**Martha Long talks about the early challenges involved in working at the Village and realizing its mission…**

**…**we had trouble marching in step. I don't know how else to describe it. It was just a herky-jerkiness that you could feel. I could feel it. In fact, about eighteen months after we started the Village, our management team was talking and we all agreed, "there's something that's just not -- we're not in unison." So we decided we would get some of the training tapes that we had done at the very beginning and we'd do this whole big conference -- not a *big* conference, but I mean a big training thing and really work on this, because we had to be more in unity. About three weeks later, I thought, "I better get on that. We haven't done anything about that." And then I thought, "but it's gone, it's gone."…

I'm just telling you -- it was potent, you could feel it. All of a sudden feeling we were together, we were in unison, and I'd like to know what that was and bottle it. So I think the lesson is don't have too high expectations. If you're a contractor from your agencies at the beginning, it's going to take a while. And if you're one of those staff that's killing yourself trying to do something, be a little more forgiving. It's going to take a while before you've kind of got this down, you see what works, you see what doesn't work, and all that stuff.

I wish I could just tell you, "oh well, boom, it was this," but it [wasn't]. I think the other piece of it is that we always knew we were going to try to be a model for change in the system. In fact, when we did our mission statement, and so on, we did a first thing, "this is our mission, to help people recognize their strengths and powers." But the second part of it was to bring about change in the mental health system. I can remember there was some thought that, well, "MHA, that should be MHA's mission, it's not ours." But our staff would have none of it. They said, "yes it is, and we're going to do it." So we said, "okay, it's fine." A lot of people were attracted to that piece of it, that it wouldn't just have the impact on the person you're helping, but possibly a bigger one. Always knowing that was another thing that kept people involved and interested, passionate.

**READ THE FULL TRANSCRIPT BELOW.**

**INTERVIEWEE: MARTHA LONG**

**INTERVIEWER: Howard Padwa**

**DATE: February 2, 2010**

## I. Becoming Involved in the Mental Health Field; Early Experiences with the Recovery Model and Psychosocial Rehabilitation; Thoughts on Medication and Recovery from Mental Illness

HOWARD PADWA: For starters, Martha, tell me a little bit about your background, how you wound up in this field.

MARTHA LONG: Well, I have an unconventional background. Actually, in college I majored in history. I taught school for several years. I happened to be asked to coordinate volunteers in a congressional campaign that was in my district in Virginia, northern Virginia, and that led a friend of mine to come to me and say, "there's this mental health program and they have funding for a volunteer director. Would you like the job? Would you like to interview?"

HP: And this was as an undergrad.

ML: No, I was out of undergraduate school. I was married and had -- I'd been teaching. But I had never given a thought to this really as a career. So anyway, that's sort of how it happened. I thought, "well, the heavens don't open up and jobs drop in your lap all that often." My husband had just been diagnosed with, eventually, a terminal illness. So I was thinking, "well, maybe I should work."

HP: And when was this?

ML: '74, I think. At any rate, my response to this person was, "well, I know nothing about mental health, really." She said, "oh, that's all right. We just want a League of Women Voters type." (laughs) And I never knew if that was a compliment or an insult. I don't know what sort of stereotyping was going on. But they emphasized it was primarily an education-related job. So that fit in.

HP: More like a public awareness kind of thing?

ML: Yes. So, that was how I got in the field. I went to work as the Director of Volunteers for a program that was called the Social Center, which had been started in Fairfax County, Virginia, to help people who had been released from state institutions to have a place to go and to have some kind of a relationship with people.

HP: Had Virginia done deinstitutionalization around that time also?

ML: Well, it was all happening, of course. It was all happening. But I think it was the Mental Health Association [the organization that is currently Mental Health America] in northern Virginia that actually decided that a community program like this was necessary. At that time, we were still seeing people who had been in institutions for twenty, thirty years. Had some who had been sterilized, some who had been lobotomized, grown women running around in bobby socks and with childlike behavior.

And now you really don't see those things -- I mean, I haven't seen it in years. At that time we were still seeing people from sort of that *One Flew Over the Cuckoo's Nest* age.

HP: Right. Like the real old style institution.

ML: The real old style, yes. But somehow they'd been able to at least get out. And there was a problem in northern Virginia in that there were no board and care homes. People that were too ill to attend the program had to be sent down almost to the Tennessee-Virginia border, and that was cheaper and that's where --

HP: That's where a place was. So, what did your program do for these people?

ML: Well, it totally adopted the principles of recovery, which of course have been renamed. But this was part of the psychosocial rehabilitation movement, and quickly I got very involved. It felt very natural to me right away -- it is helping people be aware of the strengths that they do have, and maximizing what their effectiveness can be, and [teaching] how they can respect themselves in their own lives.

[At] Boston University [BU], just around that time, I think a little bit before, Bill Anthony of Boston University [Professor William Anthony, Executive Director of Boston University's Center for Psychiatric Rehabilitation] had taken on the notion of applying rehabilitation techniques to people with serious mental illness. And that, in and of itself, was kind of a revolution. Nobody ever thought that you could do that, but actually it was quite effective. So we got very involved with the Boston University project. We served as a research site for a study that they wanted to do where they picked programs that were the closest in philosophy to the BU philosophy.

HP: The BU philosophy being the psychosocial --

ML: Yes. So that's sort of what happened. It still was a day program, but it was very much focused on helping people get along in the world, to understand community standards, and to learn what adjustments they had to make in their own lives if they were going to be accepted in the community. I mean, all of those things.

HP: So what was a typical day for a client in one of these programs like?

ML: Well, one of my first assignments was to come up with transportation for these people, and Fairfax County is quite large.

HP: It's huge.

ML: Probably comparable -- well, no, I guess it isn't comparable to L.A. County -- but it's quite a large area. And that helped a great deal. We were able to get transportation through a grant so we got vans, and then we got volunteers to do the driving. So we were able that way. And eventually, we got county support to do a lot of work on our part with county-supported transportation. So people would come in. We were organized somewhat like a clubhouse, if you're familiar with that [the clubhouse model is a programmatic approach to psychosocial rehabilitation for individuals with severe mental illness]. So we had the work units, and so on and so forth. Now, this did evolve over time, so this was not the case in every -- I mean, that program was ten years old, at least, when I started to work there.

HP: So they had been doing this since the early-mid sixties then?

ML: Yes, exactly. And all the time, a wonderful director, and my mentor, was Vera Mellen, who's still alive. Vera helped start the International Association of Psychosocial Rehabilitation Services. So through that network we found these other little isolated spots. New York City had probably the original clubhouse with Fountain House, which is now over fifty years old. And there were a number throughout, mostly through the northeast, that were doing this -- Horizon House in Philadelphia, a couple of programs in Pittsburgh. Anyway, so we were not one of the originals in that group, but we were very close to it. And, indeed, Vera became the first female president of the group in probably the eighties, I guess.

HP: And did you work with the other groups?

ML: Yes, we did. We got ideas from each other. I mean, that was the best thing. Jerry Dincin, who was the founder of Thresholds in Chicago, which is now one of the largest agencies like this in the country, said any good idea he ever discovered, he stole.

HP: There you go. You know that's a good idea, if someone steals it.

ML: That's exactly right. That's what I'm saying, the evolution of us being more of a clubhouse happened through the years. Anyway, that organization still exists. But I worked there for seventeen, eighteen years.

HP: Just a couple of questions.

ML: Oh, yeah, sure.

HP: I guess first of all, you said you were among the first to adopt a psychosocial model.

ML: Yes.

HP: What was the alternative model that was the norm then, and how did it differ in terms of…

ML: I have a paper, literally, that I wrote once to do a presentation, in which I described [the difference]. [Other programs were] highly clinical, [with] very little thought given to anything other than actual therapy. I mean talk therapy, it was nothing about activities being therapeutic. That was on the outside and therefore to be looked down on. Such programs were very dubious about taking people from state hospitals. Now, this is interesting because if you know that -- I'm sure you do know -- that history. The Hill-Burton Act had set up community mental health centers in order to provide services for people in the community. [The Hill-Burton Act of 1946 called for the expansion of hospitals. What Long is referring to here is the 1963 Community Mental Health Centers Act]

HP: And that was from Kennedy's days, right?

ML: Yes. I think that was '63, if I remember correctly. But the thing is, they did not have the technology, if you want to call it that. They didn't have the model that was really going to work. Insight-oriented therapy is often not all that useful for people with a serious mental illness. I mean, going deeper into their feelings often is not useful. It's just pretty scary in there, and you can absolutely do all kinds of things without having your mind dealt with. Anyway, so that was it.

I can remember that at the mental health center, when our clients had appointments at local clinics, we would send staff people over with them, because they were afraid to sit by themselves. The therapists were far too busy, of course. They didn't have any sort of program for people waiting. So we would send staff over and be with them. But the aftercare patients were very much discriminated against. They had a different door, in one case that I know of, to come in, so they didn't scare the other patients, because that was a concern. It just was very restrictive, and from our perspective at least, not very helpful. Now, from the clinic's point of view, they did send a number of clients to us, but they would not give us case management responsibility, I think because they thought we were not professional enough.

HP: Were there trained clinicians in the place where you were?

ML: Yes, but not solely. I mean, we had several. I'm trying to think if we even hired consumers at that point-- probably not. But we had a lot of people that may have majored in geology but their interest really turned out to be this [mental health care]. Everyone had at least a B.A., but it was not a professionalized organization. And because of that, our program was very much looked down upon by the clinics.

A couple of years ago I was invited to go back and present, because they wanted to understand the recovery model. And it was just astounding to me that they were willing to listen because all those years and years and years we begged and pled to do things like ACT [Assertive Community Treatment] teams. Well, they've just recently formed ACT teams now, and they're enthralled. And there we were in the seventies and eighties writing proposal after proposal trying to get it done. Actually, one of the reasons I came to California was because I saw the proposal for AB 3777 [California's Wright-Bronzan-McCorquodale Act of 1988, which called for the creation of intensive service programs called Integrated Service Agencies through pilot projects], and [thought] "here's a community that wants this to happen." Because our community [in Virginia] didn't. It would [have] upset things too much.

HP: And when you say that they would look down upon it [the recovery model], can you give me some examples of how it was looked down upon?

ML: Well, one time I remember Vera, my boss, was beginning to get some national recognition. One day, we were at some reception or something and one of the mental health center directors came up to me and said, "You know, the darndest thing. Whenever I travel, people always ask me about Vera Mellen's program. Can you imagine?" (laughs) I would say, "well, yeah, I can imagine."

But yes, there was a very strong turf war -- Fairfax County had three or four community mental health centers. There were just remarks all the time – "if we want someone to do clay pottery, send them to the Social Center," that sort of thing. So there was very little respect for what we did. And we were thought, I think, to be a sort of last stop. Although,

actually, we were able to get large numbers of people back to work. We were keeping records of that very early on, far before that was ever done. I think one of the things that is very satisfying now is, because the recovery model is basically like psychosocial rehab, so that it's getting some respect and people are recognizing its value is very pleasing.

HP: One other question. I'm just curious, because you said your training was as an historian and as a teacher. What did you expect when you started working with mental health consumers? And then what did you learn on the job?

ML: Well, I think I remember walking in the first day and sort of keeping my eyes straight because I didn't know exactly what I was going to see. But I thought it was worthwhile. Actually, my mother had had depression when I was in high school, so I was a little familiar with that. But it took me twenty years to figure out there might be some relationship. (laughs) Because I had never thought of doing this.

For me, teaching school or working in this field really has to do with getting to know the individual, and the minute you know the individual, the labels fall away -- at least, I found it was very easy to do that. So I found individual personalities. And of course we know now it's one of the truisms that just because you have a certain diagnosis doesn't mean that your personality, your interests, your abilities are similar to the next person that has that disease as well. So I think that's the secret. A lot of it is just learning to know that individual and what their wants and needs are, and educating them to think it's okay to have wants and needs. Certainly, when we started the Village [the Integrated Service Agency in Long Beach that Long ran], we'd ask people, “what do you want, what do you need?” and they'd say, “huh?” They were just stunned at being asked.

HP: They usually weren't asked that in the hospital.

ML: No.

HP: Were there any clients you worked with early in your career, at that point, that maybe stick out as showing you that this recovery philosophy could work?

ML: Well, sure. As I said, we put a number of people to work. We had a group of four Vietnamese people, so these people had the additional handicap of language problems. We had a little group placement in one of the department stores in that area and they were able, with a supervisor, to work on packaging clothing and steaming it, or this or that. And they worked, and within, I don't know, a year or two, maybe a year and a half, I think, if I remember correctly, three of those four had moved on. They had improved enough that they could do individual jobs without that degree of supervision. One of them didn't fall out. I mean, he stayed there, but he still kept the job.

At that time, so many people were looking at work as stressful, and [believed] that [it] would make you ill again. I remember that particularly just because here's this glowing example, where not only did they not get ill again, but they actually moved on and were able to take on permanent jobs. Not necessarily full-time -- I don't even remember whether they were full time or not -- but they were able to move beyond that. So I think that's probably one area.

