

**Suzane Wilbur talks about the the AMI-ABLE program at UCLA-Harbor and the collaboration with NAMI:**

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For the store that we operated, the NAMI people kept track of the money. But they weren't as involved as the ABLE staff was in teaching the clients appropriate dress and how to talk to people and how to make change, in addition to other work skills. NAMI gave us money for the initial purchase of candy bars and fruit, and things like that. But then we would sell it for a little bit more than it cost us. We bought it in big, huge quantities so that we had discounts, and then we would sell it for a little bit more, and that way any profit that was earned went to the clients' stipends. We had a waiver from the Department of Labor so that we did not have to pay minimum wage. The money earned by the members of ABLE was considered to be training stipends, because the ABLE staff did job training.

Being in the office, where the staff had offices – NAMI had an office, I'm pretty sure it's still that way today, they still have that office – NAMI parents were constantly involved in the day-to-day activities of the program. Patients could drop in. I still say "patient," because I'm an old nurse from the olden days. But clients – members – could drop in, and if there were problems that we needed help with, the NAMI people would come out of their office and sit down and talk. One parent used to come and bake cookies and talk to clients. We called the clients "members," signifying an active participation in their services, rather than the passive recipient role of the "patient."

We also did dinner on the holidays. We did Thanksgiving on Thanksgiving Day and Christmas on Christmas Day. So the staff rotated those holidays and so did the NAMI people. And they helped cook. And the clients would help. The cooks would come early and they would all cook the turkey. Actually, I often used to stuff the turkey the night before and put it in the refrigerator. Then I'd call over to the ward and have the nurse come over and stick it in the oven at five o'clock in the morning. I would get up and do it myself the first couple of years. Then I got this brainstorm, well, the nurses are there, they're on duty, they can just come in and if it's ready, you just take the turkey out of the refrigerator and stick it into the oven. And then we would have this big family dinner with the clients and any family members who wanted to come, and staff, and we would invite the Psychiatry Residents from the Psych ER because they were away from home on Christmas or Thanksgiving.

I remember very clearly sitting down at the Thanksgiving table across from one of the Residents. She looked down the table and she said, "Is that the same woman that was naked and soaked in urine in our emergency room last month?" I said, "Yes." The member had on this nice dress and her hair was fixed. So the Residents were able to see that their work really made a difference in the lives of these patients that were really sick when they would come to the Psych ER. They were really sick. And the Residents could see a difference when they saw the members in a community setting.

**READ THE FULL TRANSCRIPT BELOW.**

**SUZANE WILBUR INTERVIEW**  
**February 25, 2011**

MM: Good morning. It's February the 25th, 2011. We're talking with Suzane Wilbur, who for many years was -- what was your title exactly?

SW: Actually, I was the director of the AMI/ABLE Program for all those years.

MM: And you were working with the [Los Angeles County] Department of Mental Health [LAC-DMH].

SW: Yes. I was an employee of the Department of Mental Health.

MM: I'd like to start to just asking you to tell me a little bit about your background, where you grew up, sort of what led you into nursing in the first place.

SW: Well, I grew up in New Orleans, Louisiana, and when I was twelve, my mother developed asthma and we were advised to move to a drier climate, so we came to Los Angeles. When I was in high school, my mother saw an ad in the paper for Candy Strippers [hospital volunteers, often students]. She said, "Oh, you should try this, at that new hospital they're building in the San Fernando Valley." So I did. And as soon as I walked in the door, I said, "I love this. I love this place."

I was a Candy Stripper, as a volunteer, for a number of years, and then when I got old enough to work and have a paycheck, I became a nurse's aide at that hospital [Valley Presbyterian Hospital in Van Nuys, California]. And [from then on,] I just wanted to be a nurse. So I applied to St. Vincent's College of Nursing in Los Angeles [established in 1899 at St. Vincent's Hospital, the oldest in Los Angeles] and I was accepted. I'm having my forty-sixth reunion next year. Our class has stayed in touch, so it's very nice.

And then I got married and had kids. I worked part time in medical-surgical nursing in hospitals, Good Samaritan, St. Vincent's, and Huntington Memorial. I was working in an oncology unit at night, because my kids were little [and I could be at] home during the day. I felt inadequate to work with patients and families that were struggling with this illness. So I thought, "Well, I'm going to go back to school and get a degree in psychology." I was advised, "Well, why don't you get a degree in nursing and major in mental health nursing?" So that's what I did. I got a bachelor's [degree in nursing in 1980].

Then I heard from one of my classmates about positions being open in the Department of Mental Health, so I applied. My children were much older by then. So I was hired to work at the Therapeutic Residential Center (TRC) in El Monte [in the San Gabriel Valley], which was a 24-hour program [which prepared patients who had been living in hospitals or board and care homes for independent living]. There was a Crisis House, as they called it, upstairs, and a longer-term [residential unit] downstairs. So I did that for a while, and then I got laid off because there was a big budget crunch.

MM: This was about the late eighties?

SW: It was the early eighties. It was '82. All the nurses at our clinic got laid off. I had transferred from the Therapeutic Residential Center to Arcadia Mental Health [Center], which is an outpatient clinic [operated by the Los Angeles County Department of Mental Health (LAC-DMH)], and they laid me off with three other nurses and said, "We don't

need nurses here." My nurse friends who had master's degrees got other jobs right away, but the only thing available to me was the night shift at the local hospital.

So I said, "I need more education." [I was told by Phyllis Key, the Program Head at Arcadia Mental Health Center], "Well, if you come back to the Therapeutic Residential Center and work, we won't lay you off because nobody wants to work there [because of the 24-hour shifts], no nurses want to work there, and they can all get other jobs." So I said, "Fine. I need a job and I need to keep working." So I did that, and I adjusted the schedule so that I could go to school certain days and work the rest of the time.

I got my master's [degree] in nursing [in 1983], and then, after the Therapeutic Residential Center Crisis Unit, I went to work at Metropolitan State Hospital [the State Psychiatric Hospital in Norwalk, California], but it was in a County [program]. I continued to be a County employee. [The DMH operated] a Crisis Unit there, and I managed that unit.

