INTERVIEWEE: **SUE CRIMIN, Supervising Psychiatric Social Worker Palmdale Mental Health Center**
INTERVIEWER: **Diane DeMartino**
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I'm Sue Crimin. I'm a Licensed Clinical Social Worker and a Supervising Psychiatric Social Worker for the [Los Angeles County] Department of Mental Health Services [at the Palmdale Mental Health Center].

How did you become interested in mental health?

I've been interested in mental health all my life. It probably stems, at least in part, from the fact that when I was 6, my mother had major depressive disorder. She had what you'd call a nervous breakdown, but we would call it decompensating. I remember her lying flat on her back on a couch in our apartment, and women from the neighborhood coming in and putting washcloths on her head. Then she just couldn't take it anymore. She left; I don't know if she went to a sanitarium or what. She just went out of our home for about three weeks, [and] when she came back, she started seeing a psychiatrist. This was in the early '50s.

My mother started talking to me about psychiatry and how it helped her. We would take her down to what used to be called Ross-Loos, in downtown LA [an early HMO medical group, now part of CIGNA] – I think [the building is] now the Scientology Building. But that was the Queen of the Angels Hospital [now in Hollywood] and there was an outpatient wing too. We'd take her down every Saturday. She'd see the psychiatrist and she'd come back in the car and be kind of a new person, and we'd take a drive, or go home.

She talked to me a lot about this. I really kind of resonated with it. She would tell me about how a lot of people don't accept it; a lot of people don't believe in it. I kind of started learning about stigma at an early age. Also, my aunt was a psychologist. She was in experimental psychology and she taught at Bryn Mawr [a women's liberal arts college in Pennsylvania]; and she was kind of an important figure for me.

We had problems in my family. It was what you would call a dysfunctional family. My mother had problems later on again. She had breast cancer and kind of dropped out again and I had to take care of the family. I was the oldest child, and I had emotional problems later on. In fact, I started drinking when I was 18. I was always a straight A student, did everything that was just right, and when I hit college – UCLA undergrad – I couldn't take it anymore.

My dad was a professor, and then a dean, at UCLA. Everything was [about] how well did we do academically. I had to get away from that and my way of doing it was to start drinking. Unfortunately, I fell right into alcoholism and I ended up getting sober many years later, at the age of 31. I started looking at things and problems and I started going to my own therapy. At the time, I was a librarian. I got my Master's in Library Science from UCLA. I moved up here in 1976, to work at Antelope Valley Hospital [in Lancaster]; they had a Family Practice residency program and they needed a librarian. So I came up. At the time I was still drinking. They started a care unit, a 28-day program. I was lucky enough to see that I had a problem and I got sober.

When I got sober, I wanted to become an alcoholism counselor [or a] drug addiction counselor. I didn't do that; I did some other things. They had to close the library. I went into working with medical education, and then I became a marketing person for the mental health unit. I decided, after doing that for a couple years, that I'd rather be providing the mental health care than selling it. With the previous interest I had, I ended up going to my MSW at UCLA. So I'm a UCLA person. I went to grammar school at UCLA – University Elementary School. To say I do not like USC – but that's another thing – that's another Oprah!

So I went back to school late in life. I got my MSW when I was 50. I've done some healthcare social work and what I always wanted to do, really, was to be a clinician and work with the mentally ill. Here I am.

I'm now a supervisor so I don't see a lot of clients. But I love mental health. It's fascinating to me; it will never not be fascinating. To learn about the ideology of personality disorders, or what's going on from a neuro, endo, [and] biochemical perspective is fascinating. They've found out that you can use an anti-psychotic drug in depression, in psychosis and in bipolar. It used to be that you'd have different drugs for each of those. So there's something that unifies the diagnoses. What is it? What goes on in the brain? What happens in neurologic structures? It's fascinating to me. And here's the world of neuro-endocrinology and psychopathology and it [all] fits in. There's a concordance with [the work of Sigmund] Freud and Anna Freud and a lot of theorists that don't talk about the anatomical basis of it. So it's very interesting to see there's kind of a concordance, a fitting in. Theoretically, it's very interesting.

