Sandra Thomas talks about continuity of care for troubled adolescents:

Additionally, we provide mental health services to the youth incarcerated in the Probation camps. There are eighteen Probation camps, with six camps located on one site which is the Challenger Memorial Youth Center (n Lancaster, CA; the other camps are located in Calabasas, Lake Hughes, LaVerne, Malibu, Santa Clarita, San Dimas, Sylmar, and Tujunga) The mental health services at the camps were significantly enhanced as part of the Memorandum of Agreement (MOA) between the County of Los Angeles and the U.S. Department of Justice that was reached in 1007 as the result of the CRIPA (Civil Rights of Institutionalized Persons Act) investigation that occurred in 2006. There were some mental health care findings related in addition to youth-on-youth violence and some other things.

So we were able to add staff. The Department of Mental Health did not have sufficient staff to staff these camps because the camps are in outlying areas; they're all over the County. The Board of Supervisors agreed to provide staffing for 88 staff and so we have two staff left to hire. We just recently hired 88 staff and we now have a full complement of mental health staff at the camps. When I first took over in probably 2006 or 2007, we only could keep kids on medication in one camp, but we now have three camps, where we're able to keep kids on medication. We have two all-girls camps. Because we found that if we could isolate the girls because their presenting problems were different, we could employ evidence-based practices that have been shown to be effective in working with some gender-based kind of practices. So we again provide medication support in the camps.

We are now beginning some family intervention kinds of services where we do provide transportation to parents who come up to visit the camps. And that recidivism rate, I just confirmed with Probation yesterday, is about 17%. We're hoping, with the development of an aftercare services program to assist the kids in transitioning from camp back to community and providing services in the communities and non-branded mental health places to improve recidivism and that's what the Mental Health Services Act dollars have allowed us to do. Because with the Prevention and Early Intervention dollars, youth in stressed families and at risk for juvenile justice were one of the focal populations for PEI funding; we were able to get two million dollars of those funds to develop some services. So what I've done is to develop a Transition Aftercare Program that's going to be heard by the Board of Supervisors on March eighth and I'm hoping that it gets passed. We'll be able to get 27 staff to offer evidence-based practices in non-branded mental health settings for youth who are discharging from the camps. So we're hoping to impact that 17% recidivism rate. Maybe in a year or two years, we'll have some outcomes like that.

READ THE FULL TRANSCRIPT BELOW.

INTERVIEWEE: SANDRA THOMAS

INTERVIEWER: MARCIA MELDRUM

DATE: February 25, 2011

I. Choosing a Career in Social Work and Working with Troubled Children

MM: I'd like to ask you a little bit about your personal background, where you grew up, where you went to school and so forth.

ST: Do I need to say my name or you have that?

MM: Well, why don't we introduce ourselves?

ST: I'm Sandra Thomas.

MM: And you're the Director –

ST: I'm the Deputy Director in charge of the Specialized Children and Youth Services Bureau [at the Los Angeles County Department of Mental Health (LAC-DMH)], that includes mental health services for youth in the Juvenile Justice system, Transition Age Youth [TAY; that is, young people ages 16-25] Countywide and Service Area 6 geographic area, [that includes the communities of] South Central, Watts/[Willowbrook], [University/Lynwood, and] Compton. [I have oversight responsibility for both the directly operated and contracted mental health services in this particular geographic area.]

MM: So a lot of responsibility.

ST: Yes, yes.

MM: Thank you for giving us this interview today. It's the 25th of February; it's about noon. OK, so yes, if you could tell us a little bit about where you grew up, where you went to school and what exactly led you into social work to begin with and then to this special area.

ST: OK. I grew up in Marshall, Texas, which is a small town in east Texas, close to the border of Louisiana, and I was raised on a farm. And I'm the eighth child of thirteen children born to one union. [In Marshall, I attended segregated schools for all of my primary and high school education. I graduated from high school in 1970 and had a choice to attend the "white" high school my senior year, but my parents opted out. This was the first phase of the school desegregation plan in the state of Texas.]

[As I approached graduation,] I wasn't real sure what I wanted to [major in], but knew I wanted to get a higher education. My mother actually suggested [Sociology], because she perceived that I was having some interpersonal interaction struggles, and that I think I was a little bit shy as well. I didn't really warm up to people very easily. So she said to me, "Well, if you're going to college, then maybe you need to study something in the social sciences, maybe Sociology." I thought that didn't sound too good. I was thinking about maybe being a teacher or maybe doing something in the business field.

I started my college education [on a part-time basis in the fall of 1970, at] Los Angeles City College. [I worked full-time at UCLA, in the Accounting Division, at Murphy Hall.] I did two years there and then I was accepted to UCLA. So I got my Bachelor's degree from UCLA in 1975. During the pursuit of my Bachelor's degree, I started leaning toward working with youth. [As I entered graduate school, my interest in working with children and youth was more solid. I say this because one of the professors at the UCLA School of Social Welfare saw the announcement of my undergraduate graduation in my hometown newspaper. In that announcement, it was noted that I planned to work with children and adolescents.] So somewhere along the line, I had made a decision about maybe working with kids.

MM: Had you done any work with kids before?

ST: I actually had not. The only work that I had done that came close to that was while I was in junior college. [While at LACC, I had a job in the] work-study program, that was a part of a mobile education [project, that involved outreach to "underprivileged" or lower socioeconomic communities to make them aware of educational opportunities at the local junior college]. So that was the first time I got an opportunity to interact with the public, [by talking and meeting directly] with people in the communities. The [particular] grant [focused on the] South Central and East Los Angeles [communities]. That was my first real exposure to a diverse population [relative to ethnicity] and I found that I was energized by those interactions.

[As I approached graduate school, I had to focus more on career development.] So I had to decide, "What do I do?" I had gotten my B.A. degree in Sociology with a minor in psychology. I thought I wanted to do social science research. That goal [proved to be a bit] lofty that I was going to [need to get] a PhD.

