

Areta Crowell
Interviewed by
Frances Lomas Feldman
at Dr. Feldman's Home
On
March 22, 1999 and November 6, 2000

ABSTRACT:

Dr. Crowell, a psychologist with a special interest in social planning analysis and demography, retired from the directorship of the Los Angeles County Department of Mental Health, which she held from 1992 to 1998. Earlier, she had taught psychology, leaving that to become the Director of Research for this county program. She interrupted that assignment to work in the innovative Center for Training in Community Psychiatry, located in the University of California, Los Angeles, then resumed her former position in the County Mental Health Department, which now had merged with the County Department of Health. The County of San Diego then recruited her to direct its mental health program and she remained there until persuaded to take the directorship of the Los Angeles County Department of Mental Health, which once again was freestanding. This interview describes her perceptions of factors that influenced the operation of the department and the programs that were developed within it. It offers some insights into elements that influence the recognition of mental health needs and the development of services to meet those needs.

FELDMAN: This is an interview on March 22, 1999, with Areta Crowell, retired Director of the County Department of Mental Health. Why don't we start, Areta, with your telling us how you got into the field of mental health.

CROWELL: That goes back to a mixture of personal and professional decisions. I am a psychologist. In New Jersey, a psychologist at the university where I was teaching, who had a very strong background in rehabilitation as well as demography and social planning analysis, got a job (in 1963) as the Director of Research for the Los Angeles County Department of Mental Health, and left the university in New Jersey to come here. That was an NIMH research project.

FELDMAN: Who was that?

CROWELL: George Moed, Ph.D.

FELDMAN: I remember his work.

CROWELL: A grant was awarded due to the work of, mainly, Don Schwartz, M.D. who was then Chief Deputy of the Department of Mental Health, and who felt that what was going on in terms of community mental health, needed to be documented and tracked and evaluated. George was recruited for that position. Meanwhile, my husband Clarence, a physicist, was recruited by Bell Telephone Labs in New Jersey, from McGill University, in Montreal, where both of us got our PhDs. While we were in New Jersey, I taught at a private university where I met Dr. Moed. When Clarence came to USC in 1966, and I looked for meaningful activity, George Moed introduced me to Dr. Arnie Beisser at the Center for Training in Community Psychiatry where I was considering employment, when this opening came in the department. I think this was quite serendipitous, because it was really quite an exciting opportunity to develop a whole program. The first thing that George worked on was the Census Tract Street Index, which did not previously exist, as a way to be able to, on a continuous basis, relate where people lived to the geography of the county, so that you could plan for service delivery. These are fundamental planning concepts, but nobody had put the tools together for Los Angeles. That NIMH grant was basically used to set up that whole mechanism for Los Angeles County, and was used by many other departments including the Sheriff's Department even. One of my first jobs was to essentially do a demographic map.

FELDMAN: What year was this? Do you recall?

CROWELL: I went to the County in December of 1966. In 1967 and 1968, we were mapping the geographic distribution of the home point of origin of all the clients in the state hospitals. There were about 5,000 State Hospital residents in Metropolitan L.A. County then, and, of course, there were no computerized records or anything like that. What there was, was a card file of all of the people. A lot of the information on that card file was very poor. So we sent clerks out there to get addresses and identify the appropriate census tracts of residence for each patient. This became the basis for planning the distribution of where clinics should be developed. What was happening at the County at that time, was post-Watts Riots Insurrection planning, and people were concerned about this impact of the Riots on the community. Some of the recommendations that came out of the Commission led the County to start building a hospital in that area. There were also several community efforts to use federal funds to start community mental health centers. According to federal regulations, there could have been 55 centers. Resthaven, Central City and Kedron covered the Central and south Central area that were the center of unrest. Another center, Gateways, was west of that. There was a lot of affirmation for that kind of facility and program development, and the County provided data and other support to help the community outreach activity that was going on in the community. Community mental health started, and they took a major interest in helping the schools.

FELDMAN: In 1995?

CROWELL: It wasn't quite that late, but it was 1993 or so, when it finally passed the Children's Planning Council. Passage of the Lanterman Petriss Short Act in 1968 required the County to have an annual plan. Then I was appointed to be in charge of that Division

and the Department had a huge job to assume the responsibilities involved in that act. We were in flux and turmoil and there had been so much change from the beginning of the Department, with the idea that we were going to have a system of community mental health for 55 catchment areas in Los Angeles County. At that time, the vision was that every catchment area would have a hospital, an outpatient clinic, a day-treatment program, kids programs, adult programs, community consultation, outreach, and just the full panorama.

I can remember one application that went into the Feds for \$5,000,000 for one of those catchment areas, and that was at a time when the whole array of services was needed in some areas, especially in the early 70s.

FELDMAN: How many of those catchment areas finally did have those services?

CROWELL: There was always a difficulty in adjusting the separate pace of demand for the mental health programs compared with what was largely running hospitals. In those days, running hospitals was a job for a young man who had an adequate budget. In reference to community needs and services for the mentally ill, a department of mental health encountered problems to just get approved, to just get it started. Roger Egeberg was the Medical Director of the County Hospital. He agreed to act as the mental health director just to get it off and running while a permanent director was recruited. I'll have to hear more from you of the details about the controversy when Harry Brickman took over the job. I've heard some of it from him, and some of it from being around and being aware through George Moed and others.

Harry Brickman had several fights. One had to do with the changes in legislation

following Short-Doyle. It was believed that more federal money should be available for community services. Some thought more money was requested in the state budget when in fact there was not an increase, but a transfer from an existing allocation. The new legislation should have said the money will be transferred. If it had said that, just some small mechanism like that, it would have made an enormous difference in the perception of the Governor's budget for the year, and saying, "Well, it's another increasing budget. Aren't you all lucky?" There was high inflation at that time. But it was obvious that there was no increase in the total amount that would be available to mental health.

CROWELL: Harry's next big challenge came with the merger of Mental Health and the Department of Health Services. It was not nice politically to stop that. I think he didn't have a chance to stop it because he did not have a very good reputation as an administrator. Even though I've talked about the administrative problems of the health and hospital directors relative to mental health, which they couldn't do as well either, but that was why I think the merger went ahead and happened. All the problems came from that, the merger of mental health and the health department, or maybe they had had them all along. A hospital superintendent in the state program became the mental health director. He was very involved in all of the state-wide issues in terms of what needed to be done, what the legislative problems were, how to lobby the budget, and do all those kinds of things that I had asked Dick Alpers about. I ultimately left the County and went to the Center for Training in Community Psychiatry. While I was there, I got Dick Alpers to be on my advisory group for that project we worked on. We tried to develop a common language and common framework for the entire state. That required a long,

collaborative process with the stakeholders in California to do that. I staffed that committee for a few months and did some of the preliminary work. That was helpful to a lot of places in the state and it caused a lot of conflict around the state about defending the process. We were trying very hard to get private insurance coverage for mental health, because public monies were not available. It was consistent with some Republican policy to the extent that it relied on private insurance, but this had to be extensively mandated and that was not so acceptable. That was the reason for trying to get direct funding through a ballot initiative for getting tax on alcohol, the proceeds of which would be for mental health services. Enough signatures were obtained and the measure did well enough.

We finally got some state legislation passed that set up a planning council that was required to report back to the State on unmet needs and how we were going to address them year after year. I had nine months in the San Gabriel district. Then I was put in a central office job, called Community Support and Residential Services

While I was doing that, I became interested in the San Diego job. I was a finalist from Los Angeles. Part of being part of the Health Department in San Diego was that their health service and mental health service people met regularly and had good policy discussions. It was a very healthy group together, with a lot of sharing and concern about the various aspects of health. At least, that was a much better run than the Health Department had been when I was in Los Angeles, at least. They contributed to each other's programs when they talked to one another; they were less likely to get into turf problems. Los Angeles was organized around the hospitals, and went back and forth over

the years, primarily focusing on the hospitals with some focusing on the clinics. We could never easily benefit from the knowledge growth that happened over the years, and we have been able to get block money to be used for mental health services. So it ends up that the mental health providers, who are trying to be forward thinking, and recognizing the real problems and multiple disorders, are ending up spending all the mental health funds. So I do blame Harry for that piece of our history.