I guess I'm betraying my prejudice that work is really healthy and good for people. We think that when someone gets a sort of place in the world and they can see themselves as a contributor, that's really a big deal. That's probably one of the fundamental measures we would have of success. [It] would be how little do you need us anymore, all of which is a good thing. But our first numbers that we collected, that we started with, [was] where they work, and we started long before anybody I know of.

HP: So, what you said about work, it's not just in terms of the money that it's therapeutic.

ML: No. Oh, not at all. Well, I mean, yes, that's a nice thing, but frequently the money is not the important thing. It *is* in self-esteem, it *is* in seeing yourself in a different role in life – "I'm not always a taker. I can help others, I can contribute to the workforce, I can help my boss." All those things.

HP: These are things that severe mental illness can sometimes take away, I guess.

ML: Totally. Totally. If you see yourself as a patient, you don't leave much room – for example, if we draw a chart. It's a pie chart [that says] this percent of you is a parent, or this percent of you is a son or a daughter, this percent is a worker, this percent is a -- you know. And in schizophrenia in particular, the whole circle becomes absorbed with "I'm a patient, I'm helpless, I watch myself, I can't get out of the hospital, or if I do I'm back in very shortly." And helplessness really takes over.

HP: Now, how is it different with medical illness versus other chronic illnesses? Does someone with diabetes or severe asthma suffer the same way, in terms of their identity, the way that someone with mental illness does?

ML: Well, I think the biggest difference is stigma. There's not as much stigma against a person with diabetes. In fact, diabetes is the common disease that everyone compares mental illness to, but heart disease can be chronic. And the whole notion about recovery is [that] you can do a heart transplant. I mean, in a sense, that's not recovery, but you're able with support to function quite normally. That's really the idea of the interventions we make in working with people with mental illness -- what supports do you need, what are the things that you have to conquer, and what can you bring to the plate?

HP: And the medicine can play a role in that, but the medicine isn't the end-all and be-all.

ML: No, -- particularly, I mean, now we're kind of -- I mean, personally, I'm horrified at this CATIE study [the National Institute of Mental Health's Clinical Antipsychotic Trials of Intervention Effectiveness study, which compares antipsychotic medications] because we anecdotally see improvements in people quite frequently with medication.

HP: What's the study?

ML: Oh, it's the CATIE study, it's a very large study that was done -- maybe came out about two years ago, which said that basically the new anti-psychotics are not effective, virtually none of them. And it was a large enough one that it was pretty scary. Mark

Ragins, our medical director [of the Village], did write a response to it, and he's in correspondence with people about it.

Then I read another study just this week that said that maybe half -- there's a new theory about serotonin receptors and maybe you can have too many. And for that group, you'd have to personalize the diagnosis. So they're not writing it off. And many of them [medications] do have painful side effects, and so on. But I have to say this, just from my own experience, I do often see that people are really able to function better when they have medication.

HP: So the meds are often a necessary component.

ML: I wouldn't say often, I would say [they] can be.

HP: Enough that it's worth a shot.

ML: Oh, well, yes, yes, I think it is. But, you know, Mark [Ragins] has a wonderful way of talking to people about this, and what specifically bothers you [talking to people about what is bothering them]. Like the man that wanted to talk to women, and what bothers you. [The man says] "well, I perspire and I get nervous, and so on." So then he [Ragins] goes down [through a list of] the medicines that might help that and says, "these are the benefits and these are the side effects that might happen." The person chooses, not from every medicine available, but from the ones that he [Ragins] thinks will be appropriate.
And then when the client comes back, you don't say, "how are you feeling?" You say, "did you talk to women?" Because [what's important to know is] did the medicine help you achieve your goal. So when the guy says, "no, I'm shaking too hard," well then there's another medicine you can do for that, but you don't want to assume that that's going to happen all the time. So then again they would go through that choice process.

HP: So that is very interesting to ask, "are you feeling better" versus, "have you been able to achieve this goal."

ML: Yes. We had a group of Eli Lilly executives out some years ago, including their chief neuroscientist, and they were just stunned at the notion that you don't ask, "are you feeling better" but really tie it to the goals of the treatment and say, "have you been able to do this?" He just could barely get it through his head. But it was an interesting couple of days that we spent with him, because really, the person isn't the symptoms. The person is the person who happens to have some symptoms. So just for symptom relief, lots of time a small amount of medication gives enough symptom relief that the person, say, isn't groggy and can sort of meet the world. That's why the dosage is really very important.

HP: Interesting, if you think about it. Because [with] recovery [the recovery model], the mantra you often hear is you treat the whole person, not just the symptoms. But from what you're saying it sounds like by targeting a more specific symptom, you can actually do more good in terms of how people progress.

ML: That's been our experience. And we also feel that if people say they want to go off medication, we talk to them about what will be the signs that will help you know that perhaps you should be on them, and they help identify some stuff like that. We have

one member who says, "I just still can hardly believe that I have this. I have to go off it periodically and experience going through the symptoms again in order to just really, really believe [that I have a mental illness]." She said, "It may be magical. I just think someday it's going to go away." I mean, we can help supervise, we can help in any way you want. We can support you through that. But we are not saying you have to take medicine to be in our program, which many people, and many organizations have done.

HP: They've said you have to take medicine.

ML: Mm-hmm.

**II. Moving to California and Starting the Village; How the Village Differed from Other Mental Health Agencies; Early Challenges and Successes at the Village**

HP: Okay. So you were in Virginia.

ML: Mm-hmm.

HP: Tell me how you wound up coming here and working here.

ML: Well, one day I got a call -- let me see. That would have been in '89, I guess. I got a call from Richard Van Horn [then the Executive Director of the Mental Health Association of Los Angeles, now Mental Health America of Los Angeles]. He said, “we have this project and your name has been given to us," and so on and so forth.

HP: Which project? You mean the AB 3777?

ML: Yes. It had just passed. They had just had gotten the grant. And this was early on. This was like in the summer. By this time, my children were kind of up and out. My husband had passed away. But I was extremely happy where I was. (chuckles) By that time I was the assistant director of the organization, so I did take on more responsibility.

HP: And were you born and raised in the area also?

ML: No, no. I was born in Texas, actually. My family moved to Michigan when I was in junior high school, and I went to high school and college there. Anyway, so back to Richard [Van Horn]. My point is that I was very happy in my life, and I really didn't want to move particularly. And I had sold my big house and gotten a condo. Life was good, basically.

But then I was sort of at the point where I'd been sorry for myself for quite a while, and it seemed like maybe I should be thinking about what I can give back. And I also thought that it would be good experience. I hadn't applied for a job, I hadn't had an interview in fifteen, seventeen years, whatever it was, and I thought I really should give myself the experience of doing it. [I thought] “I should take this seriously. I'll go to California, some door will come down in that process, and then I won't feel guilty.” (chuckles) So it was just sort of a fluky thing. But I think it gave me the privilege of not being overly anxious about it, because I was sort of hoping that that door would come down and that I'd have a good reason not to leave [Virginia].

HP: Right. And then it just worked out.

ML: Well, the door never slammed. And, when I saw what they were doing and I realized the design of the Village was going to be so close to what we had been trying to do for all those years. I mean, I rewrote one grant, I bet you, four or five times, trying to get recreation services, which were very, very difficult to get. We finally were able to get like one night a week or something. But everything was hard, and nobody thought this was something that worked. They thought of it as sort of a holding place for people so they'd have someplace to go but there's just no hope really for them.

HP: That they [recreation services] had no therapeutic value.

ML: Oh, yes. And, oh God, we tried to get funding for ACT programs [Assertive Community Treatment, a team treatment model], we just tried all this stuff. So here [at the Village], this was a project that included teams that do case management. We would have the authority, which we could never get in the other system, and we would be able to do all sorts of marvelous stuff. So that was very persuasive to me. And -- I don't know. I agonized. I really did agonize. That was in the fall then, but I did finally agree, and then I came out here in December of '89.

HP: Okay. And the Village started up in '90?

ML: Actually, I came out briefly and then I went back. I moved out here. I landed on the first day of the first year of the new decade, and by then that was -- so, obviously, January of '90, and by about April we got our first clients. I had to hire a staff in between.

HP: What was your position at the Village?

ML: I was the director.

HP: Okay. So you were the director and Dr. Ragins was the medical director?

ML: Well, yes. We just sort of made up a title for him. He was the first psychiatrist that I hired. And it was funny because the RFP [Request For Proposal] said something to the effect that this will be your hardest hire. But he was like the second person I interviewed in the whole project. He had been following the progress of AB 3777 and was planning to ask to go to work [on a program created by the legislation], because he said he had noticed in his work in mental health clinics in the county that when he could assemble a kind of a team of staff and they could work closely together, that the results were really better. So that's what made him think that he would like to work on a team. So he was, as I said, I think the second person I hired in the whole thing. And so we focused on getting one team structured, and then there was a very complex formula for selecting clients. There was also an evaluation that went with the project, that the bill [AB 3777] provided, that Lewin & Company [a healthcare policy research and management consulting firm] was doing.

HP: Measuring outcomes?

ML: Well, it was more than measuring outcomes. They wanted control over -- not control over who we selected, but wanted to know how and why we selected people. They wanted a control group that was similar in diagnosis and in the spread of

diagnoses, like in Long Beach Mental Health [a county-operated outpatient clinic in Los Angeles]. They wanted us to have a representative population to be working with and that we used, not [in] the whole county or the city of Long Beach, but Long Beach Mental Health's spread of different categories.

HP: So you could really compare how you guys were doing versus how they were doing.

ML: That was the idea. So then it ended up -- my image of this was -- do you remember the old TV show, really old, *Hollywood Squares*?

HP: Oh, yeah.

ML: So you know how the stars would sit in these chairs. So if you visualize, we had all these boxes. We had white male, thirty-five to forty. We had Asian -- you know.

HP: Oh, wow. So you really had to fill every demographic slot.

ML: Well, the thing was, these two statisticians from the county -- or I guess it was from the state -- calculated later that that would have required seven thousand interviews or, something like that, to get an exact representation [of the population to participate in the Village program]. And, don't forget, we were not the only program. I mean, Stanislaus [county] had a program too that was like this. So we did -- I'd have to look, but we did hundreds and hundreds of interviews. We did not do thousands of interviews. We had over ninety places of referral, and we were going to all the local mental health clinics, and to the jails, and the hospitals, and asked people to recommend the people that were really challenging for what people could offer. That recruitment process was really something. We would get faxes down from Sacramento, the state folks, who were wonderful, and they'd say, "you got five more people [approved for your program] today out of the twenty that you interviewed."

We also had an important selection process, which included me and a representative from the county and a representative from the State Department of Mental Health. So [Los Angeles] county mental health, the State Department of Mental Health, and me -- we would get these blind forms. There were ten pages maybe that all of our staff would be interviewing people and getting them -- and a code was assigned, so we had no idea who they were. But that was done. I think it was very smart to do, so that there was no question [of whether or not] we creamed off the easiest [only accepted clients who they thought would be easy to work with]. In fact, probably the only reason we ever denied people was that we didn't see enough symptomatology to make us think that we would really be a good match.

HP: And how many clients did you wind up starting with?

ML: One hundred and twenty. I think the total was supposed to be two hundred and forty, and then the same number in a comparison group. When we were interviewing we had no idea whether people would wind up in a comparison group or in the program.

HP: Oh, interesting.

ML: So that was a little challenge, because we [had to tell prospective clients] “we’re going to have this really wonderful program but you may not get in, and we don't know exactly when it’s going to start, but it's going to start soon.” It was very vague, hard for people.

HP: Right. So a hundred and twenty, and how many staff?

ML: We had a rich staff, fairly rich. We hired sequentially -- one of the concerns in the Stanislaus program was that they hired all their staff first, and then they basically sat around and didn't have a lot to do. Richard [Van Horn] didn't want to do that, so I hired enough for the first team, and then we got the team all out recruiting. We hired the majority of them at the very end of March of '90 because we knew that we were going to be receiving the names of our members by that point.

But there were -- oh, gosh, it seems to me there was a very rich staff. I think it was maybe forty people. Because we thought we were going to go up -- that's the piece I left out for you. The one hundred and twenty was half of the two hundred and forty that we were supposed to get, and the governor put a stay [on the number of clients we could enroll], so we never knew if that [number] was going to come back or not. So we kept the staff we had in anticipation of more people coming in.

HP: So you wound up with a three-to-one [client to staff] ratio, right?

ML: Yeah, we did.

HP: That's amazing.

ML: It *was* amazing. And they were not requiring us to bill MediCal either.

HP: Oh, wow. So that's really a great staff.

ML: I'm sure Richard [Van Horn] filled you in a lot on how the bill itself was designed?

HP: Not so much actually. I wanted to ask you about that.