MM: I'm sorry. Did I miss something here? How did you get from Texas to LA?

ST: Oh, OK. Sorry about that. Actually my older sister, who is ten years older, had moved to California. The educational opportunities or access to educational opportunities were far greater for me in California; and also access to employment. I came from a family in the lower socio-economic [realm]. My father was a laborer and my mother actually stayed home to take care of the kids, so I did not have a college fund. I knew I would have to work my way through school. So we thought Los Angeles would be the place [to provide] the [best] opportunity [for me to attain a higher education]. [As it turned out, we were all right.]

My first year [at LACC], I paid out of state residents [tuition] fees. I worked in the daytime at UCLA; my first job was as a clerk. I worked there and went to school at night; and then my sister, who was well employed, was able to support me while I did my second year. Because I did have pretty good grades, [in 1973, I was able to] transfer to UCLA, [where I funded my time with various] grants and [federally funded] loans.

MM: So you were thinking of a career in research?

ST: I was thinking of a career in research and of course by the time I finished my B.A. degree, I was feeling pretty poor and pretty hungry. So, based on my prior experience and also based on some of my experiences in college, I started to research what I could get a Master's degree in, to do some work and make a difference. I can't remember to

be honest with you where I got exposed to social work, but I looked in the psychology field because I was kind of jazzed by human behavior and what makes people different. I looked at my family background and realized there were a whole bunch of us; while we were raised by the same parents, we all were very different or there were groups of us that were very different.

So I somehow came across [the idea of] a Master's in Social Work. [With a social work degree,] I would be able to become a therapist working with kids and I could do that in two years. So I applied for a grant and loans and was able to [continue] my education, [and successfully attained a] Master's degree from UCLA.

I first accepted a job with a community-based organization. It was called Central City Community Mental Health Center, which is now Kedren Community Mental Health Center [in South Los Angeles]. It took them a little while to hire me and meanwhile I had taken the [LA] County exam for Psychiatric Social Worker I. They called me first, and so that was the beginning of my career with the County. And that was in 1977; I probably should put some dates on this.

MM: So gosh, that was just before Dr. Elpers came [J. R. Elpers, Director of LAC-DMH from 1978-84].

ST: Exactly. We had an interim [Director] before Dr. Elpers came. So, [on September 22,] 1977, I [began] my first job at what was then MacLaren [Hall], which at that time was simply a detention facility for youth who were removed [from their families] by [what later became] the Department of Children and Family Services (DCFS), or the child welfare system. [Opened in 1961 as an emergency shelter for foster children, MacLaren was plagued for much of its history by overcrowding, overlong stays by children, and inadequate staffing. After much public criticism and several legal actions, the County closed the facility in March 2003; however, this left DCFS with limited options for temporary placement of children who had to be removed from their homes.]

[Shortly before I began working at MacLaren, the facility] was [operated] directly by [the County Department of] Probation. [However, when I joined the staff,] the responsibility was transferred to the Department of Public Social Services (DPSS). I was part of the first [Psychiatric Social Work clinical] team to work in that setting. And in that [position], I did a lot of interface with the Children's Services Workers and basically did the mental health assessments that would assist the CSWs in finding the appropriate placement for the youth and did some play therapy. I [actually established] the first play therapy program by securing a room and bought my own equipment. [Play therapy was a treatment approach that I found interesting and wanted to further develop my skills in that area.] I worked with latency age boys primarily.

MM: Is latency the same thing as transition?

ST: Well, no. Latency age [refers to] little boys from five to twelve and then they enter into adolescence, [which would be equivalent to "transition age']. I worked with the little boys who were quite a lot of fun. When I came to the County, I think I should note that I was only going to come and work until I got my LCSW, my license [as a Clinical Social Worker]; and then I was going to go out and put up a shingle and become a children's therapist full-time. That was the plan. At that point, I didn't know what the opportunities were [within the Department.] But, of course, once you start working, you start moving

up and you see the opportunities. Once I got into the system, I realized that the opportunities were a little bit more varied and there was a lot more room for upward mobility than I had imagined from working outside the system. So I worked at MacLaren until I got my license, [which was a bit more than two years].

MM: Now tell me just a little bit more about the children. They were coming out of detention?

ST: They actually were detained. It was an institution that was locked. The youth were removed from their families; they could have been removed for a 24-hour period until they could find a shelter, or an alternative home in the community, or with a relative. Or sometimes the youth might have been in a foster home, had a disruption and had to be brought back to the facility until a second placement could be found. We had, at that point, babies [in] a nursery. A lot of babies were detained, so we had a twenty-four hour nursing staff for them. The nursery was from [the age of] zero, because we did have new babies there, until [age] four. And then at age five, they would go to what was called a Tiger Cottage, [where] they lived in a dormitory kind of situation with a dayroom in the middle and they had a couple [of children] to the room.

MM: So they were moving from a home situation which hadn't worked into probably a foster care?

ST: Sometimes a foster care. Sometimes back home, because at that point, the child welfare system had not evolved to the point where they were able to make good assessments in the field. So [the policy] was always to err on the side of the child. If you got a report and it looked like the child was in danger or was severely neglected – at that point, we were not focusing on the mental health needs of the kids so much, because it was again DPSS that was making the decision. But then, when they brought them to the institution, then we had the team of children's treatment counselors and psychiatric social workers [to take care of the physical needs, supervision and mental health assessment of the children and youth]. So [the DPSS child counselors] did custody and we did more of the guidance of the treatment. And then just about the time I left, [Los Angeles County] created a new Department, the Department of Children and Family Services. I think that was in 1981 [1984].