November 6, 2000

FELDMAN: This is a continuation of the interview with Areta Crowell on her experiences with the Department of Mental Health.

CROWELL: Would you like me to start with San Diego? San Diego's political environment was far more conservative than Los Angeles'. They had not started a mental health program until they were required by law to do so, and during the 60s and 70s, when San Francisco was building a network of community mental health centers, using federal money, and Los Angeles had finally started - I think I must have talked about that in the last interview - starting the La Puente Community Mental Health Center with government funds. Then there were a number of private centers started in Los Angeles. Nobody in the City of San Diego was using the federal community mental health center money at all. In fact, they had had a very deliberate policy: their founding mental health director, Dr. Studell, had been there - the Director from the founding until the early 80s, I guess. He did not believe in using federal money. I think that reflected the general City governmental attitude in San Diego. You used as little government money as possible. So there were no community mental health centers. There were community mental health

clinics spread around the County. There was one county-operated inpatient unit, run in conjunction with the University of San Diego, UC San Diego. San Diego had essentially sold its public hospital system to the University, as did Orange County, unlike Los Angeles County. Your history project (a research project of the interviewer) might well want to do a study of the counties that sold their county hospitals and what happened and how that history, then, became very different in Los Angeles versus the counties that sold their hospitals. It's a really fascinating subject.

But in San Diego, the part that the County did not give up - and I believe it was because the University wasn't keen to have it - was the psychiatric inpatient program. That program was run by and through the Department of Health Services in the mental health branch of that department. So I, for the first time, was in charge of a hospital as well as a community programs. It wasn't just connected with the hospital services; they were in my direct line of administration. They had just authorized building a new hospital, and that was being built adjacent to the headquarters of the Health Administration on Rosecrans. That's where the Mental Health Administration was next to the new hospital.

FELDMAN: This was supposed to be a public hospital?

CROWELL: A public hospital, created by the County of San Diego. They had done a very nice job of getting architects and getting it to look like a really good program. They had a wonderful hospital administrator named Karen Lee Robinson, who had come into that job at the time that San Diego was on "Sixty Minutes" as the only psychiatric hospital in the country that had lost its Medicare certification. That's another whole, long political story, but I think their losing that certification was unmerited relative to lots of others that

should have lost theirs. I don't think they were that much worse, but there had been a couple of deaths in the hospital. It was investigated, and Sixty Minutes came, and that just fed into this political spiral: they were visible, and they had to be punished. There were deaths in plenty of other hospitals that didn't result in de-certification, but San Diego was always a political environment.

They had made a major mistake, and that was that they licensed the hospital as a free-standing hospital, which meant it was not eligible for Medicaid funding. To get Medicaid money for adult patients, you had to be part of a general hospital. They had been part of the General Hospital, but they cut and severed that tie, and then built a new, free-standing which was, seemingly, not eligible for Medicaid funding for adults aged 19 - 64. Had I been there two years earlier, I might have been able to prevent that mistake, but I wasn't. It's really, really sad when you see people make such big mistakes. Anyway, we worked hard at establishing credibility and connecting the system and getting the emergency room to work with the rest. In many ways, it was like the Los Angeles problem. But the nice thing was that in San Diego, it was so much smaller, that you had a sense that you could know everybody and know what was going on, really understand the dynamics, and make an impact on it. We did a lot of system changing, we published some nice plans of work, and we actually got a competitive NIMH grant for services to homeless mentally ill adults: one of eight in the country. We were very proud of getting that one.

NIMH had its own share of politics. Why we were successful, I'm sure, was

because of Lou Judd, who had been Chair of the Department of Psychiatry at UCSD, was the Director of the NIMH for a while. He had a colleague from UCSD who he brought back to Washington to work with him, and the colleague's wife was second in command in the San Diego City Housing Authority. She had not known my friend and colleague, Irene Levine, but she got to work with Irene. Irene was head of the homeless program for NIMH. Irene and this woman, Betsy Morris, worked together, and Irene picked Betty's brains about housing and homeless mentally ill, and out of that, they created a program and a research proposal. An RFP went out for testing theories about services for homeless mentally ill adults. The main thing that they were interested in was showing the impact of having housing available for homeless persons. The City had to contribute Section VIII Housing certificates to the project. They did, because of Betsy. When Betsy came back to San Diego, she had learned enough to be able to convince the City. Together, we were able to sell the County on applying for this and getting the money for the project. Our thesis was that you could take homeless people off the streets and put them into housing, directly, if they had enough support and case management, and then have options created for them and develop employment possibilities, and so on. We had very good success. It had about a 68 percent success ratio and could have been higher. We got almost as good with our control group as we did with the experimental group, because the contract agency that did the experiment condition (which was intensive, flexible, wrap-around case management) didn't do it as well as they could have. They didn't have that charismatic leadership that the leader of our County Case Management (Social Work) Program, who was determined to show that they could do just as good a job as the agency that had more

money and more options on what they were doing. She made sure that her staff did. It was a very good lesson on how to get your leadership hooked into making the right kind of changes. We worked hard on the homeless people in downtown San Diego. There were an awful lot of problems there.

FELDMAN: Did they have the substantial proportion of the mentally ill that they have in Los Angeles?

CROWELL: Yes. San Diego attracted homeless mentally ill individuals the way all coastal counties do in California. The weather - people can survive outside, can do recycling and things like that, and they can find ways to support themselves if they want to be cut off from all other support. San Diego was sometimes tougher on their homeless people than was Los Angeles County, but we were able to work with the sheriff and the City Police Chief in trying to help them find ways to help the people instead of putting them in jail.

We had cuts to take in San Diego at the same time that Los Angeles was taking cuts while I was gone. It was very rough, because San Diego had far fewer resources than Los Angeles, calculated on a straight dollar value of the available services. They had not used the State Hospital very much. Los Angeles had used the state hospital a lot. There is a literature that implies that distance from the state hospital is a major factor in the utilization, not need. Certainly, the San Diego experience reinforced that attitude. After the Lanterman-Petris-Short Act was passed, Counties' budgets were consolidated such that the state hospital dollars were added to the dollars of the local programs, yielding a total of available resources. In theory, you could move these dollars around, but in fact,

you could not. San Diego had 71 state hospital beds, when I went there, for a population of over 2,000,000, whereas Los Angeles had well over a thousand – I think a thousand and seventy-some, as a matter of fact. So the dollar value of those thousand and seventy beds in Los Angeles kept escalating as the state had moved to get accreditation for the state hospital, as they moved to comply with all of the standards that were reasonable for a hospital. The dollar value of what Los Angeles had practically doubled or tripled during those two decades. When you look at the grand total, Los Angeles then moved up to be slightly above the average for the state for total dollars per capita. San Diego's local resources were proportionally less than Los Angeles's, but the state hospital was so drastically less. At that time you couldn't do anything about it; you couldn't add to the state hospital resources no matter what you said. The other Counties objected. San Diego filed a lawsuit against the state to get its fair share of resources. It was a logical thing to do, because they were so far below average. They said, "Why can't we have our fair share? Give us our fair share of the state hospital and local dollars."

The other counties that were heavy state hospital users, including Los Angeles, banded together to fight against the San Diego lawsuit. While I was director in San Diego, Dick Elpers, my good friend, a previous director in Los Angeles County, was a witness for Los Angeles County against San Diego County.

FELDMAN: What was the premise for all this? Was it to protect money for Los Angeles?

CROWELL: It was to protect money for the other counties, so they wouldn't lose it. It wasn't an environment in which you could not expect to add to the State General Fund in

order to accomplish this goal. Nobody ever would have minded, had they been able to do that. But it was already well established that the State wasn't going to add overall resources for mental health. So they all said, "Well, you'll get more, and we'll get less. No thank you. We'll fight like crazy to prevent that."

FELDMAN: I gather that San Diego did not win out.

CROWELL: The judge was a local judge and very sympathetic. She ended up basically saying they were right in principle, but she was not going to order the state to do anything about it.