ML: Well, I wasn't here, so I sort of have the legend, but it was primarily pushed through by Task Force members, and they did all the research. They had a staff director in Sacramento, and beyond that they used interns to do all of the investigating. But their idea was, they would get the state-of-the-art programs from around the country, and indeed around the world if they could, and they would send people out to interview. They sent people to Thresholds in Chicago, they sent people to some intensive case management programs in Rhode Island, they went to Fountain House, they went to the PACT model [Program of Assertive Community Treatment, similar to the ACT model] out of Madison [Wisconsin]. So they did all this research, and they created a bill that was really designed to kind of do psychosocial rehab. If you look at it now, it's still pretty recovery-oriented, pretty client-centered, quite unlike the kinds of services that were available then. So that's the sort of history of it.

And it was to be an experiment. Of course, they proposed at the beginning, I think nine different centers like this, and they also did not want them run by counties. They thought

the bureaucracy would be too much of a hindrance. Well, of course, the county people did not like that, so there was apparently some bit of a conflict.

HP: Between the counties and Sacramento?

ML: Between the counties and Sacramento. So what they ended up doing, the compromise was, they had two Village-type programs, two small service providers. And then one county -- Ventura County was chosen as that -- so that they could prove that the county could, by reorganizing itself, run a program like that.

HP: So in Ventura it was the directly-operated [county run] system that adopted this.

ML: It was. And I didn't know until sometime later that there was tension. I was just dumb and happy. I just went in, and I found out belatedly that NAMI [National Alliance on Mental Illness, an organization for family members of individuals with mental illness] people didn't get real pleased with me when I talked about how great what was happening in Ventura was.

HP: Interesting. So NAMI also didn't really want it to be counties [directly run county programs operating the new programs].

ML: They were the ones that didn't want it to be the counties.

HP: Just because they thought the bureaucracy --

ML: They thought the bureaucracy would be overwhelming. I don't think they thought the counties were bad, I think they just thought -- it's very hard to do. I mean, one example is, we wanted to be available on evenings and weekends. Well, you'd start dealing with a county HR department.

HP: And a union.

ML: And a union, in many cases, yes. So that made it very hard for them.

HP: Now, I'm curious. Ventura's program, was it as successful as yours?

ML: Well, no, it was not. They had very significant opposition from the doctors, actually. They didn't want to do it. Didn't want to be on teams, didn't want to do it. So they actually -- and again, Richard [Van Horn] knows this better because I learned all this secondhand -- but eventually, I think when they saw the implacable nature of the opposition, the people that had been at the county level that were enthusiastic about it left. And eventually, one of the doctors, I think, notified Medicaid that there was some problem. So then there was a huge investigation, and it just practically rent the whole county mental health thing in two. So, no, that was not successful.

HP: So it was kind of an example of them being right, that counties can run into problems with these things.

ML: Well, I think it's hard to say. We didn't see here the kind of opposition by the doctors. I mean, we had a number of doctors who were condescending maybe, but

many who were open to seeing this. So we just didn't really encounter that kind of opposition.

HP: And also you were able to hire doctors. You didn't transform them in their current job like with what's happened recently [with transformation of the mental health system].

ML: That's right. That's a very good point. And Mark [Ragins] being appointed. I remember interviewing one woman very early on, and I said, "do you like people with mental illness?" And she looked down and she said, "well, I think my patients like me." Then she said, "of course I wouldn't have lunch with them." So we thanked her and escorted her out. But you do find -- I mean, there's just no way around it. We all have our prejudices, and there was a good deal within mental health, a good deal of prejudice against this population. I generally relate it to us not knowing what to do with and for them. I mean, still that's a challenge.

HP: And when you say "prejudice," what are the stereotypes?

ML: “Oh, I don't want those crazy people.” Well, I can give you -- the famous example is shared bathrooms. And we share bathrooms with the clients.

HP: Was that an issue when you started there?

ML: Not when we started, but over time we realized that almost no one shares bathrooms. They keep the bathrooms locked. It's an issue maybe of dirt. It's an issue of -- I don't even know what to say -- daintiness, or -- I don't know. It's hygiene, I guess. But we have always tried to be as equal as we possibly can be, so we share the same bathrooms. We do have a homeless area, and there are some people that are really -- it may be hard to do. So people that work in the homeless section can go to any bathroom on any floor. We're not saying, “you have to use this one.” But all our bathrooms are available, yeah. And that's shocking. I mean, I can't tell you -- within the field it's attracted way more attention that you would want it to have. It's a very small thing in a lot of ways, but it's --

HP: Well, it's symbolic.

ML: It's incredibly symbolic.

HP: Because of the equal footing, but also -- I've heard of this issue coming up before. And the metaphor that comes up to me is if I'm in Target and I really have to use the restroom, they say, “I'm sorry. We only have restrooms for staff.” So as a staff member, to not be able to say that, just in terms of where the line between employee and client is--

ML: Well, that's possibly one thing. We also do not have a staff lounge. And you'll find that in all these programs that are modeled in this way, we are minimizing the difference between us. I mean, if you were working in Target and you had a special staff lounge -- I don't know, I suppose there's a lunchroom or something. But basically, we don't have special facilities for staff. We don't want to encourage [that]. The original clubhouses had no desks for staff.

HP: Right. So pretty much everything's open except the HIPPA stuff [confidential information].

ML: Mm-hmm, yes, and that's a terrible burden on us.

HP: Oh, I'm sure. It brings up a real contradiction.

ML: Well yes. It's the stigma attached to it that really makes me very unhappy. We originally had our locked file cabinet up in front, and people could come and get their record out and go back to the doctor.

HP: So I could go and pull my own chart.

ML: Absolutely. And then we would help them to often write in their own chart, "what do you think happened today [in your session]," and so on. To me, that's a far less stigmatized environment. But the origins of psychiatric practice are in Vienna, they're in London, they're in places where you see zillions of people on the street. So, for example, one thing that would come up was, "if you see a member on the street, would you say hello to them?" Well, if you're in a small environment, you don't have an option. They know you. So, to me, it is sort of an awful stripping of people, of their personhood, in a way, not to acknowledge them because someone might see and might think they were ill, and so on and so forth. I never encouraged staff [to not acknowledge clients outside of clinical settings]. I never encouraged them to be the first to do the greeting, but always to respond.

HP: Interesting. So, when it started, what did the Village offer, compared to what you would get at, say, Long Beach Mental Health?

ML: Well, I remember, of course, we were very busy trying to get staff, trying to hire people. We were very interested in hiring consumers. We were interested in hiring people who had specialties. One thing we were designed to do was to do money management, which was not being done at the clinics, and which is a pain in the neck to do. It's not fun. But it's a huge problem, particularly for homeless people.

HP: Now by money management, do you mean the SSI [Supplemental Security Income, federal financial support for the disabled] check that comes to some other agency and then you help?

ML: It would come to us. If the client has been designated as one of those people who cannot manage their own money, then we are willing to be the payee, which is, as I say, especially if they're on drugs, not so much fun. One of the psychiatrists at the VA [Department of Veterans Affairs] called me one day and said, "I understand you're doing money management. I think that's the most wonderful thing, it's the best weapon there is against homelessness." And I said, "you're not doing it?" And he said, "oh, no." He said, "all our vets have small arms training." (laughs) So that was sort of the reality. We had a lot of angry people. We fortunately never had any attacks or anything like that.

So anyway, we were just trying to take the person and provide the props, wherever they were, they needed to be. If that was medication management -- I mean, we had a similar program for meds as we did for money. And in the first years we did a lot of loans, but then that just got to be [so that] we couldn't afford to do it. I mean, our payback rate was

not that good. But we were just trying to give people as much as we could to prop up the areas where they might have trouble, and work.

For homeless people, the money management is particularly important because it helps them stay housed. So if we've got them housed, and they go out and put their whole check out for crack, well then pretty soon they're going to be homeless again. Now, you have to be, of course, very careful. We had a relatively small number of people that we ever designated ourselves to be [like] that. We vastly prefer for people to be their own payees, but for people that have been on the street for a long time it's hard. It is a very potent weapon against homelessness, and you can keep people housed.

HP: And it's interesting, because it's something that's sort of taking away some of the independence that people can't handle.

ML: That was, of course, our concern. But the lack of it was causing havoc in a lot of ways. So we developed stages where the first time the PSC, the Personal Service Coordinator, goes with the individual to the store.

HP: That would be like a case manager?

ML: Yes. That's what we call them, because people don't like to be called cases. So PSC is the Personal Service Coordinator -- I was once described as a Personal Servant Coordinator to somebody. (chuckles)

So we go with them the first time, and they've all made out a budget and you say, “so how many fruits and vegetables, and how many this and how many that.” But we're there primarily to see they didn't buy all beer, and that they didn't -- sometimes we would ask for the tapes of the second stage [receipts from the second time they went shopping]. The people can pick up tapes and show them. Anyway, the first stage is, you know, you've told us that you don't want us to trust you about this, so we're going to help you from --

HP: So the client would generally say --

ML: Yes. And usually you'd have to go through several crises for the client to say, “I think I better do money management”.

HP: So it was never anything where a client didn't want to be on money management.

ML: Every once in awhile, if we thought there was a threat to life, we would. Only the psychiatrists could do it, and we were very reluctant to do it. But it's not that we didn't do it every once in awhile. I don't even know -- I would think the number would be under ten or fifteen.

HP: Okay. So you'd start with going to the supermarket with them.

ML: Mm-hmm. And after they would work out the budgeting. And of course, we were learning at the same time they're learning. I mean, what's the average amount for somebody with six hundred dollars a month so spend? We had one nurse who was just beside herself because the person was wanting to buy the more expensive meats, and she was bound and determined they were going to buy the cheap meats. And I said,

"you can't legislate that. You have got to be tolerant enough to let her buy what she wants and then see how long the money lasts."

HP: Yeah. Because I guess that's the question. It's one thing to say [someone can't buy] beer, but let's say someone wants to buy filet mignon instead of hamburger meat.

ML: That's exactly right.

HP: And then what would happen if they have no food or money with two weeks until their next check?

ML: But it's an example of the caretaking that we all sort of have to learn. Because then you get very anxious, [thinking that] "oh, they're not doing what I know they should do." Of course, sometimes you're right and sometimes you're very wrong about what they should do.

HP: Well, let's say if you're right in that scenario [about a client running out of money], what would happen to that client then?

ML: Well, then they would run out of money, probably. If they didn't run out of money, no problem.

HP: And if they did run out of money, would there be more?

ML: And if they did run out of money, usually we had emergency loans, but the team was pretty skeptical. I mean, they would certainly not be easy on that. Sometimes we had little vouchers that we could do in some of the restaurants around, and we had a way they could get a meal ticket. Then we also keep lists of all food banks. So there's lots of things you can do to get food, even if you're out of money. So we strive for independence in that regard. Well, anyway, so now what are we talking about?

HP: So you start by going to the supermarket with them.

ML: Well, that's just in the money management phase. But you do start that way, and let me tell you, there are a number of our masters-trained staff that were not thrilled about spending their time, as one of them said, "among the fruits and vegetables." But after a while you realize that's a way to build up a relationship. You have a mutual task. And the relationship is everything, it really is, so all of your clients -- definitely in a one-to-ten staff-client ratio, by design --

HP: Oh, it wasn't the three-to-one?

ML: We had three-to-one in terms of total staff, but our caseload -- because we had all these other things. We had the deli, the café, all the different worksite supervisors, the clerical supervisors, the bank manager. We had all --

HP: I see, so in terms of people who were --

ML: Who were doing the direct service, that was one-to-ten, which is still incredibly generous.

HP: So it's better than FSP [Full Service Partnership, an intensive field-based service model put in place under the Mental Health Services Act, passed by California voters in 2004] even now.

ML: Yes, I know. Well, we're, of course, above that now, too.

HP: Oh, okay. So the money management is one thing, but thinking about what did the Village offer that you wouldn't get elsewhere?

ML: Okay. So the non-traditional things were things like the very practical things. It would get you a place to live. It was after the Village was started, and I don't think influenced necessarily by that, but just what they knew was good practice, that the [Los Angeles] County Department of Mental Health acknowledged that they should support the housing of everybody, mentally ill people. They had said everyone should be housed, and that was huge. I can't tell you all the people that said, "well, we have a Housing Department, why don't we use them?" So you'd say, "well, do you know anybody that's been housed by the Housing Department?" They would say no, they didn't.

HP: So coming up with special housing just for [the mentally ill]--

ML: No. We did a lot of scattered site housing. We would help people find apartments. We would ask them what they wanted. We would tour a couple [of apartments], two or three, so they'd have some options. I mean, the more freedom they felt, the more choice they could exercise, the more their personhood expands.

We did use board and care homes. I don't know what the figures are now, but we try not to have more than ten or fifteen percent of our members in board and care homes. Most people really can do well. Now, a lot of them do not do well with roommates, and it was the practical thing, it was very hard to do. But at the time, Long Beach was in a sort of depression for about ten years when the aerospace industry basically left, and housing was quite cheap. So we were able to get people [into housing]. And then the idea is that the team analyzes the degree of support that they need and they provide that. So the member doesn't have to keep moving around. You titrate the support to the individual.

HP: So in terms of helping them get furniture once they're in a place, stuff like that.

ML: All that sort of stuff, yeah. A lot of it would need ID [identification]. A huge thing for homeless people in particular.