MM: Let me just ask you. You started working in this area because of your experiences in oncology, and looking at the psychological needs of families with very, very sick family members who were possibly dying.

SW: That's right.

MM: But when you actually started working, you were working with people with mental health issues who were in crisis. It sounds like a very different kind of practice activity.

SW: It was a switch. In fact, when I left Huntington to go back to school, I said, "I'll be back. After I'm finished with school, I'll come back and work here." And I had to let them know that I wasn't going to do that, because I was able to get a job with the Department of Mental Health. Mental health patients, working with them as a student, it just drew me. I felt like [the clients] really needed us. They're so sick, and they have so little. Usually, when [the illness is] severe and persistent, a lot of them are homeless, a lot of them have medical problems, and I was just drawn to it. Since I focused on that in school, it just felt like I should continue rather than go back to a medical-surgical setting, that I would just really focus on mental health.

And I've done that for thirty years. I started in 1980, so it's more than thirty years. I tell people that I've never worked a day in my life. I get up and I go to a place that I love, work with people that I enjoy working with. I've put up with frustration, but in the overall, it's – for me, it's a calling. It's really like a calling. I love working with people who need us the most, that's what I always say. They need us.

People who used to interview with me and say, "I want to work here," or "I have another interview over there," and I'd say, "Oh, you don't want to go work there. We need you. We need you more. Our clients need you." [DMH clients] deserve nothing but the best, so the *best* people should be working for the Department of Mental Health. That's the way I saw it. I found that to be true. The best people come to work with us.

MM: That's cool. So you were working at TRC.

SW: TRC, right. [In 1984,] I had a chance to move to – it was a promotion – to the Crisis Unit, the L.A. County Crisis Unit on the grounds of Metropolitan State Hospital. So I went there, and the director there, the program manager, was Chuck (Charles) Veals. I don't know if you've heard his name, but he was the director of the Crisis Unit. He said, "I really need somebody to run the day-to-day operations because I'm the administrator, I'm in meetings all the time." So that's what I did.

I set up – people were working kind of independently there. A patient would come in, you'd see the patient, present [the case] to the doctor, move the patient out. I said, "Why don't we conference these patients so everybody can have some input?" So I assigned nurses on each shift to be the conference supervisors, and had the doctors doing in-service [education], because we had a lot of psychiatric technicians.

Then eventually we had students that would come and learn with our patients. So I thought the doctors should teach, because they're on duty for twenty-four hours. When there's downtime, they could do a little class on assessment, or whatever. So they did that.

I was there for a couple of years, and I was recruited by a private hospital nearer to my home. So I thought, "OK, I'll go work there." And I lasted four months in the private sector. I couldn't do it. It felt like these patients who are well, but they still have insurance left, they have to stay. But the patients who are really sick but they're out of insurance, "Well, let's find a way to discharge them." I'm not saying that in a critical way. That was just the reality. [The private hospitals] had to stay open, and so they had to have income.

But it just didn't work for me, so I went back to work at the Skid Row Mental Health [Center] and set up the Psychiatric Emergency Team for the Central – [the County was organized into] Regions at that time – Central Region – we called it the PET Team. I supervised that and went out once a week with different staff to make sure that they were assessing properly.

I worked with Dr. Richard Lamb [a USC psychiatrist who has worked actively in mental health advocacy and to promote vocational rehabilitation] over at USC. I need to find that data, because for a whole year we looked at the PET Team stats, and I was able to show that by sending the PET Team out, forty percent of those patients were sent home [with referrals to treatment], and only sixty percent were hospitalized. Those would have been – a hundred percent would have been hospitalized. I thought, "Well, forty percent, we can improve on that." But then I got this opportunity to move to Harbor-UCLA [Harbor-UCLA Medical Center in Torrance, CA, affiliated with the UCLA School of Medicine] and work in an Inpatient Crisis Unit there. Again, it was a promotion; it was also more money, so I did it.

While I was there, I met Dr. [J.R.] Elpers [who had been Director of LAC-DMH, 1978-84] and when the idea of integrated services and the Village [the Integrated Services Agency developed by the Mental Health Association (now Mental Health America) as a demonstration project under AB 3777 in 1990] was being [discussed], he said, "Well, we can do that [in a] directly operated [program; that is, operated by the County]. We can do that in the County." So he was the idea man and I was the person who got it done, implemented things. And new ideas that came to me, like the medical piece – without his backing that would not have happened, because our Department just didn't think that way. And at Harbor, [the staff] thought that psychosocial rehabilitation was a lower level of psychiatric care and that psychotherapy was still more valued. So we weren't popular. And we [transferred] money out of other programs to build this program. So without [Dr. Elpers] being there and advocating and pushing, it just wouldn't have happened.

MM: That's good to know. OK. Many questions. You were sort of sold on psychosocial rehabilitation.

SW: By him, really. [At the time,] I was the nurse manager for the [Inpatient] Crisis Unit [at Harbor-UCLA]. I instituted Family Night, where I invited local NAMI [members of the local chapter of the National Alliance for Mental Illness, a family-based advocacy and

support organization] to come and talk to the parents or family members of whoever was an inpatient at the time. So I got a relationship going with the local NAMI [chapter], because they'd send a different person each week.

So when Dr. Elpers started talking about psychosocial rehab and AB3777 [the California legislation that funded the ISA demonstration projects], where family participation was one of the key components, I said, "Oh, I know how to do that. We've got these NAMI people. I know them." So we invited them to help us write the [original program description and protocols] – so they participated. I don't know if you want to interview some of them, but there's a group of people who started this program with us that are still in NAMI South Bay, that are just as dedicated today as they were in 1991, and now it's 2011.

MM: So the roles they played were educating family members who were new to this experience.

SW: Right.

MM: And then what else did the families help to do? I mean, they did some fundraising?