II. Skills in Interagency Collaboration

So I worked there for, as I said, two and a half, close to three years. Then I came to the Department of Mental Health. And at that point I had developed, I think, a certain level of expertise working with children and adolescents. When I went to the Compton Mental Health Clinic [in South Los Angeles] – that was a different time than now, because you could actually run your caseloads almost like a private practice. You'd go to intake and if there was a case where you had expertise and interest, then you would pick that case. I started then to form [a plan for] what I thought I'd like to do, what I wanted to focus on. It was children and youth first, and then families, and then depressed women. That was the group that I kind of built my skill base around, treating kids, [families and women]. I also got involved in some of the community activities around preventing child abuse and served on the Suspected Child Abuse and Neglect Community Team, so that we could educate parents, develop programming, and also offer consultation to other programs.

That was probably some of my first interagency work; or maybe expanded; because,

when I was at MacLaren, that was interagency work, [in that] I worked very closely with DCFS or DPSS at that time. I worked at Compton as a Psychiatric Social Worker II for about four years. I started then to have some visions about doing something other than direct services. I guess some of my leadership abilities started to be noticed, probably more by others than myself at first. I started to get selected for representation on committees, coordinating case conferences, etc. When the supervisor wasn't there, I was appointed acting supervisor. I did it because I was always trained to do what you're asked, and if you don't know it, learn it very quickly. That was the first inkling that I started to have [about having a greater impact]. I started to realize that maybe I could have a greater impact in the communities in which I worked, if I were in a different position. That was a conscious decision.

So, after that, I started to pursue opportunities where I could have a greater exposure to what was out there. And other people could have exposure to me and what my skills were as well. So I left there with a lateral position [shift]. It was not a promotion but, because of what my interests were at the time, I came to [DMH] headquarters and was the Child Abuse Services Coordinator working under, at that time, Dr. Rose Jenkins. [African-American child psychiatrist Rose Jenkins was the first Director of Children and Youth Services, appointed in 1980, capping a long career of advocacy and services for children. She died tragically early in 1986.] The late Dr. Rose Jenkins was the Deputy Director [for Children] and then my immediate supervisor was Ada Jones who was an LCSW; she [has] passed along as well.

I worked in that position for maybe about a year. I wasn't real satisfied with it, because it was not as challenging as I needed it to be. I had learned by then that I needed something that was very challenging because if my interest didn't [hold], I couldn't stay at one place too long. But I did it for a year; and in that year, it did what I wanted it to do which was to have other people have exposure to me and what my talents were. I was selected as a Supervising Social Worker and then I [began working primarily with adults]. Before then, [my work] was all [with children and families]. But, because of my spiritual underpinning, always I know that is God working, because my exposure to the adults while I was at Compton, my interest in families, [and] my interest in depressed women, really prepared me to go into the adult arena.

I was selected as a Supervising Psych Social Worker [to work in] yet another institution, a board and care facility that had a clinical patch. It was a long-term residential treatment program that was developed as an alternative to long-term hospitalization. Most of our clients were chronically and persistently mentally ill and that was new for me. But I thought, "OK, there's something else for me to learn." It was a program where clients could stay up to three years and then they transitioned out to independent living. That was the goal. We had a two-fold goal: [the first] was to be able to decrease the long-term hospitalization and second to transition them to more permanent housing situations. So I did that for about three years, I believe. I enjoyed it [and] honed a lot of my leadership skills at that time. By then, I had a mentor who worked very closely with me. I learned a lot from her.

MM: Who was that?

ST: Stephanie Alexander, who was just a good [supervisor]. I reported to her, but off-site. We would meet regularly and our regular supervision was the time that I learned. So I quickly learned about case management. She was the program head at Augustus

[F.] Hawkins [Mental Health Center in South Los Angeles, on the grounds of the King-Drew Medical Center; the Center stayed open after King-Drew was forced to close in 2007]. The [treatment patch at] Hobart Manor, which was a long-term residential treatment facility, was operated as a part of [Hawkins], but not on-site. I worked closely with her; learned H.R. [Human Resources]; she got me involved in budgeting; just exposed me [to administrative procedures] and I learned how to do it. [I also worked closely] with Community Care Licensing [the State agency responsible for licensing 24-hour care facilities]. So again I started to expand my interagency work and my knowledge of systems and how they work together. So I did that for, I believe, about three to four years.

MM: Was the program reasonably successful?

ST: It was. One of the cases I will never forget, because I had to change my mind about the chronically and persistently mentally ill and what they could do. When I was in the outpatient clinic [and was assigned a client with severe and persistent mental illness], I did the [initial clinic] assessment, referred them for medication assessment and a maintenance group; and that was it. But I remember one client named Nick. Nick was in a board and care facility that had no treatment components; he had spent, he said, about fifteen years at Metropolitan State Hospital [the major remaining State Psychiatric Hospital in LA County, founded in 1915 and located in Norwalk]. When they discharged him from Metro, they put him into a board and care facility and I think he was on six different medications, being written by four different doctors. Needless to say, [the Board and Care Licensing Board] closed that facility. [Upon that closure, I was part of a team that evaluated] the clients [to determine if] Hobart Manor [was the appropriate level of care]. Nick was one of the people we selected [that could benefit from the Hobart Manor program].

When we got Nick, all Nick wanted to do is smoke cigarettes. He didn't want to bathe; he wanted to smoke cigarettes and drink coffee. That was the extent of his life. So we started to work with him around his ADLs [Activities of Daily Living]. Then we started to work with him just around socially going out, walking to the corner store. But we had a plan and worked with Nick for a long [time]. He was there for about two years. Then we had an in-house vocational training program. So the long and short of it [was that] he participated in the vocational training program. He had a job and his job was housekeeping. So he helped clean and he got paid for that. Then we transferred him to the Portals Transitional Living Program. [Portals, a recovery-oriented community mental health agency founded by Shirley Weiss in 1955, merged with Pacific Clinics in 2007.] He went through that and he eventually [was able to live independently] in his own apartment. [So yes, the program was successful and Nick's story was one example.]