Tell me about your job here.

There are two parts of the job: there's administrative supervision, and there's clinical supervision. Administratively, I have to do things like monitor case loads, transfer clients from one [clinician] to another.

I have to do now a lot of quality assurance [QA] monitoring, which means looking at the documentation and making sure it's properly done. We get a lot of our funds from MediCal [California's Medicaid program] and MediCal stipulates [that you explain] why you're continuing to see someone as a client. It's called medical necessity – why do you need to see somebody – and you have to document this. I've got to make sure that the clinicians are doing that. It becomes problematic because, if you're a clinician, you're really focused on treating the client, helping them with case management needs, providing therapy. You're not thinking so much about documentation. But you've got to document what you do in a certain way [and] there's a lot involved in the documentation, so I have to check on that.

I have to make sure that staff gets the proper education. I might have to discipline staff; that would be part of administrative supervision. If people call in sick, I have to take their phone call, that kind of thing. So that's part of my job. Another part of that is that I have to put out fires. There are a lot of fires in mental health. Like someone will come in who's not a client here, but a little crazy. So someone's got to go out and handle that person; it's usually me. Or somebody calls and they're suicidal on the phone. I suppose that's really clinical. I have to take care of that.

On the clinical side, I have to meet with clinicians, who are getting their hours. Social workers here have to get 3200 hours after they get their MSW, clinical hours that are supervised. Then they go and take a licensing exam. And they have to have at least one hour a week clinical supervision, to have their hours count. So I have to meet with people and we talk about things like, "OK, what's the best way to handle this case? How would you conceptualize this case?" How would you assess – that kind of thing. That's a lot of fun – I really enjoy that.

You want to review basic theories. People who get licensed have to know the DSM-IV, *Diagnostic and Statistical Manual IV* [of the American Psychiatric Association], and that's how we diagnose mental disorders. There's a lot of that on the [social work licensing] exam. They've got to basically be prepared, in supervision, to take the exam. That means you can be an independent practitioner [if you pass].

I think I like doing the QA part more now than I did. But it's very difficult to try to get a handle on that, because it's kind of impossible to track the clients that you have to track who are under the clinicians. It's difficult.

What kinds of services do you provide?

You've probably heard about the Mental Health Services Act [the California voter initiative act of 2004 which provided a new funding stream for mental health, tied to a new focus on recovery-oriented services]? With that Act, we're supposed to provide programs that do not duplicate anything else. So we have programs like the Older Adult Program; we have something **called CRS [Crisis Response Services?]** – it's short term therapy. Generally, these clinics with DMH have provided services to people who are chronically mentally ill. They come in and get their medications and they come forever.

With these programs, we do a little something different; so with the CRS programs, it's short term therapy. You can come in as a client, not with a severe diagnosis, but with a life adjustment problem. You just lost your job, you just lost your kid, that kind of thing. Certainly there are many people today who have just lost their job. You provide short term therapy to them. We've been trained in something called the Benjamin Rush model [short-term crisis intervention therapy, named after the Revolutionary era physician]. It helps them in 6, 7, 8 sessions to readjust, gives them coping skills to handle the situation and go on from there.

We've got a program that's starting now called PEI. It's Prevention and Early Intervention [one of the new programs under MHSA, PEI emphasizes focused, evidence-based treatments]. We'll be working in that program with people who have post-traumatic stress disorder [PTSD]. There are [two or] three really good treatment modalities in that field that are very effective with PTSD. So we have some people doing that.

Most of the clinicians in the clinics are social workers. We didn't hire LMFTs [Licensed Masters of Family Therapy] for a while. We are now hiring them, but they have to be licensed. If we hire social workers, they can be unlicensed. So we have also psychologists; we have PsyDs and PhDs, not as many. Most of the people are social workers. We have case managers; they have to have a bachelor's degree. And community workers; I think they have to have two years of college. So there's a variety.

In some clinics, they have mental health technicians. We don't here. In this clinic, we also have some nurses; they've had at least five years experience in mental health. And we have clients who come in and they get shots once a month, usually an anti-psychotic drug. A lot of people who are schizophrenics end up not taking their medication. They don't like to; they feel like they're being controlled. If you can give them a shot once a month, rather than an oral pill, it's much easier. They take it, they're on it, they're controlled, if they're the kind of client who just doesn't like to pop the oral pill every day.