SW: They did fundraising. Once, they had a movie night where everybody who bought a ticket, part of the ticket money went to our program. We gave them an office in the [ABLE] building [at Harbor-UCLA], and they were always there when family members would come in. They would come out and meet them and talk to them about their sons and daughters. They offered their classes. Now it's called "Family to Family" [a NAMI program where families with newly diagnosed members learn from families who have dealt with mental illness]. It started out as "Caring and Sharing", on Monday nights, I believe, in our building. They invited families from the inpatient wards as well as the outpatient people that we had enrolled into the program. It was open to everybody.

They sent out the newsletter every month, highlighting the program. I went to all their meetings. I lived in the neighborhood at the time, so I went to all the meetings.

It was really an integrated operation with those families. We had ideas of their taking somebody else's son or daughter home and giving the other parents a respite time. Then we thought, liability-wise, that's probably not a good idea, [even though] it's a great idea. I hope some program can do it some day. But they were willing.

[NAMI family members] eventually became the [clients'] money managers. That was the big thing. The South Bay NAMI became the payee for a selected number of clients. They opened a bank account, the money came in to the bank; and then they met with the client and the case manager to make a budget for each month. "How are you going to spend this money? Well, you have to pay your board and care bill, and you have to" – and taught people how to budget. Certain days were allowance days, where [the program clients] came and got their money. They would tell us, "Now, I want you to give me five dollars on Thursday and ten dollars on Friday." They set up the budget; we didn't control it. But the NAMI people had the money; they had the bank account, they brought cash and gave it to the clients, and then kept the records in Quicken [an accounting software program].

MM: So the clients then learned how to manage money and live on a budget on their own, live independently.

SW: We had a lot of people that went to independent living, particularly with Section 8. We were able to apply for Section 8 many times and get apartments that people could live in, and we helped them through the interview process. Application [would be] hard for you and me, so if a person has a mental illness and some cognitive problems, applying for housing would [probably] have been impossible.

MM: OK. But let's talk a little bit about the finances. I mean, you talked a little bit before we went on tape about fundraising for this program, and also about how the clients did some work.

SW: They worked. Any time there was fundraising, that money was a separate account from the client account where [the members] had the money management. NAMI [as an organization] had their own [separate] bank account. For example, when I won that award with the American Psychiatric Nurses Association [the 1998 APNA award for Best Practices in Treatment of Schizophrenia in a Community Setting], it was a thousand dollars. They made the check out to South Bay NAMI and it went in their [organization] account, and that was money that they used for – I don't remember. They might have bought clothes for people. They got clothes [as well,] donated to help people have good appearances [for job and housing interviews].

[For] the store that we operated, the NAMI people kept track of the money. But they weren't as involved as the [ABLE] staff was in teaching the clients appropriate dress and how to talk to people and how to make change, [in addition to other work skills]. [NAMI] gave us money for the initial purchase of candy bars and fruit, and things like that. But then we would sell it for a little bit more than it cost us. We bought it in big, huge quantities so that we had discounts, and then we would sell it for a little bit more, and that way any profit that was earned went to the clients' stipends. [We had a waiver from the Department of Labor so that we did not have to pay minimum wage. The money earned by the members of ABLE was considered to be training stipends, because the ABLE staff did job training.]

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I remember very clearly sitting down at the Thanksgiving table across from one of the Residents. She looked down the table and she said, "Is that the same woman that

was naked and [soaked in] urine in our emergency room last month?" I said, "Yes." [The member] had on this nice dress and her hair was fixed. So [the Residents] were able to see that their work really made a difference in the lives of these patients that were really sick when they would come to the Psych ER. They were really sick. And the Residents could see a difference [when they saw the members in a community setting].

I also remember that same client being an inpatient on the Crisis Unit, and one of the Residents – Oh no, [the client] came to visit her friend, and again she was all dressed nicely. One of the Residents just teared up. She started crying and said, "Look at her." [We said,] "See how hard you worked and see the results? You may not have seen it the day she left the ER, but she got better." And then we took [the client into the ABLE program] and worked with her, and [gave her the correct] meds, and [taught her] how to take the bus. That was the other thing NAMI people did, they would take the bus with the client to teach him how to get [around in the community].

MM: From one place to another. Sure.

SW: Yes. And [NAMI members] came to every meeting. We had retreats [with NAMI] every year. [We would ask,] "How can we do a better job? What can we do?" And they were also very grateful because we did our own emergency services at night. We didn't allow the PET Team to see our patients. Everybody [, including the members and their families,] had our pager number, and the staff rotated the pager, so that if, at three o'clock in the morning, somebody's acting out at home, they could call us and we would go.

MM: How did people get into this program?

SW: We had criteria. When I find that document, I'll email it to you. But anyway, the criteria were that they had to be high utilizers of hospitalizations. You had to look at their MIS [County Management Information System data] – in those days it was called MIS – records of hospitalizations, and they had to have at least – I think it was at least fifty thousand dollars of hospitalizations in the three years [prior to enrollment in the ABLE program], because anybody can have a bad year, but we looked back [further than one year].

[Potential members] had to live in the South Bay, because we did the night services and we couldn't be driving to Van Nuys [in the San Fernando Valley] for emergency services, so they did have to live within a driving range. And they had to be able to get back and forth on the bus, and whatever.

But one thing we didn't require was that they be stable, and we didn't worry if they had a history of violence. Nothing kept them out, [except not having a sufficiently high hospitalization] cost [or not] living close by [or the member's not consenting to be in the program]. They didn't have to have Social Security [benefits. ABL staff assisted members to get Social Security benefits] if they didn't have them. We [assisted them to obtain] Medi-Cal [benefits]. We did all those benefits establishment [jobs].

MM: And if they had no income. I assume most of these people had no income.

SW: Most of them didn't when they first came. Even if their family was wealthy from Palos Verdes [a group of upscale communities in southwest LA County], the clients were not. As soon as we brought them into the program, we started working on getting SSI [Social Security] and Medi-Cal and Medicare, so that they could pay for the services.

But in those days, you didn't have to have those benefits to become a County client. Actually, I don't think you still –

MM: No, I don't think so.