So then I was tapped, unbeknownst to me – again, somebody had put my name in the hat – for a promotion to Program Head. [Early in my career,] one of my mentors had said to me, any [County Civil Service examination] that becomes open that you qualify for, you get yourself on the list, because you never know what's going to happen. So I was on the Program Heads list and I was in a place where I was reachable in Band 1 [on the list of candidates qualified for the position]. Someone whom I'd never worked for, who later I developed a mentoring relationship with as well, had said, "You need to talk to Sandra Thomas."

So I was interviewed [by Deputy Director James Allen]. I got the position and became a

Program Head and returned to Compton Mental Health Center as the Program Head [in September, 1991]. And I was very happy about that. Once I got to Compton Mental Health, we had a series of problems. But that was where I stayed for about eight years and was able to implement some new programs. We were able to implement a day treatment program. We implemented the CalWORKS program [CalWORKS (Work Opportunities and Responsibility to Kids) is a state program providing temporary financial assistance and employment focused services to low-income families] and even started [clinic-level] Transition Age Youth services, because, on a Countywide basis at that time, we didn't have money earmarked for transition age youth. [That did not occur until the passage of the MHSA [the Mental Health Services Act of 2005, which created a new funding stream for mental health services and mandated new recovery-oriented program initiatives].

MM: You were perceiving this was a problem.

ST: Yes, exactly. I was able to assign one staff to take all of the youth who came in between [the ages of] nineteen and twenty five and we attempted to do some [specific] programming with them. It wasn't very successful because that population is very treatment resistant. You have to chase after them and you have to present services to them in a different kind of way. [At the time, we did not have enough staff to provide that level of outreach.]

MM: Why do they come in in the first place?

ST: Usually referred [or] brought in by a parent because they've had their first break, or referred by the school because of some behavior problems or conduct disorders. We had a few referred from the Probation Department, but not a lot. Sometimes DCFS referred them, as they were transitioning out [of foster care at age 18], so that's where we got our referrals from. I did that for seven years and then got itchy again and decided I had taken that clinic as far as I could take it. I had an opportunity to return to the children's arena [in February, 1999].

But at any rate, somewhere along the line, I came back to the Childrens Systems of Care with Elaine Lomas, who was the District Chief who hired me. I actually, for the first time, supervised or managed a field-based team, which was a challenge. A field-based team was a challenge, because I was used to a contained clinic where I had all the control [and] you could see people come and go.

But I had one team that was working at Metropolitan State Hospital [in Norwalk, CA], doing case management for the youth being discharged, discharge planning primarily for that group, for kids. Then I had another group who was doing Countywide case management, working with DCFS [to link youth to outpatient mental health services. The cases were kept open for about 90 days to ensure continuity of care]. [Additionally,] I had the hospital screening committee, that [screened children and youth to determine suitability for long-term hospitalization at Metropolitan State Hospital]. That was a very different program, but again gave me the experience of managing from a distance and then putting things into place [with] checks and balances. A lot of my budgetary experiences increased at that point. I worked [in this position for] about a year [and] then I was promoted.

Well, I just realized I skipped a job that I had for [six months, from February to

September, 1991]. When I left Hobart Manor, I went to the Contract Compliance Unit and was promoted from SPSW to Mental Health Analyst I. That job had no program and it was basically following up with contractors to ensure that they were compliant with deficits that were found on their program reviews [or audits]. So I did that for [six months], and from there I went to Compton, [as Program Head].

III. District Chief for Children in Service Area 6 and Deputy Director

When I came back down [to DMH headquarters at 550 South Vermont, in February, 1999], I was the Program Head of Countywide Case Management for about a year and then that's when I was promoted to District Chief. My assignment included the oversight and management of all the Children's programs in Service Area 6, including the directly operated and contracted programs. The directly operated program was the child clinic at Compton MHC. During this period,] the *Katie A.* lawsuit was settled [by Los Angeles County in July 2003]. [*Katie A. v. Bontá*, a class action lawsuit, was filed against Los Angeles County DCFS and County and State officials by the Western Center on Law and Poverty, and affiliated groups, in July 2002. The suit, filed on behalf of a group of children in foster care, claimed that the State and County were unlawfully denying needed intensive individualized mental health, behavioral support and case management services to foster youth. *Katie A.* was a 14-year-old foster child who had not had a permanent placement since 1995. Although the County settled its part of the suit in 2003, the State litigation was still in progress at the time of the interview. The State finally reached a settlement agreement on September 1, 2011.]

MM: And that was –

ST: This was a class action lawsuit that was brought on behalf of a youth that was at MacLaren Hall, which by that time [had] changed to MacLaren Children's Center. The allegation was that the children in that class, who were kids who were in need of mental health services, supportive services, [and] family services, were staying in congregate care [that is, large group facilities] too long. The County settled that lawsuit, where DCFS, the Department of Children [and Family] Services, and [the Department of] Mental Health were named as the defendants. As a result of the County settling that lawsuit, the Department of Mental Health ended up creating a Child Welfare Division.

[I was selected to head that] because of my experience and some work that I had started already in Service Area 6 with the local DCFS office about doing some collaborative work to ensure that the kids were being seen. [The SA6 program was in response to complaints from] mental health contract providers that they were not getting enough referrals from DCFS. I talked to the DCFS partner, my counterpart, and they were [also complaining] that the Mental Health providers were not responsive. So I actually got them together. We created a program [to address the issues] and the bones of that program were reviewed by DCFS and our [DMH] management and [they] decided that this is probably the approach that we need to take [to address the requirements in the *Katie A.* settlement agreement]. The County allocated dollars and some funding. Both of our Departments got together [and] developed a joint plan, called the Enhanced Specialized Foster Care Plan.

That was in 2005 that we jointly developed the Countywide Specialized Mental Health Services Plan to ensure that kids [received services]. Let me go back a little bit. The [*Katie A.]* lawsuit was for particular funding, to use Medi-Cal Early [and] Periodic

Screening [Diagnosis and Treatment] (EPSDT) dollars to treat these kids [EPSDT, the mandatory Medicaid program for low-income children, provides 90% Federal matching funds]. So it would be a child, who was in DCFS's care and eligible for MediCal, would then be eligible for these services. So that was 2005. So I did that for about – it seems like an eternity, but I think it was about a year and a half.

