

## **Carla Jacobs remembers how she became a member of the Task Force for the Incarcerated Mentally Ill...**

In 1991, [my husband] Brian was reading a little article about the fact that the Los Angeles County Board of Supervisors was starting a Task Force on the Incarcerated Mentally Ill. Los Angeles County [jails] had already been called and nominated as the hospital of last resort. [This statement, made in the *Los Angeles Times* series cited below, has since been repeated many times. In 1992, 3,300 of nearly 21,000 inmates in the LA County jail system were reported to need mental health services each day.]

There had been a series of articles in the *Los Angeles Times* [by Hector Tobar, August 25-26, 1991] regarding the criminalization of people with mental illness rather than the treatment thereof, and Brian said that I should apply. I said, "Brian, I'm just a property manager. I haven't even finished college. I'm not qualified to do something like that." He's a little bit more bold than I am. So he called up [County Supervisor] Mike Antonovich's office and spoke with Mike's aide, Kathryn Barger, and said, "You know, I have somebody that I think would be perfect on that task force." And Mike Antonovich appointed me to it. Believe it, I was out of my element, but it gave me an opportunity to learn very quickly about the criminalization. That's exactly what had happened in our situation was the criminalization.

There's a constitutional right to treatment in jails and prisons. There is no corresponding right in the community, and if a law enforcement officer is confronted, if you will, with a person with mental illness on the streets, there are three options. He can do nothing, but the merchants are complaining. He can take the person to the hospital, but the hospitals now are too full; or the person doesn't meet that narrow criteria of dangerous-to-self, dangerous-to-others, because most people with mental illness are not dangerous. Second of all, you don't want them to get to that level, [because] waiting for danger is too late. That would be an automatic arrest.

Therefore, jail frequently will become a viable option. The person is just sick, but the merchants are complaining. There's so many nuisance crimes that we can charge somebody with that are going to fit the behavioral by-products of untreated illness: Trespassing, drunk in public, shoplifting, basically homeless with mental illness [on board].

So [the] Los Angeles County jails had come under great scrutiny because of the fact that people were beginning to recognize that the mental health system as it was set up wasn't working. People were going to jail. Plus, there being a constitutional right to treatment *in* jail, jail was becoming a better mousetrap. At that time in Los Angeles' history, there was only one psychiatrist, as I remember right, in the entire jail system. His name was Gene Kunsman. Fantastic man with roller skates on. But some of the people that were in jail, that was the only time they saw a psychiatrist is when they saw Gene. I can remember one guy, somebody asked him, "Do you have a psychiatrist?" and he names Gene Kunsman in the jail. The Task Force was charged with [determining]: what is causing this criminalization and what can be done in the jail system to prevent abusive conditions, if you will, for the people that are in there?

**READ THE FULL TRANSCRIPT BELOW.**

**INTERVIEWEE: CARLA JACOBS**

**INTERVIEWER: KEVIN MILLER**

**DATE: April 14, 2010**

**I. Family and Early Background; Personal Experiences with Mental Illness**

KM: This is Kevin Miller. I'm here with Carla Jacobs on April 14, 2010. So why don't we begin right at the beginning? Please tell me where you were born and raised and a little bit about your family.

CJ: I was born in a little town that frankly doesn't really exist anymore. It was called Portage la Prairie, Ontario. [Now it has merged with Thunder Bay. I wasn't until fairly recently aware that my parents were living there at the time.] When I did get my birth certificate, [my father's employment was] listed as a horse salesman. In reality, in my early years, I lived primarily in Manitoba, where my father worked as a large animal doctor, veterinarian, going out to the cattle farms and out into the hinterlands. My father was the son of an Englishman, and my mother was the daughter of Icelanders. In Canada, the ethnicities are not divided; they're very proud of who they are. But it was a little bit of a difference in that the English, of course, were considered the upper class, and the Icelanders at that time were effectively struggling immigrants.

KM: So you're third generation on both sides?

CJ: No, I would be – let's see. On my mum's side, I guess I would be considered second generation. On my father's side, I'd be third generation Canadian.

Then wrestling calves out of cows in snowstorms became a little bit too much for my father. He was older for having little kids. And we moved down here into California, where my mother's sister had already come. But basically he had already had his first heart attack, and the Manitoban blizzards were a little bit more than he could handle in his career.

KM: Was your mother a homemaker?

CJ: My mother – that was an interesting situation that actually pertains to mental health. My mum had every intention of going through college and becoming a scientist, but she had to move from the little lake town where she lived into what was considered to be “the big city” to do that. And she became – what I was always told was – the companion to Mrs. Rowlin, my paternal grandmother, but of course it was many, many years before my parents married. So she, when she was going to university, companioned Mrs. Rowlin.

She never completed the university, and it was only after both of my parents' deaths that I discovered that the reason my mother was Mrs. Rowlin's companion was because my paternal grandmother had schizophrenia. [Neither] my mother, nor my father, ever told me that. My mother told me about my paternal grandmother that she was “jolly, but different.”

After my mother had passed away, I was speaking with my father's brother's wife, and she remembered very clearly, because she was older, when

the old family doctor had come to the house and had explained that Mrs. Rowlin – Fanny was her name – had a medical condition known as schizophrenia. Of course, by the time I was growing up, a lot of our mental health system had forgotten that mental illness was a neurobiological medical disorder.

KM: And did you overlap with Fanny in terms of – ?

CJ: No, no. I didn't really know [my grandmother. She had died before I was born]. My father, I guess – he was a very jolly man. I knew an awful lot about my mother's family, but my mother had gone to work for the Rowlin's when she was seventeen, and my parents did not get married until the '40s. So this was maybe a twenty-year gap, if you will. As I said, both my parents were older. Not really a gap. My mother continued to be Mrs. Rowlin's companion until Mrs. Rowlin died. So I never knew my paternal grandmother, nor my paternal grandfather, who had married a woman who later developed schizophrenia, but had fully integrated that lady into the family. It had required having companions.

When my father was a baby, they always had a child's nurse. And I'll never forget because her name was Mrs. Goodchild. So my father talked a lot about Mrs. Goodchild. [Mrs. Goodchild also acted as my grandmother's companion.] And, as I said, it really wasn't until I was well into my adulthood that I found out that the reason that my father had a nanny, if you will, was because his mother had schizophrenia, or the reason that my mother had been hired into the family as her companion [after Mrs. Goodchild retired]. I've got beautiful pictures of my grandmother where they're on family trips. And I've got a gorgeous picture of my mum when she was about eighteen, with my grandmother. And they look very happy, and they were happy. You could tell.

I think, first of all, my father was what they call the young man around town then. He got to pursue just about anything he wanted to pursue, because my grandfather allowed his sons whatever education and such they wanted. I think there was also – well, Mrs. Rowlin quite apparently did adore my mother. [But] an Icelandic girl wasn't [perhaps] supposed to marry into an English family. I don't really know that part of the story because, one, I wasn't there, and it's a different culture than what we live in now. Very different culture.

This much I do know is that quite apparently from all the documents I have, from all the stories I have, from all the pictures I have, my grandmother was a full-fledged member of the family, and these ideas that we have about the people being locked away for life – in some cases they were, but [it isn't an absolute.] That's a bit of mythology in our mental health system. Families have always tried to do what they can to [help and] include their loved ones.

KM: So your mother was essentially in mental health services as a companion?

CJ: I guess you could say that. When I was growing up, she worked as a doctor's assistant, and that was here in California.

KM: Let's go back to when you made that transition to Southern California. About how old were you?

CJ: It wasn't Southern California, it was Northern California, and I was just a child. I was seven. My brother was ten, I guess. It was different, believe it or

not. I can remember the difference between the two cultures. But I was just a child.

KM: So how long were you in Northern California?

CJ: I was in Northern California until I was about twenty-one, and then I came down to Southern California.

KM: Were there any major influences on your young adult life or your childhood?

CJ: Well, my childhood was absolutely a wonderful childhood. I spent most of it slopping around in cow barns with my father. I guess a lot of people won't think that's a wonderful life, but it was, it was to me. There was just my brother and I. My brother was three years older than me and always took very good care of me, if you will. Both of us grew up in the lazy, hazy days of hippiedom, so by the time I was eighteen, I guess he was around twenty-one. He was, is brilliant. His IQ never tested less than 180. So when you compared me coming up behind my brother, my mother was always a little concerned about Carla being slow.

During that period those days we were politically active, [at] People's Park [and the like] [People's Park in Berkeley was created on university land by student and community activists in 1969 and has remained an ongoing focus of community tensions]. I had what's called a light show, where we did the visual lights, the backup lights for [rock] groups like the Grateful Dead, Jefferson Airplane, and Janis Joplin. We were marching to different drummers then.

KM: You and your brother?

CJ: Me and my brother [and] our friends. And Frank was always so good and brilliant at what he did. We just kind of all thought that he marched to the different drummer a little bit better than we did. Most of my friends grew up, and we grew away, and we had to go to work. What we'd say back then is we sold out. And Frankie never sold out. At times, I was mad at him because he wasn't living up to the potential he had. He was a golden boy. Other times I used to try to justify the fact that he was still basically living off my mother and not accomplishing anything, with the idea that if you're that brilliant, you have to have an all-consuming interest. In reality, my brother was showing the genetic history of the family and developing a severe mental illness.