HP: Well, you need that for anything.

ML: Absolutely. So we got to be very good at getting birth certificates. You can go on the computer and get birth certificates, and many who have been in long-term hospitalizations -- the jail, the long-term hospitalization, and the homeless, the street -- were really our three points of referral. So even people in jail have lost their papers, or they don't have an identity really. So getting that going, getting all the benefits, doing that benefits establishment. Medicaid is hard to get. At that time it was taking six months. I think it's actually close to that again now. But helping the people decipher the welfare [system], the two hundred dollars a month that the people --

HP: GR (General Relief]?

ML: GR, that's an ordeal. You have to go sit there for a day or two. That's really painful for staff to do, but it's the glue between the holes in the safety net. I mean, it's those things, and so you've got to do them. But I think some of the mundane tasks that our staff does are upsetting to people that have worked very hard to get advanced degrees.

HP: "I didn't get my master's to go wait in an office." Now, what would a case manager at a county clinic do back then? I mean, they didn't do those things then?

ML: They didn't have case managers.

HP: They didn't?

ML: As far as I know they didn't.

HP: There were just therapists and psychiatrists?

ML: There were therapists. And I know Long Beach Mental Health was ahead of things and had some social groups, and maybe the other clinics did too, I don't know. But as far as I know, there was nothing like that individual attention. Now, there were some organizations in L.A. that were also doing this kind of stuff. Portals in West L.A. [a community-based provider in Los Angeles] Then there were some that started up that -- well, Step Up on Second [another community-based provider]. Some of those had been following this philosophy. But it's been very difficult for them to get doctors to supplement all of the practical things that they do.

HP: The goal needs to be to kind of mix the two.

ML: Absolutely.

HP: You mentioned you had a lot of consumers working there [at the Village]. What did consumers do?

ML: The same thing everybody else did. But this is the thing -- these are some of the learnings -- we at first had peer trainers, or I forget what we called them -- peer advocates I guess we called them. And we sent them downtown to Project BACUP [Benefits Assistance Clients Urban Projects, a client-run organization in Los Angeles] to be trained in how to do benefits, and this and that. But, after about a year or two, we looked at that and we saw, "who's going down to GR and waiting all day long with people? It's consumers. Who's going to the Social Security office and standing in line?" So we unconsciously were stigmatizing --

HP: Saying "this is for the consumers to do, not for the officially trained staff."

ML: This was giving the worst jobs to [the consumers] -- so that's when we said, "okay, we've got to stop this." We made a determination that we would look for comparability in our hiring, and that if somebody was a consumer that would give them an advantage if the qualifications were the same. So we actually are great believers in not -- I know this sounds terrible -- but in not having consumer identified [positions]

where their main job was to be a consumer. The main job has to be something else. And we have been able to find an amazing number of people.

Also, we have hired family members, too. And some people I know work for us and probably have something in their past, and we don't require that they disclose. But that is the source, I think, of a number of people's interest [in working with the mentally ill] is to have someone in your family or some experience, something like that.

So the consumers, it would depend -- they would have a job description, and whatever job. So we hired them for PSCs, we hired them for working in the kitchen. We had a consumer manager of the deli for a long time. I mean, just whatever roles we have, we have consumers who have done wonderful jobs.

HP: Now, can you give me an example, from those early days at the Village, of a shining success story?

ML: Sure. Well, I can think of one guy that came to the Village, and he was -- now, he passed the interviews, and so on, so he had psychiatric symptoms, but he was such an addict, a drug addict, that he literally could not speak coherently. He would put words together that didn't go. If you listened very carefully, you could pick out kind of what he was trying to say. So the first chore with him was just simply to find out whether it was brain damage, whether it was organic, or whether it was psychiatric, or what. We concluded it was primarily the drugs, and who knew, if we ever got him free of the drugs what would happen.

He would get unhappy about various pieces. One of the things is, we've always encouraged people to come in with their complaints, and they've not hesitated to do that. He would always be complaining, but you couldn't understand what he was saying. It was very hard to be respectful and try to figure out what the hell he was saying. So eventually, he did get better. He and Mark [Ragins] worked significantly around the medications. He did reduce his drug usage, but he did not stop it entirely. Harm reduction [a drug treatment philosophy that focuses on reducing the damage that drugs cause] is another very big thing that we talk about. This was for, I don't know, five years maybe. I mean, he was around for a while.

But what happened was, he had to skip town because angry drug dealers were chasing him wanting payment. So he came in and said, "I'm leaving. I don't know whether I'll be back or not," and off he went. For years we never saw him. And then one day he walked in. He had gone to Kentucky, where his mother worked. He had stopped using. He said, "man, this is too scary. I'm not going to do this." He had a job, he had gotten married, he had a family. It was just “are you kidding?” I think part of that reality was his symptoms were not as much, his illness was not as much.

HP: What had his diagnosis been?

ML: I don't remember what his diagnosis was. We could probably go dig it up. That's not entirely an accident. One of the things we try to do is not use the diagnosis to frame our expectations from people, in many respects. Now, the docs have to have them, but basically, we don't put a huge store in that.

HP: So the philosophy and approach with someone with depression is the same as someone with schizophrenia.

ML: Yes. You'd be asking the same questions. "What bothers you? What's going on in your life?" Lots of times with people with schizophrenia I'll say, "If you weren't hearing voices today what do you think you'd be doing in your life?" And that way I can find out. They might have been a beauty operator or a biologist, or whatever. And that gets to what I talked about earlier, that personhood that then gives you some meaty stuff to work. Mark [Ragins] used to do this. It was almost like a parlor trick. He'd be at conferences, and they would get the most immobile faces on people, and he could always get them talking by doing those kinds of things. "What did you like to do when you were a kid?" And really get at who they were as opposed to what was wrong with them.

HP: So the same motivational techniques you would use for someone without a mental illness.

ML: Yeah. I think it might be a little more straightforward in regular medicine. You know, much is made of mental patients and compliance with medication, but heart patients are far less compliant. It's just one of those things nobody knows. I mean, there are a number of different groups that are way less compliant.

HP: People in general don't like to take their medicine.

ML: Right. Exactly right.

**III. Finances and Cost-Effectiveness of the Village; The Village Becoming a National Model; Expansion of the Village; AB 34 and AB 2034**

HP: Now, in terms of the Village, it was obviously considered a success. Was this in terms of outcomes, or in terms of --

ML: To me, it's almost mysterious how it happened. This sounds really strange, but this is a show business town, and I think early on, people wanted to do articles, or they wanted to do little films, or they wanted to do training films for nurses. And then Dan Weisburd [a film-maker and advocate for the mentally ill], who was on the original commission [that wrote AB 3777], and one of the designers of the project, was doing films around homeless people, around this, around that. I think somehow, at least within the mental health community, that really made us known. We are still, as I said, basically invisible. Many people in Long Beach have never heard of the Village. Although, now I think --

HP: The White House Report [the President's 2003 New Freedom Commission on Mental Illness, which recognized the Village as a model program] has --

ML: Oh, yeah. That's the thing. I mean, that's what's weird. That's one piece of it, I think. And the outcomes were that people were doing well. One of the things with the county was we never got that extra hundred and twenty people that we were supposed to get. So in about '92, '93, Areta Crowell was the director of the [Los Angeles County] Department of Mental Health, and she said, "could you take some of high using people?" This is kind of complicated, because we had been reducing the number of our clients

every year, which we were able to do by people leaving the town, the city, or something. The same amount of money was allocated, but the costs were going up, so they would just reduce every year. They'd tell us, "you have to be down two slots this year." So we were down to like a hundred and ten. Then we were thinking, "we've got all this paraphernalia here and all this stuff, we should really think about this."

But it was kind of terrifying when you thought – she [Crowell] was talking about basically people who cost the county over a hundred thousand dollars [to serve] a year only. But I think we all thought this would be a way to more fully use what resources we had, and that it would be a good thing to know whether we could really make an impact on that group.

HP: On a broader scale.

ML: Yes. Well, this was a small number of people. It was twelve. We took in twelve that first year, because we just felt like we needed to see what we could do. We had six from state hospitals and six from the extreme use of emergency rooms, and so on.

HP: Over a hundred thousand, right?

ML: Yes. Well, most of them were. We had done some figures, and if I remember correctly -- I haven't even told you about the capitation --

HP: I was going to ask about that.

ML: The county was paying -- the best figure we could come up with was, for anybody that had cost the county ten thousand dollars and up all the way, the average amount that the county was spending was twenty-eight thousand per year. That included the state hospitals, everything. We said we would do that for seventeen [thousand dollars per year], and we based that on our experience.

HP: And that was your capitation from the beginning. It was seventeen?

ML: No, no. That's separate. We could tell them what our rate was, but with what we had in place we thought that was a fair thing, and that was a big savings for the county. So we started in with this group, and the first year they were really expensive, and oh, my God, in the hospital and really acting out. You know, we were thinking "jeez, what have we done?" But you know how you sort of get accustomed to people, so it took a little while to really realize they were blending in.

HP: Blending in?

ML: They were blending in to our other clients. They don't act sicker, they're not costing us as much money as they did last year.

HP: So they started --

ML: So they started to assimilate. That's what made us think then, this is a productive thing to be doing. Think what the County Mental Health could do if they didn't have as many of these enormously expensive clients. And hospitalization rarely helps.

HP: Yeah, but it costs a lot.

ML: But it costs a lot. I forget what -- it was like forty-eight percent of their revenue -- don't quote me on that -- I don't know the exact figure. But a huge percent of their revenue was being spent on those very expensive clients.

HP: Now, when your program started was there a set amount? Like you were allocating --

ML: Fifteen thousand dollars per person per year. Out of that, we had to pay all of the cost of their psychiatric illness [care] and their medication and lab fees and --

HP: What about hospitalization or rent, things like that?

ML: Well, absolutely, we paid hospitalization, but only for the psychiatric illness. We did not pay for pneumonia. That was quite a challenge, and that was before the real psychotropics came in. Clozapine [an antipsychotic drug approved by the Food and Drug Administration in 1989 for the treatment of schizophrenia] was just happening then, and so the figures for the cap rate [capitation rate] were based on the old kinds of meds.

So one of the things we did, the cost of our medication jumped -- almost doubled from one year to the next year before there were many new drugs added. That's when we started counting prescriptions, and it was not our prescribing habits that were changing. It was that the drug companies even then were raising their fees. So that was pretty disillusioning.

One of the things over time, though, that we realized is that we were not going to be able to continue using the philosophy "best drug first," because that [price] was shooting up. But then everything changed and we were pretty well able to do that, under the assumption, of course, that the best drugs were the newer neuroleptics [antipsychotic medications]. And there certainly were fewer side effects, which is I think what we were looking at.

So the whole medication issue was [that] we were scrambling. We had a deal with a local community hospital for the cost of hospitalizations at the beginning, and we negotiated a much lower rate than other hospitals. Actually, it was a great hospital, too. But about two or three years in, Medicaid set a rate and we all had to agree with that. That was one way we had been able to keep our costs down, because we were paying way less for hospitalization, and because we could so personalize it. The doctors were going to see them every day. When they weren't medicated we could have them on trial visits outside [of the agency].

HP: So the advantage of keeping it small, keeping it local.

ML: Keeping it small is a huge thing. I always thought about three hundred and fifty would be probably the best scale. I mean, that's just intuitive. I don't really know.

HP: How many people are there now?

ML: How many people? Well, overall we have -- gosh, I'm just blanking on that. We have about five hundred in the Village, close to five hundred. But they've just, since I

retired, have taken away the second tier to the FSP, so a number of the people that we had were in that second tier. Those are mostly sent over to the Wellness Center [of the Village –- a program designed for clients further along in their recovery]. We have yet to see how they're going to do. I'm a little worried about this. I think, with all that, we probably have five or six hundred maybe.

HP: Okay. And one other thing back on the early days of the Village. Was there this idea of graduation or of flowing out?

ML: No. We argue among ourselves [about this]. We didn't push graduation, hadn't really thought about it. What *we* were battling, and in the old community support program, the federal days of the community support program, one of the fundamental principles was treatment of indefinite duration, because they felt there had so many time limited programs that people would act out in order to stay where they wanted to stay, or that they were being coddled, or whatever else, or abandoned. So that was the big push in the community support thing was the treatment of indefinite duration.

So we started out with that notion, but always thinking that the more people we can get independent and on their own would be good. But we didn't have that culture of “we better act fast because we only have a limited time.” Now, I think that's happened. We had big arguments about it. Of course, a lot of the Village was sitting around a table and pounding on it, advocating for your point of view. We have the idealists, we have the practical people, we have all of that. But we did have the autonomy to basically do what we wanted.

We started out with a team that we called Main Street, which developed a lot of tools for you to analyze how much you'd needed a case manager in the past year, and you can ask yourself these questions, and so on and so forth. Then we did do graduation, and we started in a small kind of way. But the problem with the Main Street was that we assumed we could get people out of the mental health system entirely, and what we found was people had to have psychiatrists who accepted Medicaid. I mean, there was no way they could pay these prices out of their [own pockets]. And, frankly, the quality of the doctors who were available and who accepted Medicaid had not in any way adapted to the style of mental health that we had been serving up.

