INTERVIEWEE: **WENDY DOUGLAS, SOCIAL WORKER, EDELMAN**
INTERVIEWER: **Diane DeMartino**
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I'm Wendy Douglas and I'm a social worker here at Edelman. I've been here for six years. I'm on the Welcoming and Triage Team, which means I do assessment and intake for the clients who walk in. Then I transfer them to the appropriate County program. I also do individual and group therapy in the afternoon.

How did you get into this field?

Well, I came from public health. I studied public health and was actually working in an administrative role at an STD and HIV clinic in Hollywood. I realize that I that I really enjoyed working with the clients that came into the clinic, doing HIV counseling. And I realized I didn't want to be behind a desk, doing policy and program planning for the rest of my life, even though I love the concepts, and I liked the work. But the practice of doing clinical work really appealed to me. I traveled a lot too, and just really felt a lot of compassion for people. When I traveled, I lived for some time in West Africa and in East Africa. It just felt like there was something to be gained by doing individual work with people in a clinical setting.

Maybe it was the Catholics. I am not Catholic but I was raised by Catholics; I went to Catholic school where there was always a volunteer component and my mother always encouraged that. And I was always involved with church programs. But I really think it was probably in college, going away to another place, going away to West Africa and studying sociology and interviewing – I interviewed almost 100 Ghanaian women about their life situation. I was studying education and I just loved it. I loved hearing – I developed a penchant for hearing someone's story, and learning about where someone comes from.

I'm from Los Angeles. (laughs) I grew up in the [San Fernando] Valley, in a middle-class family. They weren't particularly religious; but we participated in the local church, which was never really religious to me, but more of a community setting. So I was always surrounded by great people, very progressive minded people. I think Martin Luther King came to speak at our church and it's a church where there is no gender-biased language. So it was really a progressive place and there was real investment in music and theater and it was a really cool place. All my friends were from there.

I guess I was really just active as a kid, so I danced and I acted and did a bunch of stuff in high school theater. I guess I'm an extrovert. I'm not an introvert, so it's easier for me to connect with people, better than the next person. I don't know. Even though I work at DMH, I am an actor as well. I am also a social worker, and it's an interesting career path (laughs), because I do both, and I'm invested in both equally. Of course I spend most of my days here, and [I act] in between, maybe on my vacation time. On my time off, I'm often doing films, commercials, television shows.

It's interesting because when you are in a professional, social work, therapeutic capacity, you are in a clinical frame of mind. It's often a combination of left brain and right brain. So it's logical and a little bit emotional. But you're really trying to take a step back from the client, to be able to help them. Then, when you go into acting, it's really opposite. It's the right side of the brain; it's very emotional, it's very present, and you're really trying to not limit your emotions at *all*. You're really trying to step outside the box and not fear what's expressed. So [it's] the opposite of what I do during the day. So it's a release in a way. Because when I'm acting, it's like everything I can't do

on the job. So if someone says something upsetting in an acting class, or in a film, you can really respond to it. Whereas, when I am in therapy with someone, it's just a completely different role. You're more contained and it has to be just a different part of the brain. It's a different activity. So I really like doing both.

How did you decide to work in mental health and here at Edelman specifically?

I don't know if I had a perception of mental illness growing up. It wasn't really until I was into my 20s or 30s. Even once I decided to become a social worker, I wasn't so attuned to [the idea that] I would be working with mentally ill people. I think I was, in college, in my twenties, more prone to wanting to understand how people worked [and] how society works. So I studied sociology and had an interest in the bigger picture. And it wasn't until now [that] I'm in my 30s [that] I am more interested in the individual and how one person thinks and experiences the world. So it's been refined. I don't think I knew the path that I was going down when I was younger. It just took a while.

To become a social worker, you do internships for two years and then you're set free. Then you have a period of two to three years, if you want to become licensed. So you [have to] collect 3200 hours, which takes about 2 1/2 years, mostly, to do. I knew that I wanted to have a better understanding of the full spectrum of mental health issues. I was in a hospital setting for a year and I thought, "I'm not really understanding what I want to know." I figured [Edelman] would be a great place to train and get a lot of exposure to what people were going through, especially with severe and persistent mental illness. I just knew I wanted that scope of understanding. That's sort of my personality – I wanted to see the whole picture, before embarking on the later part of my career, whatever I did in the future, either running a program or doing individual therapy. So I knew this was it, that this was just a good training ground.