My father died when I was fairly young, early twenties. My mother didn't die until I was in my thirties. And Frank was still living with her. Mum and I never talked about what the problem was with Frank. Again that goes back to that reticence that could be Icelandic, could be British, could be Canadian, could be just the way our family did things. It didn't matter. Frankie was Frankie. But anyhow, after a while, even I recognized that this was substantially more than Frank just being spoiled or brilliant. He was very ill.

KM: Where were you in terms of your education?

CJ: I never graduated from college, and the reason I didn't is because I became a hippie. I mean, when I was in school, I was studying sociology and political science and such, and I had every intention of going on and becoming

some sort of sociological researcher, and I just didn't do that. It was much more fun to run a light show and think that we were going to be artists.

So when I came down here to Southern California, I ended up married, [with] a small child and a baby, and recognizing I have to make a living. When I was up in Northern California, I worked for a small newspaper for a while, doing classified ads, subscriptions, police stories, obituaries, various small reportings. I thought, OK, well, I can go down to the local newspaper and get a job. I couldn't even get a job in classified ads, because I couldn't type fast enough.

I ended up getting my real estate license and went to work for a while selling houses. That bored the heck out of me. Over and beyond boring me, it just didn't hold my interest, shall we say. I didn't have the personality for that. If somebody was complaining that the kitchen was yellow, and they didn't like yellow, my unspoken response in my head would be, "Well, paint it."

So instead, the company I worked for asked me to go into their property management division, which I did, and within a few years I was vice president of that company. And then went to work for someone else. That person and I became business partners and we owned a property management company. So most of my working life was always property management, primarily in Southern California, managing medical buildings. My particular type of property management was I managed medical buildings and shopping centers and, of course, always apartments and such, but mostly commercial. I sold my share of the company, however, when I went into mental health advocacy on a pretty full-time basis as a volunteer.

KM: So what caused this transition from property management to mental health?

CJ: It was kind of double-fold, if you will. When my mother died, my brother was effectively having an episode, and my mother had always been his silver thread, the thing that kept him going. Instead he ended up wandering around the country and became lost. He was just gone. By this time I'm divorced, have been several years. I meet [my now husband, Brian,] and five minutes into the meeting I said, "I understand you have a sister that lives with you." And he said, "Well, perhaps I should explain that. Do you know what paranoid schizophrenia is?" And of course I do. My brother was missing, and [Brian's] sister had just left his home, with her eight-year-old child at that time, to live on the streets.

We were not people without intelligence or resources. We worked for two years to try to get her and the child into a place of safety, but it was her right to live on the streets and eat out of dumpsters. And it was her right to have her child living with her on the streets. Eventually, over those two years, we pled with Mental Health, we pled with law enforcement. Of course, there was no law that she was breaking, and Mental Health couldn't intervene because she wasn't considered dangerous. But we did eventually get Child Protective Services to take the child in.

And then Brian and I went off to England for a vacation, and we thought that things were getting better because in order to get the child back, and she loved the child dearly, she would have to comply with getting mental health treatment, according to the service plan. The child was now in a place of safety, sleeping in a bed with food, with people that supposedly were there to help him. So we thought that things were OK.

We came back from England and, two weeks after we got back, we discovered that Child Protective Services had given the boy back to [Brian's] sister, on what was called a so-called supervised visit. She dressed the boy in women's clothing, and herself as a Rambo woman, and they taxied seventy-five miles from Orange [County] here to Los Angeles County, to La Canada, where she very brutally murdered my mother-in-law, whom she hadn't seen for two years, because she'd been living out in the streets. There was no reason. It was a delusional-based murder.

Anyhow, this just wasn't right. A woman being left on the streets with a child, and then effectively nobody helping her, or being willing to help her or the family until she became a danger. Of course, waiting for danger is too late. So for the next three years – and it took us about three years to advocate for her to go on what is called a “not guilty by reason of insanity” [plea] into the state hospital instead of going to prison, because you can't punish mental illness out of someone. It was during this time that we saw how terribly broken and ineffective the system was. She would have stabilized very well with some intervention, a little bit of support. This was 1991. I did some figures at the time, and the absolute maximum that it would have cost the system to give her the help that she needed was about three or four thousand dollars. Instead she has now ended up costing the system two or three million dollars. So we were looking at wasted lives, wasted resources, and so many terrible tragedies that – basically, I sold my company and I went into mental health advocacy.

KM: So what was that first step into mental health advocacy?

CJ: The first step was – this was before the murder – I was trying to figure out the basis of homelessness. (she laughs) And I couldn't figure out why we had homelessness. It just didn't make sense to me. So I went over to UCI [University of California Irvine], and this is back when they used to have the microfiche, and started researching papers on homelessness. And so much of it was garbage [about] poverty and so on and so forth. Yes, there is an economic basis for some homelessness, but it's not the homelessness that we see amongst people with severe mental illness, and they, of course, represent at minimum a third of the homeless individuals we have.

In fact, it was such garbage, and I was trying to research – I ended up hiring a graduate student to turn out the papers, look for them for me. And I found papers by a gentleman, H.R. [“Dick”] Lamb, with the School of Psychiatry at USC. [Dr. Lamb is Professor of Psychiatry and Director of Mental Health Policy and Law at the University of Southern California, and on the Board of Directors of the National Alliance on Mental Illness (NAMI, founded in 1979).] He was the only person at that time that was really publishing and researching the fact that mental illness and homelessness is directly related to, usually, a lack of treatment. I know that sounds like “duh” now, but at that time it wasn't being talked about.

So I went over to Brian, a lot gutsier person than I am. I was just really amazed with this man's work. And Brian said, “Well, pick up the phone and call him.” I said, “Oh, Brian, I can't do that. He's an important man.” And Brian says, “Pick up the phone and call him.” And I did. Believe me, I just couldn't believe that I was doing this gutsy sort of a thing. Even though I've never been known not to have guts, but I just didn't know that you could insinuate yourself into a

situation where somebody is so expert and they'd say, "Come on down." He had me down to his office and he started pulling out more research papers for me.

Then, after the tragedy, of course, that was front-page news, not only in Los Angeles County. but around the world. My Canadian cousins read about it before I had an opportunity to call them. It was a very hard time, the night of the murder. Brian and I weren't married yet. Gee, I just said we had come back from vacation in England. No, we weren't married yet. I was living here in Orange County. The night before, I had taken his mum – I used to do ballroom dancing competitively, and I'd taken his mum to a ballroom dance competition. This was before *Dancing With the Stars*, believe me. [*Dancing with the Stars*, a very popular television show of the 2000s, was a dance competition between celebrities paired with professional dance partners.]

Brian would have been at the house the next day, except for the fact that I had taken his mum out, so he didn't feel the obligation to go over there. We were talking on the phone that night and he hadn't been over there.

Our phone call was interrupted with an emergency call from [the] LA Sheriff's Department. We just heard that – they said there'd been a murder at his mother's house. So Brian came from Long Beach, I came from Orange County, and by that time the media had already picked up the story. A quiet cul-de-sac street in La Canada, but there's a bunch of P.D. [cars and TV] trucks, and they were shining lights on the house.

Anyhow, the media [was all over the place asking me what happened]. Basically, I said there's nothing going on here. But [by the time we arrived,] the police had already arrested my sister-in-law and her son, who then was actually was charged with the crime also; but he was ten years old. Anyhow, we were captured in the house by all this media. Five o'clock in the morning, we're trying to figure out, how do we get out of the house. We don't know how to explain what's going on. They've had their lights on the house all night. Brian called a man he knew, who was involved with the National Alliance on Mental Illness (NAMI). He said, "Look, this is what happened. We've got all these TV cameras on us right now. How do we get out [of the house]?" And [the NAMI member] said, "Well, we're having a hearing on mental health down at the" – I think it was the Museum of Science or something. He said, "Go out and tell them you'll have a statement for them at that hearing." So we did that.

It was a budget hearing on mental illness, at which time we testified right there, to the fact that waiting for danger is too late. Civil rights are imperative. With my background, I can guarantee you I know how important civil rights are. But there is a difference between civil neglect and allowing somebody to live on the streets in psychosis versus claiming that that is their civil rights. What we were looking at was absolute systematic neglect under the guise of civil rights.

The senators at this hearing, Diane Watson [Representative from California's 33<sup>rd</sup> District, which includes much of Central LA County], who is now retiring as a congresswoman [in 2010], and [California State] Senator [Richard G.] Polanco [representing Northeast LA; he retired in 2002], were having a hearing in Sacramento the next day, and they asked us if we would come and testify there. With that much notoriety – what's my point there? How did we get into mental health advocacy? It was foisted on us. We didn't just one day say, "Oh, I think I'm going to become a mental health advocate."