HP: And this was from the Village?

ML: This was graduation from the Village. This was in the mid-to-late nineties. And so, for example, where you can get to talk to a doctor easily through the Village, and we have a 24/7 call line there. The sisters of one of the clients who did do a major decompensation [withdrew and/or lost control of their behavior] after graduating, called a psychiatrist who we had assured her was good, because we'd investigated all of them, and we only found out in practice [that they weren’t]. The sister was calling because she was very alarmed about her brother. The nurse said, "I will lose my job if I connect you to the doctor."

HP: And dealing with the health insurance companies on top of that--

ML: All of that. Well, the health insurance companies weren't involved because this was Medicaid.

HP: Oh, this was Medicaid.

ML: Because our clients couldn't afford to do that. But even so, they practiced in a private practice model, which we already knew was not effective. But we had a big argument about did we want a psychiatrist at the Wellness Center or not. This was highly contentious, and we finally decided there are a lot of people who don't need case management but who still need medication, and we cannot find the appropriate people in the community to give it to them, so we better have someone. So we had a doc, we had several docs, we now have a nurse practitioner under the scope of one of the doctors, prescribing and renewing meds for people who can pretty well function on their own, but they have to take the medicine to do it. This is the sort of thing that makes us a little leery of this CATIE study.

So that was a big decision, but that has worked out well. And the last couple of years, we've even had a therapist there, who does a lot of DBT, the dialectical behavioral therapy for people with personality disorders, because those are people that are highly emotional and tend to get themselves in a state of dysregulation and all that.

I am concerned about the people -- I think they made a very strict definition of their FSP people -- and I'm concerned they're taking out that second group. These were people that we had not analyzed as -- or most of them had not analyzed -- as ready to graduate, or wanting to graduate.

HP: So you talk about FSP, that they've added a second level of FSP that's supposed to be more like Wellness [a Wellness Center]?

ML: Yes.

HP: And this is at the Village?

ML: No, it's system-wide.

HP: Oh, it’s everywhere in the county.

ML: And what I'm hoping is that this is still experimental. They were so strict [in terms of the criteria for FSP]

HP: Elsewhere the idea was that once you were at the point where you didn't need an FSP anymore, you'd graduate to Usual Care or to Wellness or to Field Capable [Field Capable Clinical Services, a less intensive field-based service program created by the Mental Health Services Act], or something like that. But adding that other level--

ML: But it may work. I mean, it may be fine once everybody accepts it and knows. I was also worried -- I once was speaking at a place in Connecticut and they had eight levels of care, and all they did, it seemed like to me as they described it to me, was shift people from one level to the other, back and forth, back and forth, back and forth. And the bottom level did nothing but deliver meds. So it's the categorizing that you have to be very careful about it. And then you look at the size of L.A. and you can certainly understand why it's not titrated real carefully.

The other thing that concerns me is [that] we managed to get our consumers, for the most part, not afraid to graduate, because many of them had never had that degree of independence in their lives, and they are very reluctant to take a chance. And by telling people that we would not force them to leave, and that we would also accept them back into the Village if they had a big decompensation, we were able to negate some of that fear, so more people were willing. I don't know how it's working now. Paul [Paul Barry, Executive Director of the Village] might have a better handle on that. But I'm concerned that that's being taken away and that that may make the outcomes less good.

HP: Right. In terms of the way that the MHSA [the Mental Health Services Act] programs have been structured.

ML: Mm-hmm.

HP: Okay. We'll get to that in a little bit. So tell me a little bit about major changes and the expansion of the Village, both in terms of numbers and reputation.

ML: I used to be able to do this like that [snaps fingers]. I haven't had to do it for a while.

HP: Well, I mean, just a few particular things. Thinking about AB 34, [AB] 2034 [pieces of legislation from 1999 and 2000 that expanded the types of programs created by AB 3777], and then also how you came to be in the New Freedom Report [2003 President's New Freedom Commission Report], and things like that.

ML: Well, we started out with a hundred and twenty people, and we, after about two years, were thinking, "well, you know, this seems to be working pretty well. Gulp, do we dare try this? Well, yeah." We thought we would try that. That worked out pretty well. We had been state-funded entirely out of the General Fund, not out of Medicaid, and in about '96 the legislature said, "this organization is operating pretty well and they don't need us anymore, and we're going to pass it down to the county, just like all the other programs. We'll provide the funding stream, but –"

HP: So the county had to disperse the funds.

ML: Yeah. And for us to meet their contracting requirements and all that sort of stuff. So we did that. At that time we had a whole bunch of people that we were scared to death would just fall apart, so Richard [Van Horn] negotiated -- I think it was Richard, and Ann [Ann Stone, Executive Vice President of Mental Health America of of Los Angeles] probably, too -- with the county not to dump anybody, but to take on almost twice as many people as we had. So that's when we developed the tiered capitation, because we knew there were some real low users, but we weren't sure what would happen. John -- oh, gosh, the guy at USC, the researcher.

HP: John Brekke. [Professor of Social Work at the University of Southern California]

HP: Well, John Brekke had done all this work saying that when the supports were pulled away, the people did poorly again. So, based on that, it was frightening to us to think of these lower [levels of support for some clients] -- so we developed two tiered capitation for these people of ten thousand [dollars per year of mental health services] and above -- I think it was seventeen [thousand] at that point. For the below group, it's really

interesting. We actually spent more money on those people than we could justify. So we would say, “we'll do it for six thousand.” The county at that time was doing it, I don't know, for maybe five. But what we found was that people in this lower rank were getting better and they were more willing to -- they wanted jobs, they wanted a lot of the services.

In our original capitation, we actually -- we had, again, a number of arguments about this. Dave Pilon [research director of Mental Health America of Los Angeles] wanted us to make that smaller category. I said, "no. That's the only place we can break even. We break even by dramatically reducing the people with the high cost, and we have to put that in to augment the money we're losing,” which was sort of crazy. But that was the reality of it. And actually, I know of a study in Rochester, upstate New York, -- I think that at first they had four or five cap rates [capitation rates]. Well, the big one was like thirty-five thousand and then it went down in the twenties, and so on. But they found quite quickly that they could reduce those high costs so much. And it was that they needed to squash it down this way and make the lower categories higher [spend less on the very expensive clients and spend more on the ones who weren’t receiving as many services].

HP: Yeah, because if you think about it, if you take someone who you're spending a hundred thousand on and spend fifteen [thousand] on them, that's eighty-five thousand that can be distributed to double the services for a lot of clients.

ML: And, as Richard [Van Horn] always used to say, and I always tried to say this when I was speaking, “it's a lot of those people that are sitting in board and care homes rocking [in their chairs] and smoking and doing absolutely nothing that we want to have some money left over to do something with. Right now they're docile, they're not costing anybody hardly any money, and their lives are –“

HP: Meaningless.

ML: And that was always one big motivator for us is we were trying to save money so that we could enrich lower level --

HP: So really engage people who weren't in crisis but not thriving.

ML: Oh, not thriving – that’s the understatement of the year. They were just quiet.

HP: Okay. So --

ML: So that was the next thing. We had the two-tier capitation. And then, I think it was in '99 when AB 34 came along, and Darrell Steinberg, newly elected to the [California] House of Representatives, stopped by the mental health office -- you've heard this story -- and said, "can I carry any legislation for you? Is there anything you want to have happen?" And they about fell off their chair. Nobody had ever made an offering.

HP: This was the State Department of Mental Health?

ML: No, this was the Association of Mental Health. It was Mental Health Association, it was the directors, it was the --

HP: Oh, the CCCMHA [California Council of Community Mental Heatlh Agencies].

ML: That was, I think, the group. I'm not sure they were organized like that at the time. But it was not the state.

HP: So this was the group headed by Rusty Selix [Executive Director of the CCCMHA]?

ML: Yes. So they said, "well, my God, we could complete the adult system of care. I mean, children have a whole system of care. Adults have it fine up until they -- they don't have anything for youth, they don't have anything for homeless. So these are all populations that we should include." And it had been one of our big frustrations actually, it was that Mental Health Association here had been running a homeless drop-in center for a long time, but we could never get any money from the state, or anybody else, to treat the homeless. And within the Village we couldn't have homeless people.

HP: Why not?

ML: Well, my answer used to be that there's nothing cheaper than nothing. I mean, the homeless, they weren't costing the county any money. But I think it was again looked upon by county officials as something that would not respond to therapy and, therefore, we don't really have the options to do it.

HP: Homelessness wasn't really your business.

ML: It's hard to presume, but I think it was just thought of as street outreach. There were already organizations that did that already. I just don't think they saw it as a huge problem, or that they had the structure to offer services. But AB 34 changed that radically, and we were thrilled to do it. We were asked to be one of the three -- I think they had three organizations -- to test it for a year. And they wanted it to be agencies that had been working with a capitated, or at least a recovery, model.

HP: What did AB 34 stipulate exactly?

ML: Good question. The thing that I remember it stipulated was the idea of completing the adult system of care, of having services for youth, homeless mentally ill, and the jails. I think those were the main populations that they all of a sudden were going to be able to work with. Now, at the Village we had been already doing that in our homeless assistance program, but not with support from the county. Most of our support was city, actually. But we were not afraid. I mean, we were not intimidated. We were not as intimidated as we had been thinking of the twelve people and were we going to be enough to work that. And we'd also been doing integrated services for seven, eight years at this point, so we felt pretty comfortable with that.

HP: And AB 34 called for the ISA [Integrated Service Agency] model to continue?

ML: Yes. Well, that was no accident. I mean, they worked to try to do that. We did have confidence that it was working well. But this is what State DMH did. In the middle of October it looked like all of a sudden this was going to happen, and they said, "oh, gosh, we'd like you to be one of the three." I don't remember how that process

happened. So the money came -- it happened on the first of November, and my God, we had to hire all this staff. We had two new teams worth of members, so that's got to have been -- I think it was a hundred and seventy-six members we had to take in within a short period of time. It was chaos personified.

My great story about that is, we had two of our guys, relatively new staff, that were out interviewing, trying to get people -- we were trying to find people [to enroll in the program] that fit these categories. They were going to a hospital in Orange County, but they weren't there yet and they made a wrong turn. They turned down an alley which was a dead-end, so they went to back up and there was this guy standing against the building, and he directed them out so they could get out. And the staff person rolled down the window and said, "are you homeless by any chance?" And the guy said, "yeah, I just got out of the hospital." Which is what used to happen. So there he was. They said, "get in." So I said, "The next think you know we're going to be accused of Shanghaiing people. You've got to be a little careful about this."

It was very intense to do our regular work, and to hire, and to deal with clients. That was a very chaotic time. Now we have gotten down in numbers because they haven't been referring people recently, so we're going to get a big group all together. Now the Village built what they're calling a welcoming team, and it's going to specifically work on these large numbers, because it was really very taxing and staff was exhausted. We had to temporarily go up to caseloads of twenty people, and that made a big difference. So now -- I don't even know. When I left we were at fourteen, and I'm sure we're at --

HP: This is fourteen --

ML: Fourteen [clients] per PSC. And I'm sure it's probably higher than that. I should ask that question. I should know, even if I'm not the director anymore.

HP: So AB 34, then AB 2034, was that just more of the same?

ML: That was just more of the same, yeah. Well, and that was the other thing they said. [With the AB 34 programs, the state said that] "not only do you have to hire and get the clients, you have to have good outcomes by May for the May revise of the governor's budget because we're going to go through and we want to extend this [program]." I think it ended up being extended to half the state, so half the mental health entities in the state were covered by AB 2034 [as an extension of the AB 34 program]. And they were smart in giving it to the people that had been doing it for awhile, because we did get good outcomes, it did go to the governor and he was able to say "it's really dramatically reduced costs, and blah, blah, blah."

HP: Now, these were the outcomes in terms of people who used to cost the system twenty-five thousand dollars per year?

ML: Yes, and Dave Pilon is really the person to talk to about outcomes because he had some experiences lobbying -- or maybe "advocating," shall we say -- in Sacramento and was told by one guy, "I think mental health is just a big hole down which we dump money and from which we see no results, and until you can prove to me that something is happening, I'm not going to support it." So Dave got really teased with the idea of developing something that would do that. And the state had developed an outcome system for us as part of the original Village, but we did not find it very feasible. It didn't

work very well. So we have redone outcomes. And Dave can show you the figures for the AB 2034 outcomes. They're incredibly dramatic. With an N [sample size] of about five thousand people over, I don't know, three or four years that AB 34 existed, and we were able to dramatically -- I mean in the sixty and seventy percents -- reduce homelessness, reduce incarceration, and [psychotic] episodes as well for individuals.

HP: So great outcomes for the consumers, which translate to great savings for the system.

ML: Yes. It's just heartbreaking that they pulled that, we thought. One year it did save us. [California Governor Arnold] Schwarzenegger, in his budget message, said, "AB 34 has been able to show these remarkable results, and until other organizations get more accountable, we're going to go with that." But then two years ago they pulled the plug.