When re-alignment passed in 1991, a special deal was hammered out with the County Supervisors Association California (CSAL) and the legislature so that San Diego would get more money as sales tax revenue grew after re-alignment. How it works is this: re-alignment was passed to replace the existing revenue base in the county programs by sales tax dollar in the base year. The legislation specified it in such a way that if the sales tax didn't equal what had been the appropriation, then you got projection of the sales tax. San Diego and other under-equity counties were to get a larger share of growth after revenues equal to the base year were realized. Well, as you will remember, the year after that passed, the economy tanked, and the sales tax went way down, so the counties did not get what they were expecting, even at that baseline. The deal was that as soon as the sales tax enabled all the counties to get back up to baseline, San Diego would get a greater share. Some of the other counties that were also significantly below equity, would also get a greater share of the growth before the growth would start to be spread around among all the counties. That was the benefit of that lawsuit. Of course, part of the funding level

resulted from San Diego's failure to take advantage of the Federal Community Mental Health Center funding in the 1960s and 1970s when it was available to help raise the whole funding level. Funding remained the main problem in San Diego.

I did manage one resource increment for San Diego while I was there. Using all the political connections I could, I got a hundred-bed skilled nursing facility, a dedicated psychiatric skilled nursing facility, funded by the State, unrelated to the rest of the appropriations. But we got one hundred beds in San Diego. I really worked with friends and buddies and used everything I could. So that raised the resource level some.

One of the nicest things was that before I left, they asked and got permission to name a Skid Row outreach center – an outpatient and outreach program for me. So there's an Areta Crowell Center in San Diego. When they first asked me, I said, "I don't know. That usually happens to people who are dead. I'm not sure."

I was going to tell you a little bit about one other political thing, and that was taking budget cuts. With resources so low, what do you do? Well, the medical director of our hospital – by the time we got to this stage, the hospital had been opened, and it was a wonderful hospital, doing a great job, and there were all kinds of nice things about that. But he came up with an idea: he was concerned that the hospital was divided into three major units, two of them serving as acute wards, and the third one serving as a specialized gero-psychiatric unit. It was supposed to be for acute care, but because of difficulty in finding placements, that often did not turn out to be the case. The hospital was much more long-term maintenance than acute care. We accumulated patients who could not be placed and were really on maintenance rather than high acuity in need of hospital service.

We were able to take that major cut just before I left by changing the hospital so that instead of having 99 acute beds, one third was converted to a skilled nursing facility where we could get Medicaid dollars. One third was acute, and the gero-psychiatric unit was able to get Medicaid dollars, anyway, but we were able to increase the efficiency of its use by sharing that Medicaid. We cut the \$5,000,000 worth that we had to cut. We didn't cut any beds, but what we really did was to re-designate them to be what they had functionally become, to be able to get more revenue and realize some cuts in "local dollar" expenditures. You don't spend as much on a nursing facility bed as you do on an acute bed. It was a good compromise. That physician really came up with that idea. I would not have thought it could work, but he was the medical director there and said, "I know this can work. This is what we're doing, anyway, so we only need to change the licensure."

The politics were very intense against doing that. That was a proposal that we worked on in the summer of '91. Budget cut announcements came in May or June, and we worked at it over the summer. We presented it to the Board of Supervisors in September. They had much opposition from the court and the emergency room doctors who said, "This won't work." They were sure - even though they were in the same hospital, they couldn't get it through their heads what was happening within the hospital and understand that they would have the same flow of patients from the emergency room that they had had before. There would be just as many acute beds available. Sometimes you wonder where people are in terms of system-understanding.

FELDMAN: Dukemejian was still Governor then, wasn't he?

CROWELL: Yes. Anyway, the upshot was the board wouldn't approve the plan in September. They ordered some more studies and more information, and requested me to come back before they could act on the budget proposal. It was scheduled for the Board of supervisors at the end of January, 1992. I wasn't going to change the plan, but they were asking me to see what I could do to lessen the political opposition. That was all happening at the time I was approached to come back to Los Angeles.

The board approved that plan, basically, on my last day in San Diego. They implemented it, and the medical director and I kept in touch, and he said it worked. It did fine. People have to use the dollars the best way they can. The judges were trying to get more money. They thought surely they could get it if they just hollered loud enough.

The same kind of situation had occurred in Los Angeles County. USC Medical Center had developed a habit of making a big crisis when they could, figuring that sooner or later, somebody would pay attention and give them some more money. It just wasn't in the cards for so many of those years. There was no political will to raise taxes or cut other programs, so there was no hope of significant budget misuses, no matter how much it was needed.

While we were going through the budget cuts in San Diego, when it was vacant, I sent in an application for the L.A. Directorship. When it got down to the interviews, I said, "I don't want to go through the L.A. politics again. Forget it, this is bad enough. At least I could live with San Diego politics. I know people and they know me very well now. We'll survive." So I withdrew, and I started getting calls from people about the finalists for the job. There were several finalists I was sure could do the job just fine."

One was Dick Elpers' wife, Bev Abbott, who was Director of San Mateo. Bev could do that. She had graduated from Long Beach and trained at Metro State Hospital. She knew Los Angeles and, certainly, a county health director has to know all the content, regulations, etc., that every county needs you to know. She's a good administrator, and I thought she could do it. But people kept coming back to me and saying, "They're not going to appoint her. They don't really like the other finalists. Won't you reconsider?" Finally, Supervisor Ed Edelman called me and so I said, "Okay, if you really want this, then you have to support me. You have to not put us through the ropes in terms of cutting programs, and so on." Ed was quite proud when he retired. He got the CEO to write me a letter, which stated, "We'll do our best not to cut funding, but you know that we can't guarantee what the financial situation is going to be." But that was what it took, getting me on the phone several times to agree to come back and be interviewed. That was how that all happened – in late fall, 1991. I couldn't come right away, because I was committed to the San Diego Board of Supervisor's hearing at the end of January. I felt it was my moral obligation to be there. I had to see that situation through. Then I could start something else. And I did.

I came to L.A. with the idea of, "What do you do to make some changes?" I was told by many that the department was extremely demoralized because of the large number of cuts that had been forced on the department, and had resulted in closing several community programs. That meant that proportionally, out of the budget, there was still a lot more in the state hospital than there had been, certainly. Compared with San Diego, and knowing that we were able to survive as well as we had in San Diego, I was

comfortable that we could push the Los Angeles system to survive with less hospital beds if we didn't have money to expand things. In fact, over-reliance on hospital beds had been unhealthy to the whole system. It meant the system did not try to keep people in the community, because there was a convenient back door. You could send patients to the hospital easily. You can't help human nature: people are going to do what's easiest if they can. If the door opens, that's a lot easier. It was "Out of sight, out of mind."

The challenge of coming to Los Angeles was to try to restore some sense of hope and optimism in the mental health system across the county. There was a great deal of dissatisfaction with the system on the part of the public and the Board of Supervisors, and the people inside the system were very demoralized. There was a general sense of depression in the whole system, and so the question was what can we do to make a difference? How can we make it better when we don't have nearly enough resources and no prospect of getting more resources? Because I had known how San Diego survived with a fraction of the per capita resources available that Los Angeles had, I had some confidence that by being able to move resources around, which re-alignment permitted, we could make some positive changes. So I started with the families and the clients and the constituents to talk about this as a concept; moving money from state hospitals into community programs. But I was very specific that what I thought we needed in a community program was to have targeted programs where people would be enrolled as members of a program. Then there would be accountability for what happened to each person over time. That was the key concept: to maintain accountability over the duration of someone's disability and illness and not just on an episodic basis. L.A. had, as San

Diego had had, pockets of quality, but what was needed was to make the longitudinal accountability a reality.

We developed a program, ultimately called “Partners,” as a way of implementing that change. It was originally funded by reducing state hospital beds so that we transferred spending from State Hospitals to local programs. We developed detailed specifications for the community-based programs that were to replace the state hospital beds. We had 500 enrollees budgeted in PARTNERS for the first phase. Now, 500 is a small number in terms of Los Angeles County’s population of persons with severe and persistent mental illness, but it was still a sizable enough group, and it was quite a challenge to get that organized and operating.

We did that with support from all of the constituent groups, and that was vital to make a change of that magnitude. It involved cutting 200 state hospital beds. It meant that we could serve more people overall: instead of 200 in State hospital beds, there were 500 in the community with intensive, wrap-around services. In writing up the specifications for that program, we drew from the experience of the Village in Long Beach, which had been funded by the State as an AB3-777 Integrated Systems of Care for Adults Project Grant (ISA). They had developed and done very well. There were other similar programs around the country, and we tried to pull those things together and write up a good description. It was more prescriptive as an RFP than most of them are because we didn’t have the confidence that everybody would understand what had been shown to be required for successful ISA.