The nurses help there. The nurses help in other areas. One of our nurses is in the Older Adult program, [where] we have clients who are both mentally ill and have a lot of physical problems. So obviously, a nurse would be good there.

Who are your clients?

We probably serve a greater number of people who are not making a lot of money. They might be on SSI [Supplemental Security Income for the disabled], or SSDI [Social Security Disability Insurance] – Social Security of some sort. But we have a great variety of diagnoses. Some people are working; probably most aren't. We certainly encourage people to work. We've got a lot of ethnic diversity. There's a growing number of Latinos who are moving up here. So we have many monolingual Spanish speaking people. I know we have one Russian client; we had a guy from Nigeria; we have a lot of Caucasians; we have some Asians, probably not an awful lot. So ethnically there's diversity, and that's probably growing.

There are people who are referred by DCFS [Department of Children and Family Services], people who have or are going to lose their children – that's one group of people. The court often orders them here. And there's a problem there, because that's a judge [saying that] this person needs mental health. Well, the judge may not be a mental health specialist or professional, so there can be a conflict there.

[There are] people who've just gotten out of the hospital. "Andrew" [client pseudonym] was a person who had just gotten out of the hospital. He had slashed his wrists pretty deeply. We have maybe two or three people every Wednesday who may have just gotten out of the hospital, suicidal, homicidal – so they come. We have people who have transferred from LA, from the San Fernando Valley, and they've moved up here because there's cheaper housing, and they're going to transfer here from one clinic to another.

Last week, we had a first break. When somebody is schizophrenic and they have their first episode they're usually 18, 19, 20. We had a very handsome young man and his mother, and this guy is very, very brilliant. He had his first psychotic break. He's probably from an upper middle class family; his dad is an engineer, and he's got kind of a mathematical mind – you can see it. But he's talking nonsense, and delusional. The mother does not know what to do; the mother just can't handle it. So she brought him in. He wouldn't have come in, had the mother not brought him in. You talk to the young man and he's off in another world and she's sitting there crying. So we'll get someone like that.

And you've got to treat both. The mom's got to know more about schizophrenia. There's a [family] support group. It's called NAMI [the National Alliance for Mental Illness], very important for the family members. Because they've got to know what it is,

how to deal with it; if you've got someone in the family, you have to try to treat the whole family. We'll have people like that.

We'll have people who all of a sudden are having – maybe they're people who were sexually abused when they were two. Now they're having memories or they're having problems with PTSD [post-traumatic stress disorder]; or maybe they were abused when they were two and then their husbands started abusing them. Then you get a kind of layered effect, and all of a sudden, they are having – depression, anxiety, PTSD. You get that kind of people.

Tell me about PTSD.

Post-traumatic stress disorder is old. It used to be called shell shock. I think that was the term that was used during WWI.

There's [a new therapy] called Prolonged Exposure; I think it's been around for several years. It was developed by a woman who's at the University of Pennsylvania – and it involves – well, you process emotions is what you do. A certain number of people who have PTSD get over it – they just spontaneously remiss. Others don't. Others, for some reason – we don't know why – don't get over the symptoms. With PTSD, you avoid things, you have flash backs, you have nightmares. If you see somebody who reminds you of the trauma, you may have a startle response, and you limit your activities greatly. You don't want to go to a theater, or you don't want to go to a market. You don't want to have any friends.

So what this treatment is [is that] you have your client come into the office for 15-18 sessions. I think 15 is [usually] the highest number – but it could be 18, depending on the case. They close their eyes and they re-experience the index trauma – the worst trauma. And what they do is they go back to that place and they tell you exactly what is happening as if it was now. To some people, that may seem counter-intuitive. It would seem like it wouldn't work, but what you're doing is helping the client to digest the experience, kind of like you would digest a meal. You have your steak meal, you eat it – it's gone. The PTSD client hasn't digested the experience.