HP: It's something I guess I don't understand, because if you have a program that saves money, why would you cut it to save money?

ML: He said it's going to go to Prop. 63 [California's 2004 Proposition 63, which passed and created the Mental Health Services Act]. [He said] "you can get your money from Prop. 63 now." Which, in fact, we do. That is what happened. Supposedly, the legislation [Prop. 63] was specifically designed to keep that from happening. You couldn't take money out. But he just sort of thumbed his nose and said, "sue me." Which we did [claiming that the governor violated the section of Prop. 63 that stipulated the funds could not go to compensate for cuts to pre-existing programs].

HP: That's still in court now, right?

ML: Well, no, I think they lost.

HP: Oh, really.

ML: I think so. That's another thing I have to ask. You're dealing with a faulty memory here [joking]. The victory that we had, though -- they upheld it, because he put it [an initiative allowing him to use Prop. 63 funding for purposes other than those laid out in the original legislation] back on the ballot this last year and, in fact, wants to put it on again, and the state voted it down. So at least theoretically we'll get some of our money back some day. But they can still borrow from it, I understand. One way or another they [the state] want their hands on that money. I was so happy to see in yesterday's *L.A. Times*, maybe Sunday's, a whole article about stem cell research. There was three point five billion dollars that year allocated for stem cell research, with virtually no oversight. I keep saying, "they're taking our money. What's going on with the stem cells?" That was an amazing amount of money.

HP: That is huge, when you think about what the state budget is for mental health.

ML: Absolutely. Absolutely. I mean, it's not that we don't want to have stem cell research, but the accountability is very poor, with some Internet millionaire who got the whole thing financed because his son has juvenile diabetes. But it's done with almost no publicity. It's really something.

HP: But with mental health, there's always pressure to make cuts.

ML: Well, at least that's the way it's worked out this time. I hate to make a totally broad statement, but -- yes. But that's how it happened. So we've been at risk of losing our funding several times. The most serious one was a couple of years ago. Then we did lose that funding.

HP: When they cut AB 2034.

ML: And I think at the time of AB 34 in '99, I think at that time Marv Southard [Director of the Los Angeles County Department of Mental Health] and Steve Mayberg [Director of the California Department of Mental Health] made a deal that we [the Village] would be funded through the AB 34 plan. So we have had, I do want to say, some real support, because I think people believe our outcomes. There's some trust that we have earned in the system. I'd like to think that anyway. So we were able to limp along with that. Now, then they pulled some magic stuff and we're funded by Prop. 63, I'm not sure how. The next plot will be -- I don't know what.

**IV. Interpreting the Success of the Village; Adjusting to the Integrated Service Agency Model; Wellness Centers**

HP: So in terms of the outcomes, I'm curious. It could be a combination, but do you think that the good outcomes for the Village were a result of a philosophy, the quality of staff, or perhaps just the [staff to client] ratios that you guys were able to have because of the way the program was set up?

ML: I don't think it's only the ratios. I think all those things are very important. When I speak around the country I always say philosophy counts. I think it's one of the things that's a hallmark of the Village. We've had a very definite philosophical reason for everything we did, and we were lucky enough to have a program that was structured to allow these things to happen. I mean, the legislation [that created the program] is very much like that. So I think we've been fortunate in doing that.

Of course, I think we have fabulous staff, too. I think the Village has been more successful than either the Stanislaus [county program] or -- at least in the early years -- or the Ventura [county program]. And part of that I think has to do perhaps with rural versus urban. It's probably not as hard for us to find idealistic people. Many of our people that we hired were people that were just disillusioned with the regular system and wanted to try something different, and that's been a real appeal. It's part of the reason we have these fist pounding arguments, because everybody's passionate about it. We find our younger staff has never worked anyplace else. We always like to talk to them after they've tried something else. But the people that have been in the system for a long time, many of them are really very passionate about what they're doing. So I think it's a combination of all those things. I wouldn't want to take away any.

HP: Okay. Also, tell me a little bit about how and why the Village has gained the sort of recognition it has nationally.

ML: Well, as I say, it still is pretty mysterious to me. I think one thing is that Richard [Van Horn] has always been a huge supporter of the national Mental Health Association, of which we are a chapter, and of course now it's Mental Health America [MHA]. I think

at the federal level MHA was trying to do some sort of programs of excellence, “Partners in Care” I think they called it. They identified outstanding programs from around the country that were run by MHA’s. So I think that's one reason. We were that. And we did a bunch of training. I haven't talked about training, but we've been since very early on doing lots and lots and lots of training, which was not foreseen in the structure of the bill [that created the Village].

I think that's another way that people will come, and they started coming really quite soon. I mean, the first call I got was the Ventura project, and their director called up and said, "we need to see how you're doing things. We're not sure how to act in a team. We're not sure how to do that." So we did. Then somebody else said “could we come?” By that time I got a speech professor from the university to come over and kind of practice with our staff and see if we could be fairly coherent.

So then we thought, well, maybe this would a resource, maybe this would be something we could actually charge for. We had a number of replication projects through Partners in Care and also through just different consultants. I remember Dr. David Goodrick, who used to be [mental health] commissioner in Wisconsin. By that time he was a consultant in Washington. He brought a number of [people from] Cincinnati and -- gosh, where else? They were doing a -- probably the best replication of the Village, actually, is in Baltimore, and David Goodrick is the one that brought it to us.

Then as AB 34 and AB 2034 happened, then mental health offices had to decide. [They were thinking] “we don't know how to do homeless -- how do we do homeless outreach? How do we have homeless programs?” So then we got this whole new wave of people that came in and learned how to do it. Many of them were marvelous. Again, we always learned from them too. But I thought I would have a bunch of county employees who were pissed off, who would look me in the eye and just [say] “don't tell me what to do.” And to the absolute contrary, they were people that were so eager to do a good job and to do it well that they were open, they were excited. I mean, that was one of the nicest surprises I ever had because I thought we were going to have a bunch of really angry people who were being asked to change and didn't want to. But for whatever reason, that’s [how it’s been]. So that's continued. We have contracts now with the State Department [California Department of Mental Health]. And we do a lot of national stuff that's not [related to that].

So to go back to your original question, I can remember your original question. I think the recognition from the national MHA probably was a key thing, I think. Richard [Van Horn] -- he's a very good advocate, so I think he's been out there. And then people like Dan Weisburd. We have any number of people that consider themselves the father of the bill [AB 3777], and that's been a help. But some of it still mystifies me. It's just very interesting. But I think it is the outcomes. I think there's word of mouth. I think all these various professional organizations.

This is the other thing: Mark [Ragins] and I and one of our consumers did a conference in New York fairly early on. A man came up afterward and talked to Mark about how he had never seen such a sort of wonderful convergence of the structure, the infrastructure, with the goal of what was going to happen, and the fact that we had been designed to do this rather than tearing down walls was really, really significant. And I think that's true. I think that design has been very helpful to us. Even so, we found that it took -- this is my anecdotal information -- that it takes about eighteen months for a program to really get

its feet on the ground. A lot of people think, “oh, everything is going to be magical six months in,” and that I just don't think happens.

HP: It's very difficult that you have people demanding results right away, be they people in Sacramento or headquarters.

ML: Yes. We actually didn't have so much trouble with that, but we had trouble marching in step. I don't know how else to describe it. It was just a herky-jerkiness that you could feel. I could feel it. In fact, about eighteen months after we started the Village, our management team was talking and we all agreed, “there's something that's just not -- we're not in unison.” So we decided we would get some of the training tapes that we had done at the very beginning and we'd do this whole big conference -- not a *big* conference, but I mean a big training thing and really work on this, because we had to be more in unity. About three weeks later, I thought, “I better get on that. We haven't done anything about that.” And then I thought, “but it's gone, it's gone.”

HP: Once you realize that it's gone.

ML: Well, I don't know if that's the lesson to get. I'm just telling you -- it was potent, you could feel it. All of a sudden feeling we were together, we were in unison, and I'd like to know what that was and bottle it. So I think the lesson is don't have too high expectations. If you're a contractor from your agencies at the beginning, it's going to take a while. And if you're one of those staff that's killing yourself trying to do something, be a little more forgiving. It's going to take a while before you've kind of got this down, you see what works, you see what doesn't work, and all that stuff.

I wish I could just tell you, “oh well, boom, it was this,” but it [wasn’t]. I think the other piece of it is that we always knew we were going to try to be a model for change in the system. In fact, when we did our mission statement, and so on, we did a first thing, “this is our mission, to help people recognize their strengths and powers.” But the second part of it was to bring about change in the mental health system. I can remember there was some thought that, well, “MHA, that should be MHA's mission, it's not ours.” But our staff would have none of it. They said, “yes it is, and we're going to do it.” So we said, “okay, it's fine.” A lot of people were attracted to that piece of it, that it wouldn't just have the impact on the person you're helping, but possibly a bigger one. Always knowing that was another thing that kept people involved and interested, passionate.

[recorder off, then resumes]

HP: Okay. One other thing -- was there a Wellness Center before Prop.63, in some way, shape, or form? [most Wellness Centers were formed and funded as part of the Mental Health Service Act]

ML: Yes. I think that happened -- I hope I'm telling you correctly, because sometimes the years get fuzzy. Prop. 63, that was 2004, so absolutely we had one before that, because that was all part of our plan. We started out with Main Street, and I told you how then we developed the Wellness Center. And plus, we thought that other clients might come from the other mental health clinics, and so on, which has, I think, happened now. It took a number of years to get that to happen, but I think it has happened now.

HP: Now, what exactly was the Wellness Center when it first started?

ML: Well, the Wellness Center was a place to focus on people who did not need case management, but perhaps did need some other services, such as help finding a job, or medication. We also saw it kind of replacing, to some degree, the purpose of Project Return, The Next Step [a recovery oriented client organization affiliated with Mental Health America]. Because they [Project Return] were a series of sort of social clubs. That kind of idea just ran out of steam. So there's a social component to the Wellness Center of health and wellness. I mean, we're trying to monitor things like blood sugars, and encourage people to walk, and do all those things.

This is reminding me, *Time* magazine did a story on the Village in about '96, I think it was. And the fellow who wrote that, who at that time was working for *Time*, has volunteered with us for many years and done a writing group. The consumers come from all over to attend his writing group, and that's still going on.

Let's see. What else? Just things that might interest somebody. If someone is interested in a particular topic, then you maybe set up [a program for it]. We now also do individual tutoring for GEDs or for and help with access. Again, we're really trying to be focused on accessing what already exists in the community, instead of making a special program. But some of the basic tutoring, we have found, we pretty much have to do ourselves. But as soon as we can, we get them into classes.

HP: So it's kind of envisioned the way that the Wellness Centers are today under MHSA, kind of as a middle ground between the system and the clinic.

ML: Yes, and offering opportunities, acknowledging the importance of health. There was some emphasis on that at the very beginning of the Village. We did do a physical exam for everybody, but we found we couldn't afford it, we couldn't keep up with it. So our doctors then just tried to be more alert as to physical symptoms. We did a lot of work with people with diabetes. We had at least one nurse on every team, as well as the doctor, and usually, another like a medical -- not a physician's assistant but kind of like a vocational nurse or someone like that. So we were able to really impact on people's health, too. Some of that was transferring over. We do have a nurse, as I told you, at the Wellness Center.

HP: Now, what necessitated the creation of the new program if a lot of this was being done at the Village already?

ML: Because of, I think, the dependence. Because in some cases you have to increase dependence in order to -- I mean, just like I was saying when we're going to the supermarket with somebody and you don't want to keep that up, you want to provide the amount of support someone needs and not one iota more. Figuring that out is not always easy. But as a way to sustain, hopefully, I think that's what we really thought. And to pay more attention to physical health.

It's still highly frustrating, and it angers me, that we ask people to take these medications which are so -- I mean, people can gain fifty, seventy-five pounds, which throws them into diabetes, blood pressure problems, all sorts of other stuff. And then we expect them to diet and be miserable in order to get it [the weight] off. Unfortunately, it doesn't work that way. So the Wellness Center is part of our effort to really help people focus. I can't

say, frankly, that an awful lot of people use it in that way. People are still pretty set in their ways.

HP: What *do* they use it for then, if not that?

ML: Well, I think everybody's different. I just mean we do not have people flocking to take hikes --

HP: People aren't excited to go and learn fitness.

ML: Well, I think, for our purpose, not so much. I think there are people that get the meds there. There are people there that just want a social experience. We have a consumer that teaches classes in computers. And there's people to the degree that they want to socialize and get out. But the idea is that they do not have a life consisting of emergency after emergency, that they are able to handle their own [lives]. So this is a support effort, a wellness effort, and a place where people can sort of derive the support as much as they want.

The woman who started Main Street resigned a few years ago. We had a going away party for her, and I was thrilled to see the number of old consumers that came back to the party to say goodbye to her. And they were telling me, "no, I never go to the Wellness Center. Look here. I open my refrigerator, I've got it full of food, I've got a car, my son comes to see me." And fine! Better yet! But it is for people that do want some degree of connectedness, I think it serves that purpose as well.