## II. Task Force on the Incarcerated Mentally III; MET; First Legislative Initiatives

In 1991 – the murder occurred in 1990 – Brian was reading a little article about the fact that the Los Angeles County Board of Supervisors was starting a Task Force on the Incarcerated Mentally III. Los Angeles County [jails] had already been called and nominated as the hospital of last resort. [This statement, made in the *Los Angeles Times* series cited below, has since been repeated many times. In 1992, 3,300 of nearly 21,000 inmates in the LA County jail system were reported to need mental health services each day.]

There had been a series of articles in the *Los Angeles Times* [by Hector Tobar, August 25-26, 1991] regarding the criminalization of people with mental illness rather than the treatment thereof, and Brian said that I should apply. I said, “Brian, I’m just a property manager. I haven’t even finished college. I’m not qualified to do something like that.” He’s a little bit more bold than I am. So he called up [County Supervisor] Mike Antonovich’s office and spoke with Mike’s aide, Kathryn Barger, and said, “You know, I have somebody that I think would be perfect on that task force.” And Mike Antonovich appointed me to it. [Antonovich served as Supervisor of LA County’s Fifth District from 1980 to the time of this interview in 2010.] Believe it, I was out of my element, but it gave me an opportunity to learn very quickly about the criminalization. That’s exactly what had happened in our situation was the criminalization.

There’s a constitutional right to treatment in jails and prisons. There is no corresponding right in the community, and if a law enforcement officer is confronted, if you will, with a person with mental illness on the streets, there are three options. He can do nothing, but the merchants are complaining. He can take the person to the hospital, but the hospitals now are too full; or the person doesn’t meet that narrow criteria of dangerous-to-self, dangerous-to-others, because most people with mental illness are not dangerous. Second of all, you don’t want them to get to that level, [because] waiting for danger is too late. That would be an automatic arrest.

Therefore, jail frequently will become a viable option. The person is just sick, but the merchants are complaining. There’s so many nuisance crimes that we can charge somebody with that are going to fit the behavioral by-products of untreated illness: Trespassing, drunk in public, shoplifting, basically homeless with mental illness [on board].

So [the] Los Angeles County jails had come under great scrutiny because of the fact that people were beginning to recognize that the mental health system as it was set up wasn’t working. People were going to jail. Plus, there being a constitutional right to treatment *in* jail, jail was becoming a better mousetrap. At that time in Los Angeles’ history, there was only one psychiatrist, as I remember right, in the entire jail system. His name was Gene Kunsman. Fantastic man with roller skates on. But some of the people that were in jail, that was the only time they saw a psychiatrist is when they saw Gene. I can remember one guy, somebody asked him, “Do you have a psychiatrist?” and he names Gene Kunsman in the jail. The Task Force was charged with [determining]: what is causing this criminalization and what can be done in the jail system to prevent abusive conditions, if you will, for the people that are in there?

Ask me some more questions. The Task Force was extremely important in the history of Los Angeles mental health, because the white paper [Final Report] that was released by that Task Force [in April, 1993] actually didn’t



become a paper on the shelf with dusty good intents, like most do. Screening was increased in the jails so staff would know whether the person has a mental illness. Sometimes general population isn't the best place for that person [and the person could be moved to the mental health unit]. The staffing of the jail was increased considerably.

Out of the Task Force also came two projects. One was Law Enforcement/Mental Health Collaboration. The first one was what we call MET, the Metropolitan Evaluation Team, by the Los Angeles County Sheriff's Department. That was kind of interesting because the subcommittee that I was chairing for the task force was on law enforcement/mental health interaction. This then young deputy sheriff and young nurse came into that [subcommittee meeting] and said, "You know, we think we've got an idea here." And it was now retired Sergeant Barry Perrou and Linda Boyd from the Department of Mental Health. They had on their own, without official or public sanction – I don't think they ever got in trouble for it – ridden together as a mental health nurse and a law enforcement officer [for 17 days] to respond to 911 calls for what we call 5150, which is the police code for a mental health evaluation based on grave disability [and risk of] danger-to-self, danger-to-others; it may result in a person being involuntarily confined for 72 hours].

What they discovered during those seventeen days is that, by combining the knowledge of mental health and the knowledge of law enforcement, they were able to frequently calm a situation in the community, but more than that, exponentially avoid arrest, because they were able to divert the person with mental illness to the hospital, if necessary, to community programs, get hold of their social worker. [They were able to use] intelligences that neither entity had on their own. By combining their efforts, they now had the intelligence.

The MET team came out of recommendation of that Task Force. And then one of the other members on the Task Force was Detective Walt DeCuir from LAPD. Walt had been running LAPD's Mental Evaluation Unit since I think about 1984, when there had been some incident regarding mental illness. The Mental Evaluation Unit was a resource to Los Angeles cops, but it didn't have this go-out-of-the-office-with-mental-health component. So Walt started what is called SMART, Systemized Mobile Assessment Response Team. Walt now is also retired. And while these two guys were, with the support of advocates – I think I'd like to say that I was one of them. Long Beach MET calls me the "Mother of MET." (she laughs)

That MET concept has replicated itself throughout a fair amount of Los Angeles County and the United States. [There is no particular funding for it,] but the [police agencies and mental health] departments that are forward-thinking are recognizing that they are not only making better use of resources, but they're also doing more appropriate dispositions for the individuals involved. So those two programs came under that Task Force.

KM: So you were on the Task Force. Do you feel like you were representing a particular group by your presence?

CJ: Was I representing a particular group? I guess if somebody was to ask that question, I would be representing family members, but I honestly don't remember if that task force was divided down in that manner. Each Board of Supervisors had certain appointees. I have a feeling that I was a token family member. In fact, I'm pretty sure I was.

KM: OK. So it sounds like a pretty productive Task Force.

CJ: It was a productive Task Force. There were a lot more that could be done, if you will, when you recognize that a minimum of sixteen percent of our jail population has a severe mental illness on board. It was not enough, though, in that through CRIPA, [the] Civil Rights of Institutionalized Persons [Act of 1980], the Department of Justice did come in and investigate the Los Angeles County jail [in 1996] for abusive conditions. There were some fantastic people that were working very hard. Conditions were pretty bad.

I remember there was one woman. I was walking the deck in the old women's jail. She was in a one-woman cell, but she seemed to be dirty, and then I thought, no, she's covered with chocolate. She had basically covered herself with her own feces. The Mental Health staff were able to get her upstairs; but [in] the inpatient unit for LA jail at that time, I think there were only ten [mental health] beds and [they were] over in the men's jail. There was no place to transfer her, and she was so psychotic and so ill, she basically had to be kept in restraints for ten days until a bed opened for her. So conditions were pretty, pretty bad.

KM: This was in the early '90s?

CJ: And before. Based on those conditions, CRIPA came in, which is interesting. Threats of suit are sometimes just as effective as actual suits. I think that – some people may not agree with me – I think the investigation was actually welcomed by the various departments that were involved, the Sheriff's Department [and the] Mental Health Department. They knew they had a problem, they had to do something about it, and this gave them the impetus to be able to move forward more rapidly than they would have been able to otherwise.

Is it perfect in jail? Heavens, no. Jail can never be a hospital. Jail and prison is the wrong place to be shuffling people with mental illness. Usually, when they're this ill, they're too ill to recognize their own need for treatment. I think that the real problems, while there is a constitutional right to treat them in jails and prisons, allowed for these various suits, like the CRIPA investigation of the LA County jail system, like the Coleman case of the prison system in California, which still has not been settled, by the way. It's still open. [Ralph Coleman, an inmate of the Pelican Bay facility in Crescent City, filed suit in 1990 against Governor Pete Wilson and the Department of Corrections, citing "cruel and unusual punishment" for his failure to receive adequate treatment for his major mental disorder. In 1991, the federal court amended this to a class action suit on behalf of "all inmates with major mental disorders" in California prisons where no treatment was available – that is, all prisons except San Quentin and Vacaville.]

We remain in constitutional violation of the medical needs of mentally ill people. To be in constitutional violation, it means that you're aware there's a problem, you know what to do about the problem, and you have with wanton indifference failed to do so. That's a pretty high standard. This isn't any wishy-washy little bit of a problem. In the prison system, about the time of the Coleman case, up in Pelican Bay, men who were psychotic, who were ill, were being hogtied, stripped naked, and made to lap their food out of bowls without a utensil, like a dog would lap their food. Because the person was so ill and there were no

resources to handle people like this in the prison system. Some of it was pure wanton indifference and neglect. Some of it was resources.

So where'd I go? Off into the wilderness somewhere.

KM: Do you remember where the recommendations of the Task Force, where the money came to implement those changes?

CJ: Where the money came to implement those changes. I think the money for the Sheriff's Department – the Sheriff runs the jail – came directly from the Board of Supervisors through [the] County of Los Angeles. See, I think [in] about fifty percent of the jails in California, the mental health services are done by the local Department of Mental Health. Here in Los Angeles County, I believe that the local Department of Mental Health does pay for in-jail services. But there was more than just the in-jail services that went along with this, so it's no specific money stream.

