California Social Welfare Archives
University of Southern California, School of Social Work

Oral History Interview

October 28, 2014

Interviewer: Areta Crowell, PhD

Interviewee: Vivian Brown, PhD

Dr. Crowell: *Hello, my name is Dr. Areta Crowell. I am the director emeritus of the Los Angeles County Department of Mental Health, retired for several years. And I'm here to conduct an interview with Dr. Vivian Brown, an esteemed colleague and friend who has been a leader in mental health and substance abuse services in Los Angeles, California, the nation, and internationally (00:00:30). Neither of us are social workers, but we have great interest in the subject matter of the California Social Welfare Archives, because our interest has really been social welfare. And I am delighted and honored to be able to interview Dr. Brown for the Archives.*

Well, Dr. Brown, we're going to start with asking you to tell us a little bit about how you became such a leader in this field of substance abuse and mental health.

Dr. Brown: Well, thank you for calling me a leader. I really started my career, I think, as I filled out my application for USC for graduate school in psychology, and put down that I was very interested in mental health and substance abuse in order to do research around those areas (00:01:52). And when I came to the school, of course, I found out that there were no courses in substance abuse and no faculty that were really interested in substance abuse. But I had the fortunate experience of interviewing with the VA hospital in Brentwood. And on the Wadsworth side, Dr. Sidney Cohen was doing incredible research on substance abuse including LSD at the time. I'm talking about the sixties, early sixties (00:02:20). And he was someone who not only did this incredible research on LSD but helped contribute to the knowledge for the community people who were using LSD of what was, in

fact, in the LSD such as strychnine and etc. And so with that information getting out to the community was extremely important. So I had this wonderful experience of working with him (00:02:50). And on the other side at Brentwood I was on the last blocked ward at the VA hospital in Brentwood as the anti-psychotic medications would distribute, and people for the first time at the VA would really leave the VA and have a functioning life. So it was a very exciting time and it was exciting for me, because I was seeing mental illness, serious mental illness a lot more, and substance abuse combined (00:03:25). So there was my interest and my dream living in the internship and I found other exciting internships, such as Bystanders for children, Los Angeles Psychiatric Service which became Didi Hirsch Community Mental Health Center. And what was really emerging for me was not only the interest but looking at the silos so there was mental health and then there was substance abuse. There were children's services and there were adult services (00:03:59). And there was crises intervention and there was long-term psychoanalytical and you had (00:04:04) psychotherapy. And all of that just kept striking me as, you have to break down the silos. So my career has really been about breaking down the silos and working with co-occurring disorders.

Dr. Crowell: *Tell us more about, though, how you came to want to be interested in the substance abuse and mental health. As you said, it was very unusual; nobody was doing that.*
(00:04:30)

Dr. Brown: Right.

Dr. Crowell: *And then you were then talking about your application to USC for a doctrine in psychology.*

Dr. Brown: Correct.

Dr. Crowell: *So you had some previous experience that led you to make that choice.*

Dr. Brown: Well, a few things: one, I was very interested in psychoanalysis, reading Freud at a young age, and thinking I'm going to be a psychoanalyst. So then what also occurred to me was that I had an uncle who was very young and a

heroin addict (00:05:02). The family didn't want to talk about it, but I happened to love this uncle, you know, I was real young. Of course, he died at 25 of an overdose. He was put in the narcotic farm, which was the Lexington Hospital, affectionately known as the Narcotic Farm where they did a number of research services, which they shouldn't have done, under human subjects protocol. They were testing things like LSD and other things before LSD on patients.

(00:05:40)

Dr. Crowell: *And what years would that have been that he was in that institution?*

Dr. Brown: And that would have been very early. That would've been probably the forties.

Dr. Crowell: *And you say Lexington, Kentucky for California, and somebody watching the Archives.*

Dr. Brown: Yes, thank you.

Dr. Crowell: *There was no comparable facility in California.*

Dr. Brown: No. (00:06:03) No, it was really a drug treatment program in the country. And what was interesting is that when I met Sid Cohen, Dr. Cohen was then going to be the director of NIM. He left sabbatical for a couple of years to be the head of the National Institute of Drug Abuse. And one of the things he said was, "I wanted to close Lexington," and they wouldn't let him (00:06:29). They eventually closed it. It's sort of like everything was intertwined at that point between family history, interest, and starting a career and interning with the VA. So it was very interesting that all of that came together. They forgot to tell me that I could only go about one problem. And I always say that we never told our patients they could only have one problem (00:06:58). And it seems so odd to me that if a person who had a substance abuse problem showed up at the mental health agency, the mental health agency said, "You've got to go to substance abuse." And if they showed up in the other direction the same thing happened. And no one was talking about trauma. And, of course, I had just, you know, I interned at the VA where trauma was alive and well right there in front of me.