Before the responses for the RFP were due in, we had a very large conference,

focusing on rehabilitation. At that conference, we introduced many people for the first time to Bob Lieberman's well-established concepts of psychiatric rehabilitation and his research and experience of how, with enough support and training, you could accomplish positive outcomes. We had people from San Diego talking about what we had done with the federally funded "homeless mentally ill" adult project there. We had some other national research described, and we talked about what we wanted in this program. I really wanted to emphasize client empowerment and active participation in their treatment programs and plans. That's not radical at all today: it wasn't even radical then, but it certainly was not mainstream and not widely accepted or practiced in Los Angeles County. That was the challenge: how do you set the direction and move along it? You need to get a critical mass that accepts all the concepts that we wrote into that plan, and that are, I think, much more accepted today than they were ten years ago. That was the approach we took. Some of the providers of drug and alcohol programs came to those conferences because I also had been very aware of the large number of high-need people who have substance abuse problems as well as mental illness. I was very interested in assuring the new programs would not turn people away just because they had substance abuse problems.

The word I got back from the substance abuse community was they taught were very impressed by the strong social model recovery approach we took at that conference. People knew there was a change, and it was being circulated around the community as people talked about what we were trying to do. Getting the "Partners" off the ground was the first big step of system change. While we were doing other training and other work on

system relationships and issues, that was the major one.

Another approach I took was to try to upgrade all of the county facilities, to show that both staff and patients deserved dignity and respect. We had many very deteriorated facilities. As we managed to get more MediCal and other revenue into the system we put a fair amount of it into upgrading facilities. At one time, we had a program we were trying to move into a new space. The county budget was in bad shape, so the CAO recommended against approving our request for a lease in a new facility. We got the community out, and we protested. The board understood our logic and didn't want to turn it down. They needed us to help them find a way so they could not turn it down, and we met the technical things that they wanted. But I explained to all of them that we would be cutting more state hospital beds before we would cut any of these community programs, and having a decent place for them was an important part of the comprehensive system plans. The CAO at that time didn't like that at all. However, Supervisor Edelman triumphed and the board approved the lease. After he retired, he told that beating the CAO on that one item tickled him a lot. Unfortunately, there was always "NIMBY"ism" (not in my back yard) when we tried to open any facility, and no other CAO budget obstacles

In addition to the strategies of developing the Partners integrated flexible, wrap-around, targeted services, and improving the service delivery facilities, we emphasized honesty in dealing with everybody. The fourth was letting everybody know what was going on all the time, trying to have no secrets and no hidden agenda, and that everybody would buy into the agenda so that we would all be together. That was one of the things I

think I've learned over my career: when you have a small, stigmatized community, if they fight among themselves, it's easy for the rest of the world to dismiss them. They just say, "Well, you can't agree, so we won't do anything." So then you don't get support. You have to speak with one voice. That was the California Coalition for Mental Health experience, of which I was President in 1993, as much as anything we really reinforced the importance of a single voice in California politics.

What else is important? Since we put so much down in the history book now, I don't want to duplicate a lot. We obviously had an ongoing concern about having a lot of bi-lingual, bi-cultural service providers, and that has had a disappointing history: we did not have enough appropriate human resources and couldn't get enough money to support people and training. We tried some creative things like helping employees to get some scholarship money from the county so they could work part-time on degrees. We did some of that, but it was not nearly as feasible as it is today. That's one of the nice changes as more money has come in. That is one track that the county can support. We had human resources legislation developed that came out of a group called together by the Mental Health Association in Los Angeles. They'd come up with the idea of getting kids in high school interested in human service and treating them like candy stripers. They would give them jobs and money and support and mentoring and nurturing and everything it would take to get them to pick a mental health career and stick with it. It was a wonderfully developed program concept, but nobody knew how to fund it. We were so short of services, people were afraid to take money out of existing service to do something like that. You're subject to so much criticism for cutting any available service when you

were so short. Polanco introduced legislation to fund that program, using professional fees: social work, psychologist and physician fees. Well, the physicians at large objected; they didn't want to pay for the mental health professions. There was no way to identify the psychiatrists as a body, because they are not maintained as a separate listing in the California licensure system.

FELDMAN: I didn't realize that.

CROWELL: Yes. If they belong to the Psychiatric Association, that's one thing, but a lot of psychiatrists don't, so that was kind of difficult. So they didn't support it. The psychologists supported it. I was very active in the California Psychological Association, at that time, as were quite a few others from the public sector of mental health. They were very supportive of the public mental health concerns. They supported the legislation to tax themselves to help with the professional development. Social workers didn't support it. So, without enough support, it just died. The psychologists weren't able to carry it.

FELDMAN: I wonder why that would be, because they.....

CROWELL: Other professionals said, "Why should we, out of our licensure, pay for what is a whole community's responsibility." It's a fine argument, but it's guaranteed to make something not work at a time when people are absolutely resisting raising your taxes for anything. There wasn't enough money to spread around. It sounded good, but it meant that you couldn't do it.

Now that plan has been resurrected and is being implemented in a much smaller way. The Mental Health Association in Los Angeles County has started what they call "The Academy" in two schools. One is in Long Beach. It's like a magnet school to do

human services. It's giving kids some exposure to human service jobs – not just mental health – with a big emphasis on minority kids. This way, they would have money coming in, have people talking to their families and them about how this is a good career path, what to do, and so on. I'm quite excited that that is finally happening.

Other things are happening too. Welfare reform is opening up a lot of possibilities for people in human services. The Welfare Department is just doing an enormous amount of supporting people in their career goals out of the “Welfare to Work” money. It's spinning off into many creative ways to identify persons with mental health problems and help them resolve the problems, get treatment and supported employment. Lynn Bayer, the director of the DPSS, tells that many of their employees don't even have high school degrees, so they're helping them get GEDs. We're just raising a whole level of accomplishment possibilities for people. It's exciting.

The other big area of development in Los Angeles, while I was director, was the expansion of the children's System of Care (SOC). There was no implementation of the system of care in Los Angeles when I came in '92. We worked for, and got, kids system care funding. I don't remember the year, but it will be in the book. I think it was '94 or '95. We brought in Randy Feltman, who received the first State grant for the SOC in Ventura, to learn from their experiences. The Children's Round Table was very supportive in trying to get this moving. Again, the whole community was behind it and supported it and pushed it. We were able to get money to start in two small areas: East Los Angeles and Antelope Valley. They were picked because they had the highest number of Severely Emotionally Disturbed SED referrals. It was targeted to be as logical as

possible to pick something – you always have to balance the logical and the politics. With five supervisorial districts, you very often end up doing things in five places. You might not choose those five places, but we've been able to keep pretty consistent in terms of priority and not having to break it down too far because of politics. Partners, for instance – we had one in each supervisorial district. (Laughter) Five programs. Actually, we started with six programs.

Anyway, the Children's System of Care is something important. It went really well, and we worked hard to get a lot of creative things going there. The Early Periodic Screening, Diagnosis and Treatment (EPSDT) federal requirements helped fund a lot. We worked with the statewide Mental Health Directors and the state to move these good programs forward.

The other major point in looking at our history was that mine was the only administration during which there were non-stop disaster grants to administer almost throughout my entire tenure. I came at the end of January in 1992. In April, the Rodney King verdict came and the fires and court unrest followed. Civil unrest. We felt that it was indeed a sufficiently traumatic experience for the whole community, that we should apply for, and we did, and we got, federal disaster assistance money to provide counseling and support. We brought people together who were experts in disaster response, and people, in this case, who were expert in ethnic relationships as well, trying to guide what we did. I think we did some creative things. But that grant had not terminated before we had fires in Malibu and in the hills near Altadena, followed by floods. Both of those were labeled as disasters for which, in order to make services available to people, we were

expected to apply for and get the federal money. So we did. Then you have to administer the funds. So all that was happening, plus continued reductions in budget, plus our efforts to streamline and re-organize and make the department more efficient and effective and bring in quality improvement procedures. Then we had the earthquake in '94.

FELDMAN: It was a non-stop.....

