretty immutable, we've really got to watch you." And it tends to say, "Yes, it's a medical condition of people that are very unstable, so they need to constantly have medications." And they don't talk about just going to psychotherapy or hospitalizing. It is much more restrictive. So it's not as conducive to people being, quote, "empowered."

And that's the reality, and here I'm talking to them, and I often go and quote [picking up a piece of paper] – this isn't something I gave you. I try to do one-page things, sometimes with several quotes from the literature. This is something that I presented, just to say, "Stop," because what they were planning to do – this is supposed to be thinking outside the box. Have you ever heard that from here?

HP: Yeah.

RS: The only box that they think about is more of the pill box and the cash box, which I know they have to have that in order to pay for things. And some of the MHSA – because if they can do things that get matching funds –

HP: The MediCal match.

RS: Yes, but that also takes away from the innovative aspect of it, possibly, because they're still using more of that [standardized] criteria. But that can be contrary [to reducing stigma].

HP: But if we could back-track a little to talk about the MHSA. When it was first being discussed – when it first passed – what were your hopes for it?

RS: Sometimes people say to me, "Ron, things are slow," and I've been involved in this for over 30 years. And both academically and just [being] into reading history, I know that change is slow. And it's more like I said; OK, there's a difference – and there's vested very strong interest financially, especially with corporations. So I didn't feel [about MHSA] like, "whoop de doo," because, see, this is the basic thing. Most social change – and I look at the [client movement like] one of the civil rights movements. What do they say? "Power. When do we want it? Now." They don't say, "I want empowerment now." When it's the black civil rights, gays – they got power, not just by saying, "Look" – and this is one of the anti-stigma strategies – I know that it can be helpful – about where people talk to other people and you show them you're a human being. Of course, a lot of times they'll exceptionalize you, just like if a woman who's not been in a traditional profession – like a fighter pilot or something. If she fails, all women fail. If she even succeeds, then they might exceptionalize. "Well, yeah, there's always one."

But overall, change usually doesn't come, I mean initially, without the protest and the actions of the group that's being marginalized and discriminated against. It wasn't like [civil rights activist] Rosa Parks went over and said – [to] the White Citizens' Council [a segregationist group of the 1950s and 1960s] – she went to some social group and just said, "Look, I'm a nice seamstress," which she was. That's one of the reasons they helped pick her for this. And that would decrease it [discrimination]. No, she had to get arrested [in 1955], and they had to boycott for a year to get lousy seats on a bus.

What we're asking is that people who are vested in [and] taught in the old paradigm – even though there are some good people here. The medical model is a hierarchical model. There's a book out with the California Network of Mental Health Clients – I contributed one chapter – it's called *Reaching Across [Medical Clients Helping One Another]*. The traditional model is somebody's is reaching down to lift you up like they're the expert. So what I use – and it's comparable, in a historical analogy – like the Copernican Revolution, [when Copernicus showed that] the earth goes around the sun, rather than [vice versa]. And it took the Pope [and] the Catholic Church 500 years to pardon Galileo [for accepting] that. [So] the people that are in charge of instituting at the universities the Copernican model, the heliocentric, rather than the geocentric model, are the same ones who have been teaching that [the geocentric] for 40 years of their life. Even if some people want to accept it, they're not going to have the same enthusiasm.

It's not surprising that if you have Einstein, as well as Newton, they came up with their greatest ideas when they were in their 20s – 26, I think, both of them. And even both of them saying – well, it's Newton's quote – that "[If I have seen further, it is by standing] on the shoulders of Giants." You know? I don't know shit about physics, really, but Einstein clung to his belief in the unified field theory and he wasn't that much into quantum physics with the Uncertainty Principle [introduced by Heisenberg in 1927], because he said, "God doesn't play dice with the universe." But he didn't have any great [insights] after what they call the "miracle year," 1905. Maybe he had some others.

But what I'm saying is that you're asking people that have been taught in the traditional model –

HP: The medical model.

RS: Yeah, basically the medical model, and that's their sense of identity. "I'm the helping profession." That's one of the things we had to realize. I mean, there wasn't a formal discussion. I used to think about [this]. We [the clients] used to say, "You didn't help us." Well, if that's their sense of identity, it's not just a paycheck. They're the helping profession; you don't do that. They're going to get their backs up. So if you're going to be successful – Nobody wants to be criticized, let alone clients. I mean, they're no different. I mean, when I try to say, "Look, people who have been clients are constantly criticized – 'You have inadequate this, you have to change.'" And then most people find difficulties doing that [changing]." I may have even said that – I'm sorry if I [did]. Like this great quote – "Can I take constructive criticism? Hell, I can't even take constructive praise." And yet, that's the way clients have been [told]. You have to change. It's very difficult – even positive, upward mobility is –

HP: Change is always difficult.

RS: Yeah. And that's what they used to do. This is an example – they're instituting Housing First – you know that concept?

HP: Yeah, with the FSPs [Full Service Partnerships – one of the kinds of programs funded by the MHSA] and things like that.

RS: Yes. But traditionally, it was "You're at a low level of functioning." We don't like the term "low level of functioning," but you're considered to be, quote, " 'more pathological, less functional' so we'll put you in a more structured [environment]." What people who have been diagnosed said is "Give me a decent place to live," instead of being ghettoized, and – "Now I'm in with all the other losers," you know? [he chuckles] And you're not being treated that well; you're sort of herded. You're expected to comport to rules that nobody else would, that a normal person –

HP: This was, like, in board and care [homes]?

RS: Yeah, just traditionally – or group homes or institutions. Sorry that I just lost my train of thought.

HP: So you were talking about the Housing First.

RS: Yeah, that [when] you get a decent place, you feel more like a human being. The basic thing is a reclamation of your sense of self as a human being. Going from what we called "patienthood" to personhood. If you look at, whether it's Jessie Jackson's "I am somebody," all groups that have been marginalized, seen as less than human – they then have black pride, gay pride – and we have even something of mad pride, which has come out. So there are issues if you're just seen as pathologizing. NAMI is beginning to loosen up in some areas. (Still, however,) like they said, this isn't a civil rights issue, this is a medical issue.

[Picking up a brochure] And this is alluded to [here], [reading], "Prejudice and schizophrenia, review of the 'mental illness is an illness like any other' approach," and they say that [this approach] doesn't really work. [article by J. Read *et al,* in *Acta Psychiatrica Scandinavica* 114 (Nov 2006): 303-318.] I mean, there are a lot of more reviews. And he [the author] is somebody who as a psychologist is critical. It doesn't mean that he doesn't have any [bias of his own]. He does good research, I think.

HP: So, in terms of the MHSA, when it first came out – you weren't too optimistic?

RS: No. I mean, I can't say that I didn't think that maybe certain things would help, because they did adapt – all the things [programs] are supposed to be based on recovery principles. And as the Surgeon General [said] – even though I don't agree with everything in there, but naturally I quote [him]. I tend to quote authority figures, not because – I know it's a fallacy in logic – it's not me. I'm the stigmatized or the radical, and so that's why you saw me that day, passing out these things – which reminds me, if I go on one thing, is that the old expression – it's like the lunatics taking over the asylum? Well, one of the programs that we want that can be funded from the Innovations [funded initiative created by the MHSA] is a crisis residential center, which, in this synopsis that I printed out from *Medical News* – that's exactly what it is. And it was less costly and more client satisfaction, etc.

HP: Client-run residential services.

RS: Yeah. And that is the "lunatics taking over the asylum." We can't do any worse. Like when they say, "Well, those days are relegated to the past," like when I was there, when there was all these death news at Metropolitan State Hospital. But even recent studies within the last few years – they said that being at Metro was deleterious to your health.

And it cost $125,000 a year then – I think I may have said this. That's why I said, "Look, give me $62,500, and I'll abuse them at half the price." [They both laugh.]

HP: So what were some of the recovery principles that they were going to do when it first started?

RS: Well, it doesn't mean that there wasn't some impact. And that's one of the reasons why I said talk to Gerald Minsk. I don't agree with Gerald on certain things

HP: Who is he?