HP: When it started, was this funded under the same pot [of money] that funded the Village?

ML: No, I don't think so. Ann [Stone] would be the person to talk to about the funding, but I know we didn't have any compensation. We started it scrounging around ourselves, just to complete the system of care that we thought was necessary to support graduates.

HP: Right. And these were the Pearl Johnson one [the Pearl E. Johsnon Wellness Center] and --

ML: The Pearl Johnson one started much later.

HP: Oh, that was later.

ML: Way later.

HP: Okay. And the original one was here [at the Village].

ML: As far as I know this is the original one. But it took a long time to catch on.

HP: How long was it until people did start coming, after you launched it?

ML: Are you going to talk to John Travers [Director of Mental Health America's Wellness Center]

HP: I'm not sure.

ML: Well, I mean, it isn't that nobody went, but just the numbers to support it, there certainly was not. We had thought we would get a lot of people who had Medicaid and that they could get their medication there and that would help support it, and that just simply did not happen. So for several years we floated it. And how Ann [Stone] scrounged around and got the money for it, I really don't know. She's a master at finding a little bit of money here and a little bit of money there.

HP: So it took years. It's interesting, just thinking about how everywhere in the county now they are trying to start Wellness programs.

ML: Yes. Well, and that was partially because we thought it was necessary. We couldn't just absolutely drop everybody off the map. We probably needed to have some way that people could remain connected. And then, as I say, the additional health concerns because the weight gains are just phenomenal.

### V. The Mental Health Services Act and Its Implementation; Mental Health System Design; Contracted vs. Directly Operated Services; The Recovery Model; The Future of the Mental Health System

HP: Okay. Let's talk a little bit about the Mental Health Services Act. I guess for starters, were you involved at all in terms of helping organize or facilitate the passage of the legislation?

ML: Well, I physically went out and gathered signatures. But I was not part of the process of the strategizing that was done in Sacramento. Of course, Richard [Van Horn] was in the middle of it, and Dena Bloomgarden Stein, who had been one of our training specialists. She had gotten a CORO fellowship [a fellowship for leadership] and came back, so she was the person that we sent up to Sacramento to really represent us and do all that. A lot of the logistical stuff, a lot of arranging fundraisers and arranging petition signing parties, and all this stuff.
We do think of it very much as sort of an MHA project, which isn't technically true -- a lot of other people supported it -- but we put a huge amount of resources into it, and that's one of our capacities. We are an advocacy agency, so it's probably appropriate. They asked us all for donations, and I think some of the mental health clinics did [donate] and some did not. Some felt it was a compromise in some way, and they didn't want to do it.

When various people would sort of need to understand what was going on, they'd come down to the Village. Like the pollsters, when they figured out that because of the passage of Prop. 36, [a 2000 California voter initiative that allowed for some non-violent drug law offenders to enter treatment as an alternative to incarceration] there's a vein of sympathy that runs through the voters that they could tap again. But the pollsters wanted to see what does this looked like in [real] life. What's a real life setting?

HP: So the Village was kind of envisioned as what Prop. 63 would look like.

ML: Oh, yes. Prop. 63 is based almost entirely on the Village, as far as I know.

HP: What are the similarities and difference between an FSP somewhere and the Village?

ML: I don't know. I don't know. I've spoken to Richard [Van Horn] a couple of times about my concern about dividing so strictly. I worry about that.

HP: Dividing, you mean classifying clients as FSP or FCCS [in the Field Capable Clinical Services program]?

ML: Yes. And I'm concerned, if you get too rigid in those things. But I don't have a statewide perspective.

HP: Well, even within the county.

ML: Well, from what I see -- and know that I haven't been involved in the daily operations for a year now, so I am somewhat removed -- but from what I see, I am concerned about whether or not they're going to allow choice in people graduating [from FSP programs] or not. And I think that's going to affect the number of people that would be willing to do it. It's not that I just want people to have their way all the time, but I think if you make it "this is going to happen to you whether you like it or not" --

HP: Saying "in six months you're out of here."

ML: Yes. I just am fearful of that. And [telling clients] "you may not think you're well enough, but we think you're well enough" -- I think that's unfortunate. But they may be tooling along pretty well without me.

HP: Is this at the Village that they're having this rigidity, or throughout the county?

ML: Well, they're experiencing it. No, it's what I hear from the system.

HP: Have you heard stories about this happening?

ML: Right after I retired I went away for a great trip for three weeks, and when I got back they had just had this hellacious thing where they had to separate all the clients [into different programs]. There was a huge amount of clerical [work] that went with it, and we had to identify the people that we could keep in the FSP and the people that had to go to the next down level, Field Capable Clinical Services, I guess that was.

HP: And they had that the Village also.

ML: Yes, we're an FSP.

HP: You're an FSP, and you also have Field Capable Clinical Services and Wellness.

ML: Mm-hmm.

HP: So what was that like doing that kind of separation?

ML: Everybody was just like – "wow." Again, I'm trying to pull back, I'm trying not to be over there as much. I want Paul [Barry] and the management team to [work on this issue], so I haven't been following that directly. I do know that we began to not get referrals. It's my understanding that -- how can I put this -- that there are large numbers

of people waiting to be referred, and it's a county issue as to why that's happened. It's dropped off dramatically, but yet they're still saying we're going to have to take in this very large number of new people.

HP: People waiting to be referred to the FSP.

ML: I gather. It's partially too because the county is changing their computer system, I think. I mean, there's all these changes going on in various place. I think it's a little hard right now to get a perspective on it. But I felt pretty strongly that we were successful in getting people to leave because we could be flexible about it. In fact, I'd love a graduate student to study that sometime, because I don't know how many people we actually had, but probably under ten that actually came back into the Village. So I was very pleased by that. It only goes to show you can't predict lots of times.

HP: And that it's not that mechanical. Someone can be doing better and something terrible can happen in their lives and they'd have to come back.

ML: Yes, all of that. And is our system flexible enough to be able to tolerate that? I don't know. But, as I say, I've talked to Richard [Van Horn] about it. He's working with the Oversight Commission [California's Mental Health Services Oversight and Accountability Commission], so I know he's aware of the issue and I think that he agrees also that perhaps those standards, at least as applied in the county, which is the only thing I have experience with, have been too strict. I'm just fearful that that will mean that then people won't cooperate, and that will tear down the whole system.

HP: Do folks at the county seem to also be concerned about this issue?

ML: I don't know. I mean, I haven't spoken to anyone about it, as again, it's not my bailiwick anymore, so I don't know if they are or not. My impression is they're just really desperately trying to catch up with everything, with changes.

HP: And the funding.

ML: And the funding. Oh my God.

HP: Okay. So when MHSA first passed, what was your hope of what it would accomplish? What was your vision?

ML: Well, our hope was that it would spread AB 2034 to the rest of the state. It had only been enacted in half of the state. So that was a huge disappointment. We were saving money like crazy. And in fact, the outcome figures were so good that it made me nervous about the methodology. I wouldn't talk about it for the first year and a half, two years, until we began to get consistent results that looked the same, and then I was able to identify a few other programs that were employing the same methods. Much smaller, but still, they were seeing the same things so that I felt comfortable. You know, in research, you just don't see sixty percent improvement of anything. You don't see those numbers. So they all tease me now because I was like, "I don't want to talk about it. We'll see what happens."

So that was a huge blow when we lost the money for the AB 34 program. I thought that Prop. 63 would probably allow us to reinstate those programs which had proven to be so

dynamic and so successful. I thought it would really give us a system that was more flexible, that was open to non-clinical activities as well. Back East there are many more programs that have taken on what sort of now would be called recovery principles, but California was a pretty formidable medical model place, from my perspective. I couldn't hire anybody who had experience in a psychosocial program, for example. Whereas, back East I could always find people to hire.

HP: Why do you think that is?

ML: I don't know. I don't know. Richard [Van Horn] might have a better perspective on that than I do because he's been here so much longer. I don't know why that is, but I could feel that it existed. And that's why we hired a lot of young people and we hired a lot of people who wanted the chance to try something different.

So I just thought, in terms of system design, in terms of identifying the high users, working with them first and save money, then maybe we would be able to work with the people who were the rockers and the smokers [people who sat inactively in board and care facilities]. A lot of what we were doing in the system really wasn't all that helpful. And a lot of what *we* [at the Village] do isn't all that helpful. You just don't know which half. It's hard to tell.

But I think we did have, by that point, some really strong ideas about what would work better and what mental health services should look like in the twenty-first century. One thing that helped that a lot, if you're familiar with the Institute of Medicine, they did a book about four or five years ago, *Bridging the Quality Chasm*. Now, this is not only about mental health, this is just medicine in the twenty-first century. But it was just uncanny how much it mimicked the principles that we set when we started in 1990. We tried to talk about the differences between a medical model and a psychosocial model. Now I guess they would say recovery model.

HP: This report referred to sort of a recovery model for all medicine?

ML: Well, it was saying how does medicine have to change, what does it need to do? In 1990 they put out the thing on medical errors that has had such an impact. It's quite a prestigious group -- it's a federally funded group. They've done the one on mental health, and we were very disappointed in that, that they didn't talk about recovery or rehab very much in that. But this is just the structure, with fewer silos. The patient directed care. So we were, without knowing it, very on top of, very close to what eventually they would see as the future of all medicine.

HP: But I guess there's sort of irony in that MHSA has also, to a degree, created silos as well.

ML: [chuckling] Yes, indeed.

HP: So overall, you mentioned your concern in terms of that. What are some other shortcomings, and also some of the successes of Prop. 63?

ML: Well, I don't think we really know yet. So little of it has been applied. It's taken so long. I think the planning process was excruciating, frankly. I participated in that for two years.

HP: The stakeholder process?

ML: Mm-hmm.

HP: What was --

ML: It was endless meetings. I was going several times a month, driving downtown, and watching process, which to some degree is useful, but I thought they expanded it to be too large. When we started it was I don't even know how many people, fifty-five people. And then it got up to seventy-two, and then it got up to a hundred and twenty. I'm making those figures up, but by expanding it so much you absolutely diminished their capacity to make decisions. And the focus was really on total inclusion for everybody -- which is fine, I mean, not that I want to say no -- but at some point you've got to limit it. So in the end I think it kind of imploded, that's my impression. What they did, I believe, at the end of that, at that time, they decided they would work with a fifteen-member group or something. The decision making group. So that was hard. That was very hard.

Some of the things that I thought might have helped it, in our own planning, I was rooting for more therapists trained in cognitive behavioral therapy, which I think is really one -- well, it's hardly up and coming, it's very much arrived. We couldn't find anybody in the county that was even licensed in it. We did get the county to do a training in it, and now it's coming around. But I thought as part of the new kinds of services offered, [cognitive behavioral therapy should have been there]. Because you have to be working with personality disorders, which frankly I think a lot of psychosocial programs and a lot of medical clinic programs had just said "oh, we can't tolerate them, we'll do nothing, we won't serve them." And that was just not acceptable.

HP: Well, yeah. I guess technically they don't meet criteria for services in many places.

ML: But they sure cause a lot of misery.

HP: And they need help.

ML: Oh, totally they need help, that's the thing. And really, that was one of the great things the training did for people – it was to make staff more sympathetic, and help them understand this behavior is not just manipulation but that there is real pain. So I had tried to see if I couldn't get some more acknowledgement for some of the newer techniques. Because we never wanted to say we think therapy is bad. It's just that often it's not as helpful as it might be and that perhaps we had placed too much confidence in it. We had people here -- we had one woman that had been going weekly for therapy at one of the mental health clinics for twenty-four years. You kind of wonder.

HP: It's a lot of time.

ML: It's a lot. And it was not apparently helping very much. So those are some of the things that we've kind of fallen into.

So I had a vision of it [the MHSA] being real system change. Of it really focusing on where the most acute needs were. Of shortening hospitalization at times, which not only are expensive, but which are miserable experiences for people, and they increase dependency. I mean, they're just awful. There's so many sorts of things that would be, like medication clinics, where everybody who took the same drug would go in one day, and they'd have cake and punch, and then they'd all go take their medicines. Those are just -- again, it's technology from the *One Flew Over the Cuckoo's Nest* days. I would have liked to have seen a lot of that go by. We think day treatment programs, for the most part, have not been fruitful, have not been good, but they were kind of a cash cow, so people hated to give them up. But there's no research that demonstrates their effectiveness.

So those are the kinds of things. Let's stop doing the things that [don't work very well]. We don't know perfectly, but we do have some clues about what works and what doesn't. At the Village, it was very traumatic. When Paul Barry came, which was very early on, he said we had gotten all the clinical pieces in place before we started on the employment and the worksites and the café, and so on. He was our director of employment, and he said, "we're going to not have a day program." And we all went, "what?" But he was insistent upon that, and it has actually worked out very well. Our members, if they need help, they can come in always, but they don't have to. We have mobile service. That is just fabulous. I mean, I think that's a huge thing. When I was in Virginia, often we would have somebody who had been referred by their therapist, and the only weapons we had were the telephone or sending mail, and we couldn't stop running our own programs to go out.