Dr. Crowell: *But not identified.*

(00:07:25)

Dr. Brown: But not identified.

Dr. Crowell: *You led the way on doing that.*

Dr. Brown: Right.

Dr. Crowell: *We'll talk about that in a little bit; a bit later, because we need to get some of your earlier career development on the record before we get to how trauma became such a prominent part of your contribution; your unique coming together of all those background characteristics. And your interest is, I think, symbolic of the fact that you not only were a groundbreaker then, you continue to be so. But how interesting that all of these things came together in you, how wonderful.*

(00:08:03)

Dr. Brown: Well, thank you.

Dr. Crowell: *So tell us, then, you talked about your internship. Tell us about your career moving forward from the internship.*

Dr. Brown: Well, one of the places, of course, I interned was Los Angeles Psychiatric Service, which became the Didi Hirsch Community Mental Health Center, and that was my first job. So I entered that system and I was very excited, because the funding, of course, under Kennedy (00:08:32), President Kennedy for community mental health centers was coming to be, and Didi Hirsch was back when the mental health center was born, and they allowed me to keep developing programs, which I was very excited to do. So I developed the substance abuse treatment program, I developed a number of specialized services for the Venice community, specialized African-American program, and specialized Latino program, crisis center in Venice, and kept going so that what happened was I started writing grants for the community, and then as my staff said, "You really are

now a grant junkie," I kept writing grants to develop bigger and better co-occurring programs (00:09:26). And so when I said, "We're going to be doing both mental health and substance abuse," everybody said, "Well, we can't do that. Where do you get funding for it?" But I found ways to get some funding going in different directions. One is the substance abuse direction, and the other one is mental health. At the time of the HIV/AIDS epidemic, of course, that was another piece of the puzzle. And most of the community mental health centers were not moving fast enough for HIV/AIDS (00:10:01). And trauma was already on the radar at that time too, because I was working with rape crisis centers and domestic violence shelters, and the DV shelters didn't want to take women with substance abuse or were mentally ill, and so they kept sending them away. And, again, that was the piece that connected the trauma from both the rape crisis and domestic violence. And that began my journey in the seventies for trauma.

(00:10:36)

Dr. Crowell: *And you spoke about becoming a grant junkie. Perhaps it would be useful if you described something about the funding history and the politics in which you were working in the sense you said how that evolved.*

Dr. Brown: That was pretty exciting, too. We had Lanterman-Petris Short-Doyle funding for community mental health centers.

(00:11:02)

Dr. Crowell: *I think you're going to have to spell these out for Archives' listens who don't know what we're talking about.*

Dr. Brown: Well, there's a note in the future. Well, with the Community Mental Health Center Act, of course, this was extremely important, because it was national, federal funding across the country to flaming catchment areas throughout the country of a certain population. Didi Hirsch's population was a 170,000 people (00:11:33). Catchment area, 89. And the charge was to provide all mental health and substance abuse services to that catchment area. And that definitely caught my imagination and my boss's imagination, Dr. Jerry Jacobson, who was very much committed to community mental health. And so we saw this picture of this 170,000

people are family (00:12:02). And when I began thinking about the first substance abuse program, because really you had to have a substance abuse program for the Community Mental Health Center funding, but you could sort of contract with one outside. Well, I explained it to Jerry Jacobson at the time that we should have a model of this (00:12:24) and we would design it for co-occurring disease, and he was very supportive. So once that started I then went for funding through some of the substance abuse grants. And, of course, National…

(00:12:43)

Dr. Crowell: *Federal.*

Dr. Brown: Federal. National Institute of Drug Abuse had a sizeable budget, and there was National Institute of Alcoholism as well, NIAAA. So I went for funding through them. And I kept seeing the federal money as the experimental money. I wanted to try models that would fit best for people who had both mental health problems and substance abuse problems (00:13:12). And that would allow me to develop a new model, then do the research, so we could do research. I was encouraged to do it, I did it. And then be able to refine the model, and then go back and say, "Okay, now here's the new model," and then receive some funding for that until it really showed good outcomes to be able to go to the county in Los Angeles county and say, "These programs really work (00:13:44)." And that's sort of been the development, again, throughout my career as I added things like the trauma or HIV/AIDS to go to the federal government for the research funding or R&D funding, Research and Demonstration projects to show that this could work, and then how to do it better, and then how to get that model disseminated across the country. And that's really how my career sort of kept developing, because I kept adding the other pieces (00:14:19). And then looking at the population; once I looked at the population of people who had substance abuse problems and serious mental illness, I'd say about 90 percent of them had experienced trauma in childhood and in adulthood. And that became the next piece of the puzzle (00:14:43). So we add the trauma piece. And I thought all of mental health would be very excited about adding trauma, but they weren't. That wasn't a priority issue for mental health at that time—now, we're talking seventies—it was not a priority issue. But the federal government did have special funding for community mental health centers, particularly, around intervention and looking at trauma and violence