RS: Gerald Minsk is also a client who's been working for years. He worked for years at LAMP. I worked there for four years before he got there. And he's been homeless and he's dually diagnosed [with a mental illness and substance abuse disorder] and he's now working at an FSP. And I think that when you do provide for basic needs of people as people, then they can be helped. It's hard to say how much because one of the things – somebody said, "We'll see a reduc[tion] in complaints," and I said, "Well, actually, if you have a good program, you may see a[n] increase of complaints, because people feel that if they complain, you may respond to them." When you're totally demoralized or you're intimidated, you don't complain. So I said, "If there's a decrease, it might [not] even mean that it's a better program." So these are some of the usual criteria – also around hospitalization, that's one of the common ones. Of course, if they have less hospitalization, they can save a lot of money. What was your question? You have to read your question [again].

HP: Well, in terms of the recovery principles of the MHSA. When it first came out, what were the main ones that seemed promising?

RS: Well, that there would be a partnership.

HP: With the Stakeholder process?

RS: Yes, but especially with the clients. Even though they've said this for a long time, [they want a] client-run, family-focused mental health system. The New Freedom Commission called it client-directed, [and] family-directed. As I've pointed out, on the Executive Management team [at DMH], there's one identified client, which is –

HP: Eduardo [Vega]?

RS: Eduardo. Out of 16 [staff]. I've said this at meetings. In fact, when I got an award for advocacy – and then, of course, I was taken off the [stakeholder process as a delegate] – is that if you say this was an Albanian-driven system and you have 15 Bulgarians and only one Albanian, you wouldn't consider it [Albanian]. [HP chuckles]. Sometimes Dr. Southard [Dr. Marv Southard, director of DMH since 1998] says – he doesn't say it that much – it's his stepson [who] has bipolar [disorder]. One time, he tried to say, "No, there's no family member," but he's Mental Health Director [that is, he is a family member of a client, but that's not his major perspective]. I, for instance, am a Client Advocate. I also am a family member of somebody close, but for me to say I speak for families – I mean, I understand some of it, but that's not my passion. He's got another role. So there's neither just people who are identifying with that group – except for Eduardo. So that says something to me.

It's still the same thing. I'm sympathetic around bureaucracy – you want to get a job done and all of these people with their input are slowing you down sometimes, and it can be a legitimate thing. Like they say a giraffe is a horse planned by a committee [HP laughs], and everybody's got their this and that. And sometimes you feel that you may know what's best. I mean, I know about doing that myself, and you've got to watch that type of thing. So some of that can just be related to efficiency issues. But if this is supposed to transcend the traditional role – [shuffling through papers]

This is a letter I wrote. There was this thing from SAMHSA [Substance Abuse and Mental Health Services Administration], and they quoted what transformation is supposed to be: "Transformation – a complex, revolutionary, and continuous process demands fundamental changes in the organizational structure and systems through which products are developed and services are delivered. In this process, laws often must be modified, norms and values reassessed, and systems of service delivery and finance changed." The finance hasn't basically changed with the MediCal structure. On another aspect, the MHSA has some possibilities. Of course, they look for matching funds, which makes sense.

HP: What are the possibilities that it has?

RS: What?

HP: The MHSA.

RS: Well, I think clients have to make it – what I say, unlike some of the '60s [activists, you don't] hold people up against the wall, you hold them up against their word. That's what I try to do – [I say] "here's this quote, it's from your mainline literature." But there has to be other people to do it. And even talking to you and about getting this out – even though I'm more outspoken – you're worried about what if this gets back [to the DMH leadership]? I mean, it's OK, but some of the stuff is, to be honest – which means implicitly we lie all the time –

HP: They're not being honest most of the time. [They both laugh]

RS: I may like somebody, but I may be critical of them in a certain role that is crucial. Right now, I will tell you, we have to be on the cutting edge. And if you're going to be on the cutting edge the way I put it, you expect to bleed. There's this old saying that he who rocks the boat shouldn't expect smooth sailing. A lot of times, I go, "Why couldn't you do this?" Well, if you want to do this – and you get more, quote, "punished" or "ostracized," not for doing nothing here – some of it's related to civil service, which has its good and bad – but you get more in trouble if you say, "Wait a minute, let's look at this," rather than just having the group think or "Let's go on."

HP: Could you give me some examples with the MHSA process?

RS: Well, especially this issue around the stigma and discrimination thing where they're holding on to something – even if there weren't doubts about mental illness as a biological thing, it doesn't work in public, so you think about doing something else. And even NAMI, in their [Harris Poll] study, says that most people – this was a random sample, it was some computer [analysis] so the methodologies are pretty good, I guess – they accept, after all this propaganda, that it's a medical thing – but it hasn't decreased the stigma, especially around social distance and discrimination, social distance [meaning] would you want to work with this person, etc. One of the ironies is that people are much more afraid of untreated people with [the biological model], because that's been a lot of the stuff they propagate, and it's part of the culture. A man killed somebody and they said he wasn't on medications. I've said at trainings sometimes, "If I killed somebody and they said, 'We knew this was bound to happen because Ron stopped taking his medicines 35 years ago.'" See, it's that tie-in, and it's the master status of being labeled as "mentally ill."

So when it comes to what has been EMT [Executive Management Team], [clients have] limited access to it. You have a letter I think I gave you, where [I said that] clients don't really feel involved. I mean, some of it is social skill, but Dr. Southard also said – I don't demonize people. He's still the same basic – he has a Doctor of Social Work, and he is pretty much wed to the general thing. He once said that I didn't represent clients. That's an old tactic, even if people believe it – that the more radical or the people who are more outspoken – it's a way of de-legitimizing it. That's the irony [of] being labeled "mentally ill" because it helps delegitimize you because who listens to a person [who is] not in their right mind, crazy. Then when we organize, we start trying to represent some of the people [on] our issues, then you don't represent them because you aren't really mentally ill, because you're misdiagnosed, and then when they say, "Well, even you admit," [that] you weren't really mentally ill, and I say, "Well, but that's, according to you, one of the hallmarks of being considered mentally ill – is denying you're mentally ill."

HP: So you can't get out of it.

RS: Yeah, I mean, if they want to delegitimize what you're saying. Even though Dr. Southard wrote something, even though I said something about the Sheriff, that was something that really needed to be said about the LA County Jail being the largest mental hospital, which I really dislike. I said a lot of people have foot problems, because they've been homeless. Are they the largest podiatry clinic? [HP laughs] Why don't they say that? And historically, they say all these people are out due to deinstitutionalization; [but] homelessness, in the periodic review [Readers' Guide to Periodical Literature], wasn't really starting to appear until the '80's, like 20 years after. I mean, a lot of the stuff, if you just look at it, it's almost like it's impossible. I'm sure you've heard it's pretty impossible to commit somebody here with the laws, but there were over 150,000 instances of 5150s [involuntary psychiatric holds in confinement under Section 5150 of the California Welfare and Institutions Code]. I mean, you could say it's 30 million, but it's sure as heck not like you might think, "Oh, there's 2,000."

HP: There's a lot.

RS: Yeah, there's a significant amount. But it's amazing when you look at popular prejudices, and people here – this is another example – they're terrified about [their illness being known] if they're in the closet, which a lot of people are.

HP: You mean people who work for DMH, [who have] mental illness.

RS: Yeah. They are terrified to come out. There's various reasons. I'm more together, I'm a professional. And you have to admit that. And yet they tell everybody there's nothing to be ashamed about in public, and one of the things about Peer Advocates [mental heath clients working at LAC-DMH to provide advocacy and support services for their peers] is – somebody said [at a training], "Who here's a Peer Advocate? Who's a social worker?"

And the people didn't raise their hand[s]. They came up [after] and said, "I didn't want to raise my hand. I didn't want to admit [my illness]." Some people said, "I didn't want to be called that." Why? Because there's so much prejudice in the Department. Dr. Southard has even admitted that. I gave you that article from the *LA Times,* where he said that a lot of people didn't like it, that they thought they [Department staff] were prejudiced [against mental illness]. But it was that they had no power.

But the MHSA, that comes from above – the rank and file still feel that [prejudice]. When you have a massive bureaucracy, people are going to feel not respected that much. There still is the predominant thing that, even if there's supposed to be a meritocracy, people will hire their friends. Sometimes that can make sense in the sense that if you can get along with them and they're qualified, then that makes a better work partner. And it doesn't mean they're all terrible people. But there's tremendous demoralization in general in the Department.

HP: Now, tell me a little bit about the Stakeholder process.