CROWELL: It was non-stop. I was extremely fortunate to have Kathleen Snook as my Chief Deputy. When I was offered the job in L.A., I called Kathleen and asked her if she would consider coming back to the Department of Mental Health. She had been the Director of Administrative Services, which was not a Chief Deputy, but she functioned rather like that. When Dick Elpers was Director, he had Dr. Harold Mavritte as his Medical Director and Kathleen as his Administrative Services Director. The three of them did all of the administrative things together; when Kathleen came back as Chief Deputy, we followed the same model. Everyone else reported to us. Kathleen was a very hard worker, a very knowledgeable and tough administrator with long county history. She knew everybody and everything in the county, including being a very good friend of the CEO who was there when I came in. I asked him for permission to hire her away from where he had just put her. He had another problem that he was trying to solve by her prior appointment, but he agreed. Part of his deal in getting me to LA was that Kathleen could come back to the Department of Mental Health.

I don't think we could have maintained credibility if I hadn't had her throughout that enormous administrative stress. She was a really tough right hand and could cut through and get things done with the CAO's office that somebody who had to learn all

that, could never have accomplished. You lose credibility if you can't do things fairly quickly. We had enough problems, but not nearly the problems that could have been without someone who knew the ropes.

FELDMAN: Is she still there?

CROWELL: No, she retired before I did. I knew when she was going to retire, and I did decide to stay on after she left, long enough to try to make a transition before a new director would have to come in. I had thought I might appoint a Chief Deputy in between, but I decided that it probably would be better to leave that for the next person. I'm not sure that was the right decision or not, but that was my thinking and that's what I did. I worked without a Chief Deputy from September until I left the following March.

Another of my early strategies was to cut down on administration. One of the first things I did was significantly reduce what had been a contract audit compliance unit and take clinical positions out of administration and free them up to be moved to do some clinical work. We wanted to augment aftercare services at LACUSC Medical Center, and this is why: before I came back – after I had accepted the job, and before I came back, there were quite a few articles in the paper about the emergency rooms at USC, specifically, the Psychiatric Emergency Room. They were closed a great deal of the time. That meant the police couldn't bring emergencies to that hospital. They had to traipse all over the County, looking for another emergency room to take somebody to.

FELDMAN: Why were they closed?

CROWELL: They said they were closed because they didn't have resources, they didn't have places to put people. The Emergency Room was crowded, so they couldn't admit

people. This was what I meant when I said we would talk about the doctors circling the wagons, saying, “we won’t do” as an effort to make a point. At the same time that was happening, there was a scandal in the Medical Emergency Room of psychiatric patients being left there, in restraints, too long. One patient died after staying too long in restraints. There was a big squabble between the Medical ER and the Psych ER. Psych wasn’t taking them, so they’d end up in the medical ER. The police just wanted to dump the problem and get on with their jobs. They have never seen psychiatric emergencies as their job. It doesn’t matter that when you have an emergency, you can call the 911 system. They think their job is to deal with crime, and they’re trying to deal with using their guns and doing all that kind of stuff. I don’t know if that’s good or bad, but that’s what was easier. That’s their job, and they don’t know how to handle psychiatric patients.

That was the situation. I went to Dick Lamb, who was the head of the emergency room at the time. Now, Dick has a great track record of writing about community psychiatry, so I expected Dick to be rather sympathetic when I came and said, “You know, Dick, we’ve had this really great experience in San Diego with revamping the emergency room and making sure that we had a system so that you could move people out of the emergency room and have a support program for them. You could use some support.” One of the things we did in San Diego was that we had some targeted case management to work with the high users of the ER. We called them the “frequent flier group” and assigned them to a designated case management unit. I forgot to mention that, but that was one of the other experimental things I did in San Diego that worked extremely well. We got a bunch of real problem patients into this intensive case

management that was very targeted, very personally designed for each one. They had a wonderful advisory group, with family members and consumers and staff. They would bring the client's case story into that advisory group and go over it in detail to get ideas on what to do for the person. That advisory group knew them all by pseudonym, not by real name. It was a small enough community that after a while, I'm sure, some of them knew who they were. But anyway, the staff were full of good ideas. The social worker who ran that program published and got a lot of visibility from that successful experience around California and the country. He did a wonderful job. He often talked about how, beforehand, he didn't believe it would work. But I insisted that he do all these things like getting the clients involved and helping clients in establishing the consumer/family advisory group. I went to Dick Lamb, saying that we would take these resources and direct them to him so that he would have this same kind of intensive case management program to work with his ER. He said, in effect, "Thanks, but no thanks." He wasn't the least bit interested. We did end up, however, sending some resources over to work with the emergency room, though not quite the way we had in San Diego, but at least it did get them more resources so that they could move people out of the ER faster. We also gave directives to the rest of the system to give priority to these individuals, so the ER would be able to make an appointment with the clinic immediately. With that linkage in place, you don't have to keep patients in the ER for long periods of time.

I concluded, however, that more action was needed, and they were still closing the ER too often. I went to Bob Gates, who was then the head of the Department of Health Services and said, "Bob, I think you really need to partner with me in this. We've got to

make some changes the ER problems are bad for both departments. So, we got some changes made, and things did improve a lot.

A few years later, as part of the MediCal and other funding problems of the Department of Health Services, the DHS proposed to cut all of the psychiatric programs out of their hospitals.

FELDMAN: That's pretty bizarre.

CROWELL: Yes, it was pretty bizarre. It was clearly political. That was the summer that the Supervisors had a special external task force meeting all summer to talk about how the health department budget was going to be resolved. It wasn't the DMH budget, per se. But DHS said they had been subsidizing the psychiatric beds, and they were going to stop subsidizing them. They said they had spent – I forget the numbers. I'd have to go back to the documents. Some of them are in the history book. They claimed that they were spending fifty percent more on the beds than I was paying.

Now by the time this happened, we were into MediCal consolidation, and the Department of Mental Health was administering the fee-for-service psychiatric beds. That was the first stage of consolidation of fee-for-service MediCal into a single mental health MediCal system. We had the responsibility for admission, and funding for the use of psychiatric inpatient beds. We had negotiated contracts with all the hospitals at a rate that was fifty percent of the rate that health services claimed for the beds for acute hospital services. Since they were going to play hardball, I decided I had to play hardball too. So I said, "Fine, you close your units, and we'll contract because there are plenty of beds in the community in these private hospitals. We'll contract with them for all the patients."

That we could do within our budget.

FELDMAN: They weren't happy about that, I would gather.

CROWELL: It ended up in a compromise. They cut some of their beds. We did it in a way that we calculated very carefully: if they would bring their length of stay down to the length of stay that was the average in the community, no fewer people would be treated than had been treated before. That was – we worked very, very hard, because I do believe that the county hospitals took people who were more difficult, with more physical problems than the free-standing psychiatric hospitals could do. And, they were more accustomed to that. But at the same time, from the point of view of system efficiency, their problems had to do with not having learned and worked with the community programs as well as they should have, and having too much turnover. That's part of the downside of the academic training program – having people turning over all the time. That was one of the reasons why the Crisis Residential Treatment System beds never got off the ground in Los Angeles County. We were able to get funding for a small number when the Bates Bill was passed in 1979.

FELDMAN: Which bill?

CROWELL: Bates Bill for Community Residential Treatment System was the thing. We ended up with six 6-bed crisis programs (36 beds). They were modeled after San Francisco, where they had been twelve plus, twelve to sixteen bed programs that Steve Fields had started and modeled, and he was close to Bates in the Bay Area. That was how the Bates legislation came through.

We knew we didn't have the stock of bigger old housing that you could put 12

beds into, and especially, we didn't have the zoning openness to that because of the conservative nature in Southern California. San Diego, however, even though they're conservative, managed to get five of those programs going; one in each of their five health districts, with about twelve beds in each. So they had 60 beds. San Diego had 60 crisis residential treatment beds and 60 acute hospital beds in the county system, not counting before MediCal consolidation -- what the other MediCal beds would take. And there were very few of those. Other hospitals didn't want the county patients, and even though they could be paid under Medicaid, they just didn't do it. So, 60/60, and that ER loved the crisis beds, used them, knew how to, said they would die if we cut the crisis beds. In contrast, L.A. never used them. I think it had to do with critical mass and the personnel turnover in the emergency rooms. The County hospital in San Diego was largely a stable medical force. Yes, they had some residents, but they were not the key human resource in the emergency room the way they are in emergency rooms in the hospitals in Los Angeles. I think that had a lot to do with it. Anyway, we finally came up with a compromise in L.A. and funded some beds in each of the hospitals, based on the length of stay and the number of cases and what we thought they should be able to live with.