(00:15:16). And so we got some of the first funding from the Rape Prevention Study Center in federal government and we, then, had the Southern California Rape Prevention Center at Didi Hirsch, and began working on trauma. And similar things with HIV/AIDS. Again, with the right funding was very available for HIV/AIDS after…

Dr. Crowell: *Again, this is federal funding?*

(00:15:42)

Dr. Brown: Federal funding. Based on real advocates storming the federal government to say, "You're not saving lives. People are dying on the streets. People are dying in hospitals." People were dying and some of us wanted to save them. So we began doing the HIV/AIDS services as well. So we kept adding the pieces. By that time we were talking about AIDS for the HIV/AIDS, and I and my business partner, Maryann Fraser felt that community mental health centers, a couple of problems (00:16:22). One is they weren't keeping up with the emerging community needs, which CMHs were supposed to, but they weren't. And part of the reason they weren't is they became too involved in trying to raise funds, because the Community Mental Health Center funding from the federal government decreased based on the fantasy that poorer communities could pick up their share (00:16:50). Eventually, County Mental Health, of course, picked up some funding for the community mental health centers, but they could never reach the amount of money that was supposed to be picked up. So the Community Mental Health Center is worrying about the funding, we're not going to take on new projects. Maryann Fraser and I decided to form a new program, so we founded Prototypes Centers for Innovation in Health, Mental Health, and Social Services.

Dr. Crowell: *In what year?*

Dr. Brown: 1986. And we were launched and…

Dr. Crowell: *Can you capsulate the mission statement for that at that time?*

(00:17:35)

Dr. Brown: Yes. It was an agency designed to, one, meet emerging community needs, that was in our mission statement, emerging community needs, to develop models to meet those needs, to test them and refine them with research, and disseminate the information to the country to increase the knowledge base (00:18:01). And everybody thought, wow, what a name, you know, that was a long name and a long mission statement. And I, you know, it's a pleasure to say we did it. So we started with funding for the L.A. county substance abuse, alcohol and drug abuse. And we wrote a proposal for drug residential treatment for women who were living with HIV/AIDS or at-risk for HIV/AIDS. We also had substance abuse and mental illness, and their children. And we were funded.

(00:18:44)

Dr. Crowell: *Taking on all the problems at once.*

Dr. Brown: That's right. We were funded for 22 beds for the women and their children, the extra beds. And then within the year as we were developing the facility, finding a facility starting up, there came additional funding from substance—it was from L.A. county—alcohol and drug abuse to pick up another 11 to 13 beds, which I graciously accepted *(laughs)* (00:19:18). So we really were launched and I began with Maryann Fraser the Prototypes Women's Center in Pomona. And when we took over this facility that was a Christian school that was no longer able to economically keep up the school, so we took over this facility, which was three and a half acres (00:19:44). Fabulously scenic. And through that we then were funded from a number of places, began adding to the residential outpatient services, eventually mental health services funding from L.A. county, HIV/AIDS services both from the federal and the county, because L.A. county had millions that was receiving funding because of California's AIDS epidemic (00:20:17). And we also had some additional funding that came a little later for the women with co-occurring disorders and violence study, the SAMHSA funding five-year study that you were intricately involved in and we were so happy that you would lead our expert group, the global expert group (00:20:43). But that study was extremely important for us and the country, because SAMHSA wanted to know what are the best practices for women with serious mental illness, substance abuse, and trauma? And then there was a subset study for their children. There were nine sites to look at the women and four sites to look at the children as

well, and Prototypes was one of both major study and subset.

(00:21:20)

Dr. Crowell: *I should probably clarify when I was involved with that project after I had retired as director of mental health, because it would've been a conflict of interest for me to do that much as I endorsed all the experimental things you did over the years (laughing).*

Dr. Brown: Correct. That's right. You were retired and we were thrilled that you would work with us, and that was a wonderful experience.

