

STACY WILLIAMS, CLINICAL PROGRAM HEAD, DOWNTOWN MENTAL HEALTH

INTERVIEWER: Jinah Kim

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Tell us your name and what your job is here at Downtown Mental Health.

My name is Stacy Williams. I am a Mental Health Clinical Program Head for Downtown Mental Health, for the Crisis Resolution Service Program. I provide administrative support for CRS, the Crisis Resolution Service. That program is funded through MHSA [Mental Health Services Act] money, which was the Proposition 63 bill that was funded in 2007, I believe, for my program. What that did for Downtown Mental Health was provide a opportunity.

What Proposition 63 meant for our program was that we had the opportunity to provide services that were much needed and were not available, due to a shortage of staff prior to CRS starting. Prior to our program, we were losing about 50 percent of our new enrollees, because we didn't have staff to see the number of clients that came into the clinic for services. The wait time to get an appointment would be as long as a month or two. Once the client came in for screening, it would take often several more weeks before they could come back in for an intake and several *more* weeks before they could come back and see a physician for medication. With the MHSA money and the CRS program, we now have the opportunity to screen clients the same day, and often provide medication the same day.

Before, we would lose about 50 percent of our clients before they even made it to the medication appointment date. Now we are retaining ninety-some odd percent of our clients and carrying them through the 60-day CRS program length. CRS is comprised of multidisciplinary employees. We have psychiatrists, psychiatric social workers, medical case workers, registered nurses, psychologists and case managers. Together, they provide a comprehensive short term experience for the client with the idea of stabilizing them in order to assist them in moving on to a longer term program.

What is a typical day like for you?

Well, I tell you, there's never a dull moment. I'm always surprised however how unfazed folks that are down in the Skid Row area are by crises themselves, what would be considered unbearable conditions for us. The folks that come and receive services here are very resilient. I'm always impressed by that. But on a typical day, clients come in often who have never received services. We get referrals from the jail. We get referrals from residential programs. We get folks that return to us after having had services and maybe they've been disengaged for a while.

There's never a typical day. Every day is different. It is not unusual that we have street closures on which there's a bomb threat or some kind of public works emergency. We never close our doors. We have to roll with the punches. We've had to set up triage stations at the end of either [end of the] street so that we can continue to see our clients and make sure that they get the services that they need. We've had to manually go down and escort folks into the clinic.

We unfortunately had a homicide right outside of the clinic; and again we had our doors open and continued to provide services, as the investigation went on outside. So

sometimes we do have days like that. But a typical day would be a variety of clients coming from a variety of referral sources.

We get folks that come in self referred. We get referrals from residential agencies in the area, from the missions, from local jails, and folks that are recently discharged out of the hospital. We provide a screening for clients that present for services, and, if they qualify for enrollment, we provide an intake. Again, we are able to do that same-day, which was unheard of before the CRS program began.

So these clients are not actually in crisis?

Oh no, make no mistake, we also handle crises. Not everyone that comes in is in crisis; and actually in the area that we're in, we often get folks that if they were in any other area, would probably be in what would be considered more of a crisis than here. 50 percent of the clients that come through our door are homeless and that's a crisis in most other clinics. Certainly, it is an emergent state. But our clients are incredibly resilient and are able to often navigate the resources that are in the area. We provide referrals and resources to help with that. But we also get folks that come in needing crisis intervention [and] hospitalization and we do provide those services and we are ready to provide those services at any given time. So certainly, we do provide crisis [stabilization], but not everyone that comes in is in crisis at the time.

We provide screening to determine eligibility for services. Everyone comes through my program. All new, unopened clients come through Crisis Resolution Service to determine appropriateness for either our program or some other program. For example, if someone comes in and we believe that they would qualify for our Full Service Partnership program, which provides intensive case management on a ten to one [client to staff] ratio with clinical services, we would then refer that person to that program. Perhaps, what we call a Transitional Aged youth [ages 16-25] would come in and we think that [a TAY program] would be a more appropriate service for them, then we would link them to that service. But most of the clients that come in do meet criteria [for CRS]. We open them in our program, which is short-term up to 60 days, and we provide them with comprehensive case management, medication services, brief therapy, and emergency services as needed.

How would you characterize your clients? You said 50% were homeless? What kinds of diagnoses do they have?

About 50 percent of the folks that come through our door do not have residential rights where they are. They are often living with friends or family, but they do not have legal rights to that dwelling. In that case, they are considered homeless. Or they're actually living on the streets.

We traditionally have folks that come in with severe and persistent mental illness – bipolar disorder, schizophrenia, major mood disorder. But we have recently had a lot of returning vets with PTSD [post-traumatic stress disorder], depression related to situations – the economy, unemployment. The demographics are slowly changing. We also have had a great increase in homeless families.

Ten, fifteen years ago, you would never see a family on the streets. Now [we see] a great number. I don't want to give the incorrect statistics because that's under Lisa Wong's program and she would have that information. But definitely [there's been] a

huge increase in homeless families on the street. Again, I think the economy would be considered most responsible for that, the unavailability of affordable housing.

I think that it would be hard to argue that we aren't one of the most welcoming clinics in all of the DMH system. I'm going to put that out there and make that claim. Because we have clients that come to our programs and they receive services; usually they come to us because they're living in the Skid Row area. They're often homeless and they get their benefits and are able to move out and get housing as far out as Lancaster, Riverside, [or] Long Beach. But they do not want to link with services in those areas. They continue to want to come and receive services here, because they felt so welcome and so taken care of. I've often heard from clients that they didn't get that same feeling when they went to clinics in other areas. So we've gotten that feedback a lot from clients, that they felt welcomed and comfortable here.