SW: [A person would] become a client [member of ABLE] and then we started working on benefits for him or her. The benefits establishment piece that we did in those days was extensive, to the point of driving people to the Social Security office, and sitting with them for the interview because they would be hostile, or afraid of “what's going to happen to me when the government finds out that I need money,” and things like that. So we worked with them.

And we would go with them for doctors' appointments, too, same reason, because the doctor would say, "What brings you here today?" And they'd say, "Well, who wants to know?" That's why we ended up developing our own medical services.

MM: I guess one question is, What's the long-term goal here? I mean, yes, OK, so you get them into some sort of stable housing, Section 8 [The U.S. Department of Housing and Urban Development's (HUD) Section 8 program provides housing assistance to low-income individuals, families, senior citizens, and persons with disabilities, usually through rent subsidies] or something else. You find them some kind of steady source of income. Were there efforts to find people permanent employment?

SW: Yes.

MM: And how did that work out?

SW: We had some people that were hired [, for example,] by Goodwill [Industries, which provides education, training, and jobs for disabled individuals], to work for Goodwill. We had a woman that was hired – it was a financial job. She was really good with math and she was hired by a CPA's office, but not to do CPA [certified public accounting] work, just to maybe keep the books or file, or whatever. That's interesting. I should look for [the data on] those jobs – one person was hired by a kennel and he walked the dogs, because he loved animals. We would try to find something that would interest [the member]. And some of our members got jobs at the Village, in the café. They were able to get themselves transported over there and they would get jobs. [Also, some got jobs as Salvation Army “bell ringers” at Christmas time.]

And then we hired some of them. I hired one person, he [stayed employed with DMH for] five years, and he was sick the entire time; but he never missed a day's work. He was the best typist I ever saw. You'd give him any job and he would do it. He would say, "Wow, I'm just really hearing voices." And I'd say, "Well, you know, I'm not going to [be able to] do this typing myself today." And he'd say, "Oh no, when I type, the voices go in the back of my head." So he would just type. We signed him up as a volunteer with the Oath of Confidentiality [required of LA County employees and volunteers that may have access to patient information], because he was typing conservatorship papers [that is, appointing a legal conservator to manage the affairs of a person unable to care for him/herself] for the wards because clerical help was hard to find. And he [worked sometimes as] a “runner”. He went to the different wards to get things, where our people would be hospitalized, and he'd go visit them. He would Xerox the chart when people were sent [, for example,] to La Casa [a residential program for older adults operated by the Telecare Corporation] or another facility.



But the long-term goal that you asked about was to keep them out of the hospital [and living independently in the community], and to keep their [hospital] costs down. And there's paperwork with [data about this]. Paul Arns [DMH District Chief for Clinical Informatics at the time of the interview in 2011] did some really good research on that. For one group of fifty clients, we reduced – they cost one point eight million dollars before ABLE, and the very first year after [enrollment in ABLE], the fifty clients' [hospitalization costs were] nine hundred thousand dollars, so we cut their hospital costs in half, fifty percent. And that was just in their first year [of receiving services].

If you look at the ACT [Assertive Community Treatment] model [which provides intensive treatment to assist recovery and independent living] and AB3777, these services are for life. It's not like, "Well, now you're well, you're out of the program." We were supposed to be a program and a place for them to come for life. As [members] got better and better and better, they needed us less and less and less. But they would, over their lifetime, stay out of the hospital. That was the main thing.

MM: And they would always have that connection. They might need you less and less, but then there might be some problem that might bring them back.

SW: Right. And this illness will bring you back. Unfortunately, we haven't found a cure, and Martha Long [founding Director of the Village] used to say, "Never underestimate the power of mental illness, because it comes back and it gets you." So, yeah, they need us. We studied a lot of writing by Dr. Anthony, I can't think of his first name.

MM: Bill Anthony [Director of the Center for Psychiatric Rehabilitation at Boston University and one of the leaders of the Mental Health Recovery Movement].

SW: Yes. Psychosocial rehab. You have somebody in a wheelchair, and you take away the wheelchair and say, "OK, you've been in the program a year now. You're out." They can't walk again. [The person] loses the gains that [he or she] has made. And it's the same with mental illness. Case management is the support. It's their wheelchair more or less, if you do an analogy. So you don't take away, you continue to support.

What happened recently, I understand, when they disbanded the ABLE program was that they said, "Well, these people haven't been sick," and hello, you know why, because of the support. Hopefully, [DMH] found other support for [the members]. The NAMI people were very upset [about the closing of the ABLE program]. They called me, they called Dr. Elpers. I put together a packet; I'll give this to you. It's all stuff that you have in some ways, but I wanted them to have a packet that they could take with them. They were meeting with various mental health officials, and this was to show what had been done by the program, [its] history. Because once I left, then Paul Arns took over as director for a number of years, so the program pretty much stayed intact. But then, after that, I think some of the guiding principles – [for example,] they stopped the holiday dinners. They started having them the day before Thanksgiving instead of on the day. That family involvement and inclusion kind of diminished, I think.

One of the other things was that, when the ATCMS, Adult Targeted Case Management Program, came into being, we were given two social worker positions [in order to enroll] twenty clients from Metropolitan State Hospital that had criminal records. They had served their time for their crimes, but they were still mentally ill, and the goal was to move them out of the hospital [and into the community]. Paul has some data in there that shows [that] we kept all but one out of the hospital for a long period of time. These were people that had really bad backgrounds; but once they were on meds and in

a program where they had social contacts [and support], and they had money, and they had a stable place to live, those crimes were not repeated. I don't know what happened to all twenty of them. Paul may know, because he was pretty involved in the records and research on that group.

What [DMH] said was, "Well, we're going to give you these two social workers and you assign them each ten of those patients." And I said, "No, we're going to integrate [those clients]." So every staff member [was assigned to work with] some of the twenty, and the two social workers [were assigned to work with] existing ABLE members. We changed case manager assignments a lot because I wanted the clients to identify with the program, not with a person. There was a lot of consternation about that. The families thought, "Oh, he's doing so well with this social worker, why are you switching?" "Well, you watch, he's going to do well with that one. And it isn't the social worker, it's him; your son is making progress." So we're just those little supports that are helping along, but he's the one who's doing well. I didn't want them to give too much credit to a program or a person. It was this mentally ill person who was doing the work. We always told [the members], "We'll work as hard as you do. If you work hard on getting better, we will be right there next to you." That was our plan; that was what we did.