The other thing there was that Dr. Milton Miller had worked over the years to get the performance at Harbor/UCLA more in line with national norms. They had a shorter length of stay than the other county hospitals. That was part of the deal. You bring your length of stay down; we know it can be done, "If Harbor can do it, you can do it." That's what we worked out.

That was probably the most traumatic time of my L.A. directorship in terms of

trying to make things work so that nobody would fall through the cracks, and we wouldn't have any crises and tragedies. It just haunted me that the hospitals might try to sabotage the arrangements; it needed everyone's cooperation to try to prevent another tragedy. The whole time you're a mental health director, you read the paper every morning, just looking to see if there's a tragedy that is on your watch. It's a wonderful thing not to have to look at the paper and worry anymore.

FELDMAN: The advantage of retirement.

CROWELL: That's right. (Laughter) We were able to expand the Partners program. In its second year, because the contractors agreed to expand it by ten percent (to 550) without any more money. The year after that, we got more money and expanded it to 750 members. There were a lot of clients that were having trouble getting into that program, because staff felt the clients needed more intensive support than they could be given, including some time, often, in skilled nursing facilities. We spent a lot of time in designing what is now called the Adult Targeted Case Management system, which was a continuation of Partners, but targeted at slightly higher average-use-history groups of clients. They're following the same idea that "the only way to deal with the L.A. system is to divide it into component parts where you can have accountability for the people on a longitudinal basis, and where that accountability rests could be defined. You target unique services to them, rather than having a generic service that everyone is supposed to come to. That was the theme of what I tried to do in my time, and I think what the Director is trying to do now is moving that forward into comprehensive systems that deal with families and communities in a yet even smaller scale.

FELDMAN: I guess they have re-organized the department.

CROWELL: They are re-organizing, I think. (laughter) I have to tell you that in terms of philosophy, I didn't do a lot of re-organizing. I worked with the people who were there, and I went to San Diego and worked on making the parts of the system work together better, rather than changing the structure. I did end up changing the structure some in Los Angeles. I cut out some layers of administration, but I didn't change the rest of it. So you weren't dealing with different people at the community level. We tried to cut down the layers above. That's my philosophy about administration.

FELDMAN: I would think that it was especially important then, because there had been so much change and so much shifting. How else do you get people to stabilize what they're doing? If you continue with re-organization, then they never settle down. Now the department is very extensive, it seems to me.

CROWELL: Almost doubled since I left, in budgets. It's a wonderful time. The CAO, Dave Janssen, said to me before I left, "Why do you want to leave now that they're going to have money?"

FELDMAN: Yes, they not only have money, but along with that, there's a better attitude about what mental health needs are and who should do something about that. I think for so long, that was just on the fringe.

What have you been doing since you left? I know you did the history of the department. I know you've been on numerous national committees.

CROWELL: I'm on the National Mental Health Association Board, and I chair the Public Policy Committee for that Board. That's a two-year assignment: last year and this

year. It's a three-year term. I expect to be re-elected, but I won't be Public Policy Chair. I'll have some other assignment, because they try to move their Chairs around. That will keep me busy. They have four meetings a year.

FELDMAN: Are they in Washington?

CROWELL: Yes. They have quite a bit of assignments to keep up with the staff. They have wonderful staff at the National Mental Health Association. If you don't see what they're doing, you ought to try to get some of their things. They have a website now, and you can find out a lot about what they're doing. They have produced very good resource material for people to use around the country. The federal school-based anti-violence youth initiative (Safe Schools/Healthy Children) really came out of the NMHA legislative staff work after the Columbine tragedy. Al Guida, the head chief lobbyist, kept pushing. Put some more resources in mental health. NIMH and the Center for Health Services weren't even pushing much for it. They didn't think it was possible. But he got it. While it was only \$20 million that first year, nevertheless, that was a substantial increase in federal funding, and it has been increased again since. But they've worked to minimize use of restraints. We just got a new bill we've been working on for two years finally introduced, which is the Intensive Community Mental Health Treatment Act. It's intended to provide a cohesive Medicaid reimbursement program. Instead of having to bill Medicaid separately for the inpatient, the outpatient, the day treatment, the medical treatment, the medication, and other items, it would wrap it up in one like the Partners people. It would have made life so much easier, administratively, if we could have had that then. So it seems to be timely now, as people are understanding that integrated

services are more useful than fragmented services, and that the fiscal can be integrated as well. It would be helpful.

I'm also on the California Mental Health Association Board, and its Policy Committee. I have just agreed to stand for president-elect.

FELDMAN: A really big job.

CROWELL: It will be a big job. I've been on the Healthy Families Advisory Panel. That's California's version of the federally funded State Children's Health Insurance, passed in 1996, late in the year. California got its program off the ground in July of '98. The panel met first in December 1997, and legislation was passed with the requirement for a mental health provider and a substance abuse provider, a certain amount of consumers and other representatives. I was the mental health provider representative. We report to Managed Risk Medical Insurance Board (MRMIB), which is politically-appointed Board that runs this whole program. It reports to the MRMIB Board instead of to the Secretary of Health and Welfare, but of course, they work very closely with the Secretary. My term on that advisory panel ends next June. I was Chair of the HFAP in 1999-2000, and the statute also provides that the Chair of the Advisory Panel is ex-officio on the Managed Risk Medical Insurance Board. I went to those meetings as an ex-officio member. There are only three out of the five authorized positions filled. So those three people have to make every meeting in order for them to have a quorum and do the business that has to be done.

FELDMAN: Why aren't there more?

CROWELL: Well, our governor doesn't like to make appointments, we gather. There

were five on before, but they all had to resign when the administration changed.

FELDMAN: He's very slow about all appointments.

CROWELL: He's very slow about his appointments. One of the three asked me if I would apply to be one of the five. He said, "We'd like to have more; we'd like qualified people. We've never had anyone from southern California. We've never had anybody with a mental health background on the Board." He thought it was a great idea, so he was this big salesman. I have agreed to seek the appointment. I've sent my letter to the governor (appointment to MRMIB by Assembly Speaker Robert Hertzberg, November 2001). The interface with health and mental health, I probably am good at, because I've been part of health agencies as well as the mental health experience. I have a lot of opinions about it. But the kids' stuff I know well. I think it has a lot of potential. It turns out it may be a very cutting edge kind of thing, because we have parity now for mental health insurance. That means that the health plans are going to have to take care of more than they ever have. They can no longer just send somebody to the public sector without any accountability on their part. The interface issues are just starting to be visible. People were starting to get nervous about it. For the Healthy Families Program, the activity of the local mental health director and the State Department of Mental Health helped set it up so that the Severely Emotionally Disturbed (SED) kids would be referred by the plans to the counties. It made sense, because counties have the SED system of care set up. They don't know anything about how to do all these things other than treatment (e.g. work with schools, probation, etc.) that the kids need. They just send them to County, which then can get the two-thirds Federal funding support.

FELDMAN: What about mental retardation? Where does that fit in, if it does?

CROWELL: It does as a carve-out the same way that – well, all the people who are Developmentally Disabled qualify for Medicaid, so they don't need the Healthy Families Program. Healthy Families is for families whose income is too high for MediCal and not high enough to afford private insurance. It's that overlap. SED kids are eligible for the services whether the families bought into Healthy Families or not. Counties are obligated to provide them. H.F. enrollment provides more revenue to the county; 66%, instead of being one hundred percent funded by the County. That would be a nice incentive if you could make those things work. It seems like a logical incentive for the counties to make it work. So far, it's been like the emergency rooms and the crisis residential treatment houses. There hasn't been the critical mass for the counties to get the systems down as to how to make this work. You could say the same thing for the health plans. They don't know how to make them work with the counties. I'm hopeful that the problems will be resolved, because if they aren't, then the plans will be to lobby to get the money, and they will take care of the kids without involving the counties. I think that would be too bad for the kids, because it would take the places a long time to learn to be able to deal with the rehabilitation emphasis that goes with the SED kids as well as all the system development work in schools which is very expensive. It takes high overhead to make those systems work. I don't think the plans are going to want to make that investment.