RS: OK, well, the Stakeholder process with Dr. Southard – oh, let me just finish, if I could just say. [reads] "In addition, those involved in carrying out the changes, as well as those who will benefit from it must be reeducated to acquire and apply new knowledge needed for the transformation. Guided by visionary leadership, transformative change can gather momentum until it reaches a, quote, 'tipping point,' where it will spread like an epidemic throughout the many intertwined systems and dramatically alter how organizational systems operate." What I said, before that quote, [was] "Do you really feel that you can say that the Department is truly transforming?" This is where, around employment – let me just deal with employment before we get [to the Stakeholder process].

That's when there's a mandate to increase client and family employment. There's a couple of things about that – one, when they started hiring clients – and they always encourage people to take meds – people who were taking meds, then they had to go through [and show] three years of their pharmaceutical records. They didn't know anything about the Americans with Disabilities [Act of 1990, an anti-discrimination Act mandating that employers do not discriminate in hiring against people with disabilities and make reasonable accommodations allowing such individuals to hold jobs]. The mere fact of being diagnosed or being on medicine doesn't mean that you can't perform the essential functions of the job. And the people – they contract out to these groups, who do the medical evaluations – this was a degradation ceremony for people, in the sense that you had to prove that you were OK.

Like they say, "Oh, you're taking risperdal, an antipsychotic [drug]." Well, here they're telling people to take these meds when they apply for a job, and even these people could say, "Yeah, you should stay on medication." They shouldn't do that – they should say, "I find it helpful." Just like I would say, "It wasn't helpful to me. I know some people that say it's been helpful." There's also some literature that a lot of people benefit and a lot of people don't, and I tell people that I would advise, if you can use alternatives, I don't care whether it's physical – they're very powerful drugs for whatever condition, so if you can use something that doesn't entail the ingestion of a major drug for whatever condition, that's probably better. But it's ultimately up to you because it's your life and your body.

So anyway, redirect me. I'm sorry.

HP: OK, so talking about the Peer Advocate hiring process and how it has transformed …

RS: So here, when they did hire [clients], then there was this knee-jerk reaction from the County, [from] some of these doctors, and people felt so – here they work hard, and some of them who take their drug regimen, which, hopefully, has really helped them – and then they're told that they have to go and have another review. It's like throwing something in their face, and we had to try to reform that. If they went through something – Claudia Center, who's an attorney from this disability group [the Legal Aid Society's Employment Law Center] in San Francisco; it's actually a County thing [that funds the Center]. She's also been diagnosed herself with bipolar, and she has argued before the Supreme Court on other disability issues. She became involved here about people – "Why are you saying [that]? It's a violation of their privacy. You don't need to get certain things from their doctor. You've interviewed them."

HP: "You interviewed them, they're qualified. That should be enough."

RS: Right, and in this instance, under the ADA (Americans with Disabilities Act), you're not supposed to ask people about any previous medical condition, except for this. And I pointed this out. I haven't re-read this thing, which goes into a lot of my concerns. The ADA's different. And I pointed out, and I gave them over 50 job announcements – I did research that – where they said something to the effect [of] "past and present mental health consumer clients are especially" – "you must be," not just "especially," which makes sense, if you think about it, if you're a Peer – and they were saying we can't do that [make medical status a job qualification] because the ADA says you can't ask if you have a condition. And I said to them, "First of all, there's 50 organizations that [do] this, OK?" So there may be some basis, including Protection and Advocacy, which is now called Disability Rights California [a state agency], which is mandated under the federal government to be in every state.

And they're doing that; and what they did is hire people as consultants who [had] worked for the County for 30 years. And some of it's the Old Boys and Old Girls Network, but they're not going to have any – they interpret things in the most constricted way, and that's one of the things that's happened with the Mental Health Services Act. [What happens] is that often, when there's more challenges because there is more funding, it gets more challenged, and the status quo becomes even more tight. And it's not just [that] you have Human Resources at the Department of Mental Health level, you have it at the County, which doesn't know jack about MHSA. It just interprets it. You have all the unions and their scope of practice, and the different things, and if they're going to get, "I went to college," and "You're telling me your life experience is worth the same thing," and there's a lot of dynamics.

And as one example, District Chiefs, which are like the third level [of County administration]. There's, of course, the Director, then there's the Chief Deputy Director, then there's the Deputy Directors, and then there's District Chiefs. And not all of them have geographic [Service] Areas. But that's sort of like they have their fiefdoms. And they were saying that Peer Advocates – it was primarily a supportive employment thing. No, it's therapeutic for the client. Yes, work for anybody can be, quote, "therapeutic" – we need something meaningful to do. [Peer Advocates were] hired like any other employee to help people, and they had a special skill set.

HP: Who was saying that? You were saying that?

RS: No, some of the District Chiefs. I wrote this thing, saying that this is sort of like they're not taking us seriously. You always will be a patient. Just like ACT – Assertive Community Treatment – have you ever heard of that?

HP: Yeah.

RS: It's considered a best practice. Some of the programs can be really good, but ACT was called a "hospital without walls." I think I went into this with you.

HP: Yeah, we talked about it.

RS: But that says you're always a patient. [It is as if] you're always going to be in a hospital.

HP: So is a Peer Advocate job also [like that], because you're defined as a patient?

RS: No, well, you have to be a Peer. If you're talking about experiential knowledge and having that special empathy, as well as knowledge, it entails that – the way I put it, being diagnosed with mental illness is not just a diagnosed clinical condition, it's a social status. If you want to go out with somebody and you say, "Hello, my name's Joe. And I've been diagnosed with paranoid schizophrenia. Would you like to go out for dinner and dancing?" You're probably not going to get a lot of people to say "Yes." And people know that if you try to put any type of psychiatric [facility] that's related to, quote, "mental patients," like even independent living, [in] just an apartment building that they're going to let to people that they think are really cool [he chuckles], the neighborhood goes wild – like "not in our backyard."

Believe me, it's not just a matter of education; it's a matter of status consideration. If you try to place one in Beverly Hills – if somebody donated their mansion, which you could [use] – there would be, "Look, I worked hard to inherit my money," or "I'm a big show business person. I don't want to live next to mental patients." A lot of this is status.

HP: So how does that play into the role of the Peer Advocate? I guess my question would be – what if you could get someone without a mental illness who was sympathetic to the clients' problems?

RS: But that's not a Peer Advocate. One of the big things is hope. The report from the Surgeon General says that the Recovery Movement came from mental health clients. We rejected our social death sentence. There's a paper written by a client who did some research called, "Mental Health Stigma is Social Death." It's [by] Patricia Deegan, who's a psychologist, as well as a client, a voice-hearer. They said, "Give up your dreams. At most, you can hope to be stabilized on a Saturday night." She said, "I didn't think that was the best I wanted to do in my life." [The paper "Stigma is Social Death" was written by Deborah Reidy; Deegan was a contributor to the research.]

And that's what they would say – "You can't handle stress." And the thing about stress – and I'm sorry if I'm being redundant, but people relate to this – stress is not how hard the job is, it's whether you have meaning. That's the same thing with relationships. There's a song – "There isn't an ocean too deep, a valley too [low], a mountain too steep to keep me away." [From "I Will Follow Him," classic 1960s song by Jacques Plant] If you fall out of love, and [the person you loved] asks you to go to the corner drug store, you just go, "Forget it, man. That's too much of a burden." So it's having meaningfulness in your life.

As an example, we have put on Hope and Recovery conferences, prior to the MHSA. We just did our eleventh, and then we have one in Spanish, which is [in its] seventh year, and the fourth year in Asian languages, where we have translation. And they were going to cancel that during the time of the MHSA.

HP: Why?

RS: Well, they said, "We have funding problems." We have an Empowerment and Advocacy Division here, under Eduardo. They were going to fund this big extravaganza around Empowerment and Advocacy, called an Advocacy Conference. I had to fight that. And you're wondering; because now the [DMH] Vision Statement [of DMH] has the word[s] "hope," "recovery," and "wellness," and if they're going to cancel that. And a lot of people, and I don't see it as a panacea, but one of the key things is that people who have been socialized into hopelessness about "You can't do anything really. Forget it," and "If you don't cause problems, you're basically OK, or maybe you can get a low-functioning job." Which are what we call the Four F's that have traditionally been given to other marginalized people, usually people of color or women: food, doing food work, filth, [which means] cleaning up after people, filing, and flowers, which means doing landscaping, like "give 'em a hoe." Those were the type of things that people were allowed [to do as jobs], and when I was at Camarillo the first time – "You want work therapy?" That was putting cotton into bottles.