MM: OK. So tell me just a little bit more then about getting people working. We talked a little off tape about how they were working in the store, and you couldn't have a store at Harbor itself.

SW: In the hospital, yes, because of [the hospital] contract with Food Services.

MM: So they went and sold in the out-buildings or the maintenance area.

SW: Mm-hmm. My dream was always to get a Starbuck's concession going, because people would stop for that and our [members] could be the people who worked in it, made the coffee, and sold the coffee, and [the members would] make a lot of money. It just never happened because, again, the contractor had the contract for Food. What I tried to do, I met with Morrison's people [the Food Services contractor] and I wanted them to hire our people. The [member-employees] could take trays up to the wards, pass out trays, they could help with dishes. Some of them could help you with your books; some of them didn't lose all their cognitive abilities, so there were various levels [of ability].

My vision was that, as I walked through the hospital, our clients would be employed in various jobs. Housekeeping Services hired several of our clients. And, again, we were like the job coaches, so if anything happened on the job, we'd get a call and go. Whoever was there would go and work with them and help them, or do their job for them so that the employer wouldn't lose out on that person. The argument was, "Well, you know, it costs a lot of money to train somebody, to bring them in and train them in the safety issues of housekeeping and all that. And if they're going to get sick over and over again, we're going to lose money." "Well, maybe, but we'll put somebody else in." "But then we have to train [another person]." "Yes, you do, but these people need this [work] and you have the ability [to hire them]."

MM: But the food concession people wouldn't buy that.

SW: No. They never hired any of our people, while I was there.

MM: And do you think that was the main issue for people, in terms of hiring mental health clients, was this problem of training them but not feeling secure that they would stay on the job?

SW: Yes. What if [the member had a relapse] and had to go to the hospital? And then they would not have that employee. That was probably one concern. The way [the members] looked and talked was something we could work with. We could get them the right clothes and coach them on their mannerisms and [tell them that,] "You don't talk to your voices while you're on the job, you wait till you get home in the bathroom and talk to your voices. Don't do it on the bus. People will think you're mentally ill. You may be, but you don't have to broadcast it."

We would help them to see what it takes to integrate into the community. Community tenure was really a big thing, having them live in the community for an extended period of time. We had relationships with the Section 8 landlords, and they would call us, "Oh, he's making noise at the trashcan." "OK. What are you doing? Let's talk about this. How are you going to keep this apartment?" "Well, I guess I better not go out to the trash and talk to my voices."

They may have a mental illness, but it shouldn't define them. [Mentally ill people are] people [first]. And I'll tell you – I said this recently in a talk [to a group of] nurses – that no client ever came to me and said, "My goal in life is to become compliant on my medication." Yet that's our goal. That's always our goal, compliance. They come and they say, "I want to live by myself. I don't want to live in the board-and-care anymore. I want a job and I want a spouse. Can you get me a spouse?" [Our response would be,] "Well, sure. We can work on all of that. Let's start with what you need to do to get the things that you want."

And we were pretty successful with a lot of our members. We had one marriage, a couple, and a board-and-care that allowed them to live together until we got the Section 8 apartment for them. She's since died, but they did have a section of their lives where it was kind of normal.

MM: That's cool.

SW: But the employment part was never easy, never as successful as I wanted. I thought that [the members] could work. I have a new job now at a different hospital, and I'm already talking to them about, "Well, what if one of the people got hired at the gift shop?" "Oh, my gosh, what a concept!" But little by little, maybe. Employment is what really helps people stay well. They have to get a certain amount better and more stable before they can get a job, where they can go through an interview. But once they do that, and they get on the job – The person that I hired was the best County employee I ever had. He was really, really faithful and good, until he had some life crises that then [precipitated] his getting sick again. And he decided to resign from the County after five years, I think it was, and because he had accumulated retirement money, SSI cut him off. He had too much money [in the bank], so he had to spend that money on his board and care rent every month, until [the money] was "spent down" to the two thousand [dollars allowed by the State]. And he said, "Oh, you know, this happens. I can do that." So our system isn't set up [for workers with mental illnesses] to succeed.

MM: No, not really. It doesn't support you in that way. So tell me a little bit about how you attempted to integrate physical health, or put physical health within a mental health program? How did that work?

SW: That was really cool, because, first of all, you couldn't bring a medical student or a Resident over from the hospital to our building unless you had an attending [physician]. You had to have faculty on site. But a Fellow could come [without an attending on site]. There was a psychiatrist in our department who was friends with a physician in Family Medicine, and they started talking about this need. This Family Medicine doc started talking about the need [to his Fellows], and one of the Fellows [Dr. John Cheng] said, "Oh, I'd like to do that. I'd love it." So he came over and said he'd do it.

Then we ordered an exam table and stethoscope and all the things that most mental health clinics don't have. Scale, thermometer, everything, otoscope [for ear examinations], ophthalmoscope. [Dr. Cheng] started seeing patients; [the members] would just bring their complaints, "Well, I've got this rash, or I got a pain here, or I have diabetes," and he would start treating that. And then he got to where he could see people who weren't complaining. I'd say [to a member], "Well, this is your day for your physical, and this is your appointment." And [the member] would come and just get some baseline assessment done.

Then we were able to get a computer in that building [2-South at Harbor-UCLA Medical Center, where the AMI-ABLE program was housed] that communicated with the computer in the main hospital, so then [Dr. Cheng] could do labs and get results [sent to him]. He could order labs and then get the results through the computer, I'm pretty sure, which is a big thing, because if you are in a [County] Department [of Mental Health] outpatient clinic and you send somebody to a local clinic for a chest X-ray, your chances are not that good that you're going to get the results. It's just not that good. You have to hound those people to get [client test results]. Or they'll give it to the client. "Here's your results." And then [the client will say], "Well, I think I left it on the bus." (both laugh) So by having that computer, it was really a big thing. That computer mattered because it allowed [Dr. Cheng] to get those [lab, X-ray, etc] results.