The reason that Mental Health in LA County pays for the services was because of an old MOU [Memorandum of Understanding]. You've got to recognize, these were the old days; mental health was a stepchild of the system, and the Sheriff back then was a nine hundred pound gorilla, and if the nine hundred pound gorilla was to be fed, that gorilla's going to be fed and if it means taking some money out of Mental Health services to do it, then that might happen.

I'm not sure how the funding stream goes right now, but it's really fiscally unintelligent. I will say that, even though I do like a lot of people in LA County politics, to use Mental Health monies for in-jail services [is not a good idea], for a couple of reasons. Go back to the constitutionality. There's a constitutional right to treatment in jails and prisons, and the responsibility of that accrues to who is removing their ability to get services on their own. In this case, it's not Mental Health, it's the sheriff, OK, who has done that.

But the more important thing is that the money that goes into jail from the Department of Mental Health now can't be maximized by Medicaid, because Medicaid, through what's called the IMD exclusion, [the] Institute for Mental Disorder exclusion, is not available for institutional care for anybody between the ages of eighteen and sixty-five that have mental illness. So any money that goes into jail is money two times that is taken out of the community that could prevent criminalization in the first place.

So what was it? It was political, though, yes, the Board of Supervisors was responding to a series in the *LA Times*, but the Board of Supervisors back then didn't have to do that. CRIPA wasn't on their back then, there was no Coleman case, it was really a case of, I think, the community of Los Angeles County recognizing, "Whoa, man, what's going on here?" This isn't too smart when we've got most likely more people in our jail than we do in the largest psychiatric institution in the United States.

KM: What was the next initiative that you were involved with as an advocate, your next activity?

CJ: I don't remember when I was appointed to the Mental Health Commission. (she laughs) But sometime around this time, [I concluded that the law needed to change]. Remember, I'm going back to the Lanterman-Petris-Short Act [of 1967, known as LPS], which governs involuntary treatment of

people with mental illness. It is the Act that says that we will not intervene unless that person is a danger. My attitude is, that's discrimination. And the reason that's discrimination is [that in] any other medical disorder, we intervene based upon the person's medical capacity to make an informed decision. We don't wait for [the] behavioral byproduct that the person may or may not show. Most people with mental illness are not dangerous. They may be very, very ill.

By this time, I had, in my mind at least, I haven't [convinced] the entire community of the United States of this yet. (she laughs) I'm still working on it. In my mind, I had concluded that the LPS Act was discriminating, and that it was contributing to abuse towards people with mental illness [and] their families, costing the system way too much money, and had contributed greatly to the criminalization of people with mental illness.

My first legislative foray was a bill called SB104. Basically, SB104 was sponsored by then [California State] Senator Newt Russell from the La Canada-Flintridge area. [Russell retired in 1996.] And it changed or added a criteria that substantial deterioration due to mental illness and lack of capacity [were criteria for involuntary commitment]. Those weren't quite the same words, but that concept – the idea that somebody didn't have to be starving or bloody before we intervened.

I fell so far flat on my face with that legislative bill. I didn't realize – at that time, I still thought that people up in Sacramento were these old sage men, stroking their beards, [and] pondering our wellbeing. The State Department of Mental Health especially didn't like that bill, and the reason they didn't is because they thought they were going to have to spend more money treating people in the hospitals. So SB104 did not pass.

KM: It did not pass.

CJ: Newt Russell was great, and that wasn't the problem. The problem was that I hadn't recognized that you had to have groups of supporters behind [a bill]. I didn't understand the legislative process.

Out of the Task Force – [Senator] Polanco sponsored it for us. A couple of the guys – it wasn't really sponsored by the Task Force, but a judge, Judge [Harold] Shabo, and Dave Meyer, who was at that time Public Defender [later Deputy Director of the Mental Health Court], and I, ran with a diversion bill. Basically, we were saying that if somebody was arrested for relatively minor crimes, misdemeanors, they could be diverted from the jail to mental health treatment. That bill got a fair amount of support, moral support, in the mental health community. It was the District Attorneys' Association that kept that bill from passing.

The interesting thing, though, is that all these mental health and behavioral health courts that we're setting up, what they try to do is diversion. So it was an early emphasis on the fact that there are people in jail who are not dangerous, they're just ill, and they can be diverted to the community, where it won't be as expensive as holding them in jail, but they would also get well.

It was during that time, sometime around then, that I was elected to the NAMI California Board of Directors. NAMI, the National Alliance [on Mental Illness], back then it was actually CAMI, the California Alliance on Mental Illness, started out in 1978 as a family advocacy group. The people who started it here in California [were] Tony Hoffman and his wife [Fran]; they've since passed away. I think all of those – except for Dr. Lamb, Richard Lamb, that guy that educated

me, without making me go to school. He worked with the Hoffmans, and [their group] was [first] called Parents of [Adult] Schizophrenics. [PAS was founded by the Hoffmans and Eve Oliphant in San Mateo County in 1974.] He was Mental Health Director, I think, for San Mateo County at the time.

So I was elected to the state board of CAMI, now the National Alliance [for Mental Illness]. And where did it go from there? [I was appointed] Mental Health Commissioner in Los Angeles County. All this time I'm going around, trying to put together little task forces and groups of people, to look at what I see as an abusive treatment law that is still contributing to much of this problem.

### **III. Task Force on LPS Reform; AB1424 (“Laura’s Law”); NAMI Programs**

In 1996, NAMI Los Angeles County and the Southern California Psychiatric Association put together a Task Force to look at the involuntary treatment laws, the LPS Act. I co-chaired that Task Force with Dr. Elizabeth Galton [a Santa Monica psychiatrist]. Out of that Task Force came our white paper, the New Vision for Mental Health Treatment Laws. By this time, I was on the National Board of NAMI, and I was doing a fair amount of speaking around the state and nationally on the issue of criminalization. And at one of those meetings I had run into a woman by the name of Helen Thomson. Her husband, Cap Thomson, is an M.D., a former Mental Health Director in Northern California. And Helen had just been elected to the [California State] Assembly from Yolo County [where she served from 1996 to 2002. In 2010, she was a member of the Board of Supervisors for Yolo County, in California’s Central Valley]. So Helen knew that we were doing this Task Force. In fact, I think Cap actually came down [and] we met for two years. We had no official sanction, we just put ourselves together.

But we had some really interesting people. Gil Abdalian. Gil was from Gateways Hospital, [and Mental Health Center, where he was director of the] Forensic Mental Health [Division]. [Abdalian in 2010 was Director of Portals, a division of Pacific Clinics, a major contract mental health provider in LA County.] Lori Altshuler [professor of psychiatry at UCLA in 2010], who's quite a [researcher]. [Randall Hager, who dedicated himself to this issue as the father of a young man with mental illness; in 2010 he was serving as director of government affairs for the California Psychiatric Association.] June Husted [a psychologist at the Long Beach VA and associate clinical professor at UCLA]. Barry Perrou was the guy who started the MET team from the Sheriff's Department. [Dr. Barry Perrou, a clinical psychologist, in 2010 was Commander of the LA Police Department's Hostage/Crisis Negotiations Team, and Coordinator of Mental Health Services; he also served as a Mental Health Commissioner.]

June was a psychologist at the VA in Long Beach, and she and I did a survey out of my back bedroom, when you come right down to it, where we sent a questionnaire to every police chief in California, and we were asking effectively, “How many times do your cops become involved with somebody with mental illness? What are the resources you have?” It turned out that the law enforcement officer at that time was as likely to respond to a call involving mental illness as the officer was to any crime having to do with burglary, robbery, theft, et cetera, et cetera. We think that [when the] cops are out there, they're chasing down all those robbers and such. [Actually,] a good portion of them are responding to 911 calls involving 5150s.

The other thing we discovered with that survey – and the fact that we got about eighty percent return, which is amazing, because this was just a “Would you please fill this out for us?” [request to the police chiefs] – showed that there was such an astronomical problem in California that wasn't being addressed. I'd have to look back and see how many hours. I think that the average training that a law enforcement officer had at that time, according to that survey, was less than four hours on the issue of mental illness, and those four hours were shared with [training on dealing with the] hearing impaired, developmentally disabled, and a few other things. It took me more than four hours to learn how to spell schizophrenia (she chuckles) and here we're putting people out on the corners, out on the streets, as street corner psychiatrists. Cops never intended to be [psychiatrists]. Anyhow, so Barry and June published that paper.

Dr. [Robert] Liberman [UCLA professor emeritus of psychiatry in 2010] was on the Task Force. Drs. Roger Schock and Ed Titus. Ed Titus was a doctor in the Parole Division here in Los Angeles County, the Parole Division being the state parole, and the regional outpatient center. Marvelous man, but again, most likely one person, one psychiatrist, for hundreds and hundreds of mentally ill people. Dr. Schock worked for, I believe, the Department of Mental Health. He was a forensic psychiatrist [and] did a lot of consulting. [Dr. Schock was first assigned to work on jail mental health services by Director Harry Brickman in 1972.]