HP: Well, has it changed recently?

RS: Well, I think they try, but not the abuse. Institutions are sort of like – I use the word death cultures. There are some good people there.

HP: Well, the institutions are one thing, but how about in the clinics, the outpatient clinics?

RS: Well, I'm not there all the time. You can take issues of race or gender, or gay [rights]. There've been changes, but there are still a lot of attitudes, whether it's about equality around marriage, and certain attitudes. Even if a president [Barack Obama] has been elected, you can have, like in Israel, a Golda Meir [Foreign Minister of Israel 1956-66 and Prime Minister 1969-74], [about] which David Ben-Gurion [Prime Minister 1948-53 and 1955-63] once said that she's the only real man in the cabinet [he laughs]. You can have that type of thing, but you still have a lot of sexism.

HP: So I guess getting back to –

RS: I'm just saying the permeating sanism of this – and you can just see from the attitudes, like [that] we're not really as involved as we could be. I mean, even if my mouth goes off – and sometimes I say not the most political thing – I usually use humor, well-documented. [But] I'm kicked out; he doesn't want to hear it.

HP: Why don't they want to hear it?

RS: Well, some of it was because I might have been overly personal. But it wasn't just that. I only do that when I [feel] totally negated. Without going into it, it [wasn't a] "You and your momma" type of thing. It's disruptive, in part, and even though I never blocked any action – you go by a consensus model, and I have concerns, but I never blocked anything, even though I would express [my ideas], and sometimes I would just say, "Hey," and get indignant about things, because we're dealing with basic, established and entrenched power and ideological relationships. It doesn't mean that you have an infusion of money where people can get housing, that some people *will* learn about recovery. When they first were going to do something about recovery, they didn't have one client on the planning committee.

HP: When was that?

RS: That was towards the start, within the first year.

HP: The start of the MHSA?

RS: Yeah. And when you talk about the Stakeholder process, let me just say that at the start, Dr. Southard was quite politically astute. He started a Stakeholder process prior to the MHSA.

HP: Tell me a little bit about the Stakeholder process – what's been good about it, what its faults were.

RS: I haven't been as involved recently.

HP: OK, well, from the beginning, when you were involved.

RS: He started a Stakeholder process prior to that, when there were serious budget cuts, which there always are. You have the structural budget, and then you have the MHSA funds, and you can't use that to [offset each other]. So it starts off, and there's 40 people in the Stakeholder process. [There were only] two clients. It's supposed to be client-centered, family-focused. Two out of 40? Now, I pointed this out in something I wrote – saying that, on certain federally-mandated committees, it's supposed to be minimally 20 percent client and family. I start off thanking him for being willing to have us, like you do, and then you tell him what you really think.

HP: Were you one of the original stakeholders?

RS: I was on there, yes. We got it expanded some. Now I know that he's got a lot of issues he meets. He has to think about this group, and he doesn't want to offend. But two out of 40 – come on. I wrote an article, and they even published it in their [DMH] newsletter, called "Minds and Matters." But I wrote a longer thing to him. So the numbers haven't really been there. There's not the encouragement. When Dr. Southard has said we are going from a system where the major thing was about controlling people, to one of empowering and working with them as a partner, you have to take special efforts to really empower people. There's been a lot of issues around the Client Coalitions, and there's often internecine conflict, which is endemic to any movement. It's not just these mental patients. I mean, the anti-war movement, you name it, and NAMI, too.

HP: Well, the Client Coalitions and the client voice in the Stakeholder process – have these voices been heard?

RS: Well, a lot of times I would say not as strongly, no. Of recent times, I gave you a letter where there was a protest from the Coalition.

HP: Tell me a little bit about what that said.

RS: Well, Catherine Bond could probably tell you more about that. At one time, I was very involved. [In the past], we got like 100 people to go to the meetings. Now we're lucky if we get 40. But like a lot of things, [there was a lot] of initial enthusiasm. The English-speaking Coalition was actually started by the Mental Health Department. But it was down to, literally, seven people, and we really worked on it. What was the exact question?

HP: Tell me a little bit about the clients' involvement in the Stakeholder process. What did they accomplish?

RS: Well, again, there was hardly –

HP: There weren't enough.

RS: There weren't enough. They are constantly – Often, they come up with ideas, and then you don't have much time to go over it. It's very difficult to say "No." I don't like to say, "Hold on." You want to be part of a group. Then, on a lot of issues, there hasn't been as substantive of a voice as far as being intimately involved. You see that at the EMT level – the Executive Management [Team].

HP: Can you give me an example of maybe one issue where clients wanted one thing but that was [ignored or dropped]?

RS: Recently, we tried to get more client-run – Well, even right now, I'm not saying this thing about stigma and discrimination [won't change]. They may come around. But it's one example of adhering to the traditional model. There's other examples – since I haven't been [involved] – I was taken unceremoniously off of it.

HP: Off of the Stakeholder [process].

RS: Yes. I was a Stakeholder delegate. It was agreed that they would not take anybody off who was there. They replaced me with Eduardo. But there was a real effort not to have me on after a while. I got to the point where I took off for three months, not because I was having a breakdown. [It was because] I was getting pissed off, and naturally, some of my behavior was pathologized. That's why we say I'm not mad, I'm angry.

HP: Well, what were your concerns that weren't being heard?

RS: Well, I'm trying to [remember]. It's tough – it's not because they weren't there. A lot of stuff about client-run programs, hiring clients more. As I said, the ADA, they're ruling on that. They said that you can't even put that you have to be Peers on there, that you have a history [to qualify for a client job in a program]. They changed it finally. And they didn't listen, even if I wrote these 50 things. There were things that I have written on stigma, not in journals, [but] in the *LA Times*. That's enough. You don't need journals. Anyway, and [I also] presented at conferences. [I] have done keynotes before the California Endowment, the biggest charity around, and all this stuff. And it doesn't matter as much. Have you talked to Dennis Murata?

HP: Not yet for this project.

RS: Well, he used to kid me and say, “How dare you do research?” And I try to establish where non-traditional models would work, the basic thing about representation. These things about the Full Service Partnerships; they’re supposed to do “whatever it takes.” It’s hard to be against that, even though there’s a difference between a Big Brother in a helping way and being a Big Brother –

HP: – in an Orwellian way.

RS: Yes, in an Orwellian way. And one of the things [that] they found when they instituted some ACT programs, even though some with a more humanistic sensibility can work in a positive way, is that people were being committed more because they were always watched. And that’s why we’d have a case manager. We’d say, “We’re not a case. We don’t want to be managed.” I’m talking not necessarily here, but in general, they’ve found in some studies that people were actually being committed more. They weren’t being hospitalized less, which was part of the intent to save money. So, because I’ve been somewhat outside of the Stakeholders process – Ruth Hollman [the founder of SHARE!, the Self-Help and Recovery Exchange in downtown LA and Culver City] you’re going to talk to, right?

HP: I believe so, yeah.

RS: And there [are] people that are going to be apprehensive about saying certain things. And I will tell you – Eduardo’s an affable guy, but when it comes to sticking up around these issues, it just ain’t there. And even around the stigma and discrimination thing, even if I know that he has certain feelings about it, he ain’t gonna be there. And that undercuts people such as myself. And he helped expedite some [things]. He even said to me once, “I’m not going to be as much of a company man, feeling somewhat bad and also being frustrated by the system.” I mean, the system’s terribly frustrating anyway.

HP: What’s frustrating about it?

RS: Well, it’s a labyrinth type of thing. It’s often, of course, who you know. I mean, I was able to stop them [from] canceling the Hope and Recovery [conferences]. Again, I want to make this [point] – Hope and Recovery. This thing about innovative projects, and we were ahead of our time, and we have to fight [the conferences being discontinued] because they say, well, we should be funded ongoing, but can you use a form of MHSA funding because it’s already been established? Well, you shouldn’t be penalized. Well, we were able to work with that. But they were willing to sacrifice these programs; and they were also multicultural. We have three of them. And they were quite popular. We’d get over a thousand people combined, up to 1,200, we’ve gotten. And it was with Project Return, which Catherine was the head of, and some others, including the Coalition, that protested. And they said, “Oh, we’d better do this.” And [Eduardo] just had his extravaganza at the Sheraton [he chuckles]. I’m sorry if I’m –

HP: Oh, no. I guess one thing I would ask – overall, what have the major accomplishments of the MHSA been, if you had to just name them?