HP: To go out, and that's so important.

ML: Yes. So not having a day program and being able to go out and find somebody where they are. Go with them when they go to their father's funeral, or -- you know. Those [interventions] I think far more effective.

HP: Okay. So you had a vision of what it [the MHSA] should accomplish, but in terms of what it has accomplished it's kind of still too early to say.

ML: That's my take. And I fault it. I think the long planning processes, and I know they're trying to be responsible with taxpayers' money, but I think they've been really harmful. I was chairman of our Service Area Advisory Committee [SAAC], so I have been at the SAAC level, and that's been challenging. But then, of course, you have to think, well, so what would you do if you were doing differently, and I have a few ideas. I don't have a whole lot of ideas. I don't have the whole picture.

HP: That was actually my next question. Let's say you were the queen of MHSA, what would you have done differently?

ML: Well, all I know is L.A. County and I think it's a Richard [Van Horn] question more than it is [one for] me. I would just look to see some of those same things. I would look to see "are we doing services that really help people? Can we demonstrate that by outcomes, and in any way that people's lives are better?" I think by stratifying the costs you learn a great deal. I think you can tell from this that I believe in highly humanistic kinds of services, but I think it's very important to look at the cost, look at what you're spending, and look at why you're spending it. And I think in a county like L.A., the

unions and the culture make it very difficult. I think they have a farseeing leader in Dr. Southard, and I think he's been really kind of amazingly willing to try to take this on. But even so, there's huge numbers of very dissatisfied staff, or agencies, within the county. People never like to be told to do something very different, I think.

HP: So just resistance to change.

ML: Yeah. Poor Mark [Ragins] has been training, working, working, working a long time [on facilitating the transformation of the mental health system throughout Los Angeles county]. I think it's a work of years, certainly, but he's been working along with another guy. I don't know how effective that has been. Who knows? We do still get a lot of training. A lot of people come in and buddy up and do the three-day training. But I think that's an awareness thing, that's not a proficiency thing, so there needs to be some proficiency.

HP: Right. I have one more kind of funding/bureaucratic question, then I'll wrap up. What are your thoughts on the way the system is split between directly operated and contractors. Do they each bring something to the table? Is one better than the other in some respects but not others?

ML: It's interesting, I was just talking with someone this morning. In the city [Long Beach] they now have a mental health worker. This is a big deal. She said something to the effect of "we have not thought about yet, offering direct services, but we're thinking maybe that that's not such a good idea." Just in my experience, in Baltimore, for example, there was a Robert Wood Johnson project [a project funded by the Robert Wood Johnson Foundation]. They did not have a mental health department and they built their -- I forget now what it's called, but it's a sort of commission that only contracts out services and monitors the quality. And I have in general thought that would be a better system than not. But that's sort of a simplistic thing, too. I mean, again, getting people to change. I know many direct service organizations that do not have a culture of change and rehab and recovery, and all these things are very much sort of mired in the past. So I would not want to say that one is better than the other, but I think if I were to start out again, just trying to design a mental health system, I would do a commission, I think, like the Robert Wood Johnson cities have done, and not provide direct service.

HP: And having agencies do it instead of the county do it, what are the advantages of that?

ML: The advantages I think are the scale, I think, of knowing your population. Every time a proclamation or a policy is done, in each political district -- there has to be one here and one here and one here, in every single district. Every decision has to be made pretty much with the entire county under consideration, and one cannot be neglected usually. I think tailoring to your [population]. Certainly, they've done I think a good job in terms of the Asian language group, some of those kinds of things. I think we've done a poor job in, say, East L.A. with the Hispanic populations. There are very few services there, very few. And that's hard to understand.

HP: It is. I would think that that would be expected.

ML: Yeah. So just minimizing the bureaucracy. We in SAAC 8 [the Los Angeles County Department of Mental Health's Service Area 8, which includes the Long Beach

area] have been able to I think get a very effective navigator system going [Navigators work to direct clients to the proper services within their service area]. You know what that is?

HP: Mm-hmm.

ML: Well, they're doing it in other places, but the impression I get when I refer people -- that's all I'm talking about -- is that it's not developed to as high a degree in some of the other areas. I think that's really unfortunate. At one time they certainly did think about decentralizing [the Los Angeles County Department of Mental Health], but then that stopped. I'm not sure why.

HP: When was that?

ML: Oh, gosh, it was when we -- we developed a whole plan. Gosh, I think it was in the nineties. You may have heard Ann [Stone] talk about how we developed a plan that would contain a service area with a kind of an ISA sort of program in the center of it, and then contracting out for special services. Then we talked about how there would have to be an intake service, and Ann was wanting to call it the "concierge group." Areta [Crowell, the director of the Los Angles County Department of Mental Health at the time] did not like the term "concierge," and I don't think many people would have understood what it was. But we used to laugh about the "concierge service."

This [Los Angeles County] is such an enormous area. And I understand New York is even divided up into smaller areas. So I think some division and some decentralization certainly would be good.

HP: I mean, you can see that because certain areas may have a big Asian need, other areas might have a big Armenian need.

ML: Absolutely. And they do.

HP: Exactly. So it's very difficult to delegate from the center if you're making policies that govern the whole county. What might work in one area and it might not work in another.

ML: And I think it's very difficult to then make program innovation. I mean, creativity gets very limited. And again, human resources is one of the big problems. And the unions are difficult. Although I feel like many times the unions are more willing to try things. But there are huge limitations the larger you get. But this is a very parochial perspective that I'm giving you.

HP: But it's one that makes sense, absolutely.

So that's my bureaucratic question. The other one is, if I asked you to define recovery, compared to what's come before it, be it the medical model or whatever you like -- that's what's often defined -- how would you explain the difference?

ML: Well, I would talk about it in terms of working with the person rather than the illness. I would talk about it being based on the wants and needs of the client. I would talk about it being individualized rather than in so many groups, which of course I know

has a financial implication, but for success I think individual tailoring is almost impossible to compete with. Those are probably the main things. I would like to see more promotion of people achieving roles where they could garner some respect in the community. I think that our current system is still very stigmatizing.

HP: How so?

ML: Well, just look at rules of confidentiality such as HIPPA, not acknowledging a person who speaks to you on the street. Although I understand HIPPA may get weaker. It, to some degree has, just because if you were in an automobile accident, it would be great to have an electronic record. So I think HIPPA may be affected by the electronic record thing, which I think is going to happen.

I think those are really the main things. I think with a smaller group you can take some chances. If you have high support for people you can encourage them to take a job, or ask a girl out for dinner, or just take a chance, risk failure because you've got a really strong support.

HP: You have the supports in case you do fail.

ML: Exactly. There always needs to be a Plan B. And I understand families and providers have both gotten just terrified of what might happen. I mean, if you've got stability now, God forbid you should risk it. But we really push a growth idea – that you can grow, and you can like yourself better and really contribute to the world. These are the things that seem to appeal to people. Many of our members, when I ask them, "what made the difference for you? How did you decide to start to cooperate and figure out what you wanted?" Many of them don't fall on their feet and say "the Village was so wonderful to me." They all say things like, "well, you know, I'm going to be forty pretty soon, I'm thinking that I better grow up, I better take some responsibility." So they talk in terms of maturation. It's just interesting to me. So I think that's an important concept to people as they mature.

HP: Now, how does this differ from the medical model?

ML: We've got tons of stuff. I can pull out stuff that we've done -- charts on ways that it does. I can even send you the IOM [Institute of Medicine] stuff about medicine.

But I think probably the biggest thing is that the medical model is all about cure, and they would not be involved in people's lives in any way to the extent that we are. They would see that as intrusive and unnecessary, probably. And you can't have doctors running around doing all this stuff. Economically, you obviously cannot do that. So you've got a group of highly paid and highly trained individuals and they want to do things at their level of sophistication and mastery of their subject, and so on and so forth. So they're not going to want to stand in line with somebody at the Social Security office. But it is those kinds of things that can really make a huge difference.

And then I think we have people for whom therapy is actually very significant. And those are people, like with the borderline personality disorders, with people who have life adjustment difficulties that are quite severe. But they don't necessarily have just a severe mental illness. I do want to recognize that there are some -- but I think we've

gotten stuck with that group and not with the really seriously mentally ill. I mean, now I think the focus is changing, and Prop. 63 helped change it.

HP: How so?

ML: Because it was for the adults. I mean, it was the kind of programming, the kind of structures that they are promoting that would allow for more individualization, fewer group activities, no day treatment. I mean, all those things. And less assumption that therapy is *the* treatment of choice. It may be, but it isn't necessarily. And that could even be such a commodity that needs to be meted out sort of carefully, as opposed to what we offer. I really think our mental health clinics have gotten that drift, but I think it's a lot of the therapists that have worked with someone for twenty years, so that they need it as much as the clients do. (laughs)

HP: Yeah, they do. There's attachment on both ends.

ML: Absolutely. And not that we don't have that too. It's not unique to that. But in terms of assessing what people's needs are and what they need to have, I think this is the way to go.

HP: So where do you see public mental health care in Los Angeles County going?

ML: Well, I can only hope for the next boom to come back to California. I think it's going terribly, and not at any fault of the County either, or not much. I really think they've made a heroic effort to try to provide the best services, I think, with huge obstacles. It's easy for me to say, as one little program, one little island that's been given a lot of shelter and a lot of support. And to then generalize that to a large model is, I think, probably not realistic in this age. I don't see much positive now. I don't know, five years, ten years I think maybe it'll come back.

HP: Before the economy sank, would you have done it differently?

ML: Well, I think we were making some real headway at that time. Now, whatever we can keep getting from Prop. 63 [is good], but I'm very dubious about that because I think Schwarzenegger, or the next governor, will borrow from it or will figure out some way to do what they want to do.

HP: Yeah. Or we may run out of millionaires [the Mental Health Services Act is funded by a surtax on incomes over $1 million].

ML: Yes, all of the above. But I think, like the Silicon Valley, give them five years, I think they're going to be on top again. I do feel like there'll be some comeback, so I'm not pessimistic overall. Sometimes, when you have drastic change or curtailment, you get more permission from the world to make changes.

HP: Necessity is the mother of invention.

ML: All of that. There are programs here that I know to be poor, everybody in the system knows they're poor, but they've got such good strong political support that in a good year nobody's going to do anything. Maybe in a bad year, maybe there'd be some chance of getting things changed. That's as optimistic as I can be. I'm very concerned.

HP: And what can fix it? Just more funding?

ML: No, it has to be more funding to do the right thing, and that's what Prop. 63 is about. I think it's what we've been fighting for, and hopefully, we've been able to demonstrate some validity and some success so that people will feel more comfortable thinking about programs like this. This is not a program for everyone. It's a niche program. If you had a niche like this in every [place] I think it would make a significant difference. I do think it would.

HP: Okay. Final question. Looking back on your career, what would you say is your biggest accomplishment, and the thing that you wish you could have accomplished that didn't come to fruition?

ML: Good heavens! Well, I think nurturing the Village and just being part of that, and sharing the headiness of trying something new and being able to pull it off. I'm still, as I said, not entirely clear how that evolved, but it seems to have. And it's certainly, given my life -- you know, I was fifty years old before I came here -- so I didn't expect anything like this to unfold. So that's been a perfectly marvelous experience.

What would I hope to have accomplished? Well, I'd like to see more Villages in more places, but I know there are a million barriers to that happening. I don't even really aspire too much. I don't feel too bad about failing because there's so many reasons to fail. But I think we're just going to have to see how this goes. In other words, how the economy goes. The thought about our philosophy and the way we treat people and what we do is still unaccomplished, largely, I think. We have a group from Phoenix we've been working with down there, and sending over staff and doing training. And they said they came to us not so much because of our philosophy but because we've been in existence for twenty years.

HP: It shows you're doing something right.

ML: Well, I don't know if it does or not, but from their perspective it does. I don't know that I would have thought about it. Given the vagaries of funding, any number of good programs have just gone. But you just don't ever know what people are going to draw from your experience, and that was their criteria, that we managed to last. So we'll see.

But we are doing a lot of consulting work, a lot of training work, so that's, I think, hope for the future. Even if people are aspiring to be able to do this, that's a change. I mean, our trainings used to be shocking to people. Shocking. I had one psychologist that pulled me out of a meeting -- this is very early in the Village -- and he said to me, "I didn't want to say anything in front of the group, but I think I need to tell you that you are risking people's lives. You are going to cause damage. People will die." I said, "well, thank you so much for not saying that in front of the group. I appreciate that, and I appreciate the sincerity with which you say that, but I've had now a number of years of experience using this model, and we have not had all these terrible things happen. In fact, people have, for the most part, thrived. So I'm not intending that we're going to change this. In any case, the legislature requires -- they give us things we have to do, so that's what we will do." But that shows you the degree of concern. He was dead serious. He thought were going to kill them.

HP: Anything else you'd like to add?

ML: I'll probably think of many things later, but I will let you know if I think something is just critical.

END OF INTERVIEW