Dr. Crowell: *That was a great project and you can talk more about it as it reflected all you had learned over the years before, and how you used it to document and further promulgate the information about those practices.*

(00:22:02)

Dr. Brown: Right. That study had so many incredible pieces to it, because I think even SAMHSA, I think, was a bit surprised by the results. They didn't expect the results to be quite as good as they were. What we were ready to show was that if you integrated mental health, substance abuse, and trauma in all the interventions, so that if you, you know, in residential, we have residential programs, we had outpatient programs (00:22:32). But every point of contact with the woman and her child, you integrated all of that within the individual session or the group session. We implemented trauma-specific interventions, seeking safety, trauma recovery and empowerment, TREM, and two that were designed specifically for the site, seeking safety and TREM in evidence-based practices (00:23:03). So we showed that if you incorporate that, which was very easy to do, because both mental health and substance abuse programs do group therapy. So the group intervention was very easily and quickly integrated. The trauma-informed piece, which I'm still working on across the country now in consultation, the trauma-informed piece was beyond the intervention (00:23:31). It goes to the system, to the practice that we assume every client has experienced trauma. And if you assume it, then we change our practices so that we do not re-traumatize, and we understand how important it is that the trauma is a part of the practice. And that part has really penetrated the

country. A couple of studies did that (00:24:00). One was the ACE study, the Adverse Childhood Event study done by Drs. Anda and Felitti out of Kaiser Permanente San Diego and CDC out of Atlanta, Georgia. And the women with co-occurring disorders and violence study, again, another major piece of the puzzle. Because, again, we could show the country most of the people, most of the clients that we were seeing, particularly women, there were some men, have trauma experiences (00:24:36). In fact, that was the major other piece. Mental health, around 90 percent; substance abuse around 90 percent trauma. And the ACE study showed that the childhood adverse events that people experienced not only caused mental health and substance abuse problems but health problems (00:25:00). And so they were able because of Kaiser Permanente's study, they had 1700 people. They looked at them asking about their childhood adverse events, but they had now at around age 50 all of their health problems. And it was very clear that the higher the number of childhood adverse events, abuse, trauma, the higher the likelihood of serious health problems (00:25:29). And then they continued their studies and, of course, they liked the serious mental illness studies that showed seriously mentally ill, people who have serious mental illness will die earlier. Same thing with the ACE people who have significant childhood adverse events will die earlier, and we're talking somewhere around the age of 20 to 25 years. So very important studies (00:25:55). And we kept disseminating information from our study, women with co-occurring disorders and the ACE, because we felt the ACE study fit right in with what we were doing. And so we wrote about 75 publications just for that study. And I think people were quite shocked. But they kept showing more and more pieces of what we needed to do to change our practice, including the children. If children are seen with—what we were able to show—if children are seen with the moms, both the moms and the children do well. And that was pretty significant (00:26:39). So rather than separating children and parents to really bringing things together and doing the family-centered intervention, which they bring up some of these studies. So it's been a great journey, and I've now taken it to a whole other level, which is, I've been asked to consult with what is known as Family Drug Treatment Court Systems, which are amazing, because they're real systems that work (00:27:10). You have mental health sitting at the table, substance abuse, children services, child welfare, the court, juvenile justice, education, parenting services, housing services, and it's for families who are involved with child welfare, and the children are being taken away or they're left while the parents go into the treatment (00:27:39). And so they wanted to become

trauma-informed, because they had the pieces together, but they still weren't quite trauma-informed. So I've been working with a number of these across the country, and it's been very exciting.

(00:27:54)

Dr. Crowell: *You've talked about your role as a consultant. Let's just review your role in terms of policy development and advice over the years. So when you first started having a say in what's happening, perhaps you will want to clarify the silos and the funding silos a little bit more as you walk through this.*

Dr. Brown: Great. Thank you. Great question. I really started pretty early in my career, Doreen Loso (00:28:26) from Region 9, National Institute of Mental Health, asked me two things (00:28:33). She wanted me on review committees and she wanted me to be a resource for Community Mental Health Centers. So that began a whole other piece of the career, because sitting on review committees is exciting, because you also have a chance to shape questions.

Dr. Crowell: *Let me just insert, that is a privilege which comes to very few, and it comes out of her role as a reviewer and seeing what you're doing at Didi Hirsch Community Mental Center; right (00:29:08)? So that's where it started, you putting into practice what you were gaining in your beliefs and your values, and your curiosity early on, and leading to results (until @ 00:29:19) Doreen got you onto the first level of influence.*

Dr. Brown: Exactly. And the site visits were another place for the influence (00:29:29), because here I was very excited that Community Mental Health Centers would break down with silos, and then I go visit some of them, and they weren't even doing what they were supposed to be doing (00:29:40). So they weren't even putting into place things like drug prevention or substance abuse, etc. So that gave me another piece to work on. Then I was invited to do some review of proposals for National Institute on Drug Abuse, National Institute of Mental Health, and the Rape Prevention Center in Washington, D.C. as well (00:30:10). So that kept bringing up questions that we hadn't received answers to research questions, and really started helping me formulate as well as pass on information and I was, then, invited to join a number of advisory councils for the federal

government (00:30:33). So I served on SAMHSA's National Advisory Council, Substance Abuse Mental Health Services Administration. They fund quite a few programs including block grants to other states in the United States. I served on their National Advisory Council, I was co-chair with Charles Curry for a number of years, and I was a member for even longer. I was a member of the SAMHSA Women's Advisory Committee. I served on the state California co-occurring joint action committee, affectionately known as COJAC.