Bernie Zuber was a man with bipolar disorder. He didn't become ill until he was about forty-eight. He then ended up spending eight years on the street. He was so psychotic he thought that he had already died and gone to hell. And if, as he explained it to me, you've died and you've gone to hell, why would you take treatment? You can't get out of there. He eventually did receive treatment in the state hospital, and he became very, very well. But then he had to have stomach surgery a few years ago and they took him off all of his medication for the surgery, and when he came out of the anesthetic, he was delusional again. He thought he had died and gone to hell, so he was refusing medication. He died directly from that, I believe. He died because they couldn't get him to eat. If you've died and gone to hell, why would you eat? The medical system didn't know how to deal with the laws that have to do with involuntary medication as it pertains to mental illness. [Bernie Zuber, an artist and writer, died in 2005. His first episode with depression actually occurred at the age of 19.]

So it's just an amazing group of people.

KM: Right. So we just tell the tape recorder what we were looking at here. [Referring to white paper] This is the “LPS Reform, a New Vision for Mental Health Treatment Laws” from about 1999? [The full report can be found at: <http://www.desertpacific.mirecc.va.gov/news/lps-reform.shtml>.]

CJ: Mm-hmm.

KM: And the list of people you were just reading were all people involved on the [LPS Reform] Task Force [convened in 1995 by Los Angeles AMI and the Southern California Psychiatric Association].

CJ: Mm-hmm. There were people there from the ACLU. Rosa Kaplan [DSW]. She has since passed away. [Other people.] But out of that Task Force, several laws were introduced. One of them was AB1800, which would have

been a major reform to the LPS Act. That passed the Assembly extraordinarily well [in 2000]. It would have been looking more at the idea of medical capacity being the deciding factor as to whether somebody received social intervention or societal intervention, as far as medication goes. There's an awful lot of hearings right now.

It would have combined the hearings into what we were calling a super Gallinot, where the idea [was to consider in one hearing whether] a person [should] be detained AND treated in a hospital? Those are two separate hearings right now. [Gallinot hearings are certification and review hearings to determine if a 5150 hold should be extended, based on *Doe v. Gallinot* 1981.] So we can detain somebody in a hospital, but we can't give him the treatment unless there's another hearing. And we were bringing those hearings together into one hearing, because my attitude is that's the deciding factor.

If the person has the stable capacity to recognize they have an illness, weigh the benefits and the detriments of treatment, and the consequences of their decision, then as a society we have no right to intervene. They have the right to their decision and the responsibility of the consequences. But, if the person doesn't have the capacity to recognize they have an illness, weigh the benefits and detriments of treatment, as well as the consequences of the decision, then we as a society are obliged to intervene. The reason we live in a society is to help protect each other. Also Assisted Outpatient Treatment. Also the idea that the historical course of a person's illness should be considered in every step of the involuntary treatment way.

It was not a bill without controversy. And it especially was extraordinarily controversial to Senator John Burton, who was President Pro Tem of the Senate back then. [Burton, California State Senator 1996-2004, had served earlier in both the State Assembly and the US House of Representatives. In 2010, he was Chair of the California Democratic Party.] Some consumer movements, and also the Church of Scientology, they didn't like it at all. And we never got it out of the [legislature]. While it passed the Assembly, Senator Burton was head of the Ways and Means Committee and he refused to allow it to go to committee on the Senate side.

So it was like this silent scream. We have this bill that is going to make what at least I thought [was] major, imperative reform. We had support. Every major paper in California, with the exception of the *Orange County Register*, had come out in support. The *LA Times*, *San Francisco Chronicle*, *Sacramento Bee*, high support. That means something. For the series that the *LA Times* did that had to do with the homelessness, the criminalization, Laura's Law, and the reform to the LPS Act, they received the Pulitzer Prize for concise thought and moral purpose. But there's the silent scream, because one man had enough power to waylay the legislation.

KM: What was his motivation?

CJ: I really don't know. John Burton came out of the sixties, like I did, steeped in civil rights. He also is a man that reacts by his gut a lot. And we never found out his motivation, other than he didn't like it and "it ain't gonna happen," quote/unquote. "It ain't gonna happen." And so it didn't happen, but it didn't happen, [not] because of the democratic process. It happened because he controlled access to the committees that it would have to be heard in. And it was not without controversy. Believe me, you're going to [be] interviewing some

people that say that involuntary treatment is abusive, [that] we should never, ever utilize it. I believe it should be the last resort, but it should be a resort before we'd make somebody become dangerous. That's abuse, and it's discrimination.

So the next year, Assemblywoman Helen Thomson and [LA County Supervisor] Mike Antonovich held a hearing – actually, it was before [AB]1800, because they had a hearing down here in LA for us, for the Task Force, and this is a summary of that hearing [referring to the LPS Task Force Report]. “Mental Health Laws: Is Reform Overdue?” This is August 6th, 1998. The attendance of this [hearing] was beyond belief, because the question was: Do the mental health laws need to be changed? And on something like that, you would expect, oh, fifty people [for] an hour or two. It was five and a half hours straight of absolutely heart wrenching testimony. Five and a half hours. And they were keeping people to three minutes. This is how much it was known that things weren't working.

But 1800 didn't pass. The next year we had AB1421. AB1421 became known as Laura's Law, Assisted Outpatient Treatment [which allows for court-ordered outpatient treatment of mental health patients who refuse voluntary medication. That did have a very easy passage within the Assembly. I can't remember, but it passed by seventy out of eighty-two votes, or something like that, just astronomical. But when we got over to the Senate side, there was Senator Burton. He did let it through, and he didn't vote against it. He remained neutral, because it was so popular in the press, so popular with his fellow legislators and his constituents. But he did double-refer it – rarely does a bill get double referred to two different committees. And he had instructed one of the committee chairs not to let the bill through. [AB1421 became law in 2002.]

We had to settle for taking an amendment that has made it very difficult to get Assisted Outpatient Treatment implemented throughout California. That amendment basically said that each County Board of Supervisors would have to pass a resolution that no voluntary programs would be reduced in order to implement Assisted Outpatient Treatment. Very difficult for a Director of Mental Health to say that they can find money to do anything, unless there's new money coming in. So that was pretty good motivation for most Directors of Mental Health to not support implementing the new law.

The reality is, though, you have to have the political will, as well as the bureaucratic creativity. In Los Angeles County, we did have it. [In] Los Angeles County, the Board of Supervisors, early along, I think a year after passage of the bill, passed that resolution, and Marv Southard, the Director of Mental Health, [Dr. Marvin Southard, Director of the LA County Department of Mental Health from 1998 to the time of this interview in 2010] did start and has a pilot project with forensic patients. However, now, he has just started a pilot project as a hospital discharge plan. And it's that hospital discharge plan that's so very important, because it'll keep people from revolving back into the expensive hospitalization. It will give them the opportunity to get well, stay well in the community so they don't *have* to be arrested, so they don't *have* to become a danger, and they don't *have* to go to a hospital. I can't see why that's controversial. Guess what? It is.

But the other county that implemented it was Nevada County [in the Sierra Nevada mountains in NE California]. I just got off the phone yesterday with Judge [Tom Anderson] from Nevada County, where he says that Assisted Outpatient Treatment in his County has reduced 5150s by half. Now that's not because all the people are on Assisted Outpatient Treatment [AOT]. There's a



lot of reasons. Law enforcement, mental health, the judiciary, and the consumers and everybody have come together to work better together. It also has allowed mental health providers to model themselves on the fact that you get intensive treatment and you can avoid hospitalization.

One way or the other, he credits Laura's Law, AOT, for reducing 5150s by fifty percent. That's pretty extraordinary. That's real cost savings and that's real life saving.

KM: Incidentally, who is the Laura of Laura's Law?

CJ: Laura was Laura Wilcox. She was a nineteen-year-old girl volunteering at a Department of Mental Health [in Nevada County] during [her winter college break], when a man on treatment for mental illness came in and murdered her and two or three other people [in January, 2001]. Her parents were Quakers. They never believed in involuntary treatment; they just didn't believe in that. But they recognized that if Laura's life was going to mean something, they needed to make her death mean something. [The bill, AB]1421, Assisted Outpatient Treatment, most likely wouldn't have prevented this particular tragedy right away. But they became supporters of AOT and threw their support behind us.

Some people will say that we're promoting violence by naming it after a young girl that was murdered. It wasn't because of the murder, it was because of this family. They have no relationship to mental illness. It wasn't like me. I mean, my genetics are all over the place when it comes to that. They had nobody in their family, but instead of being vindictive and throwing – Scott Thorpe was the guy that murdered Laura – pushing for him to go to prison, to get the death penalty, all those things – they actually pushed for him to get a not-guilty-by-reason-of-insanity [plea] to go to the state hospital. They pushed for his treatment rather than his punishment.

And it was in honor of that dedication that they've shown to people with mental illness. [If it was] my eighteen-year-old daughter? I don't know if I could have been that gracious of heart. And then to show you how gracious of heart they really were – There was a lawsuit, of course. Not much. They asked for, I think, a building to be named after her and a very small amount of money. They could have gone for more, but the settlement that they got, they [gave as] the largest individual donor to the Mental Health Services Act [of 2005]. I personally think that I'm honored to have Laura's name attached to that bill. Very honored.