I had graduated school and was done with my internship. In fact, to get into the [LA] County [system], here at Edelman, is really difficult. I waited, I think, a year, to get here. I interviewed and I waited a year to get this job. So I was at St. John's, a local hospital [in Santa Monica], working in medical social work, sort of biding my time so that I could come here to work.

Has the job met your expectations? Is it your dream job?

It's a really challenging job. Working here, working with this population of people, where there is a dearth of resources in Los Angeles – we're just lacking in resources. From a social work perspective, you can't really heal someone or you can't really work with them on the problems, until they have basic needs met. So there's a lack of housing, a lack of food, a lack of everything. It's just not something we have. So the job is frustrating. Meanwhile, while you're dealing with the lack of resources, you're dealing with people with severe personality disorders and people [who] are difficult to be around and they're drinking or there are just all of these obstacles.

In some ways, the job is really, really satisfying, because there are moments in this job where you just can't take that away. It's brilliant. You really get to see huge transformation in people, and miraculous success. But at the same time, it's very, very challenging, on a day-to-day basis, to work with people in crisis. I mean, just emotionally. So I would say – It's such an interesting question – It is a dream job in a way and I'm lucky that I get to work in a helping profession, where I get the privilege of being able to be there when people need something. But on the other hand, from a selfish perspective (laughs), it's not necessarily a dream job. It would be much easier to do something where things were a little easier, to be honest.

What is Welcoming and Triage, exactly?

[The Center] is run in a sort of ramshackle building, a little rundown, from the 80s. There's lack of funding to do a lot of repairs right now. We have a broken front door, it's all boarded up; the elevators barely work; the copiers don't work. So, on some level, I don't know how welcoming it is visually. But the Welcoming and Triage Program is really the entry point at which someone first encounters the County mental health system, the team of social workers that interface with someone upon their first visit here at the clinic. And it's really about doing the assessment, the complete assessment of where someone is at and what their problem is, what they're coming in with, what their needs are, and what they want, seeing if we can't help them understand the problem better and what resources might be available.

I mean, sometimes it's a crisis. Sometimes someone is completely in crisis or they're sort of at the end of their rope. They are homeless for the first time or they've lost the housing that they've had or their depression is worsened or they're completely psychotic and it's managing that kind of crisis. So it's providing a welcoming atmosphere, but also triaging and assessing for problems.

In the morning, we have all of our walk-ins. We have probably about 10 to 30, depending on the day. New people right off the street, maybe have been here, a long while in the past, and coming back or have never been here before, walking in. We go down the list and each take someone and talk to them from anywhere between fifteen minutes and three hours, depending on what their needs are.

Now, of course, in 2011, we're sort of in the middle of an economic crisis and there's a whole new population of people coming here. They are people who've worked maybe their whole lives, people who have been holding on and have had jobs and were just getting by – maybe had some health insurance or didn't have health insurance, but were doing OK. These people lose their jobs and they're homeless for the first time, or they're out of work for the first time and their unemployment is about to run out. A lot of people are running out of unemployment now and it's a first time encounter with mental health problems or a first-time depression, a lot of freaking out. We're seeing a whole new group of people emerge into the clinic. It's not just the classic Axis I type of diagnosis of severe mental illness [in the DSM classification, Axis I are the most serious mental disorders].

So they walk in and I try to first ask them, "What brings you in today?" To get an understanding of what they are wanting, what they are hoping that we can offer them. It's assessing for sort of a multidimensional understanding of what's going on. I want to know what's the presenting problem, what's going on with their mood, their affect. I want to know what's going on. I want to know what their mental health symptoms are, and what their socio-economic problems are. Are they housed? Do they have income? If not, are they in a shelter? Are they eating? Do they have a food source? Are they having any psychotic symptoms? So it's a biopsychosocial assessment, assessing for the whole picture and trying to understand if they get help from their family [and] do they have a social support system? A little bit of everything.

We decide where to put someone, based on what programs we have. (laughs) I mean, in some ways it's easy, because we're fairly limited. If they are symptomatic and they're wanting medication management, it's fairly easy. We can put them in our program where they are just monitored by a physician and a caseworker, doing care plans and medications. Some people just want medication and that's fine.

But other people want to interface with the social worker, so they need more help than just medication. They need the assistance of a social worker who can clinically manage their case, so they can deal with the dynamic issues of their mental health problems in the environment. How does their mental health issue affect their housing, or their ability to work or not get work? How does it affect their social system? We see a lot of substance abuse so if someone is using substances – that is a huge component here – we want to make sure they're connected, depending on their readiness, with a substance abuse counselor and the doctor and the social worker. So it is a team approach here. Some people are doing a little better. They are higher functioning. They might be ready for work. So there are a lot of different programs – specialties. We try to make sure [that] people are connected to the appropriate program.