(00:31:16)

Dr. Crowell: *Which was started when?*

Dr. Brown: That was about maybe '98. I don't remember the exact date.

Dr. Crowell: *I was going to say it took a long time for that to happen.*

Dr. Brown: A long time. A long time.

Dr. Crowell: *During which you had been very active at the federal level, the National Women's Center.*

Dr. Brown: Yes. In fact, our committees helped write the federal monograph for co-occurring disorders so we could report to congress including for the CDC. We were somewhat happy with that before. It didn't go far enough. They took out a number of things that we had suggested, getting more integration (00:31:59). But that was really important. I served on the Board of National Health Association. I served on the Los Angeles County Commission on drugs and alcohol. So in all of these what is very exciting for me is to really be able to push the agendas for doing more and more on integration (00:32:25). So for me, of course, now the integration of behavioral health in primary care is a natural. I mean, so they said, "What took you so long?" kind of thing. And I'm hoping, again, that it doesn't take as long as it took for substance abuse and mental health to put in place co-occurring disorders programs, because integrating these systems is really a major problem, and then everyone would get us to protect their turf and their funding, and they don't want the funding to be limited, and that slows everything down and, of course, we're going to see more of the new era with primary care and behavioral health care.

(00:33:15)

Dr. Crowell: *So that's a logical lead into for the lessons we learned, what would you say to people who are trying to do this integration of mental health and primary healthcare? What rules, what approach should be taken?*

Dr. Brown: Well, I think we should have started a long time ago, but we haven't *(laughs)*. So we need to start quickly discussing the issues, and I believe trauma is the core issue (00:33:49). I think it takes away some of the stigma, right, of what we've lived through with serious mental illness and what we've lived through with substance abuse problems. Because even a recent article, journal, will show that people really dislike substance abusers even more than they dislike people with serious mental illness (00:34:16). Well, trauma sort of takes away a little bit of the stigma for the outside people. And by that I mean when I was working, particularly within the substance abuse problems but also mental health. You understand when I said, "particularly." If I talked to people, even professionals like myself, they would say, "How can you work with those people (00:34:45)?" "Those people," you know, I'm talking about mental health people are saying this. And I'd say, "Who are you talking about?" And they'd say, "These women who use substances around their children and they're destroying the children." And I began to share the fact that most of these women had early trauma way before they started using substances (00:35:14). And that's where we started trying to even educate the federal agencies and pushing that agenda, because we could show the women with substance abuse problems had early childhood sexual assault, early childhood physical abuse, neglect, etc., and then started using substances (00:35:44). Once people started to hear that—and it took a while for people to even hear that—their feelings about these women changed. And there's similar things with HIV/AIDS. If they told their doctors, "I want to have a child," and part of that was because they thought, I'm going to be dead, I'd like a child to live after me, the doctor said, "You can't be serious. You can't have a child, you have AIDS (00:36:15)." So we've harmed people of many, many mix, our own attitudes, as well as the general public's attitudes, but our own attitudes. And, of course, we've also harm people by not recognizing trauma, so that our seclusion and restraint, the core issues are around seclusion and restraint. When we didn't realize how many people have been already traumatized, we re-traumatize them over and over again in the

psychiatric hospitals (00:36:46). They want attention. We thought we were doing good, but we were doing harm. And so when we could, again, share that with people to have them hear you are dealing with populations who are re-traumatized. And if you can accept that as the expectation and not the exception, you look at your practices, and really understand what trauma is about.

(00:37:14)

Dr. Crowell: *So then next the recommendation is that they accept and understand the role of trauma. How do you see that message getting across?*

Dr. Brown: Okay. So what now I am studying is looking at programs and, of course, I have my own prototypes program and I was able to do this work to other programs in other areas. I'm researching in the healthcare we have a program in pediatric cancer care that's trauma-informed in Philadelphia (00:37:54). We have the emergency room that John Rich in Philadelphia at Drexel has included the ACE study questions and really working with young African-American women who end up in the emergency room shot and working on trauma (00:38:21). Montefiore Hospital in New York has just integrated the ACE study questions for any woman who comes in who's pregnant if she has more than four of the ACE questions scored, she goes into a special track extremely different (00:38:40). That's the kind of thing I'm going to be talking about; that we know more about the models of how we can incorporate them. In Prototypes in corporate we had a medical team right on the campus at all times (00:38:54). You know, we built low cost housing on the campus, so people could live there and still get support. Those are the kinds of things that we have to really address. And we can't spend too much time quibbling over whose funding it is; right? And, you know, who's in charge and who's doing what, and we have to stick together and say, "Look, this is what we know, this is what we know." Trauma leads us.