Is the need greater than it was a few years ago?

You know, if you were to carve out any chunk of time – last week, five years ago, ten years ago, I would've imagined you'd get the same. Never having the feeling of having enough resources for all of the people that you need to serve; but again, as we discussed, the demographics are changing a little bit. But there's always been a great need [among] clients with mental health needs, as well as co-occurring needs [co-occurring substance abuse problems]. I would say that is probably an area in which we simply haven't scratched the surface on having enough resources for that.

You've been here a while.

I have, since 2005.

What is your background?

Well, I started out in medical nursing at LA County/USC hospital. I went back to school to get my Bachelor's and back again to get a Master's in Health Administration. Somewhere in that academic pursuit, I went from medical nursing to psychiatric nursing inpatient. Around 1997, I went from Health Services, which was inpatient psych, to outpatient psych. I enjoyed that very much, providing direct services. But I wanted to go and get my Master's in Health Administration, in order to make a difference from the other side.

After coming out of school, there wasn't a whole lot of excitement on the administrative end. But then MHSA came about and while here, under Larry Hurst, now our District Chief, I did my residency in Health Admin and he convinced me to stay on. I was going to go back to Department of Mental Health headquarters and see what I could find in an administrative position there. But he talked me into staying. I was able to get involved in the new programs. The FSP, CRS, these were all new programs under MHSA and it was just very exciting and a very unique opportunity to be involved with that from the inception; and I've been here ever since.

So you segued into this field from medical nursing?

Yes. You know, it just feels natural. I don't know if I can put it into words. There are certainly other assignments out there that would be more glamorous. I know you toured our clinic here, and there would certainly be other opportunities [with more perks]. We're down in the basement here with no window. But that's OK, because I feel that I

contribute to a program that makes a difference, and it just feels good to be in that position.

I don't think it's an accident that we have clinicians that stand in line to come to Downtown Mental Health to work. We recently had a job fair, and of all the places in the Department that folks had to choose from – these were psychiatric social workers that were looking for employment – we had no shortage of folks that were specifically wanting to come to Downtown Mental Health to work. Again, I just think it's a rewarding opportunity and it just feels good to make a difference to folks that probably need our assistance the most.

Did you have any experiences with family or friends that might have inspired your decision to work in mental health?

I have a huge family. I have only one uncle in my childhood that I recall my parents trying to help. He was a Vietnam vet at the time and exhibited what I can, in retrospect, probably diagnose as paranoid schizophrenia. I only have these memories as a child; but I also suspect that part of his mental illness was exacerbated by probably some co-occurring issues, as well as PTSD. He had kind of three fold issues going on there. But at that time, this was I guess in the '70s, comprehensive treatment just wasn't available to him. So I recall him having been hospitalized back and forth and released to the streets and his quality of life was not that wonderful. If I can participate in a system in which someone else's loved one would not have to go that course, I feel that I'm making somewhat of a contribution and I feel that's good.

What changes have you seen in understanding of mental health and available services during your career?

Well, I remember in having been a nurse in a Med-Surg setting. When we would call for a psych consult, the only intervention for patients at that time – we're talking about the early '90s – was to push medication and that was it. That person went home without much of a referral for services. They may have been referred to their local mental health clinic, again primarily for medication. There weren't the wellness programs that we have now.

I think the biggest difference that I've seen in my career is the idea that the person with a mental illness is just that. Now there is the attitude – and it's changing globally, but it started with mental health professionals and mental health advocates – that people aren't their illness. They are people who happen to have the challenges of dealing with a mental health issue. Folks can recover and they can live fulfilling and wonderful lives just like anyone else. I think that's the biggest change that I've seen and it's a huge one.

What are your present frustrations?

Present frustrations? They're expected, so I don't know if I would call them frustrations. It just comes along with the job. It's hard to call them frustrations. I don't want to say we never have enough resources. That's always going to be the case. You're never going to have everything that you need, or feel you need, to serve the number of people that you have to serve.

Sometimes change has been ever present since MHSA was rolled out, but it's been a good thing too. We've had some wonderful opportunities to make big changes. But change is also often frustrating. I think that the one thing I feel for my staff that has to

roll with the punches sometimes – [DMH] comes out with this wonderful plan and this is how we're going to do it, x, y, z, and the next week, you have to come back and say "Well, I told you we're going to do it this way, but this week we're going to do it another way." But they're troopers and they're the hardest working folks I've ever worked with in my entire twenty-something odd career. So I can say there are frustrations.

Do you have a vision for mental health here in Downtown?

My vision – you know, there's often talk about moving people from the Skid Row area out of Skid Row, and cleaning up Skid Row. I don't know if that is necessarily my vision. I think, if I had my way, we would have a system in which folks could come here, utilize services in a safer environment, and then have the opportunity to move out. There is something to be said for having housing and medical resources for folks all in one area, and that has been helpful. But then have the opportunity, once you've been able to take advantage of all of those resources and get financial benefits, and then be able to move out of Skid Row and have a choice. We do have some folks that have participated in recovery and wellness services and have done well and decide to live here. You also have folks that do not necessarily use public services, who live down the way, and have a half-million dollar condo. So Skid Row is not necessarily a horrible place.

Choices. I think that would be my vision for folks that live here. The ability to leave when they're ready.

END OF INTERVIEW