FELDMAN: If we have a voucher system, what is that going to do to children who need special care?

CROWELL: It would just mean more schools that need to know how to make those

referrals. I'm not sure that private schools, even with vouchers, accept SED kids. One of the issues today is that yes, you may have a voucher. You may have money to pay, but that doesn't mean that often minority kids get into the private schools.

FELDMAN: Or even non-minority kids. I was at a meeting a few days ago with a young woman who called herself Headmistress of the Chandler Schools in Pasadena. They have 420 students there. It's hard to get in. They're full to capacity and always have a waiting list. I said, "What will you do if the voucher system happens?" She said a couple of their teachers have said they'll just go out and start their own schools. They'll just take them home; they'll each take six or eight children. They'll get \$24,000 to \$30,000, and nobody will pay any attention to what kind of teaching they do and who the children are. It will be custodial and nothing else. She was quite worried about it, because they don't have room to take in any more, no matter what is paid for them. I've been worrying about that, especially with children who are mentally ill or retarded. What will happen to them? It's dreadful, just dreadful.

CROWELL: There will be less money in the schools. In the public schools, there will be a higher and higher concentration of the most difficult kids. Then they will still say, "See, they're still failing." Sure, they'll make it fail, like public sector care when it doesn't have enough resources. They just don't put those pieces together.

FELDMAN: Yes that is one of the things about this election that worries me.

Now, I want some personal information from you. We don't have anything personal. Tell me about your family.

CROWELL: My husband is retired from USC. We ended up coming to Los Angeles in

1966. We were married in Montreal in 1956 where Clarence was on the McGill faculty. We're both McGill graduates; Canadians. Clarence went to Bell Labs in 1960 – a very prestigious research center and published lots of papers. While he was there, he worked with a man who was from L.A. and came to the USC faculty. Because of that connection, Clarence agreed to come out. We had thought we would never want to live in California, especially never in Los Angeles. We had all the prejudices one could possibly have. But we came, and Clarence was very impressed with USC. This was when Dean Zohrab Kaprelian was working towards his “focus on excellence” in the Engineering School. Clarence was very, very fond of the gentleman who made the contact, whom you know. It's Bill Spitzer.

FELDMAN: Oh, yes.

CROWELL: Bill and Jenny were our very good friends all the years after we moved. They were wonderful. So that's why we came to Los Angeles, from Bell Labs to USC.

I was teaching at a university in New Jersey when we were there, and had just started working with a juvenile judge. I was going to see what kind of research we might put together, when this move came up. Besides just straight academic/professional teaching, I was one of the psychology observers and mentors for the Master of Arts in Teaching program. I also was the advisor to the Married Women's Club, which was the funniest thing, because all the married women were older than I was. But they had to have a faculty advisor.

FELDMAN: Well, they got old before their time, because they didn't have you.

CROWELL: In those days, this was one of the few places in the country that took part-

time students and evening students. It was ahead of its time that way. It was a private university, and the man who founded it was a real entrepreneur and a real character. In fact, the day that Kennedy was assassinated, I came out of a class and heard somebody saying, "The President has been shot." I was sure it had been the president of the university, because he was such a character, I wouldn't have been surprised if somebody took a potshot at him. That was my first thought: it couldn't possibly have been our President.

I was teaching there, and I enjoyed the married women and that faculty advising. They had special interest in women's programs. The dean and his wife were sociologists and established women's issues publication. So they were very supportive of me and of the married women students on the campus. It was a wonderful old campus. It had been Florence Vanderbilt Twombly's home. Twombly owned the Erie-Lackawanna Railroad. His name isn't known like Vanderbilt's, but he had about as much money. They built a mansion in New Jersey, a replica of Hampton Court. After Mrs. Twombly died, nobody knew what to do with it. It was empty for a long time. Finally, the university got it – bought it, I guess. They did some remodeling and renovating. Upstairs in the mansion were the bedrooms, and you could get 35 to 40 students in one of those bedrooms. You can see how big they were. Between the bedrooms were marble baths, and they became faculty offices. So we had a marble bath that two faculty shared between bed/classrooms. It was fun. A beautiful, beautiful campus. Mrs. Twombly had specimen plants brought from all around the world. The entry driveway was lined with lawn, backed by azaleas backed by rhododendrons and behind that were huge tall trees. The azaleas grew to eight

to ten feet. Then the rhododendrons behind them grew to twenty.

FELDMAN: Sounds beautiful.

CROWELL: It was hard to leave New Jersey, but USC was very attractive, so we came to Los Angeles. After we got settled, I started looking for a job. I was on the verge.....

FELDMAN: Did you already have children?

CROWELL: Yes, our boys were born, one in Montreal in 1959 and one in New Jersey in 1962.

I was on the verge of accepting a job with Dr. Arnie Beisser at the Center for Training for Community Psychiatry, the job that George Wollan had given up when he went to USC. Then a job opened up with my friend George Moed, who had taught with me at Fairleigh Dickenson University in New Jersey. He was Chief of the Evaluation and Research Division at the Los Angeles County Department of Mental Health. His research associate left just at that moment.

The history book (of the Department of Mental Health) details how the County Department got the NIMH grant to start the Evaluation and Research Division, and George headed the Division. I had appreciated working with him in New Jersey. We both taught one course that was the same, and we shared preparations and had a good time with that. I thought he had a lot on the ball. To back up a little bit, I had decided that I did not want to do more academic work. I wanted to do something more practical, at least for a while. I felt very much that I was teaching what everybody else had discovered, but I wanted something that I would discover. (Laughter)

FELDMAN: That's a logical idea.

CROWELL: When he offered me the job at the County, I jumped to do that. A lot of what I did in the early days is in the Department of Mental Health history book. I think one of the most dramatic things for me was the state hospital census tracking, trying to find out where every patient had lived when admitted, to get that data precisely. It was so interesting to see these demographic characteristics and locations and so on

FELDMAN: Was it at the Center, the Training Center for Community Psychiatry, that you met Helen Olander?

CROWELL: No, I met Helen – it was because I already knew her that I went to the Training Center.

FELDMAN: Oh, I see.

CROWELL: She came to the interagency meetings that I ran for the Department of Mental Health, starting in the late '60s. Don Schwartz got the idea going, and then it shifted over into my responsibility as head of planning, to have regular interagency meetings. We were the only group in town that did it in those days, so Helen came because she was interested in mental health in general. She and Marcia Buck (who was with the Los Angeles Mental Health Association at that time) were two friends that I made out of that group. Also, Steve Fox. Steve was with DPSS in those days, and he ended up coming to DMH. I knew him from the 1970s, and I liked him so much and respected him so much I was delighted to have the opportunity to have come to work with the Mental Health Department while I was there.

I took a sabbatical with Clarence in Germany in 1974. It was when I came back from that that I said, “We’ve got to do something to make an impact,” and worked on a

Federal committee application for La Puente. Then I felt I had made some real substantial contribution other than just the bureaucratic stuff. That grant brought new money and a new community mental health center to the San Gabriel Valley, which had been the most under-funded part of Los Angeles.

I was very depressed and discouraged with the merger of the Department of Mental Health and the Department of Health Services. It just seemed like we were the stepchild, and nothing went well and nobody wanted to understand and help these programs and really make them work. They didn't have any understanding of community empowerment. Au contraire! They did everything they could to keep the power in their own administration.

I liked all the people. I've enjoyed them, and I'm glad to see them. I've seen ????, ????, the DHS director, several times since I retired. We have a good relationship. I don't think he knows yet how profoundly disappointed mental health advocates were by how it turned out. He saw it in terms of politics and necessary administration. I was feeling very depressed about what was the point of staying in the County, and what could we do that would be different and make something positive. Helen said, "Hey, I'm getting this grant. Are you interested?" I said, "Yes, I am." So it was a big change to go do that. Dick Elpers served on the advisory committee, and he had been chair of the Conference of Local Mental Health Directors, so when he was deciding to come to L.A., I certainly had an active role in talking with him about community needs, etc. It was natural for me to come and work with him when he became Director for the Los Angeles Department of Mental Health. I enjoyed working with him a lot. I learned a lot from him. He was

always a tough guy – tough on the outside, but not on the inside. I guess the best psychiatrists are like that.