RS: Again, I can’t even say I know all the good things that they may be doing. I think that if you have more services for people, that are helpful around basic human needs like housing and stuff, that’s going to be positive. I think there’s been somewhat of a greater understanding about recovery principles that some people will take in. But again, you’re dealing with a culture that has very overwhelmingly prejudicial attitudes. This thing about hiring people – Often clients who were Peer Advocates were not given peer work to do with clients. They were given paperwork to do, or something like that. And while some feel very welcome, others haven't.

With the MHSA, there's been some positive [effects]. I was on the State anti-discrimination thing, although I had to fight to get on this. They did take some of our concerns seriously because we organized around it. But I'll tell you the one major thing – they didn't want to take on the issue that it's an illness like any other illness. That doesn't necessarily work, because that would violate twenty people's entrenched belief systems, and also the reality that there's often real conflict between parent groups, in particular, [NAMI], and client groups. There's a [closeness] on certain issues.

HP: Yeah, because consumer and family is often lumped together.

RS: Yeah, but the big thing about outpatient commitment [is] AB 1421 [the California involuntary commitment bill passed in 2003]. The California Network [of Mental Health Clients], which is going through a lot of problems now, was totally against it. And then NAMI was pushing it, because "We've got to get these people in before they do anything or they deteriorate." And so they haven't been there. Also, the conceptions of what mental illness is. The official ideology, including in the Network, is not to impose [a particular concept], except being against involuntary treatment, because choice is the biggest issue. And their whole thing about the medical model. which a lot of us [dispute], and "you have a brain disease," in particular, is something. There hasn't been a real opening.

Gwen [Lewis-Reid], for instance – she works [at DMH] as a secretary [level 3]. Once Dr. Southard, when he started this brief column about people [who] really contributed, and I always empowered my [staff]; if they said, "Thank you, Ron," I said, "No, Gwen did it." And he wrote some nice things. Well, they haven't promoted her, but they're letting her do the work of an analyst and still get paid as a secretary. And I tried to say she should challenge it. I don't mean they're going, "Oh, we can really rip [her] off." If somebody wants to do things, they'll let them do it. But there's some real question about that.

So [the MHSA] has helped increase some dialogue. This is not unusual, historically. There's a reform movement – what does that do? That brings out the reaction. And the people still in control are traditional professionals, and they're supposed to be doing this transformative thing, and who are most of the consultants? I'm talking about [consultants] to the Department. They get their old people that worked maybe as Deputy Directors, like in the ADA, where the guy says, "No, you can't put past and present mental health clients [have past clients work with current clients]." You have to [not] be a past or present [client], cause that violates [the discrimination rules]. No, not if it does what is a bona fide occupational qualification.

One of the key roles is that when I, as a patient rights advocate, was in a peer position, I was just the first person and I had a history and I was open about it, and I worked for Metro. First of all, I'd say, "I don't work for the hospital," which I didn't. I worked for Protection and Advocacy. So they would trust me. I'd say, "I know what you're feeling." And [that got an] overwhelming response. "I'm not you, but I have a lot of understanding about what you're going through about being locked up, because I've been there. I was a patient here." And they say, "Oh, yeah, and you're out? And you're doing something?"

And that gave them hope, because without hope, people will not – Why will you defer any gratification? Like if you get your check, you might as well go out and get loaded – sex, drugs, and rock and roll – because in order to –

HP: Right. If you're not building towards anything.

RS: Yeah. So these type of things. I know I sort of go on, rambling [he chuckles] –

HP: No, it's fine.

RS: So I am not the best [person to talk about the MHSA]. Even Gerald [Mintz], who's much more medical model. He likes to use all these words which a lot of us don't like. You know, "decompensate" – how about "he's having a bad day"? [He chuckles] Like that. They were setting up – even though it was supposed to be an open bid, not to be sole source. The County discourages sole source. They want to try to open it up. And sometimes, someone's especially – Well, they were actually writing this for NAMI.

HP: What is it?

RS: There are three parts – Family Education, Client Education, and Community Education around stigma and discrimination. Now, it's true that people will feel better – If you have a group come together, whether it's clients or family members and you're there, you're a person, you see that there's other persons, it's not like you're there as the schizophrenic. You're just a person in this room. Well, families can look and they say, "Well, there are other people here, and they're not monsters who kill their kids," they'll feel better. So in a certain sense, it alleviates some internalized feelings of what they call internalized stigma. When you apply that to either ethnic or religious groups, it's called self-hate. "I want to get a nose job" or "lighten my skin" or "straighten my hair" – that type of thing. And I looked it up, and what they called the Family Support Bureau and Education Program, I think, was [really] a NAMI Family-to-Family.

HP: So funding for NAMI Family-to-Family.

RS: Yes, basically. And then they had this other thing for children under 13, and there's a group that primarily deals with children, which is not NAMI, and sometimes they don't always agree. United Advocates for Children; and I looked up to see [if] maybe this was also a program, and they were just going to give out money.

HP: So these are existing programs.

RS: Right, but it wasn't. It was NAMI that has another program, NAMI Basic for kids under 13. This other course was 12 weeks, the NAMI Family-to-Family. They said, "Oh, we're not trying to do this." The first thing this class would teach was the biology of mental illness. I'm wondering how, even if this was laudatory [and] does alleviate some of the negative feelings – What if, overall, the research shows that these types of medical model explanations leads people to be more fearful?

HP: Yeah, they increase stigma.

RS: Right. So is that what we should do? And the other one was a six-week course, which, lo and behold, is NAMI [too]. And I made some progress at this last meeting. I'm not doing this because I have an intrinsic thing with NAMI. I am talking about evidence-based, looking at the evidence. And it's clear that studies show that discrimination, discriminatory attitudes, prejudice, has gone up. And one of the real reasons is because of these groups, including the Department of Mental Health, [using what] we call the violence card. [If] they don't give us enough money [for such and such a service], something [bad] is going to happen [e.g., violence by a person labeled with a mental illness]. And so people hear that, they more easily remember the fears. Also, if you're untreated, then people are even more afraid, which they've actually helped produce.

But what [the research] shows is that the medical model, people accepting that it's an illness, doesn't lower the discrimination. And then I just said, "Look, this is the course. It's obvious what you're trying to do. And it can be very well intentioned. And it says here, 'Family to Family – open your mind. Mental illnesses are brain disorders.'" And of course this is funded – you know how NAMI has gotten over 20 million dollars from the pharmaceuticals? Recently, Senator [Charles] Grassley [of Iowa], was looking into [this]. [Grassley, Senior Republican on the Finance Committee, has taken an active interest in the pharmaceutical industry's role in sponsoring research and education.]

I don't believe they're just puppets. They have a confluence of interests, but it does influence them. Family to Family is sponsored by an unrestricted educational grant from Bristol Myers Squibb and Otsuka American Pharmaceuticals. So there's issues around that. And so it wasn't just the evidence. And Dr. Southard, from what I've heard from others, is – I try not to; I mean, he's civil and I'm civil. [I hear that] "Oh, he doesn't believe in the brain disease, necessarily, and using that." And "Don't worry, it's not going to be in the RFP." But it was obvious that they were going ahead to give NAMI some [money] for an established [program].

HP: And it's the established view, not a recovery view.

RS: Right, they say, "We're the nation's voice on mental illness."

V. Vision for Change; Closing Comments

HP: Actually, there are a few other things we need to get to.

RS: OK, go ahead. And then I'll just wrap it up at the end.

HP: So just an overall question. Let's say you were the Director of the Department of Mental Health. What would you do?

RS: I don't know [he laughs]. I will tell you first of all, though, I would – even though there may be some reaction – I would make sure that there was a mandate to say, and come out very strongly in saying, "We must stop discriminatory attitudes and prejudicial attitudes in the same way that we would treat racism, and we know that people may have these attitudes." But as Martin Luther King said, "I want to be your brother, not necessarily your brother-in-law." [We will ensure] that you treat us with some respect. That we will be really looking at this. That it's shown that social change is much more effective when it comes from the top." I would also say that "We are really going to take the time and money with some of [these] funds to really try to recruit people." See, there's a lot of people with diagnoses that are in the closet; I'm talking the general public. Even [people] who are mental health folks.

HP: So when you say “recruit people,” do you mean consumers?