Then that was when I was actually approached to be considered for the Deputy Director position. I accepted the challenge and became Acting Deputy Director in 2006. In addition to oversight of the Child Welfare Division, the Juvenile Justice Mental Health Services Program was assigned to me, as well. As a result, the Department created a new bureau that is currently the Specialized Children and Youth Services Bureau (SCYSB).

So at that point I had Juvenile Justice [and] Child Welfare and that was it. I did that up until 2007, because I was acting [Deputy Director] at that point and then I got appointed in 2007. Then about four years ago, with the retirement of Jim Allen as the Deputy Director for Service Area 6 [and] another Department of Justice settlement agreement, we had a reorganization. [As a part of that reorganization, the management of Service Area 6 Mental Health System of Care was transferred to the SCYSB. All of the Mental Health Services programs in Service Area 6 are now under my purview and that includes three outpatient clinics, Compton Mental Health Center, Augustus Hawkins and West Central Mental Health Center [in the View Park neighborhood]. The Specialized Foster Care Program for Service Area 6 also falls under my purview and we have one freestanding [specialized foster care] clinic in the Watts area. So that brings us up to what I'm doing now.

MM: Certainly a varied career.

ST: Yes, I have to say that, [as of] September [2010], I have 33 years with the County. I'm looking at working at probably another two years. But it's been quite an experience. [There have] been a lot of changes. Of late, the changes seem to be coming faster, but in terms of Juvenile Justice or Child and Youth Services, I think I've seen all sides of it. From the DCFS [side], the biggest issue that we have is around coming up with a way to share information. I'm sure, if you follow the papers, you see that at the [LA County] Board of Supervisors [meetings], there are always frequent motions about our Departments getting together. We do have an overarching MOU [Memorandum of Understanding] that we do share information between our Departments in the context of care coordination, as long as we don't violate the HIPAA requirements [the Health Insurance Portability and Accountability Act of 1996 (HIPAA) included specific rules for the use and disclosure of personal health information]. So that just kind of brings us to where I am. And I can give you this [CV]. I think the last [update] was 2006. So that's about five years [ago], and in those five years, I was appointed as Deputy Director.

IV. Prevention, Support and Interventions for Children and Youth

MM: So tell me a little bit about the children. Tell me about the Foster Care program first. I mean, this is all going to sound very naïve; but obviously, you probably have a huge number of children in foster care. Are these kind of preventive services to sort of hopefully provide them with the kind of support they need so they won't wind up in the system later? What kinds of services are we trying to offer these kids? Go ahead.

ST: Right now, for the kids who are in foster care, we are poised to do some prevention with the MHSA Prevention and Early Intervention [PEI] dollars but the meat of the settlement agreement [is] the services that we provide to them. So I'll talk about those kids that are in the *Katie A.* class. These are youth. There's one [initiative] to move them from congregate care. Because when kids are in group homes, they just kind of pick up more bad habits and their symptoms get worse, and [there has not been a lot of success in] getting them back to their families. We actually do a lot of supportive work, individual [and] group therapy, assessments, medication support, to allow them to move from a congregate care back to either a small group home – When I say congregate care, these are Level 14 group homes [that] could [house] as many as fifty or seventy-five kids. So we're moving them now to small group homes [with] six beds. Those kids then access services in the regular community mental health clinics.

Sometimes some of the group homes might have a private social worker coming in or a psychologist doing therapy. But basically we provide outpatient mental health services for that group. Then we have another group where we actually see the whole child [for] the multidisciplinary assessment. These are [in place so that] any time a child is detained by DCFS, they refer them to mental health providers. Our contract providers – we have one [DMH] directly operated [child clinic] in Service Area 6, but most are contract providers – will then make contact with that family and do a total strength-based assessment of the family system. They'll interview the child, they'll assess the parents, the biological parents if they're available, the foster parents, if they're in the place where they're going to be. We gather information about health, dental records, school records, and do a comprehensive assessment across all of those areas and then make a recommendation to the Department of Children and Family Services as to the appropriate placement.

Once you talk to Bryan Mershon [Director of Children and Youth Services at the time of the interview], he can talk to you more specifically about the changes with the child and family teams and the different kinds of things that they've put in place now. Our Emergency Outreach Bureau has a child-trained therapist who responds as part of the Psychiatric Mobile Response Team, the PMRT. So, if there's an emergency involving a child anywhere in a group home in a community, then we go out and provide crisis intervention. It might involve hospitalization, and sometimes it might be that you go in and you just kind of distinguish what the issues are or extinguish the problems and the child is able to stay. We [also] have in-patient care that's provided. Most of the kids, and the diagnoses range from some situational kinds of things; but what we're finding for our zero to five population is [that] the attachment disorders [predominate], because we're learning that because kids in foster care are moved around so much they end up not learning to attach and trust. So we're doing a lot of remediation work with the older kids and then some preventative work with the younger kids by identifying those problems early on.

MM: Is it possible – don't they need then someone to attach to?

ST: Exactly. That's where the work with DCFS becomes really critical. They have a family finding program. Permanency is one of the major goals for the Department of Children and Family Services, because part of this [*Katie A.*] lawsuit identified that kids had been moved around a lot and they don't have any stability. So [we are involved] early on in that assessment. That's how our mental health assessment helps to inform DCFS's decisions, so that when they make a placement, it's a solid placement. They're

either adopted or they have a long-term guardianship; but you're right, they do have to have a place to attach to.