So, to be seen here at Edelman, you walk in, you are seen the same day, and you are triaged. So they are assessed for what their needs are. It's a team approach. Everyone has a social worker or a caseworker and a doctor. We really want people to be engaged in [our] services. We want them to demonstrate they're interested because there are a lot of dropouts [and] no-shows, so we try to engage them first. Usually someone sees a social worker within two weeks, and the doctor's visits are about two months out. Someone will have to wait six weeks to two months, to see a doctor, for their medication.

Now in the County, two or three years ago, they opened up an Urgent Care Center for emergency medications. [The DMH Urgent Care Centers are at Charles Drew Medical Center in South LA, Brotman Medical Center in Culver City, and Olive View Medical Center in Sylmar.] If someone's really ill and they're released from the hospital, [or] if you are in crisis, we have emergency appointments. So you get seen within a week, or even that day perhaps. But for everyone who else who is stable, who has never been on medication, we send them to the Urgent Care [Center], so that they can be assessed if that's what they want to do.

But it's not something you want to rush people into. You really want to take the time to do the assessment first. If they are not in crisis, you really want people to understand what they're getting into. You want them to be engaged. So it may sound like a long time; but we have all of these little stopgaps, these fillers, to help people get by before they see the doctor. Six weeks to two months is really outrageous. It's sort of our longest waiting period. Normally, it's usually a three to four week wait to see a doctor.

Tell me about the clients and about the therapy you give them.

Individual therapy has to be [with] people who are willing and people who are good subjects – willing to come in every week and talk, verbal. For therapy, I see a lot of really anxious people, maybe people with OCD, anxiety disorders, [or] major depressive disorders. I also work with a lot of Axis II personality disorders, primarily borderline personality disorders. So I see a very dynamic and colorful group of folks in the afternoon for therapy. It's difficult because the clients who are psychotic need a lot more attention. But it's really difficult to do individual therapy with clients who are less verbal, more limited, dealing with more of the concrete issues, [such as] housing and financial issues.

DBT is dialectical behavioral therapy. It's relatively new; it's been around for maybe 20 years. It was started by Marsha Linehan, who was, I think, a nun turned psychologist. She wanted to find a way to help people with the most pain, the people who want to kill themselves. [Linehan, Professor of Psychology at the University of Washington, has herself been diagnosed with borderline personality disorder.] That group turned out to be those with borderline personality disorders. So this is a group of people who are highly emotionally disregulated. Often really

smart and really attuned to the environment, but struggling with their interpersonal interfaces with other people. So they often get enraged really easily, or they are completely emotionally sensitive, and they have a high level of self harm. They hurt themselves and they often commit suicide; at this time, 10% end up successfully committing suicide.

DBT is the therapy – I think it's the only therapy right now – that's been proven to be successful at reducing the amount of suicides, reducing self harm, and really actually perhaps curing [or] treating borderline personality to the point where it may not show up as borderline personality anymore. It's kind of miraculous. In LA County, in the Department of Mental Health, I think there are only two places that offer DBT right now – Harbor UCLA [Medical Center in Torrance, CA] and this clinic, although [the LACDMH] Downtown Mental Health [Center] is now starting a team. So it requires a team of people – you always have to have a team, you can't just individually practice – that work together, as clients are required to attend individual therapy and group treatment. It requires a big commitment on the part of the client to participate in DBT. It's really novel that we have it here, because it requires such a big commitment on the part of the social workers who are already overloaded.

People [come here from] all over – if you can't afford DBT out in the private sector, which is probably $300 a week, I mean that is absurd, or in an inpatient setting, it's sometimes $40,000. And the interesting thing is that, if you're struggling with borderline personality disorder, you're probably not working. Perhaps you're really struggling with your relationships, you've burned a lot of bridges, you've been fired a bunch of times, and you're really in a dire situation. So a lot of people probably can't afford that kind of treatment. I'm surprised it's not offered in more of the clinics in the public sector. But it's kind of new, emerging. But, yes, we get referrals from all over the County, from the [San Fernando] Valley. We have a waiting list to get into this program.

Edelman Westside Mental Health Center is one of the only clinics in the County [mental health system to offer DBT]. I think there are only two or three clinics that offer dialectical behavior therapy, DBT. And we have a waiting list of clients. We have referrals from all over the County to get in, because it's not offered in many places. DBT is the most effective treatment right now for borderline personality disorder, but it requires a big investment of time. But on the back end, the benefits are so great. It's just that I think everyone, all of the social workers and the programs, are so inundated with people, and there are so many things to do that it requires a big commitment on the part of the staff to start a DBT program – even though it's indicated for the treatment of borderline personality disorder.