Other people may have had a lot of other stories, but that is the story as it happened. So AOT came out of that. There are now about eight counties around the state that are considering it. It's hard, very hard, because – I have to give Marv Southard a lot of credit here. A lot of Directors of Mental Health don't want the accountability that it represents. Before AOT, they were able to say, "We offered them help, but they didn't want it." With AOT, they have to assure that they're going to have services available [and] give those services for a minimum of six months to that person. That's accountability. When it passed, the [California] State Director of Mental Health [from 1993 to the time of this interview in 2010], Steve Mayberg, in a press conference with me, said it was the first time that a level of accountability had ever been introduced to the system.

Anyhow, there are [other] counties that are considering it. We need to get rid of that Board of Supervisors' Resolution because as hard as it was to pass the bill on the state level, it's now like passing it on fifty-eight different state

levels, when you have to take something to the Supervisors to pass it, who then have to instruct their [Mental Health] Director to pass it, to implement it.

Also [what] came out of this was AB1424 [which also became law in 2001]. AB1424 stated that the historical force of a person's illness shall be considered at each step of the involuntary treatment process. And the family input shall be considered. The families were frequently held mute. They had knowledge that could help the person with mental illness. They knew what medication worked, they knew what medication didn't work. Nobody would listen to them, because they weren't part of the system. So now [their input] "shall be considered." That doesn't mean that their input directs the court proceedings; it just means that they shall be listened to.

AB1424 took the immanency [out]. Basically, before, [for someone to be considered dangerous or suicidal, the] common practice or common belief was that you'd better be dripping blood. And while there was no poison pill in the bill, there wasn't an educational component to it. Where it is being utilized, I have been told many times over that it's saved a lot of lives.

There was also AB1422, another Helen Thomson bill, that basically was setting up funding the Adult System of Care. The lights were twinkling in California at the time. But that bill, AB1422, was effectively Recommendation 13, but a good portion of it went into the Mental Health Services Act, which has become (she whispers) a joke.

KM: We can talk about that a little later. (both laugh)

CJ: That's become a real joke.

KM: Can we talk a little bit more about your work with CAMI and NAMI? What were some of the activities that you did in that capacity, and who were some of the people you worked with?

CJ: I would say that with CAMI, I was chair of their Criminal Justice Advisory Committee and on the Legislative Committee here in Los Angeles County, which is most likely what your oral history is about. The people that were the true leaders, if you will, the early leaders, [include] Don Richardson. Don Richardson died five years ago [in 2005]. Don was a school administrator [and one of the founders of the Los Angeles AMI chapter; he served as Director of National NAMI in the 1980s]. But he was one of the early CAMI people. He was instrumental in getting what's called CONREP, [the] Conditional Release Program [mandated as a Governor's Mental Health Initiative in 1984,] where if somebody comes out of a state hospital, they will be released into an intensive community treatment, rather than just dumped on the streets. People who have been there on NGIs [not guilty by reason of insanity pleas] or MDOs [as mentally disordered offenders required to receive treatment as a condition of parole]. [CONREP is a statewide system of community-based services for specified parolees with mental disorders which began operations on January 1, 1986.] [Don] was on the Mental Health Commission before I was. I don't remember. It's just that Don was always there.

He started Proxy Parent Foundation. I'm on their Board of Directors now, and for a few years I was acting as their volunteer Executive Director. Proxy Parent Foundation basically is when a parent dies, we step into their shoes and try to do whatever it was that the family was doing to breach the gaps between

what the system provides and what is really needed for a person to survive safely in life. It can be as simple as just visiting the person once in awhile, helping them make arrangements for additional education, helping them get dental work, or it could be homeless outreach. It's whatever the family did, and whatever the system isn't doing. That's a heck of a lot.

Stella March. I shouldn't pick [certain] people, because I know I'm missing a million. But Stella March – have you met Stella?

KM: I have not.

CJ: Little tiny woman about this big. She's one of the forerunners of NAMI. Little tiny, tiny, feisty woman, and if she takes the lapel of a politician, believe me, that politician is going to listen. [She and Don] were real advocates. She started the Stigma Busters [a program to challenge stigmatizing representation of the mentally ill in the media], which is all over the place now, [and the] Anti-Stigma Campaign.

KM: Do you have any particular memories of her or some of her activities?

CJ: Well, the Stigma Busters – she's still alive. I would say that the Stigma Busters is the biggest activity that Stella has taken on. We just know each other very well. It's funny, after you know somebody for a while, you don't know exactly what they do. But still, I would say that she has made [the Stigma Busters] into a national movement.

Who else? Well, my husband, Brian. We both got suckered into this, if you will. Earlier, I think I said he was a little bit bolder than me. In reality, he's much nicer than I am, and more dignified. He was president of the President's Council of the NAMI affiliates. He brought what is called Family to Family to California [a twelve-week course for family caregivers of persons with mental illness, taught by family members themselves]. We were at a national conference, and he had gone to a workshop about a structured educational program where family members could go in for free and learn what mental illness is, how it's treated, what's good, what helps, what doesn't help, and gradually then become an advocate for their relatives with mental illness. He was an educator all of his life, and he thought this was a fantastic project. He said, "Somebody should bring it to California." Well, in our family, if somebody should do it, then you ought to do it. I said, "Well, Brian, I guess you should." And he did.

I was on the NAMI California Board at the time. This one wasn't easy, either. Believe it or not, there was controversy. A free educational program, and it's controversial as to whether we should have it or not. So we raised the money, the first monies, and he trained all of the first teachers in California. It was then called Journey of Hope. And I think it's gradually [grown]. Last I heard, [there were] about forty thousand [participating] families now, in California. Very successful.

KM: Can you explain the controversy to me?

CJ: It has nothing to do with Los Angeles County. It was just on the California [CAMI] Board level: "We're California. This is a program that's from someplace else. And the money that it was going to cost, should it be spent on somebody

else's project?" That sort of controversy. I remember one of the Board members saying that it shouldn't be brought to California until it could be translated into Mandarin [Chinese]. Really, he was anti [Family to Family] coming, because [of] the money [it] then would have cost the state organization to bring – not much, because we had to raise the money to do it. He felt we'd be detracting from another project that they had been working on. That sort of stuff. There's always this tension. It wasn't controversial in the community. It was controversial only on a very limited [short-term] basis. But it's made a huge difference.

Our laws are such that a person with mental illness can be sent back to live with their aged mother and the mother not even know or be allowed to know what the name of the illness is. [Having family members] who know what the illnesses are, how [they can help], is much more effective than "let them go into the night."

Who else in NAMI? There's just been so many. The real heroes are the old people who lead the local affiliates and every week get calls [for help] from somebody saying, "My kid is sick. I can't get help." Every week [they] make sure that the church will let them use their basement for the meetings, make sure that there's going to be stale Oreo cookies there, put the newsletters out. So there are always leaders, but it's the people that work on the very local level that keep things going. They're the ones that I admire more. Anybody who's a leader is always opinionated.

On the national level, Fred Frese, who is not from LA, but he is just an amazing man. He's a man who has schizophrenia, who became ill when he was in a very, very sensitive position in the U.S. Navy. I don't think he quite had his finger on the red button, but it was pretty close. For years he was actually the chief psychologist in the state hospital system of Ohio, but couldn't tell anybody that he had schizophrenia because there was so much stigma against [it]. Then finally, he realized, "This is wrong for me to be hiding *my* illness." And he came out, most likely about 1984. I have always enjoyed working with him. [Dr. Frederick J. Frese was diagnosed at the age of 25. From 1980 until he retired in 1995, he was Director of Psychology at Western Reserve Psychiatric Hospital in Cleveland. In 2010, he was serving as coordinator of the Summit County Recovery Project, in Akron, Ohio.]

Fred still experiences symptoms, and sometimes those are auditory. [If] things are getting a little bit rough, the auditory hallucinations might [kick in]. But his thought process is so good. Some of those Board meetings, like on the national level, [last] three days. It's like they try to keep us sensory deprived or something. Three days in these long, long meetings. If I ever heard Fred start whistling, "Take me out to the ballgame," then I knew it was time for me to listen up. Somebody was trying to pull something over on us. (she laughs) I learned so much from him.

[And then] there was Fuller Torrey, of course. He was never on the Board, but Fuller Torrey is the author of *Surviving Schizophrenia: A Family Manual*. He's got more books out. We always laugh because if something happens to Fuller on Wednesday, he's got a book published on Friday. [Psychiatrist E. Fuller Torrey is founder of the private Stanley Medical Research Institute in Bethesda, Maryland, and of the Treatment Advocacy Center, which seeks to eliminate treatment obstacles.]

With Fuller Torrey, I was very lucky in that I became one of the founding board members of the Treatment Advocacy Center. Fuller is a fantastic man. We met him very early on, at an early CAMI convention, before we were involved

really with the organizations. When we were still a token face, a poster child for people who wanted laws here in California. And Fuller never acted that way to us.

KM: When you say “we,” do you mean your family?

CJ: Brian and me.

KM: You and Brian.