Our adolescents in Juvenile Justice we offer [screening], because we're into our second settlement agreement with the [Federal] Department of Justice [DOJ]. The first one had to do with the mental health services that were available to youth in the [Juvenile] Halls. The average stay in the Halls is about three weeks, and the recidivism rate is pretty high. What we do there is we have mental health staff that not only provides treatment; we screen using MAYSI [Massachusetts Youth Screening Instrument, developed by Thomas Grisso and Richard Barnum at the University of Massachusetts], which is a real soft instrument that screens for mental illness and substance abuse. So every child that comes through the Juvenile Halls gets a MAYSI screening. If they're positive for substance abuse or mental health issues, then they get a more in-depth psychiatric evaluation and if there's an indication that they need meds, then they get a medication evaluation.

We also have some special handling units, [for] youth who stay in the halls for a longer period than the three weeks, because they're waiting for a suitable placement in the community and there's probably not a suitable placement. Then we do more what's akin to an outpatient treatment with them, where we see them on a more regular basis. [Additionally, we provide mental health services to the youth incarcerated in the Probation camps.] [There are] eighteen [Probation] camps, [with] six camps [located] on one site which is the Challenger Memorial Youth Center [in Lancaster, CA; the other camps are located in Calabasas, Lake Hughes, LaVerne, Malibu, Santa Clarita, San Dimas, Sylmar, and Tujunga]. [The mental health services at the camps were significantly enhanced as part of the Memorandum of Agreement (MOA) between the County of Los Angeles and the U.S. Department of Justice that was reached in 1007 as the result of] the CRIPA [Civil Rights of Institutionalized Persons Act] investigation [that occurred in 2006]. There were some mental health care findings related in addition to youth-on-youth violence and some other things.

So we were able to add [staff]. The Department of Mental Health did not have sufficient staff to staff these camps because the camps are in outlying areas; they're all over the County. The Board of Supervisors agreed to provide staffing for 88 staff and so we have two staff left to hire. We just recently hired 88 staff and we now have a full complement of mental health staff at the camps. When I first took over in probably 2006 or 2007, we only could keep kids on medication in one camp, but we now have three camps, where we're able to keep kids on medication. We have two all-girls camps. Because we found that if we could isolate the girls because their presenting problems were different, [we could] employ evidence-based practices that have been shown to be effective in working with some gender-based kind of practices. So we again provide medication support in the camps.

We are now beginning some family intervention kinds of services where we do provide transportation to parents who come up [to visit the camps]. And that recidivism rate, I just confirmed with Probation yesterday, is about 17%. We're hoping, with the development of an aftercare services program to assist the kids in transitioning from camp back to community and providing services in the communities and non-branded mental health places [to improve recidivism] and that's what the Mental Health Services Act dollars have allowed us to do. Because with the Prevention and Early Intervention dollars, youth in stressed families and at risk for juvenile justice were one of the focal

populations [for PEI funding]; we were able to get two million dollars of those funds to develop some services. So what I've done is to develop a Transition Aftercare Program that's going to be heard by the Board of Supervisors on [March] eighth and I'm hoping that it gets passed. We'll be able to get 27 staff to offer evidence-based practices in non-branded mental health settings for youth who are discharging from the camps. So we're hoping to impact that 17% recidivism rate. Maybe in a year or two years, we'll have some outcomes like that.

MM: I hope so. Just so I'm sure I'm understanding this, you're essentially trying to provide continuity of care which wasn't in place before.

ST: Right. Or it was not as organized and we didn't have the supports. We had the services out there. We've always had services for juveniles that the transition age youth could link to, but we didn't have a bridge [from the juvenile camps]. Yes, exactly, this creates that bridge.

MM: And so what about at the point where a kid's in the foster system and is approaching the age of 18 and they're going to be released from the foster system, do we have any kind of preventative system in place or any kind of continuity?

ST: We, as in the Department of Mental Health – we are partners in that; but because we don't have kids in custody for the most part, that's an initiative and a responsibility that falls with DCFS and Probation. However, we do, with the first Mental Health Services dollars for Community Services and Support, have [added] systems navigators or [Transition Age Youth] (TAY) navigators. These are staff who do outreach to the youth and many of them, even though it's not exclusively for DCFS and probation, I think last time we looked, about thirty percent of the kids that we had served had DCFS connections. But I think we still have a ways to go. Just this year, [LA County] Supervisor [Michael] Antonovich [Supervisor of the 5th District since 1981] added a fourth goal to the County strategic plan and goals; that is self-sufficiency for all the kids who are leaving care.

So there is a subgroup and Helen Berberian, who is Supervisor Antonovich**'s** Children's Deputy, sits on that committee. The Children and Family Services Commission and our Chief Executive Office coordinate this multi-agency or multi-department group [with membership] from Child Support, from DCFS, from Probation [and] from Mental Health. Some of our children's advocacy groups are developing a plan to ensure self-sufficiency for those youth. We haven't probably done as good as we should, because we are looking at our numbers. I think Children's Hospital just did a study of kids who are homeless and a large group of those kids have histories with DCFS or probation. So again, it's some work that we're having to do with our other partners.

MM: I was wondering about that, despite all this, that there probably are homeless kids and other kids who are sort of falling through the cracks. How can you reach everybody? It's just impossible.

ST: It's impossible. We're probably making some inroads, but it's harder than I think any of us even imagine. Because, in our Transition Age Youth Division, we have about eighteen staff, and that includes the supervisors, who are out doing outreach to these youth to get them connected to the Full Service Partnerships [FSPs] which is the 24-hour whatever it takes [intensive services for the seriously mentally ill, mandated under

MHSA]. We thought it probably takes about a month to forty five days to engage the youth; we can go talk to them, [but] because it's a voluntary service, you have to keep going back, and keep going back. And eventually we get them in; but it is a hard one. I think we have a ways to go in learning how to serve this population and we have a conference pending with a focus on providing services to transition age youth, where we're bringing the experts in to train our contract providers in terms of providing these services.

MM: And the children, let's see, how do I phrase this, it sort of goes back to what are the diagnoses; but I mean, can we sort of characterize the kinds of problems? It seems to me, we would automatically think, yes, well, they're probably these kids who have drug use and criminal behavior, but probably some of them also have had some rather traumatic events. And they're anxious? Withdrawn? You tell me, I don't know.