Dr. Crowell: *What have been the obstacles for you've tried to get that message across?*

(00:39:30)

Dr. Brown: I think funding has been brought up in most any discussion as we write. And for somebody, as you know, somebody who we've gone around in some way the funding by getting this funding for this piece and this funding for that piece, you know, I didn't let funding stop me. But often people are saying, "We can't get funding for that." We heard that with co-occurring disorders, "Well, you can't get funding for that (00:39:58)." You can't mark substance abuse and mental health on the… saying, you know, wrong and get funded. So that's one piece we need. We also know that there are a large number of caregivers who have experienced trauma themselves, and they on one hand are fabulous caretakers and interveners, because they are very sensitive to the issues, but on the other hand some of them may not even realize that they have been traumatized (00:40:35). They haven't worked on that, and then they tend to take on more and more, because they want to help everybody and they're not realizing that they are now re-traumatizing themselves. So we have to be very aware of that and we have to make sure that as a training we train everyone around trauma issues; what does it mean, what do you do, how do you do it, and what does it look like (00:40:58). But also to make sure that people have the option to say, "Wait a minute, I have been traumatized," or "I think I need to work on some of my issues before I do that." And then we have a really well trained staff across the board, and where we can (pull @ 00:41:21) the pieces of behavioral and mental illness care. I think some of the pediatric people are already really looking at it, because they have to deal with the early childhood trauma they're seeing. And I think they're starting to tune in. When, again, one of the things you hear about it is, "We don't have the time." Again, this even more so than in, I think, health and pediatric health and adult healthcare. You know, we have 15 minutes we've got to, you know, boom boom boom you have to be able to diagnose, we have to do our notes, and we have to get on with it, and trauma-informed says you can't do that in 15 minutes (00:42:03). You have to really have a practice that allows people to tell you what happened to them, and since they've been traumatized they don't trust us. So you can't expect someone in the first 15 minutes of contact to tell you anything. They're going to deny, just like they deny substance abuse, etc. So all of those barriers have to be reduced.

(00:42:30)

Dr. Crowell: *And, again, what's your recommendations on how to reduce those behaviors?*

Dr. Brown: Well, I'm glad you're saying that, because one of the things I'm doing with these systems is trying to reduce the barriers. I've developed a trauma-informed assessment for systems and it was published and it published in the substance abuse journal, because the mental health people weren't quite there yet, but substance abuse was and then the trauma issue (00:42:56). And using that assessment as a walkthrough, so it's not audit, it's not going in and saying, you know, '"You're doing bad things, you've got to correct it." But it's walking through systems and you could imagine with the family drug court systems it's like this huge system, I'm walking through with a team, but they have to give me staff members, managers, and peers, consumers who walk through with me. And we're all looking, you know, through different eyes, because we have different experiences (00:43:31). And what could be at any moment what process, what thing that we're doing, even the environment, could re-traumatize this person, and then we all formed this action plan around the team, without me now, to pick it up and make the changes. And some of them can be very simple, like riding outside a mental health agency at night, you know, where somebody is terrified to come in (00:44:03). You know, one of the simple things I just mentioned, one of the places in child welfare, they were taking these children for visitation through these long halls and gates and sort of dreary, and not very appealing for a child who might have been traumatized (00:44:22). And I said, "You know, to make it simple and right," I said, "You know, I happen to be short, so I have a different viewpoint than some of you tall people, but I think it might be good if you could paint some wonderful, child –friendly things along this wall, so that children are not scared as they're walking through this." And there was a, "Oh, that's simple." Right (00:44:50). Simple things as well as some of the complicated things, and we're kind of swinging instruments. We're really advocating with everybody, swinging for trauma. It can be very simple.

Dr. Crowell: *So you had lots of successes. You've had lots of frustration. How do you deal with the frustration?*

Dr. Brown: Well, I don't know. It must be my New York upbringing. But when I'm frustrated and people try to stop me and my agency, then I just say, "Okay, I'll

find another way (00:45:23)." And I think it's kept me going and I feel like I can just still doing something. Because, you know, many, many times there's been somebody who wants to stop that process for many reasons, and I would just find another way to do it. I was co-chairing the L.A. County Co-Occurring Committee and people kept saying, "Well, we can't do that funding." I said, "Yeah, Yeah, you can. You can find a different way to fund it, and try it."