CJ: Yes. We were a willing poster child, but back in 1990, 1991, because of the enormity and the publicity that went along with that tragedy, we were poster children. We can both say as much as that tragedy has impacted everybody's life, we have met better people through law enforcement, mental health, advocacy, et cetera, et cetera, than either of us could have ever met [otherwise] in our lives before. People that are just doing their job every single, solitary day. People who have stature within our community, but better people, better-hearted people.

I know I must know somebody else in Los Angeles County.

#### **IV. Working with LAC-DMH; Mental Health Commission; Persistence of Stigma; Reflections on MHSA; Closing Comments**

KM: Let me redirect that a little bit and ask you, it's a deliberately open-ended question. How would you describe the relationship, over the years that you've been involved in either CAMI and NAMI, between those groups and the Los Angeles County Department of Mental Health?

CJ: I have never known the Los Angeles Department of Mental Health not to have a working relationship with NAMI. I do know that from old stories from Don Richardson and such, [that] a long time ago, it wasn't like that. It was adversarial, because the families weren't considered a part of the system, the families were considered the cause of mental illness, and the families were looked upon as worrisome little gnats. But that was well before I came on board. I'm sure that if you go around, you're going to find lots and lots of people who say, “Hey, let's support the family, da, da, da, da,” [but who do not really mean it.] The reality is that “support the family” basically means “let's get treatment to the person who's ill.”

I've always personally had an excellent working relationship with the LA County Department of Mental Health [and the] LA Sheriff's Department. So has Brian. Overall, [in] NAMI, I'm sure it's going to depend on who you talk to, but as long as the goal is to expand treatment and get appropriate treatment, and less abusive treatment, I think the relationship's been pretty good.

KM: Do you remember any examples of very productive moments of partnership or any moments of challenge?

CJ: Moments of partnership versus moments of challenge. (pause) I think it's always challenging when you're suggesting that there could be a different way to do something other than what the system has been doing. There were moments

when I made it pretty challenging for them regarding Assisted Outpatient Treatment.

KM: Are you speaking specifically of the Department of Mental Health?

CJ: Well, the Department of Mental Health, but not in a negative manner. Whenever you've got somebody up there advocating for doing more, I'm sure that it is challenging. Working together well? The various task forces [are good examples]. The Department of Mental Health was part and parcel of the Task Force on the Incarcerated Mentally Ill. Getting AOT up and running. They've been very instrumental with that. Getting Family to Family, helping to spread Family to Family.

I'm sure there's many times that I flubbed up, and I'm sure there are times that they flubbed up, but I don't remember those times. I do remember that I'm sure there were times that I was out there protesting some flub-up, and I'm sure that I ticked somebody off in the Department, but I have not seen any of that get in the way of movement, that is slow as molasses, but I guess that's the way that our system works. But there has been movement.

There are individuals within the Department that I have admired greatly. One of them is Marv Southard.

KM: Right. You mentioned Dr. Southard. Were there previous Directors that you worked with?

CJ: The only other Director that I worked with was Areta Crowell. Areta Crowell is a very well respected fellow Canadian, a former Director [from 1992 to 1998]. She is retired. Areta was the Director during the time of the Task Force on the Incarcerated Mentally Ill.

Individuals. Steve Jacobson from the jail works for the Department of Mental Health. I hope he's still there. He was a psychologist at the [LA County] female jail, Sybil Brand [Institute, which closed indefinitely in 1997, following earthquake damage]. Gene Kunsman. Those people worked their hearts out in horrible situations. I kept promising them I'd get them out of jail someday too. The people who are willing to work in jail, in the mental health units [handle] some pretty hefty, horrendous situations. I've got an awful lot of admiration for them.

There's been a lot of individual social workers that just tried their hearts out. I've never really seen anybody that I would say – I've seen some people that maybe aren't as competent as they should be in the way they do their jobs, but I don't think I've ever really seen anybody in mental health that purposely has done anything wrong or a bad job. Because nobody is going to get into mental health unless they have a moderately good heart. Why would somebody want to be Director of Mental Health at the salary that they earn when they could be earning a quarter million? Salary ranges. Being a psych tech or a psych RN, you've got all this education behind you, [but] you're just not going to be making as much money as you would in private industry. There's usually a reason that you've gone [into the field,] and it's [that] people have decided that they wanted to help each other. Sometimes it doesn't turn out that way, but the intent was always there.

KM: Just want to be sure we don't leave any gaps in your career. You mentioned the Mental Health Commission.

CJ: Mm-hmm.

KM: That's Los Angeles County?

CJ: Yes.

KM: A lot of the initiatives that you described that you did, did you do from that chair[manship], or other activities that you did?

CJ: No. What I did is I used those titles to get those initiatives done. If I went up to Sacramento and I went up there as Carla Jacobs, nobody's going to listen to me. But if I went up there as Carla Jacobs, Board Member at NAMI National, and Mental Health Commissioner of Los Angeles County, and Board Director of the Treatment Advocacy Center, and by the way, I am speaking as an individual, not as a representative, it gives me a lot more credibility than it does Carla Jacobs going up there and saying, "You know, we've gotta change this law."

Think what happened with Senator Newt Russell's bill, SB104. I was the only person up there; we were basically the only people up there advocating. That sounds terrible. Did I use those titles? Many of those pieces of legislation were sponsored by NAMI, or supported by the diversion bill, etcetera, [the] Mental Health Commission. Most of those ideas and most of those things that I worked on, there wasn't any one group, there wasn't any one person. You looked at the Task Force; that was an ad hoc group of people who got together to try to get something done. Some of them were Mental Health Commissioners, some of them worked for the Department, some were Sheriffs or worked for the Police Department. It just really takes an elephant to move this particular walk up that hill. (she laughs)

I'm trying to think of who else. As soon as you leave, I'm going to remember, "Oh, I should have mentioned so-and-so. They were fantastic." I think with the Mental Health Commission, I was Don Knabe's appointment, Supervisor Knabe's. [Knabe served as LA County Supervisor for the Fourth District from 1996 to the time of this interview in 2010.] There are pictures of people going in front of me that may have worked in jail, may have been part of the Mental Health Commission, may have been one or two of the cops who worked on the streets. Joe Santoro, the former police chief of Monrovia [1989-2002, now Dean of Public Safety at Rio Hondo College], was so instrumental in a couple of the pieces of legislation, getting all the police chiefs in California to support [them].

KM: Since you mentioned it earlier, we are interested in this project in some ways revisiting the Mental Health Services Act, so maybe you could talk a little bit about the genesis of that legislation.

CJ: Tell me a little bit more about what your interest is.

KM: Sure. Were you involved in its development at all?

CJ: Is this off the record or on the record? (she laughs)

KM: Well, it's on the record, but I can remind you that there are potentially different versions of the record. The version on the Website, there's the version that potentially can be archived for the future.

CJ: NAMI California, of course, supported the Mental Health Services Act.

KM: So that's the on-the-record.

CJ: Mm-hmm. I personally thought it was a house of cards. All of our funding streams are a house of cards.

KM: And you thought that from the beginning?

CJ: Oh, yes.

KM: Why?

CJ: Why? Because we have tied the funding sources for mental health services into schemes, a percentage of the sales tax, a surtax on people who earn over a million dollars, license fees, et cetera. If mental health was a real priority of the people in California and the legislators, it should have a steady stream. It should have a guaranteed funding source. And I felt that the Prop 63 funding was again this funding source that couldn't be counted on, because it was too volatile. [Proposition 63 was the 2004 ballot initiative that became the Mental Health Services Act.] It was based on less than one percent of the state's fluctuating income. That's just too volatile. I personally would have liked to have seen us – the times were good, the publicity was good – to go and get some structural changes in the way the funding occurred, where it wasn't going to be as [volatile].

I also had a concern, and that concern was that I had spent enough time up in Sacramento that, if times got better and the mental health community went and said, "Dear legislators, yes, we need more money. You're giving out more money to other people." They're going to say, "You got yours over there, the Mental Health Services Act." And in parts of California – I don't know [about] LA County, I haven't been involved with the budget process there for some time, but [in] a lot of counties, and also on the state level – what they're saying is, "You've got your funds there, so we're going to cut back on MediCal." There's the house of cards.

So what has happened is – and then also this entire process of stakeholders meetings grinding it all out, and all that sort of stuff – what's happened is two-tiered systems [have] occurred, where there are people who are getting supposedly good services – and we really don't have the stats yet to see whether they are or not – versus people who are being graduated out of the MediCal system. In some counties, what's going on is swaps are being made. They're just taking a person out of this program and putting them into [that] program and saying it's a new person. The regulatory process was a complete reinterpretation of what the Proposition said. So what is my opinion? Gee, on the record or off the record? (she laughs)

KM: Have you been directly involved in the stakeholders process?



CJ: No, I have avoided that like the plague. I have been involved with the regulatory process, and I have enough spies throughout California, family members, people, husbands, things like that. The stakeholder process has been good in a lot of regards, because it has brought divergent personalities to the table together to work things out. But if you get interested in that, I'll let you talk to some people who have been through the stakeholders process.