ST: It varies, depending on the experience. You're right, we did start to look at [that] and participated in a Georgetown Collaborative with about seven of the jurisdictions all over the nation, looking at the kids who cross over from dependency services to delinquency services. So you find you have a large number of those kids tend to have more serious mental health illness, more than the kids who have just juvenile justice [issues], because those are a large group of conduct disorders, some Axis-II kinds of things [second-priority diagnoses as defined by the Diagnostic and Statistical Manual of Psychiatric Disorders, the DSM-IV-R], some personality disorder things, coming along. But [look at] the kids who have both histories and it's the gamut. You have psychotic disorders, you do have kids diagnosed with bipolar disorder, with schizophrenia, who are on psychotropic meds. You have some kids who are just in crisis and you have certainly a lot of attention deficit disorders and depression.

A lot of co-occurring disorders, mental health with substance abuse; and we find that prevalent among the teenagers, both DCFS kids and Probation kids, where they're using drugs. And that makes sense, that they use what they can get to mask and to treat the disorder, because it's self medication. Probably on the high end, you have the self-mutilators. We had a case this week about a kid; we got a letter from her guardian where they can't contain her. She's about seventeen and a half and so we're now having to converge to try to get her on a conservatorship [that is, to have her care and personal affairs supervised by the court], because she runs away. She does something they call huffing, which is new to me, where they inhale any toxic inhalant and there's a high fatality risk involved in that. So we have those but that's probably not the dominant [population]; we have the [full] range.

One of the gaps in services that we have now for kids, and I hear it all the time, [occurred] when we closed MacLaren Children Center. MacLaren Children Center, when I was there in 1977, was purely a detention facility for kids who were abandoned, abused or neglected. It's about ten years now since they closed it [MacLaren closed in March 2003]. It had turned almost into a hospital because the kids who were there had multiple mental health disorders that precluded them living in the community, but they didn't have enough beds in the state hospital. All of our adolescent beds in LA County, the long term Metropolitan State Hospital [beds], were closed. We have a gap in placement now, so we've had an increase in the utilization of our acute hospitals. So it's like, where are we going to [place them]? That group of kids who are on probation, end up staying at the juvenile halls waiting for a suitable place in the community, but there really is no suitable place in the community. So that's some of the challenges that we

have right now.

MM: So it sounds like a lot of opportunities opened up with the Mental Health Services Act?

ST: Absolutely. The best thing that could have happened to us, given the financial crisis in the country as a whole and the [budget] reductions. Because our money is realignment [State General Funds for social service programs were "realigned," or distributed to Counties for management and allocation, in the Bronzan-McCorquodale Act of 1990] and most of our funding for mental health comes from vehicle licensing fees and sales taxes. So, if people are not buying cars and are not buying things, it reduces the amount of money the State has to give to us. The Mental Health Services Act dollars, because they're earmarked for Mental Health Services, have created great opportunities for us. If it were not for the Mental Health Services Act, we would not have dedicated dollars for youth between the ages of 16-25, for mental health treatment. That has just been the greatest thing; and it's been a challenge as well, because most of our funding stream comes for either child or adult [services]. We really don't have yet a service delivery system or a place if you will, where 16-25-year-olds can go. So they stay in the clinics. So what happens is that your providers who provide children's services, they can see the younger end, 16 to about 19, or even up to 21.

And then the adults get the ones over 25. But we're trying to get our providers now to a place where they can see the whole child, the whole youth, so they wouldn't have to keep changing systems. [MHSA] created great opportunities for us. Housing [is a] huge [problem] for the transition age youth and we've been able to create a few emergency shelters that are specifically for youth, just until they can transition into permanent housing. Some permanent housing – we have our first one in Santa Monica, where we have permanent housing for seven youth. I understand there are about 80 beds in the works right now where these youth, who can't go back home to their families when they transition out of the DCFS system or Probation, will now be able to be in their own apartment and will be prepared to stay there.

MM: Yeah, that's good.

ST: Yes, we're excited about that.

MM: This is a really dumb question. We're talking about kids aged 16-25. Is there ability to provide educational opportunities? I mean, this is what you think would be the solution for many of these kids is to try to get them into community college; that was something that happened for you.

ST: Exactly. We actually have some opportunities for that with DCFS. They have the Independent Living program. So we've been able to get the Community Development Center. We have a developer who developed housing, and as a part of that requirement, the kids have to go to vocational school. We are now doing outreach to the universities. But for kids coming out of foster care, they actually, if the social worker can identify the issue, present it to them, they can provide funding for them to go to school. But that is one of the targeted deliverables for the Self-Sufficiency Work Group that I talked to you about, because we do have people from education on that committee.

MM: That's exciting.

ST: Yes. It's a good time, but it's a lot to coordinate, so we don't duplicate [services]. We're doing some work with violent gang prevention. The [County] Chief Executive Office got a grant and included in that grant were some dollars for mental health. So our Mental Health staff is working with communities to identify and be able to respond to the mental health needs of kids who are in gangs, as part of the gang reduction program.

MM: You mentioned evidence-based practices. We have the PEI plan with many, many evidence-based practices. So could you just describe one and exactly what things do we have that we can do for kids, especially given that they tend to be resistant? They don't want to come [for services].

ST: One model that I like a lot is the Seeking Safety model. It's a manualized activity, where the person has to actively engage in working through for trauma and substance use. It's a train-the-trainer model. So as long as you have the workbooks and the activities and you get the kids in, it's amazing, the kind of results [you can get] with that. That's one of the models we have for the transition age youth. It actually applies also to the adult population. Then we have Trauma-Focused Cognitive Behavioral Therapy. Again, manualized, activity-driven, regular contact where you build on [each session], successive building. Once you start to have them work through some of the trauma, then you see changes in other aspects of their lives. We've [also] implemented Functional Family Therapy [FFT], which is particularly a good model and it's a community home-based model for kids [and families involved in the juvenile justice system]. We've had great results with that. Multisystemic Therapy is another home-based model, where the therapist goes into the home and these are about six-month programs. They go into the home, work intensely with the kids; kids get homework, parents get homework; you're right there with them. The family has to be willing to have you come into their home.