I feel like it's a really dangerous disorder to have. I mean, these are the people who do end up successfully killing themselves and committing suicide. I think that treatment is really important. So I predict that probably it will be an emerging therapy that's more well accepted and more pervasive in probably 10 to 20 years.

What is rewarding about your job?

It's a really tough job. This is a really hard job. [But] it's an amazing place to be. Where you're at the intersection of the only place [where] people are getting help. And as difficult as it is, as hard as it is, to work with this population, it's amazing to be there. It's rewarding to be there when someone really needs help. And I think it's amazing to be one of the only ears that someone has, the only person that listens when someone is really at a crossroads.

I think I finally understand when people say the poor have no voice, because you really see that people are out there on their own. They don't have a support network, and it's not like they have

the time or the energy to protest or join an organization to fund their cause. It's really the people who are disenfranchised and forgotten. And there are so many. (laughs) So it's rewarding to be able to contribute to that, helping other people that really don't have a voice.

What's the hardest part of your job?

The hardest part for me personally is dealing with substance use, people with dual diagnosis. So people who are struggling with a mental health disorder and homelessness and are using. For me, it's personally very difficult, because it's such a big obstacle. If you're drunk or you're high, how do you accomplish your goals? How do you get your needs met? How are you able to think clearly?

I think the mental health issues affect the substance use and the substance use impacts the mental health issues. So they need to be treated together. People often treat their symptoms with substances, if they can't get [medications] in a legal way or through a doctor. So I understand why people use [drugs] to deal. But it just worsens the situation so much and often it affects people's personalities [and] coping skills. There's a lot of manipulation, and it's just a difficult part of the job. And it's so pervasive. I think I heard once that 80% of our clients report some sort of substance use, which I don't know what that says about society and where we are and why it's such a big problem. But we see it here all the time.

What accomplishment are you most proud of here?

My proudest accomplishment is a client that I worked with. He was living in [Pacific] Palisades and camped in [Topanga] Canyon. He's in his sixties; he had no form of identification. He lost his wallet in the 80s. I think he had a little driver's license from 1982 or something, so it was not even accurate or current. But he had no ID. He was a John Doe. He had no evidence that he was existing on the planet. And he had never interfaced with anyone before. He was just really isolated. Twenty-five years he had been up in the campsite and I got to work with him. I worked with him once a week [and] saw him for 45 minutes or so. We developed a relationship over about a two-year period.

It took about that long to get his birth certificate. It was almost impossible because he was an American born in Germany, so I had to get a German translator to get his birth certificate. That took forever. I don't know if people know this. But, if you don't have any ID, it is so hard to prove that you exist. So, to get his Social Security card, you had to get a birth certificate, and to get the ID, you had to have a Social Security card. So it took about a year and a half to get all this documentation. And finally, he's a very depressed man, really low functioning, but so sweet to work with.

Finally, we were able to get him on disability, so he had some source of funding. He [had been] living on $221 a month for 20 years. He was eating one can of food a day; I mean, his nutrition was probably not great. And he was very thin and frail, but the nicest man. Finally, once we got the disability, he was able to get Medi-Cal, which helped pay for his medications. And finally we were able to get him starting to talk about housing, potentially a board and care facility. But he collapsed on the sidewalk. I crawled up in the bushes to try and find him, because he hadn't come into the clinic and I was terrified and terribly worried. And he wasn't there. I crawled through this rabbit hole of thorns to get to where he was hidden, because I knew where he was. I think I was the only person who knew where he was on the planet. I'm not kidding you. He wasn't there, so I thought something was absolutely wrong.

So I called every ER. I think I called seven ERs and I traced him to where he ended up. He ended up in the Valley somewhere. He had had an intestinal blockage and passed out on the sidewalk. Thankfully, it happened on the sidewalk so someone came by [and] took him to the hospital.

Finally, after being homeless for his entire life – not that he should have had to get sick, but because he was able to get to the hospital – he ended up being able to get better over the course of the year. I think just now, three years later, he's finally getting into an apartment. So I feel like if he didn't come in here or if we didn't have that relationship, I don't know what would've happened to him. I really don't know. I always think about him. Just this person who was like a no-name guy. He had no identification; he didn't have a friend.

END OF INTERVIEW