RS: Yes. As we said, psychiatric insiders [he laughs]. And to make it clear, just like a politician will say, “We will not tolerate these types of attitudes and prejudices on this job.” And they went back to, apparently, using separate bathrooms [for staff and clients] – and I wrote about this – at Long Beach Mental Health [Center]. [They] just lapsed into it again. It just shows there’s this “separate but equal.” And I would just say, “We will look very closely at this, that you take a strong [position]. It’s a bully pulpit, where you say you’re not going to [discriminate].” That would be the first thing, to try to create a norm that is not tolerant of [discrimination].

HP: So sort of a cultural change.

RS: Yeah, the culture of the Department needs to change. And of course, attitudes toward people that are labeled “mentally ill” is very entrenched in the culture, in general culture, and people here have the same attitudes. One of the things that I saw – [about] which, I have to admit, I didn’t say anything – you see a headline that’s on one of the administrative floors [at] 550 [Vermont Avenue, the DMH headquarters], the second floor, about some mental health client beheading somebody. That’s the thing they put up. Some of the staff put, like, “Uh-oh” about these. They put out anti-stigma campaigns; and this is something else I had to fight. I said the number one purveyor of stigma and discrimination, that people definitely feel, is the mental health system. But they rarely do anything, any anti-stigma [actions] around professionals.

HP: If you could design an anti-stigma campaign for the professionals, what would it look like? What would it entail?

RS: Well, number one, which I somewhat do, is that I try to show that we’re human beings. A lot of times I make analogies with other groups.

HP: Civil rights.

RS: Yeah, and about the stigma of violence. What happens if somebody has any history? You know, “Mental Patient Kills Two.” But if somebody has no history, they don’t say “Normal Person Kills Two,” and it’s very similar to racism, where they always bring up the race of Mexican or Negro. But there are some groups, even though I’m sure this happens, that they never bring up because they’re not associated with negative stereotypes. For instance, like I say, “Have you ever seen a headline that says, ‘Episcopalian Kills Two?’” Why not? Even with mental illness, if the person is not hearing command hallucinations – “I must go and kill” – why is that relevant? And I bring up some examples. And I get good responses, I know. I use some humor.

I know of a manager here [at DMH] that said, “I hired a mental health client. It didn’t work out. I’m never going to hire mental health clients.” I said, “Do you ever have a white guy who didn’t work out, in general?” He said, “Yeah.” I said, “Well, do you have a policy of never hiring a white man?” I just try to show; and I talk about Ralph Ellison’s [classic 1953 novel] *Invisible Man*, where he [wrote that he] wasn’t a human being, he was a Negro. And I try to also give them a [description of] what we call client culture, about what the Sick Role is.

See, a lot of times they have courses [called] “Living with Mental Illness.” That’s just symptoms. “Living with Mental Illness” to me means also the anthropological meaning of illness. Like if you’re diagnosed with mental illness, [and] if you want to go out with somebody – do you tell them? It’s similar to being what [Canadian-American sociologist] Erving Goffman [1922-1982] called “discredited and discreditable.” Like if you have [a certain] identity, then somebody’s going to say, “Well, goodbye.” Sort of like gay folks. Even if you’re not going to date somebody, you go, “Do I tell them now? Because I don’t want to go through that if they’re prejudiced.” Or you say, “No, I’ll just get to know them. They’ll see I’m a good human being. Then I’ll tell them.” But if you get rejected, then it really hurts.

HP: So one thing you would definitely focus on is this idea of making people – providers, administrators – more sensitive, more aware.

RS: Right.

HP: OK, so that’s one thing. How about more programmatic changes in terms of the bread and butter, the services offered? What would you change?

RS: Well, I would try to change – I think generally hiring people, because it’s such a profound status; and really to recruit people at good salaries, and therefore, you’ll get other people that have real abilities. [When] I did the Well-Being Project, the salary wasn’t the greatest [but it was significantly above minimum wage then]. We said, “Past and present mental health clients are especially encouraged to apply.” [We got someone] who was a part-time instructor at UC Berkeley, a biostatistician. And [the salary] was 14 dollars an hour in 1989, and he needed some additional work. If you have something, people may be willing to come out and do it. One of the ironies is when they didn’t put that you needed to be a Peer Advocate, they had people that didn’t know what it meant and were looking for a job and because of the bad economy, if you don’t have an education, there’s almost a two-tier thing; you’re going to be in a low-paid service economy. So people [who were not mental health clients] said, “Oh, plus you get benefits here, so I’ll apply.” So you really needed to cut it down to say what a Peer was.

So I believe in choice. I’d make sure that things were voluntary. Studies show – not just the Wellbeing Project – there was one done by people from the University of North Carolina, Chapel Hill. [It showed that], I think, [for] 34-46% [of persons with mental illness], at five sites, the fear of involuntary treatment kept them from seeking treatment. [Schraiber is possibly referring to to the work of Marvin S. Swartz and colleagues from Duke University, for example RA Van Dorn *et al,* The relationship between mandated community treatment and perceived barriers to care in persons with severe mental illness. *International Journal of Law and Psychiatry* 29 (Nov-Dec 2006): 495-506.]

I would also put a strong emphasis on media things. I know that’s tough.

HP: I know that’s something you’ve been involved in.

RS: I would also be trying to sincerely organize mental health clients.

HP: To what end?

RS: Both as mutual support groups as well as political action. Trying to get people to see people [with mental illness] in more positive roles. But also to, if need be, protest about certain things. I would try to create an environment where people feel [supported]. And I know you have to watch the professionals, because even about sharing bathrooms. I used to say, "How can you be a partner in your treatment if you can't go to the same bathroom?" That's one of the issues. So it doesn't mean that attitude is everything.

Like Howard Zinn [1922-2010], the radical historian, [wrote] – and I didn't read all of it, I was just browsing one time – when he talked about the southern mystique. He said when they ended segregated buses, it's not a matter of trying to educate all the southern whites. And he used the example of an old white woman. You just say, "You have to share the seat. That's the way the law is." [He laughs] And they're going to do it. It's not like, "Here, I want you to understand."

So there would be something like saying "These are mandates. If you don't like it, [because] the system needs a transformation, then you have to leave." Values direct the evidence-based practice, [what is seen as] what's important. Even for them to say, "Well, does involuntary treatment work or not?" They don't even consider that about physical illnesses, except maybe tuberculosis once in a while. It's not a value. We don't force people to get treatment to stop smoking, even if it's known to be killing them. You can make a case. What's wrong with this person? Or if they have diabetes, they've gone blind, they've lost two legs, [they might say,] "Yeah, I know it's going to do this, but I'd rather eat my ice cream." So these are values. They're not medical questions, they're more value questions.

HP: And it's also reframing mental illness not so much as an illness, but rather as a social –

RS: Look, what really bothers me when I thought about it was that people were – It's degrading to get needles stuck into you when you didn't want them, and what the effects were for many of us, which was bad. And even the newer medications – they were called miracles – now they know that they did this CATIE study that wasn't funded by pharmaceuticals [the NIMH Clinical Antipsychotic Trials of Intervention Effectiveness 2001-2007 studied the "second-generation" antipsychotic drugs], and they were found not to necessarily be any better. There's different profiles. But as somebody pointed out, with diabetes, everybody gets insulin of one basic type. There might be different products, but there isn't variations on this.

So I'd have things [be] more client-run. And I don't see it as a panacea. The reality is we're people like anybody else, for all the negative things.

See, the biggest thing that happens when you have a psychiatric breakdown is that you lose your sense of self. You have to reconstruct who you are, because all the stuff you've done hasn't worked. And then you say, "What am I supposed to do?" If you get on SSI, then you can be socialized into being on SSI; then you start to say, I'm in this group that has a pariah status.

Just as an example, one thing I talk about is delusions of grandeur. I say, OK, what are delusions of grandeur? It's where people say they're very important, they are rich, they're famous, they're maybe a religious figure, they slept with Madonna – because people want to be important. They don't want to be average. That's why we don't have delusions of mediocrity. People don't say, "I insist, doctor, I'm a used car salesman." But we all know how normal people will buy cars that are luxury cars or status cars, even if they can barely afford them, so that they seem important. So to cure somebody of their, quote, delusions of grandeur – they are somebody important now – what are they going to be [then]? A devalued, quote, mental patient. Then if you say, "Well, I wouldn't think they were mentally ill if they didn't say that." But as [Irish playwright] Oscar Wilde said, worse than being talked about is not being talked about, so at least they get some attention.