MM: Multisystemic –

ST: Multisystemic Therapy. MST.

MM: What are the systems?

ST: Actually, the systems are the parents, the kid, the therapist and the school. What you do is get all of those systems together to work. And it's manualized. Most of the Evidence-Based Practices are manualized, so we train our staff. Then the staff goes out and a lot of it is training clients on how to think differently about their illness, how to work through the trauma, get in touch with the trauma. We're doing some of the Trauma-Focused work in the camps [for juvenile offenders], not so much in the Juvenile Halls, but certainly in the camps. Aggression Replacement Therapy is one of the models. We have not implemented it from the mental health perspective; but Probation has implemented a model called Anger Replacement Therapy. It's about the same thing.

So those are some of the models that we're using. Cognitive Behavioral Therapy for Trauma in the Schools, the CBITS project. Those are the ones for TAY and it seems like I'm missing the one for depression. I think it's Cognitive Behavioral [Therapy] for Depression, because we have about eight that we're implementing now. We weren't able to implement a couple, because we weren't able to get approval and agreements with the developers. But MST and FFT we're using a lot; CBITS we're using and ART,

and I think that's it. IMPACT Model was one that we're bringing here that I'm not that familiar with; it was used by adults primarily but apparently can be used across age groups. [IMPACT [Improving Mood and Promoting Access to Collaborative Care Treatment] was originally developed in Northern California to treat depression in older adults.]

MM: IMPACT?

ST: There's an acronym for it, but I'm not that familiar with that one. The others I'm more familiar with.

MM: And so are you tracking how well all of this plays out? Do you have any way of following up on what happens with the children?

ST: That's an area where we still have work to do. But for the MHSA programs, for the kids in the Full Service Partnership programs, we have an outcome measures application where we are able to get some data, where we do the baseline around living situation, school performance, that kind of thing. We haven't been able to extract as much information out of the system as we wanted to. But at this point, there are some outcomes that we are [required] to track by the State and we're moving forward with that; but we really haven't. That's a question that gets asked of us a lot, how do we know this is working? We have desired outcomes. We track the services. For instance [at] our Drop-In Center now, we do have outcomes related to that in terms of utilization, that we're able to come in contact with kids, expose them, whereas before we did not do that.

V. Closing Comments

MM: That's interesting. So I will ask sort of a global question. What do you think that you've done in this job that you feel most proud or most happy about? You can tell me two or three things if you want.

ST: I think the work that I started with DCFS and our outpatient mental health services in Service Area 6, that ended up being the [basis for the] model, and it's a model that's been embraced. I thought it actually was probably the first way that I impacted a system. I'm sure that I had little impacts on the system but [in this case] I saw a problem in my little small group of providers, my little Service Area, and I thought, "Well, you know, this can't happen, so I need to fix it." And in the effort to fix that, then it got to be bigger. I think that's the one I'm most proud of.

I think the rebirth, I call it the rebirth of the Compton Mental Health Clinic, because at the point that I took over, in 1991, the Compton Clinic had been slated for closure and the community group persuaded the Department that that was not the best thing to do. But at the point that the community's voices were heard, the clinic physically had been closed [and the] staff had been reallocated to other places. So when they put it back together, it was co-located on the grounds of Augustus Hawkins and it ended up being one hallway of offices where people were clumped together. So I was sent over to rebirth this clinic and probably within a year I had the clinic fully staffed, we were generating revenue, I'd located a new building, [and] we had moved to the new building. So that was another accomplishment. I've always said to people, every promotion I get, it's always been hard. It's always been a difficult thing to do. And this last one was the same, to Deputy Director with two programs, with the Department of Justice or with an

external body overseeing it. But I would say those are the two major things that I've done when I look back.

MM: So next part of the question. What is it that you want to do still or what do you see as a challenge that you would like to meet, that isn't being met?

ST: In the next two years? Oh gosh, that is a difficult one. I guess it's the one that I'm in the midst of right now. This is what I said to Dr. Southard probably two or three years ago. I would really like to see funding streams [and] a whole system of care for Transition Age Youth. We don't have it yet. As long as we have Adult clinics and Child clinics and nothing in between, we don't have it. I still think that our kids who get sick at 18 or 19, and it's all voluntary services, they will choose not to go to a clinic where the waiting room is filled with adults. Particularly kids who have been in placement or have been in DCFS, where they've had to do things or get locked up, they're not going to go. So we need to develop a system of care that's responsive and that acknowledges that between the ages of 16 and 25, the developmental milestones, struggles, [and] opportunities for change, are very different than those two other groups [Child and Adult].

So, if we were successful in impacting legislation or impacting the funders – I think the Mental Health Services Act is a beginning. Because there is some recognition at the State level that this population needs something different than the other two populations. On the part of the California Mental Health Association of Directors, I know there is a TAY subcommittee, that's looking at this on a State level. So I know that it's coming. I'm not sure that it'll come in the last two years that I have, but that is a challenge that I'd like to hope that the work that we're doing in our Transition Age Youth Division will inform and propel and go on toward that end. I know we have a long ways to go, but that's what I'd like to see.

MM: Is there anything more you'd like to say?

ST: Oh God, it seems like I said a lot. I guess trying to put 33 years into an hour and a half is a lot. But basically, just that my career with the Department of Mental Health has been both challenging and, in the long run, very fulfilling. I think for a little black girl [from a small town] in Texas who thought she just wanted to be a teacher, and from a family that struggled, I have had the opportunity to be, to grow, for people to recognize my potential and for me to recognize my potential and for us together to achieve some of the things that I've achieved. I'm pretty pleased about that.

MM: Good for you. Well, thank you very much.

ST: You're welcome.

END OF INTERVIEW