Then he started doing mammograms and PSAs [prostate-specific antigen tests], things that you and I do all the time, but these patients never had [these tests], never thought of it. We had one patient that had [breast] cancer and [Dr. Cheng] kind of followed her, and we followed her. We were there when she died. We held a funeral for her at our program, and people came from all over. She was very well known and not very well appreciated by the Psych ER because of her behavior. But once she got to us, her behavior didn't really improve that much, but her stability did and she was able to live her life until she got sick.

MM: And I imagine that there were many physical health problems that these individuals had.

SW: Right. And the beauty of it was that the psychiatrist would come to see the client, and John [the Family Medicine Fellow] would be there, and the two of them would talk. "Well, I'm going to give him this med;" "Well, I think I'll give him that [medication]." So we had collaboration between the psychiatrist, which was the Resident, and the Family Medicine Fellow. And then [John Cheng] became an MD and an employee of Harbor UCLA, but he never gave up that afternoon [ABLE clinic] every other week. I think he's still coming.

MM: Well, good for him!

SW: And Dr. Elpers had the best idea, to institutionalize it and make it a mandatory part of [the Family Medicine] rotation. Never happened. I don't know where the ball got

dropped. That certainly was not in my purview, that was nothing that I could be involved in, but he tried and it just didn't happen.

MM: Family Medicine didn't go along with it?

SW: I don't know if that was it, or UCLA maybe had certain requirements that they had to meet and they couldn't spare [a doctor for] an afternoon every week, or maybe it was an elective and nobody selected it as an elective. There was a little turmoil when we required our Residents to start seeing the ABLE clients, take a couple onto their caseloads. "Why do I want to do that?" And then they would love it. Part of their job, you can see where Dr. Barone wrote about socializing [Dr. Anne Barone was one of the first Psychiatry Residents to select the ABLE Program as her elective in her final year of Residency]. She went to Disneyland one day with thirty clients. We had a van and/or a bus, and she came in her little shorts and her backpack and went off to Disneyland. And then, as their doc, she could see how they were in a situation that was normal, quote/unquote, and it gave her insight into them and their lives and their personalities, just like the Residents who would come and eat at Thanksgiving. "Is that her?" Those were the good old days. Very exciting.

That medical clinic, with the integration of psychiatry and physical medicine, we were very lucky because we were on the campus of a hospital so we were able to do it. [At] South Bay Mental Health [Center], how can they do that?

MM: Unless you have someone who's willing to rotate out there. That seems to be the key there.

SW: Right. And you set up equipment, and then for us it was [easier], just sending [members] across the driveway to the X-ray department or the lab. We had lab equipment. John would just do his own blood draws. And we would have "R", my client, who was my employee, he'd just run – "Can you run these to the lab, R?" "Oh, sure. No problem."

When we first hired "R" – I know I'm off the track, but when we first hired him and sent him up to the ward to get a chart, the nurses wouldn't let him in the door. And he came back, "Well, they wouldn't let me in, because I'm a patient." And I said, "Wait a minute. You're an employee. You signed the Oath of Confidentiality." So I had to work with [the ward nurses]. First I got angry, and then I became conciliatory and we got it to happen. Then [the nurses] were glad to have him because he'd come up there and Xerox the chart of an ABLE client who was leaving Inpatient and going to a lower level of care, [so that the nurses] didn't have to do that. Xeroxing a chart is a lot of work. "Can you send R up?" "Sure, no problem."

So we maintained good relationships with the two wards, for a time. And in my memory, that's how it worked. We hired another [client, a member of the Village] to be our receptionist. She was out at the desk and answered the phone all day, every day, and took messages. She got her performance evaluation every year, just like every other County employee gets.

MM: One of the things that has sometimes come up is the difficulty of hiring County employees who may have this kind of background. You didn't have that problem? Or was it because of the program that you would – the County has various security checks and I don't know what all?

SW: They do. And the one person that I hired as the typist/clerk, R, had to take the County typing exam. He aced it, a hundred percent. I had to drive him [to the test] because it was in the City of Commerce. I said, "Come on, it's time for your test." And he went out and took the test. He was in Band 1 [for County civil service hiring], and I hired somebody out of Band 1. And it didn't say "mental illness" on there. But then we hired somebody that did have a police record. You can do that in the County, but on the application [the potential employee would] have to explain why he or she got that and if they are on probation, or if [their probation is] done, or whatever. And she did; she [disclosed everything] and it went through.

As long as you can pass the exam – like, a typist/clerk has to pass a typing exam; [for] a receptionist, I don't know what exam it would be. Maybe review of record. Maybe they just looked at – she had a high school diploma, she had worked. She had actually worked in Family Medicine at one time, so she had connections with Family Medicine. But that wasn't what got her hired. She just went through the application process and was eligible for hire. It might be harder to get a social worker job, for example, if you have blank spaces on your resume. That's always been a problem for people with mental illness, that they're out of commission for a few years, or even a few months. [Employers ask,] "What happened?" But then people with mental illness work everywhere, all over.

You just can't start out by saying, "Well, you can't do this." You start by saying, "OK. We'll work at it and see how far we get." People who want to be President, well, first you have to be a lawyer. First you have to graduate from high school, and once they graduate from high school or get that GED, they may say, "Well, this is good enough. Now I want to walk dogs or do accounting, or whatever." But you have to start, so you say, "Well, yeah, why not?"

MM: Was there something that you tried to do that you couldn't do that was really frustrating, that you hoped to achieve and it just never happened?

SW: It's hard to say because we did achieve a lot. But the jobs thing in the hospital with the various contractors – I figured maybe [members] couldn't be hired as County employees, or maybe they could, but we had contractors for housekeeping [and] linen [services that could hire members]. Somebody could fold linen and put it on the shelf, do inventory. Dietary. All that. The housekeeping [contractor] did hire our people. We would see them throughout the hospital, mopping, cleaning. So jobs; getting good jobs for [the members].