(00:45:58)

Dr. Crowell: *Have you given up on ending the silos funding?*

Dr. Brown: No. I think we may have another chance now, because of ACA and maybe look at what I am worried about, is that we know the residential treatment programs, and I was going to say drug treatment, because they really are sort of classic. My residential drug treatment program for people with mental illness and trauma, and you know was 18 months long, so that we could take pregnant women and keep them beyond their pregnancy and still have them working on their issues (00:46:39). Now what's going to happen, I think, is everyone's going cut residential. One, we have the problem about Medicaid funding for anything under 16 beds, that's point one. That really needs to go, because you have some fabulous residential programs that should be funded and more than 16 beds because just economy of scale, you know (00:47:08). And two, we really have to look at length of treatment. You know, whenever we try to save money we think, have the treatment shorter when, in fact, the people I'm talking about, substance abuse, mental illness, trauma, health problems, poverty, stigma, abuse, you know, because of their race, their religion, their whatever, they cannot be in short residential treatment. And we've shown residential treatment to be most effective in having parents and children together most effective in not 20 days or 30 days (00:47:57). The research is clear, it should be a minimum of six months, would really be effective. So if you want to have people constantly coming in and rotating through your programs, just cut the treatment shorter.

Dr. Crowell: *So what have been your most satisfying experiences out of all of this?*

Dr. Brown: I think working with the systems that really want to change, and that's

been very exciting (00:48:32). Systems that say they want to change and they don't, is a little more frustrating. But when the system really understands that, you know, particularly if the women are under some trauma, and the integration of mental health and substance abuse as well, and health, I think working with them has been very exciting. Spending a day with Anna Freud was probably one of the highlights of my career. And she was quite wonderful, and one of the things she said to me, which I quote to child welfare all the time as they look at me, she said, "You people in your country think that the way to help child abuse or child neglect is to take the parents and children, and separate them (00:49:17). That's wrong." And, you know, really, it was indelible now, because she's right. I mean, separating, no. In certain circumstances you do have to separate some parents and some children, but if you have parents and children in treatment and you have an opportunity long enough to work with them and see what they're doing and helping them change what they're doing, and learn how to take care of themselves as well as their children, you will see, you know, better outcomes (00:49:55). So that's why I think it's exciting that the family drug treatment courts are even thinking about it.

Dr. Crowell: *So how would you describe the changes in the political and academic knowledge-based climate in which you've done your work over these 50 years?*

Dr. Brown: Well, it's definitely changed. I'm not sure that mental health, psychology, social work, etc., have all integrated the co-occurring disorders, you know, the kind I'm talking about (00:50:31). And USC, by the way, social work participated with us. We and our women with co-occurring disorders in a pilot study had USC social work, psychology, and the educational group, I'm blocking their names out, social something, they were our evaluators, and so, you know, people like Dr. Margie Getz (00:50:57) and some of the faculty and social work were part of that study, and it seems to me that they are the leaders to push the agenda that we're talking about, the co-occurring disorders (00:51:14). And there should be more coursework. No one should come into universities for psychology or social work or psychiatric nursing or any of the helping professions and not learn any of the above, and I think we need to do a little more work on that. I mean, there are many more courses around substance abuse around, but they need to be integration of all of them. I think all of us have to be doing that. That training

has to be encouraged, including medicine.

(00:51:55)

Dr. Crowell: *One of the areas where you also provided leadership was in the role of consumers. Would you like to talk about that?*

Dr. Brown: I would love to. Again, my career, because I worked so closely in substance abuse treatment, always included disorders. And so I was surprised that mental health did not include consumers early on, and we're talking now in the sixties (00:52:16). So it was easy for me to have the concept that consumers are so important to helping the practice, because in substance abuse, of course, recovery people we use are part of the staff. So I kept pushing that. So when we had the women with co-occurring disorders and violence study, we included as part of the mandate every psych had to have minimum of one consumer-survivor recovery person, which was a new concept (00:52:52). The person had to have a diagnosis of severe mental illness, diagnosis of substance abuse and also have experienced trauma. And so they named themselves consumer-survivor recovery, and we started saying CSRs, and then at the end of the project everybody said, "It's too difficult to keep saying," so the consumers said, "Let's say women or men with mental distress (00:53:20)." But throughout the study it was consumer-survivor recovery until people really understood we were talking about an incredible group of consumers, and they participated in every level of the study, including designing instruments, which the researchers had not done before doing implementation in the program. I think one of the best parts, when we did the child subset, we designed a child intervention trauma-informed, child intervention (00:53:56). The consumers wrote a letter to all the moms in the study explaining why we were doing the intervention that they shouldn't be worried about it, this is what it's about, this is why we're doing it, and saying that if you have any questions you can come to the consumer-survivor recovering staff. Not one woman refused having their children come to see them (00:54:23). And I believe it was because of the consumer-survivor recovering staff. They did everything with us and we also had an entire training program that went through the five years for the consumer-survivor recovering staff. So they learned everything about research, everything about whatever was our piece of the puzzle. And most of us have hired all the consumer-survivor recovery for good (00:54:50). As you know, from Prototypes'

Paula and Jen, and she has been working in the mental health programs since the project ended, since the study ended.