So I'm just saying yes, it's a different conceptualization. I don't know how much there may be a biological predisposition. I think [there's] some evidence that the way people can recover – like [psychiatrist] Courtenay Harding's [study showed] that people recover at a greater degree. [Harding CM, Brooks GW, Ashikaga T, Strauss JS, and Breier A. The Vermont longitudinal study of persons with severe mental illness, II: Long-term outcome of subjects who retrospectively met DSM-III criteria for schizophrenia. *American Journal of Psychiatry* 1987; 144 (6): 727-735.]

The *DSM* [*Diagnostic and Statistical Manual of Mental Disorders*, the standard diagnostic reference in psychiatry] used to say that it was a deteriorating course. Well, that was based on their opinion. Empirical research from around the world shows [that] people tend to get better. So that could also put the question: if they tend to get better, is the stigma and discrimination [misconceived]? It is something about trying to re-conceptualize who you are, and hopefully, you become more resilient, just like you become a little more knowledgeable when you get older. Although, as my dad used to say, some people have 50 years' experience and others have one year of experience 50 times [HP chuckles].

So when you talk about – If you make an analogy with other civil rights groups, it's not just that people say, "Well, those are myths," although [British philosopher] John Stuart Mill said there's nothing more noxious – that's not the exact words, but it's [close] – than to attribute the diversity of human behavior to inherent natural differences. People do it all the time – "You know the way women are," "You know the way men are," "Oh, you know, that group," and all that stuff. I also try to talk about the "us and them" thing, although a lot of times people want the "us and them" because people want to be up there.

HP: Yeah, and it makes it easier. If we could get back to a little more grounded [discussion]. So that's what you would do if you were, say, the Director of the Department. Let's say if you were –

RS: And I would try to get people who were sympathetic. There's whole things that they do about [the idea of] change – including reactions. But I'd try to get people that I know, who are already there in the Department, who could be those positive change agents as much as possible, and to set it up, to set up the foundation before you just move.

HP: Right. So how would you set up the foundation?

RS: Well, as I said, some of it would be that you would try within the Department if you knew that there were sympathetic other individuals that had certain status. If you could even get some of the Board of Supervisors, which I don't know, because a lot of their stuff is protecting against "fearful entities," including mental patients. So you have to know where people's motivations are. I would try, as I said, to educate clients, to really try to reach out to them. But I think there really would be a thing of saying, "We truly want a partnership, that we realize that people, sometimes even in their most – what we might even consider psychotic or denatured [state]" – because a lot of times I think depression is demoralization - “have some input.” And sometimes people even have to go through processes. I would look at other things of social change.

HP: And then I guess that leads to my next question, which is – how would the ideal psychiatrist work with a consumer, or how would you like the ideal case manager to work with a consumer?

RS: First of all, I would ask them, “What do you want to do?” You ask them about what their goals are.

HP: You ask the client.

RS: Yes. You don’t superimpose. You would also try to make sure that you did work in partnership, that you would tell them you were here to facilitate their goals. You can talk about things. I’ll give you an example. There was this one guy who was a case manager – and it can be whether it’s a psychiatrist or not. When it comes to medication, I’d get full informed consent. There were studies, including the Well-Being [Project], that [found] that about half the people said they benefited [from medication]. Of that, about one third of the overall said they benefited a lot, and about a quarter said it was helpful in some ways, harmful in others. About 20 percent said it was not helpful. It does benefit, we’ve seen it benefit. We’ve seen sometimes where people find it’s worse than the disease.

We will try – there’s different things you can try, [such as] cognitive therapy. I would try to give them true choices, which, in the law, you’re supposed to give them choices, which they don’t have as much. And a lot of these don’t have to be as expensive because a lot of [the cost] is in drug money, too. Of course [the expenses are] even more in salaries. And I don’t want people to be like, “Oh, let’s hire a bunch of clients, because we can exploit them for a lot less than we have to pay a psychologist.”

I don’t think there’s any totally real specialized clinical knowledge, in my opinion. When people talk about a clinician, or even, for that matter, a teacher that you may have had, there’s a special connection that inspires you, where you feel like you’re being treated [with respect]. They hit a chord. It’s not reducible. There are certain things that people can learn, but it’s that human quality, which you can’t always teach people, too, because people don’t know what to do after – They can have symptoms, but they have to also deal [with] what are they going to tell people about what they went through.

There’s issues about when you’ve had a breakdown, even if it’s against the law, or you’ve been in the system for, let’s say, five years. I mean, some people may be in there even longer. You want to go back to work and you could do a good job; you haven’t lost certain skills. Let’s say you’re a mechanic. Somebody may say, unless you lie, which sometimes you have to do, because [if] they say, “What were you doing the last five years?” [And you may say,] “Oh, I won the Lotto,” or something. People have a problem about the gaps in their work history, which can keep them from getting jobs, so you have to say, “What are you supposed to do about that?” Maybe there can be certain stimulus [programs]. You don’t want to ghettoize people, but [find places] where they can get meaningful work. Hopefully not just [that] they say, “Oh, I’m a mental health client, so I should become a peer advocate or try to get a higher position that they [DMH] may have.” People have different interests, but a lot of it is coming to have a sense of hope and identity and not getting socialized into being a, quote, “mental patient.”

And you could give people – I know there's a problem with housing. If there would start to be [more] housing [opportunities]. You know Pell grants that you get [federal grants to low-income individuals for education]? Well, they used to give them to people in prison, which makes sense because if they come out –

HP: That's when they really need it.

RS: Yeah. But you know what happened? There was a reaction, like "Oh, God, I'm not a felon. [That's why] I didn't get a Pell grant." And I understand. And there was pressure, so they canceled it [for prisoners]. And I can understand some people who say, "Oh, I might get Section 8 [HUD housing grants for low-income] or something, but I don't have a mental illness." A lot of the problem of homelessness is a lack of homes –

HP: Not mental illness.

RS: No. I'll give you an example. Somebody I know very well who's an attorney. She had her own immigration practice, and they changed the law. She was making $100,000 or so a year, and then she went to this other business that was really dog-eat-dog at some workman's comp place. But anyway, she had a breakdown, including hearing voices, and she couldn't afford a house, and she finally got a Section 8. And she took the first thing she could get. It wasn't the greatest. And then she got a nice one-bedroom. It wasn't her mental illness. Remember that the average one-bedroom apartment is $1,000. You get $850 on SSI. And most people – Believe me, I worked down on Skid Row for four years; I've been homeless. Most people have enough sense to get out of the rain. When Hurricane Katrina [hit], you didn't see a bunch of mental patients walking to the beach, as far as I know, going "Hail Katrina."

Even though they're not as important, just like [with] black folks – [we] really didn't care about drug deaths until it start[ed] hitting [the] white middle class. You would have heard if there was a lot more people really dying from this. People have enough sense to get out of the streets. I'm just saying that we need those types of supports – it's the lack of affordable housing. In fact, historically, it was under, not just [President Ronald] Reagan – I'm talking about the gentrification, destruction of cheap housing, the competition from immigrants and other folks for limited pie.

HP: So it's a lot of problems that are broader than just mental illness.

RS: Yeah, a lot of times, it's much easier. And again, it validates the system [to say] we have homelessness just due to mental illness. If you gave most people a home, they're going to do basically OK. Even if they did have a breakdown – the attorney would say, "It's my mental illness that caused me to be homeless." I said, "Well, if you had had a more supportive mother at that time, you would have had a home." I mean, Howard Hughes was pretty wigged out, to use a clinical term [HP laughs], at the end, but he owned, what, half of Las Vegas. He never was homeless. I'm saying that, yes, [mental illness] can precipitate, but it's not per se a cause of [homelessness], and when they say that it is, it's something that says that we don't have to deal with structural inequities in society, the distribution of wealth and resources.

Did I even answer any of your questions?

HP: We got, basically, your thoughts on what good service delivery would be. Are there any specific clinic services, or programs, that you think are really helpful, or on the converse, not so helpful?