We pretty much accomplished just about everything we set out to do. We did the money management, we did Section 8 housing and apartments, living in the community.

MM: It sounds like you really accomplished a lot. So I have two questions. The first question is, Why was this program brought to an end? But why is it when I talk to people in the County about programs that are successful in this respect, I always hear about the Village, but I rarely hear about this one, about AMI/ABLE? Why is that?

SW: Well, you know, I have my opinion. (chuckles) I think it was a cultural thing. There was kind of a negative [attitude towards the County]. Even though Harbor is a fabulous place to work and did great work, they never really saw themselves as part of the County. They always held themselves out as being UCLA, as academic. Even though their paycheck comes from the same place that mine comes from, that was sort of the culture there. So having a real County program that was – we were pretty devoted to the Department of Mental Health. We identified ourselves in that way, we

didn't identify ourselves as academic or UCLA. Although Dr. Arns eventually brought students and had an academic [component], [and] a piece of the [Psychology] Fellowship was the AMI/ABLE program.

Plus, we were doing psychosocial rehab, [which] at that time was kind of looked down upon, because psychotherapy was still really in favor. I think it's still in favor, and I think it has a good place, but I also feel like you get to a point where then rehab comes into the picture.

So that was one reason, that Harbor was not looked at as part of the County, and this program wasn't perceived as any big thing. And Dr. [Milton] Miller [(1927-2005), Chairman of Psychiatry at Harbor-UCLA and Deputy Medical Director of LAC-DMH from 1978 until his death] never did tout it as a separate program, he always considered it [just another] part of his outpatient services. And Dr. Elpers, brilliant though he was, was not always appreciated. He was not always appreciated. A lot of people thought, "This is Elpers' baby, this is his thing." So ABLE kind of got dismissed.

I don't know all of the reasons. And I wasn't there when they closed the program. But I've heard that the clients that had been in there for years and years and years were stable, so they didn't need the intensity of service, of one case manager to ten or fifteen clients. But also, that the case managers were not even carrying fifteen [members], they were carrying fewer.

MM: So there weren't any new patients coming in?

SW: I don't know. There should have been, because we took referrals from the inpatient units and from the Psych ER, from all the contractors, the contractors that didn't have their own little – like Exodus [Recovery Center, Inc., in Culver City] had their PARTNERS program, and Brotman [Medical Center, also in Culver City] had one. [PARTNERS was an integrated services program for high-service utilizers developed under LAC-DMH Director Areta Crowell in the 1990s; the acronym stands for "People Achieving Rehabilitation Together Need Respectful Empowering Support."]

But families could call us and say, "We've got someone for you." We were still actively enrolling – we were over a hundred clients when I left, and each case manager had fifteen clients. But [members] would come into the program – a lot of people just came and stayed. Others would come, but then they would leave and then we'd have room for more. Or we'd get more staff, like the two social workers we got with the ATCMS. [With the two ATCMS social workers,] we were able to enroll twenty more clients.

But it is a very intensive, expensive service, so unless you have expensive clients that come in [for whom] you can show you're reducing their expenses – so possibly the research wasn't being done, or the data wasn't being collected. I don't want to say a negative thing because I wasn't there; but I feel like the people who continued definitely carried on.

But it's possible that, with all the FSPs, which to me, c'mon, this is what we did in 1991. [Full Service Partnership is the intensive integrated service arm of the California Mental Health Services Act (MHSA) of 2004.] But having those programs made the Department look at the ABLE program and say, "Well, these clients could go into those FSPs." I heard that they tried to [have ABLE] become an FSP. Just like at one time we had tried to become a PARTNERS, and that didn't happen. I don't know if ABLE became an FSP, or not, or if all those clients were moved out [to other programs]. And I don't know who they see now, who is enrolled in the ABLE program, if anybody. I don't really know.

Dr. Dorit Saberi [PhD], I think, is the Director now. She was one of Paul Arns' [Harbor-UCLA post-doctoral] Fellows. The last I heard, she was the Director of the ABLÉ program. It would be good to ask her what happened politically. There's always a piece of the politics that comes into play, but then, the money. In these times, there was probably a need to juggle funds in some way. They look at everybody and juggle. It's a hard thing.

MM: Yes, it is. Certainly it's been true with MHSA. The money offered so much promise, but other things – It was being stretched in every direction.

SW: It boggles my mind that all that money is coming in, and we're laying people off, or [maybe] not laying off, but closing programs and juggling. It boggles my mind. Where is that money? My last job with the Department, I retired, and then [was] rehired to organize the Nurse Practitioner [Development] Project, where we didn't have any [psychiatric mental health nurse practitioners at LAC-DMH]. And then MHSA suddenly [funded] seventeen [PMHNP positions]. So my job was to fill those spots, which we did. They're filled. We showed that we can use more nurse practitioners, but no more [salary line] items are coming because there's no money.

MM: Let's talk a little bit about the development of psychiatric nurse practitioners, because that's very interesting. Could you talk a little bit about the different roles that workers can play, social workers, nurses, nurse practitioners? What kinds of roles do they play vis-à-vis the client? Why don't we have just one job classification, for instance?

SW: Right. Well, because each profession brings a certain expertise. Like, nurses bring the integration of medical and mental health. Social workers have a big background in family and social issues, more than nurses in terms of their education, so [social workers] bring that piece. Psychologists bring testing and looking critically at data collection [and analysis]. Obviously, they do clinical work as well. But, to me, [psychologists also] bring more of what you need [research] to keep your doors open. That's what I think. And a psychiatrist you have to have for [prescribing] the medicine, or you have a nurse practitioner for the medication.

But all those people on one team gives the client more depth to their service. Any one, a social worker could have a caseload and do individual case management and do a great job. But if the social worker's on a team, no client ever comes in the door and is told, "Oh, your worker's on vacation, come back in two weeks." [With a] team, "Oh, we'll get somebody to see you today."