Dr. Crowell: *So if you had to do it over again, anything you'd do differently?*

Dr. Brown: No. I would do it probably all the same way *(laughing)*, but I learned a lesson, which is you can't push the time (00:55:20). That I learned from, you know, of trying co-occurring disorders in the sixties couldn't be done too easily. I mean, I could do it in my program, but most people weren't going to do it, and it took this long. And trauma keeps coming back, and so I think we may be able to push the trauma in gender and childhood faster. Only because every time we have war, and we also have it, it comes to the forefront again (00:55:50). And so it's here with us on a number of levels, sexual assault, child abuse, domestic violence, and more. And we can't let it go away again.

Dr. Crowell: *You said quite a few things about how you think the field of service delivery including the service delivery by social workers, needs to change to move ahead. Are there other things you want to add to that or do you just want to recap your recommendations for improving the field of social welfare?*

(00:56:26)

Dr. Brown: Well, I think, you know, now that there are enough people, as I said, USC is in a great position, because there are enough people in psychology and social work that worked on these projects, that they, I hope, call together this group of people who worked on these projects, and really look at where they want to go (00:56:53). And I'm not sure they've done that yet, but I think they need to, because there are, again, this team that worked with us on our study, it happened in a number of the states. At the universities, you know, put together teams that really kind of crossed some of the disciplines, that now's the time, bring those teams together and say, "Where do we go?" because they're the people who lived it as well, and then a few people who are out in practice as well (00:57:23). It's in the university people on the campuses. To have the university people who've known some of this, the practice people who've done it and lived it, and the consumer-survivor recovering people sitting in the same room really saying, "Wait a minute, how do we take it to the next level?" particularly with public health care. And,

again, those people who have worked in HIV/AIDS are very significant for that, because we had to work with their docs, there was no way. And they had to work with us, so what we did is we moved our team into the health centers, into the hospitals that were doing AIDS (00:58:06), and into the healthcare system, etc., and we just moved in.

(00:58:11)

Dr. Crowell: *I would think that from the Los Angeles county perspective you have been, as we said before during this interview, you've said and done so much to move the field to be a better delivery system, a better community, and I think you must be very proud of Prototypes. You haven't said a lot about it directly, but that you founded it, you've used it to carry out that wonderful mission in terms of not only delivering service but getting to know more and more to improve the field and the practice, and to make this whole world of mental health, substance abuse, trauma, health problems much more effective in taking care of the needs of the people (00:59:41). So I think Los Angeles county, in particular, owes you a great debt of gratitude (laughs), but I think what you're doing nationally is showing that this is a field to which you have made great contributions, and I think it's amazing that so many years after you formally retired from Prototype, you continue to be having this good effect on the field, and I look forward to your continued consultation throughout the country (laughing).*

(01:00:12)

Dr. Brown: Thank you. Thank you, I want to say that I feel fortunate that I was in Los Angeles County. Many reasons for that, because, I mean, Los Angeles County is so launched and so important if they do something here that it really has some impact, because you can tell, you know, the country this is riveted with some states; right (01:00:37)? The directors of L.A. county mental health, yourself, Marv Southard, Dr. Southard right now, substance abuse, Dr. Irma Stranz, people who really cared about moving the field (01:00:57). And so you allowed people like me to obtain funding to try things out. You know, the county system can't just go around being experimental. I could go out and get federal funding and state funding, and county funding to do some of the experimental work, and I always felt that the county systems were supportive, and they always included me in, you

know, committees where I could say this (01:01:31). They might not be able to, you know, suddenly take the funding and blend it with other funding, but always very supportive. And I think that, again, the county systems, the universities, and those community-based organizations that really understand some of these issues, need to sit down and take it to the next level (01:01:55). We have another chance with ACH to really do a great job. And I really think that the trauma piece pulling this all together makes a lot of sense, and makes some sense to push their field forward.

Dr. Crowell: *USC has an entrepreneurial program, I think, if I'm not mistaken, and clearly you are the ultimate example of entrepreneurial approach being used effectively.*

(01:02:26)

Dr. Brown: Thank you.

Dr. Crowell: *They should have you in the lecture of the entrepreneurial program (laughing).*

Dr. Brown: The way around.

Dr. Crowell: *Yeah, how to do that. Well, thank you, Dr. Brown, for this, I think, very interesting interview and I hope people learn, and I hope maybe there will be attached to it some of the references, because you have so much work that had been published and research findings that need to be incorporated, and I hope people will take advantage of that.*

Dr. Brown: Thank you, Dr. Crowell.

(01:03:00)