So you go over it a certain number of sessions and you have them go to the places they avoid. And you have them come up with a hierarchy. Which [place or situation] causes the most distress would be at the bottom. Which are the least distress[ing are] at the top. And you have them go or do what is least distressful at first. And you teach them deep breathing to relax. So you would have them, say, spend five minutes at the mall, and do some deep breathing; then you'd have them come back to you and report to you. Then they go to the next most difficult thing to do.

I've been trained in it; I had four days training. The County is wanting us to do this, because it's an Evidence-Based Practice. There's very good evidence showing that it works. Nowadays it's probably best to use Evidence-Based Practices, rather than be a loose cannon and do anything. So the County provided training for 4 days, last October. The woman who taught it [Dr. Edna Foa] is the woman who wrote the section on PTSD in the DSM-IV, which is quite an honor, and she developed this approach.

I am now starting once a week with a client, and I'll do a session 90 minutes long, and I'm going to film it and I'll burn the film onto the CD. I will send the CD back to the

University of Pennsylvania, and somebody there will supervise me. They'll have seen the whole session and they'll call me up and say [what's] "good, bad; you might have thought of that [at that point]". So I'll be trained and certified in that. There are right now, obviously, a lot of veterans coming back from Iraq [and] Afghanistan, who've had terrible problems with PTSD. Maybe we can provide services to them. But there are a lot of people who come into this clinic with PTSD.

I think "Andrew" was resistant to doing it at first, because it means going back to that place. And the natural inclination is to just avoid it. But I've talked to him a lot about the procedure, and he's done a little bit of it. Another thing that we do in therapy is I'm going to give him a very small tape recorder and he will record the session. He'll take the tape recorder out of the session and play back during the week, so it's more exposure.

Dr. [Edna B.] Foa [Director of the Center for the Treatment and Study of Anxiety at Penn], who developed this technique, has shown us many, many videos of people before and after and it's just wow – really amazing. Some people have done very well. It's just like – you see someone coming in constricted, and after several sessions, you can see much more positive emotion on their faces. And they're doing things – they look different, their life is different. We want to help them reclaim their lives. We don't want them to be in a little corner where you hide in the corner and that's it; that's your life. So yes, "Andrew" will be part of it and I'm really looking forward to working with him.

What does this clinic do really well?

I think we handle emergencies really well. There can be people who will come in and we have borderline clients, with borderline personality disorder, and they'll come in and [they'll say] all of a sudden, "Well, I'm just going to go home and OD on my pills." We're really good at dealing with them in the moment, maybe hospitalizing them and turning it around. There are a lot of emergencies that come in and we calm them down. You have to just [stop what you're doing] – "OK, I'm doing this, I'm not even going to [stop], I'm writing my chart" – forget it. "I'd better go up and go out there and take care of whatever is going on."

What is your biggest challenge?

Probably making productivity standards. Because of budget constraints, we have to produce 65% direct services, billable services, every day. It's kind of like a law firm. It's really hard to be providing – being with a client and helping that person – and going back and writing it up and making sure that you've done enough write-ups for the day for clients that you've seen, that it equals 65%. I understand why it has to be done, and the County has to be worried about reimbursement and finances. But it's kind of like two very opposite poles, and you've got to deal with both of them. Usually social workers don't like to think about money – "OK, what can I charge for this?" That's really hard to do.

And we have a lot of different projects. For instance, with the new Healthcare Law [the Patient Protection and Affordable Care Act of 2010], we have something called the 1115 waivers [a California MediCal initiative to strengthen the safety net and provide coverage for the uninsured]. They are [for] people who are indigent ; they don't have health care [coverage]. We have to provide services to them, and there are maybe 80,000 County-wide. We'll be taking more and more – how we're going to do this, I don't know.

So there are different programs and different focuses. We've started seeing parolees, we've started seeing veterans – we used to refer them out. So there's so much to divide your time that it's really hard.

I think that we can't pay equal attention to all clients. Some are pretty stable and doing well. But it would really be nice to have the time to devote to everybody and their needs, and what you have to do is prioritize everything quickly in a day. You might get an emergency call and you say, "Oh, I can handle that in an hour;" and it might be three hours. You can't predict and you do the best you can to handle that; but that may mean someone else gets ignored or someone else is put on the back burner. But you've got to prioritize. First things first. But that's very frustrating.