OK. We're talking about LA County. LA County was ahead of the game, and this much I really remember. This is on the record. As far as the stakeholder process and the Mental Health Services Act goes – this is very definitely on the record – LA was way ahead of the game because LA already had family [and] client stakeholder groups meeting. So they were able to really get ahead of the game, rather than to have to go through the painful process of the state trying to figure out what they really wanted out of that process. So whatever I said about the Mental Health Services Act, I am not qualified to talk about it in Los Angeles County. I'm not.

I can tell you, though, on the state level, especially the regulation [process] where they're putting out emergency regulations and rewriting two years, three years, fighting to try to get it just moderately back to what the Proposition said. If you ever want to think about it on the state level, let me know, I'll give you some people you can talk to. [pause]

KM: Apart from the fifty-year retrospective aspect of this oral history project, the goal is to make this public through the website, with the goal of reducing stigma and educating people on both the [challenges facing the] mentally ill and Mental Health Services. Maybe we could talk a little bit about the stigma. If you agree, why do you think stigma persists?

CJ: I think stigma persists because we don't get [treatment for] people with mental illness. It's as simple as that. If people weren't eating out of garbage cans, if they were receiving treatment commensurate to their needs – People with Hansen's Disease used to be stigmatized, and that was because you could see the fact that they were lepers. It wasn't a change of name that changed the stigma that was associated from leper to Hansen's, it was because leprosy became treatable. And there's still a lot of people with Hansen's Disease. But you don't see them. You don't see the stigmata of their neglect.

So why is there stigma? I'd personally like to call it discrimination, because that's what I see it as. We don't treat neurobiological brain disorders on a parity to other medical disorders and diseases. To me, that's not stigma, that's discrimination. And if there is stigma, it's because of the fact that we don't provide people treatment that they need. And thus there is stigma. (she laughs)

KM: Yes. Related to that, how would you define “recovery” in the case of people with mental illness?

CJ: There are people who recover from mental illness and they never have another episode. And there are people who are recovering, i.e., they're getting better, and there are people who are living with mental illness. The buzzword “recovery” sounds so great. Recovery would be somebody being able to achieve what it is that they wanted to achieve, and being comfortable and safe, and being able to have some enthusiasm. They may still have their illness.

But what I worry about is that we will use this theory of recovery, and the term recovery, as a reason to excuse our own neglect of those people who can't pull themselves up by their own bootstraps and accept and go on on their own, and all of that. And there are a lot of people who can't. They just don't have – don't recognize they have an illness. And if you can't recognize you have an illness, why would you have to take treatment for it? I wouldn't.

And that is a symptom of the brain dysfunction. It's not willful denial, and it's not because of the stigma. Simply put, the brain can diagnose when the leg is broken, but the leg [can't take over for the computer of the body and see when it, the brain, is broken.] And I very, very much fear that, when so much is especially driven by money, that the word “recovery” and the idea that people [are willfully making] their own decisions, and so on and so forth, can be turned into an excuse for neglect [of the most seriously ill].

Now, yes, it's much better when people can participate, and do participate in designing the program that helps them, that really works for them, the treatment that they want, that they are able to set their own goals to what education, where they want to be. What we all do, you know? But I don't know what the movement is. I'm sorry. What is that recovery movement? The recovery movement is just good practice. Boy, am I going to be in trouble for saying that one. In some cases, it's a good PR campaign. But the reality is that, yeah, it's much better when people can actually not only survive but thrive and enjoy their lives.

KM: Accumulatively, you've probably already answered this question, but what would you think has been the most important change or development in mental health services in LA County during your tenure?

CJ: During my tenure?

KM: Yes.

CJ: I honestly think that the most important change has been the collaboration between law enforcement and mental health. I think now you're seeing that you can't take a person with mental illness and put him into a box and say, okay, when he's in his box over here, you take care of him, and when he's in his box over here, then we'll [take care of him]. There's got to be the collaboration and the willingness of law enforcement [and mental health] to recognize that mental illness is a no-fault brain disorder, [so that they] work to avoid criminalization, or avoid, whenever possible, arrest. That has been pretty life saving to a lot of people. It's more than just being able to communicate together when law enforcement knows the resources that are available, where a person can be taken to a place of safety and avoid victimization, tragedy, whatever might occur. That's my personal opinion, [that the most important change] is the collaboration.

KM: I won't keep you too much longer, but before we wrap it up – perhaps this hasn't become a personal question, but since we started off talking about your brother, I'm curious to know what happened to him.

CJ: My brother's still missing.

KM: Oh, he's still missing.

CJ: Yeah. Found him a couple of times. My brother and I loved each other and there wasn't any problem there. [But] when he would get ill, he always [needed to] outsmart people that [he felt were] following him, like the FBI, so on and so forth. He's never been dangerous to anyone, so he's never had any treatment. Anybody wanted to give him food, he'll eat. (she laughs) [So he's never been considered gravely disabled.] The last time I heard about my brother was through a missing persons [police officer]; the last time that he had come into contact with the system was when he had been assaulted in a Skid Row. For every loud and noisy tragedy, there are thousands of quiet ones, and the quiet ones are just as important to the people who love them.

KM: You talked about the most important developments in the last twenty or so years in mental health services. If you had the power to make it happen, what would be the next major thing that changed?

CJ: (she sighs and then laughs) The system is so bloody broken that it's impossible to pick one thing. My thing is medical capacity, I guess. If we would start looking at the person's medical capacity to make an informed decision. If the person has that capacity, then we have no right to intervene. [But, if the person due to their illness does not have the medical capacity to truly make an informed decision, then we must intervene in their behalf.] That I think would make the biggest difference in the overall stigma. Recovery. People being able to get well. Criminalization. Is that ever going to happen in my lifetime? I doubt it.

Right now, maybe not in LA County as much, but we're heading into a big crisis because inpatient services are being reduced so much in the state. Where the people that are failing to thrive in the community, just because we closed down the acute care bed [units] doesn't mean that they don't need help, and doesn't mean that they're not going to show up somewhere else. So they're showing up in emergency rooms [and in jails].

The overcrowding [of jails?] You know, sometimes the things that you hope for become what you dread. I want people with mental illness out of jails and prisons. I want them to receive the treatment they need. But with the overcrowding situation, now we're going to let them out with early releases [from] jails and prisons, [but so far with little planning as to their needed treatment and supervision so they don't end up in] the exact same circumstances that got them into jail in the first place. Unless there's some really proactive effort to include the very, very ill people in our system of care – and that includes the people who are going to come out of jail and prison – it's a merry, merry round robin, that's all it is.

That's going to be a big challenge because systems don't like sharing their goodies. The reason people are going to be early-released from the prison system is ostensibly because of the lawsuits, the Coleman case and such, which I referred to. We've been in constitutional violation for going on twenty years now. What it really is is [that] the prison system's a drain on the state budget. Yes, we're going to get people out of prison, but what are we going to do when we have them in the community?

Unless we can take some of the money that we put [into our jails and prisons] – when we took the people out of the hospital into the streets, and then

we put them in jail and in prison, what we did is we took all the money that used to be dedicated to their care – [we will not be one iota further along in helping people with mental illness]. OK, we're going to [have to] somehow bring that money out, too, [because without] basic human services, housing, support, and treatment, it's going to be [more] disaster on the streets.

KM: Before we wrap up, is there anything else you want to add or talk about that we haven't so far, that you want to get on the record? I feel like we've covered a lot of ground, but I know you also wear a lot of hats.

CJ: The thing is that I haven't been in Los Angeles County really for a few years. I can talk history, [but I really don't know what's happening there now]. And I guess that's what this is, it's an oral history, isn't it? It's a saga. It's the oral saga of Los Angeles Department of Mental Health.

KM: That's your Icelandic heritage coming through.

CJ: Mm-hmm. (she chuckles) And some [memory] is real and some not so real. Memory. I think there's been a fair amount of scientific research that memory is not as valid as people like to think it is. It's very shaded by opinion.

KM: The consumers of oral history will probably take that into account.

CJ: And then we'll see if somebody's reading it wherever the controversies were, in two hundred years. You know what? Most likely the controversies are still going to be there. I guess there's going to have to be a cure before things really get better.

KM: And that cure is sufficient treatment?

CJ: (she laughs) Neurobiological brain science is making such advances. What's sufficient treatment? There is no magic bullet out there. There is no magic button. What helps some people doesn't help others. Again, I'm talking from my perspective. I'm talking [about] severe persistent neurobiological brain disorders. Some day there may be a cure. Some day. Who knows? Maybe before we get the warts worked out of how we're going to deliver services. Some day we may be able to prevent it. It would be nice maybe if we could do that even sooner. I don't think we're going to fix our problems all that soon. It's [as slow as] molasses. And that's been frustrating.

What I want to know is, who is the poor soul that you have trying to transcribe this?

KM: Well, maybe you could thank them in advance for their work.

CJ: Thank you very much, and I'm very, very sorry that I've got a very strange accent, because I have an idea you're going to be scratching your head an awful lot.

**END OF INTERVIEW**