FELDMAN: Yes, I think so. I was interested to see Dr. Don Schwartz at the celebration at the Mental Health Department.

CROWELL: He really is a good man.

My family has been very supportive. Once during the merger time, there was an opening for the Director of Planning for the combined department. I applied and was one of the finalists, but I said to them, at the time, “I have a family. I give a thousand percent in the hours that I am expected to be at work. I even do some overtime, but I don’t want to have to do a lot of that. I want to be able to go home and be with my kids in the evenings and on weekends.” I didn’t get the job. I am convinced that it had to do a lot with this – a woman can’t give

FELDMAN: Priorities were not.....

CROWELL: Priorities were not what they wanted. You see it still in lots of places, but I always – it didn’t bother me. I was kind of glad I didn’t get the job, but it was typical of what things were like then.

Oh, I’ve got a good personal story for you. When I was in graduate school – this is what I tell all the young women, because they just cannot believe this story. I had finished my master’s degree and was starting on the doctorate with the man who was, at the time, head of the Department of Psychology, Dr. Ed Webster. He was an industrial psychologist who had a very active practice with big companies on executive selection. That was his specialty: getting executives. Part of the conditions for my being able to go

to the graduate school was to have stipend support from him for research projects so that that would pay the fees for the university. Not that they were high, but they were high relative to everybody's income in those days. Clarence was making \$5,000 a year as a professor in those days. So that was fine. I had a fellowship, and I had worked for a large company during my master's degree, to support myself and pay the fees. That autumn I found out I was pregnant just at the beginning of the school year. I decided that before I paid my fees, I was going to make sure that he would continue the stipend – and not have any objection to my staying in the program. So I went to see Ed Webster and tell him the story, and his response was, “Well, it's too late to get anybody else, so yes, you can stay on the stipend this year. But of course you'll never finish.” He went on like that for a while, and then he suddenly remembered that I was also scheduled to be a teaching assistant in the introductory psychology course. Now, the professor of psychology, who was teaching that introductory psychology course, was Dr. Donald Hebb. I don't know if that name means anything to you, but Donald Hebb was the outstanding psychologist in Canada. He was the President of the American Psychological Association. It was an honor to work with him, and it was certain to help my career. So Ed suddenly remembered that I was scheduled to be Don's teaching assistant in the class. There were ten or twelve of us who were competing to be the assistant in his class. Ed said, “You can't do that.” “Why not?” I said. He said, “Well, you just won't be reliable enough. Teacher's assistants have to be there every week, and you have to do that.” Well, I burst into tears. He said, “You see?” (Laughter)

FELDMAN: How unreliable!

CROWELL: How unreliable! I burst into tears. That was the end of the interview. I was utterly horrified. I went out and talked to – there were two women on the faculty at the time, one of them who had also taught that course with him and had been a good friend. She was quite a bit older than I, but she was still a good friend. So I went and told her. She laughed and said, “Oh, Ed is just being so old-fashioned. Don’t worry, I’ll take it to the rest of the faculty.” The upshot was the rest of the faculty overruled him. I told him I could do that, thank you, kindly. So I did get to do that all year. It was interesting, being pregnant in Montreal in the winter with our department building being up a steep hill. It got pretty slippery. It was interesting. Anyway, I took wonderful care of myself, and I didn’t miss a day all year long. I watched my weight and everything else, and at the end of the year, he called me into his office one day and said, “I have to eat my words. I have to apologize. I will never again say that a woman can’t.”

FELDMAN: You set a standard.

CROWELL: I set a standard, yes. Then the funny thing was that I got sick with the flu at the time of the final exams. The baby was due just before the final exam, so they made an arrangement for somebody else to mark papers so I wouldn’t have to do that. But I got sick a week before that, and I was sick in bed for two weeks. The baby was a bit late. I would have been sick in bed with the flu whether I was pregnant or not, I guess, and couldn’t have done the final exam. So they were prepared.

The next year, one of my colleagues had married a woman who was not in a professional school, but a nice young woman, and she was pregnant the following year. We all laughed, because he missed at least a day a week with her pregnancy. We all

kidded a lot among ourselves, but I made the point with Ed. He never picked on a pregnant woman again. It is unbelievable that it crossed my mind that he wouldn't let me continue, and number two, that he would respond the way he did.

FELDMAN: That was really a learning experience for him.

CROWELL: It's good for young people to know those things. I can't think of anything else, Frances. Well, perhaps people would be interested to know that our older son had epileptic seizures when he was seven, eight years old, the first time. Because of the Mental Health Department connections, they found me the best child neurologist in the city who affirmed that that's what it was: epileptic seizures. We belonged to Ross-Loos at the time, and he said the Chief pediatrician of Ross-Loos was a friend of his and the best pediatrician in the city. There was no reason for me to do anything but stay with that pediatrician. They would work together. Dr. Baladi and he were in touch, and he just took care of us. Dr. Baladi kept both the boys in his practice until they were 18, far beyond their usual limits. He had a few grand mal seizures, though not too many. A very bright kid, very bright and very competent, he basically took himself off his medicine without letting me know. I wasn't doing the counting out every day, but I'd suddenly say, "Robert, there are too many pills here." He finally confessed he cut down, because he didn't want to be on pills the rest of his life. He was fine for five years so he could get his driver's license. A very determined young man, but later in his life, he got severe depression. I have talked about that some, but I did not talk about that in L.A. We didn't know about it till close to end of my time as director, but when I spoke in San Diego at the Mental Health Association Conference in the fall of 1998, I talked about it. Having

him living here is a little harder for his confidentiality to talk about it a lot and that's some concern to me. But we don't know how much he was affected by the early brain disorder, complicating his metabolism or what. He's fine now, but.....

FELDMAN: He has to be watchful. Is he married?

CROWELL: Yes.

FELDMAN: He has a family?

CROWELL: Our only grandchild.

FELDMAN: What does he do?

CROWELL: He's a minister and an architect. He's credentialed in both and has worked as both, sometimes together and sometimes alternately.

FELDMAN: It's an interesting combination.

CROWELL: Yes. He is a very highly intellectually curious kind of person, and not one thing is ever going to be enough for him, so he likes that change, that variety, which adds to the stress and can add to the depression. It's one of those interesting challenges.

FELDMAN: I would think that it would be, and that he would probably have some insight into what he had to watch out for.

CROWELL: Yes, we hope so.

FELDMAN: What about your other boy?

CROWELL: That boy is a USC graduate in engineering, and he is now doing human service. He did engineering for a while – high tech – and enjoyed that, but his personality is that he really likes people and likes being out, and he wanted to try sales. He tried sales with several companies and found that so many of them were so unethical, he was not

happy about it. A door opened for him with a colleague friend of ours who started a service agency for seniors called Life Services. It is a non-profit organization and does some private conservatorship. It's the only non-profit conservatorship agency in California. It was started 25 years ago, and he's working for them now and is very happy. He gets along well with older folks, sees this as an important contribution where he can have real pride in service and ethics and all the rest of it. It's funny how people come around to a service approach.

FELDMAN: But that's what he likes. Well, he's lucky to have gotten into it.

CROWELL: Yes, yes. The founder of the organization would like him to take a master's in gerontology, and he's been with them a year now. He figured he needed to spend that time getting his feet on the ground and getting organized, but he might well do that at USC. In fact, she has two or three USC people on the Board of directors, including the head of the Emeriti program, Paul Hadley and Art Gutenberg. His wife is a neuropsychologist. She was at the conference in New Orleans that made the news today. You may have heard that somebody from San Diego reported at this meeting that they have been able to use adult brain stems.....

FELDMAN: Oh, I did. I read that this morning.

CROWELL: Use adult brain stem cells and not have to rely on fetal brain cells. That's the conference she's at.

FELDMAN: Well, that's pretty exciting.

CROWELL: Yes, she has gotten a young investigator's NIMH grant at UCLA. She went there for post-doc. Her degree is from UCSD, SDSU. It's a joint clinical and

research degree program that she took there; she's just been doing research here. She kept applying, and finally got a nice grant, so she's now in a really permanent status as a post-doc. It's very nice.