Do you cooperate with the other agencies here in the Antelope Valley?

I would say just the opposite. I don't think we cooperate *that* well. I mean, it's not like there's no cooperation. But I think there could be much better cooperation.

Like with DCFS. They will call us; and if we have a client from DCFS here, case managers will want us to do certain things. Well, they can't dictate to us. They'll want a report, "Should this person be a parent?" Well, we can't say that. And they'll get mad at you if you don't. They have a very different view of mental illness.

OK, what I was just talking about [with] the court system – the court will say "Suzie Smith, you need therapy." Well, number one, the basis of medical treatment is that you *agree* to it and you want it. So, if a judge is referring you to a clinic and the person comes because the person doesn't want to end up in jail or lose her kids, she'll come; but she doesn't really want the therapy. She's just doing it for the judge. And we're two silos: the legal system and the mental health system are silos. We don't talk. We don't really understand one another.

To be very truthful, I think we can do a lot more cooperation with the other [LACDMH] clinic in Lancaster. They're a little more of a closed system now. I'm being very honest. They have a Wellness Center there, and they transferred a lot of their clients to the Wellness Center, clients who were pretty stable and wanting to look at other options in life. We have not been able to transfer any to that clinic.

I think the person who was running that clinic wanted to run his clinic in such a way that he looked good, so he could be promoted. This is a system where you're promoted and there's an upper echelon and you've got to do XYZ to get there. Your productivity numbers have to be good. I think he thought first and foremost of his promotability. So there was not this cooperation with this clinic, bout transferring the people here to the Wellness Center. I think we transferred two. I think – this is my guess, I'm not sure, but if you're 40 years old, you're thinking about how to get ahead in this system. I think there are oppositional kinds of forces at work there. Really, the first thing we should be looking at, the most important priority, is the client.

It would be very nice to have another clinic. I think two clinics in this area isn't enough. Forums where there would be more cooperation. I don't know exactly how to pull that off, but somehow a mandate that agencies would have to get along, would have to know about each other. It's probably very difficult to do. And, in this period of budget cuts and

not a lot of money, you've kind of got to be selfish in a way. But I think if there was a lot more cooperation, things would be better. How to do it – I don't know.

How does Palmdale differ from Lancaster?

Our Program Head's first priority is to make sure we're all doing OK, that morale is good. That's his first priority. At other clinics, that's not the first priority. At other clinics, the first priority is get the work done, get the numbers going, keep the numbers up, do your job, I don't care if you like it or not – do it. Dr. Harry Taylor [Program Head at Palmdale] wants to make sure we're all OK. A lot comes down on us to do. It's very stressful, and he tries to protect us. I mean, I love Dr. Taylor, and he's been very good to me.

But the other clinic – and I worked there – it was all about if you don't get all the QA done, you're in trouble. And it pushes downward in this system. It's a lot of stress on supervisors. Because we're one step up from those that are in the trenches, and we've got to make the trenches work.

The people down at 550 Vermont [DMH headquarters] – don't quote me, but I wish they would spend a day in the trenches. They formulate policy and develop documentation and they don't know how hard it is to do and they haven't done it. I go to meetings downtown and you have to tell the people that are in charge of various things. "This is what's happening; this is not a good idea." There should be more connection there, I think.

I don't know how cooperative people are in the San Fernando Valley; I don't know about West LA; I don't know what you're hearing from them. But I wish there was more cooperation.

I like to develop people, teach, and I like to work with clients. I like to help clients find themselves and grow and, as much as I criticize the County, they've given us a lot too. For instance, we have wonderful training. I just – it's hard to say. I love mental illness. I don't love the fact that there is mental illness, but I like working in the field. I feel very fulfilled – I don't know, it's hard to say. But I love working with staff and working with clients. And Dr. Taylor's a special man.

What will I do when Dr. Taylor leaves? I don't know – I'm 65, maybe I'll be the Program Head.

Thank you.

END OF INTERVIEW