RS: See, I don't want to say things that I really don't know intimately about, because having been involved in programs, even when they're pretty good – the PR's usually a lot better than the reality. So I think that programs like SHARE! [are] doing a really good thing under Ruth Holman, which was her idea. I actually initially said, well, clients just like anyone want their own apartment. But she was able to get [that], if people couldn't sell their homes, and she says, look, we'll have – they're usually people with mental health histories – move into your place and run it themselves, basically, and you'll be able to pay off your mortgage because they will be paying you four or five hundred dollars, you have three or four bedrooms, you have four or five people – some sharing. Then you've got 2500, 3000 dollars. Because a lot of people have bought properties for speculation, and people can get in there rapidly.

HP: So something that gets them housing quickly.

RS: Yeah, and apparently they qualify still, since it's considered transitional housing, for Section 8. This is one of the things that happened. If you're crashing on somebody's house, you're not considered homeless. Certain people, they crash on couches, especially if they're poor. But certain people are just one foot from the [street]. So they just say, unless you're living in a shelter or you're living in your car, you're living out on the street, you're not homeless. So they've been able to maintain that.

I think, in general, some self-help programs are good. I know Project Return does some. They've advanced from being paternalistic. Westside Center for Independent Living. But I haven't been intimately involved, and as I said, I've been involved in programs, and even where you do good things, they're not [he chuckles] wave the flag totally, even if they're known as models. I mean, I worked at LAMP, and LAMP, at one time, was really, under [LAMP founder] Mollie Lowery. And this person, without overly idealizing her, she was somewhat like Mother Theresa, and of course, they say Mother Theresa was never really like Mother Theresa. She [Lowery] comes out of the Catholic worker tradition, progressive, and she had some problems with LAMP, with their old politics. And she also made it a point to say "We are not part of DMH" – even though they got some funding at that time and still do – because a lot of people were afraid to go around [to any agency, because they feared] they could be locked up or they were going to force you to take medications that may not be helpful, and all this stuff. But that's changed.

I know some people say that FSPs [Full-Service Partnerships under MHSA] have been helpful, but I've also heard – and Gerald has said – they still have the same basic attitudes. He's not as critical of the medical model as I am. Some based on experience – I didn't like certain treatments. He is more amenable [to them]. It depends. Some people may still have the same attitude.

HP: OK, so those are some of the good. Are there any programs that you know of that aren't so good?

RS: [pause] I have a general thing about forced treatment because I think it's demoralizing. I think, even where they have what they call the Thank You theory -

HP: What's that?

RS: That's where people at the end – they don't like it at first, but they'll say "thank you." And some people will say, "Well, yeah. That's the hegemonic belief system. Everybody's telling you that was good, the doctor, your family, your this and that." However, it's inherently disempowering to be forced. It's putting you in a special category. That's why, [when] they say "It's like any other illness," [it is inaccurate] because they don't go around committing people all the time [for physical illnesses].

HP: Yeah, they don't commit diabetics.

RS: That's one of the things when they say it, but when you look at it, it is such self-serving in their way. And as I said, families have different reasons why they strongly embrace it. Of course, pharmaceutical [companies] want [to medicalize] social anxiety disorder, which means you can be shy and self-conscious, and you pathologize. It's this whole thing of medicalizing. There's a good book, *From Bad to Mad* by [sociologists Peter] Conrad and [Joseph W.] Schneider.

HP: Oh, *Deviance and Medicalization [.Deviance and Medicalization: From Badness to Madness*, 1980.]

RS: I mean, you had to deal with that in your study. So you already have an idea about [that]. And I think there is a medicalization. My experience – Somebody once said that you can write a lot of autobiographies or memoirs, where somebody says, "I knew I was insecure, I knew I had some problem, but I was functioning OK, and then something really [pushed me over the brink]." If we weren't made of a house of cards – maybe it was cardboard, and then you didn't need a hell of a lot, and then the whole thing went. And then you can get into the system, and it's the whole megillah.

HP: OK, well, is there anything else you'd like to add in terms of your thoughts on the mental health system or the Mental Health Services Act and the way it's unfolded?

RS: I don't know. I think there's a real problem with the medicalization of problems because it's disempowering. You look to an expert for problem-solving. You have the contradiction between the recovery model, somewhat, that is about empowering, and the traditional medical model that is still preeminent. The people that are heads [of programs] still have the same training and degrees. When I say "change can be slow," you have to watch it. I think of Obama and not being gay, but being a typical bleeding-heart liberal type. When people say, "End the 'Don't ask, don't tell' thing [military policy]," and you should do it – which I believe he does believe in. But then he [Obama] says, "I've got enough problems with the economy and the health thing, and if I do this [end "Don't ask, don't tell"], it will help solidify the [opposition] even more against [gay rights / people who are gay serving openly in the military]. So do I do that?" If I'm in that group, I just say, "No, you do this right now."

And again, if you look at how groups have advanced, including around HIV – even though it was an illness, or whatever you want to call it with biological things, for sure – they had ACT UP [the AIDS Coalition to Unleash Power, founded in 1987]. I mean, they went into meetings and disrupted things and even, for that matter, getting [attitudes toward] homosexuality changed. They didn't want to be medicalized. So being medicalized, for them, wasn't good.

I think that it’s very difficult – human relationships. Everybody wants to have a nice relationship, even a monogamous [relationship], find the right person. We have a divorce rate of 50% or more, and even probably people staying [married] before [in previous decades] was because women didn’t have as much options and got messed over, and that was the way it was.

So one of the things I really dislike about the [mental health] system is that people act like they know things that they don’t know. That’s why good clinicians will say, “I’m not sure if this is going to work.” And this is something that does not make me popular, One of the bugaboos and I find it a little bit difficult, sometimes, to say this – I want to value trying to be a truth-seeker, too, because my thing, it’s truth against power. I did have ECT (electroconvulsive therapy), and [it was] with this doctor that I totally trusted who didn’t force it on me when I had a second real break, which I think was caused by the mental health system. The first thing was just screwed up growing up. I mean, I just got worn down constantly. And I was obsessively depressed, and when you’re depressed, you look for reasons to justify why you’re miserable.

So I’d think, oh yeah, in third grade I put some [test] answers on my shirt. I still really feel bad. My poor, little 5 foot 1 mom – I didn’t take out the garbage and she had to do it. And you magnify [things], and you can make it symbolically like being really very inconsiderate to your little mom, and you just say, “Oh, good. I have another reason why [I’m depressed].” It’s a way of saying [that] you deserve to be suffering.

But he [my doctor] didn’t force me. And he said it worked on some people and he doesn’t guarantee it. He knew that – Believe it or not, I hardly talked at all, because you figure you’ve got nothing to say, because nothing’s worked. And it did clear my head. I couldn’t remember anything. Most of the people I know, not just from the movement, say, and even the [psychiatric] literature tends to say, that it’s been more helpful, just not overall. [Most people say that] it wasn’t that helpful to them. And I know, of course, from the leading activists against it, who were in the movement. And it’s a bugaboo. But I think it had a lot to do also [with the fact] that I totally trusted him. He respected my opinions, the little bit [I expressed], even though I just said, “I don’t even know any of my opinions.” But I was [also] involved with NAPA – Network Against Psychiatric Assault.

And so I’m not adamantly, totally against it. Sometimes I use the facts to family [members], “Oh, I’ve had that.” But I know a lot of people who had it [and it] wasn’t good {for them]. But I can honestly say that that was good for me. Then I started getting committed for my usual thing.

HP: Yeah, we have that story.

RS: So that’s one of the things about choice and being respected and being an integral part. And that’s what the general thing about medicine is, for a lot of people anyway. Sally Zinman, who’s a longtime activist – she was the head of the California Network, the Executive Director, for several years, [and] noted in the anti-psychiatry movement, too. When she had forced treatment, which was unique – It wasn’t in an institution; she came from a wealthy family. They rented a farm house and they put her in the basement.

HP: Yeah, you mentioned her.

RS: And she wasn't drugged. She was humiliated. They just put her in her underwear downstairs and [she] just had a bucket for waste. This was a noted psychiatrist [who was treating her]. And she felt humiliated, and she said, "I'm going to do something about it." That was how profound it was. She has cancer. Basically, cancer treatment, either through radiation or through chemotherapy, is toxic and will either kill the cancer before it kills you [or not]. She voluntarily takes it. And it hurts. It's not the suffering – it's the sense of her humanity, that she was an active participant, not –

HP: Not being forced.

RS: Yeah. And I think it really brought something [home] to me about what a lot of this is about.

HP: OK, well, we're going to wrap up now.

END OF INTERVIEW