And we conferenced. Every single morning we had a morning meeting, so that everybody knew what everybody else's clients were about, or what was important that day. Or somebody would say, "I've got two clients. One to go to Social Security and one to do –" "Oh, I can go to Social Security because I'm taking another [client]." "OK, great. You do that." They split up the work.

And then the families came to the case conferences, I think it was weekly, that concerned one client. We would conference one client, and his family would be part of the team and they would come. Sometimes the family was the board-and-care operator. That was the only family the person had. Or another client. Whoever you want. This is your case. You're not a case. Dick Elpers [said], "Nobody wants to be a case and nobody wants to be managed." So this is your time to come in and talk about what's going on. We would hear from the board-and-care operator, "Well, he's not eating or



he's not bathing," or whatever, and we could [ask], "What's going on?" and kind of address the issues that we couldn't see, if we stayed in the office.

The field work, I think, was another really important thing. We had a client that didn't feel well. Every day [he said], "I don't feel good, I don't feel good. I feel worse." The doctor could see him getting sicker and sicker. She sent the social worker to the board-and-care to pick up the client's meds and bring them in. "Let me look at every medicine, [the doctor said]." Well, [the member] had been in the hospital and the pharmacy had made a medication error on his discharge. Instead of Paxil [paroxetine, an SSRI antidepressant], they gave him Lasix [a diuretic]. So he was losing fluids for two weeks, getting sicker and sicker, and we wouldn't have discovered it – Well, a board-and-care operator isn't trained to know. I mean, a family member might not know. But to bring all the meds in and have the doc look at – that was the social worker. If the nurse had gone out, maybe the nurse wouldn't have had to bring the meds in, she could have just said, "Oh, wow." But the social worker was faithful and brought those meds in.

Many time, [members] would be hospitalized. The doctor in the hospital would discharge them on Haldol [haloperidol, an antipsychotic drug]. [But, in addition,] they were getting Haldol [prescribed by] us, so they were being double-dosed. And the board-and-care operator faithfully [did as instructed]. "You said to give him one of these each day." Until we would look at the meds – and having a team that could do that. "Oh, if you're at that board and care, can you check my client's meds?" It was a simple thing.

MM: You would think it was simple.

SW: Well, for us it was. A lot was simple. The other thing was documentation. We documented hours and hours of time spent. But you really had to justify your time because if you spend two hours with a client, well, what were you doing during those two hours? Well, part of that time we were discussing this, and then we were assisting him to integrate into the community by learning how to shop at the supermarket and teaching him about his meds. We had to learn how to document, so that it was reimbursable. A lot of time, if you didn't document it right –

MM: Yeah, you wouldn't get paid.

SW: That was one thing. I wished that we had gone back to block grants, where you just got this lump sum of money. The Village came in on a grant from the state, and they had all this money, and they spent it, and they showed results. When that grant money ran out – Everybody wanted to be more like the Village. We all wanted to be [able to document services] like the Village [staff did]. Why can't we be like that? So what did the wisdom of the day do, they made the Village [operate] more like us and [the providers there] have to bill now for every minute of time. I always felt like – That's what our managers had to work with; but the state was making those decisions about grants or billing Medi-Cal for every minute.

I don't understand it as well as I should. So I have my opinion and that is that you shouldn't have to sit there and document every minute of time. You should be able to show that this person used to be in the hospital twice a year. Now he's only in once a year, and soon he'll not be in at all, because of our services. He lives in an apartment.

MM: So you were part of the Mental Health Services Integration Committee at Harbor? Can you tell me a little bit about that?

SW: Well, that was integrating Child and Adult [Programs]. What we did was bring the Directors of the Child and the Adult Programs together, and a couple other people and myself. When children would turn eighteen, they were no longer eligible for services in the Children's Clinic. Many times, a good discharge plan wasn't there. Or they would just say, "Go make an appointment in Adult [Outpatient Programs] and start getting your services from Adult."

So [the Integration Committee] talked about when the person turned sixteen, identifying all those sixteen-year-olds. Make a plan for what they'll be able to do when [discharged from the Child Clinic]; and if they need to transition to us, or if they don't need mental health services, maybe they need social services, or they need a Section 8 apartment, or they need employment services, or they need a job. Because the ABLE employment services were only available to ABLE members, not to others. So that was another reason why there was some animosity there. They weren't happy with that. But we had to limit our services to the people that were in the [ABLE] program because we didn't have that many staff that we could just see everybody. I wish we could have. I wish we could have been more like the Village where you just take all comers. So that was what that [Committee] was about, integrating Adult and Child, even in that two-year period, maybe even having joint family meetings with doctors from the Adult clinic to get to know the family. Everybody [would] participate in making a plan for this kid.

Oh, we had to have the [office] manager [on the Integration Committee]. She had to do with the resources and the billing and everything, because once they left Child to go to Adult, there was a different reporting unit and the money was billed [differently]. The case actually had to be open in both [reporting units] for those two years in order for that doc to get credit for units of service, productivity, by coming to these meetings with a child and a child's family. [Child Clinic staff] have to be on [Adult Clinic] books. We had that at [Augustus F.] Hawkins [Comprehensive Mental Health Center, at Drew Medical Center in South Central LA], too, when I was [managing] the Crisis Unit there. If we didn't have a doc, we'd have to go get a doc from the Outpatient Clinic, so we had to open [that doctor] in our [reporting unit], so that when they did work, the payment would come, which was a lot of paperwork. That's what we had to do to make sure the billing could happen. Because I know that's important. I would never discount the need to bill [for] a client.

MM: Right. It has to be done. And the Indigent Medication Program?

SW: Yes. After I left Harbor completely – I left the ABLE program and went to the Adult Outpatient Services and tried to kind of bring them into the Department of Mental Health and make sure that the charting was done and the billing was done, for productivity. Then I moved to Dr. [Roderick] Shaner's office downtown. [Dr. Shaner was Medical Director of LAC-DMH at the time of this interview in 2011.] I moved into the Pharmacy because he had this idea of getting free medication from the drug companies for patients who didn't have any funding. The plan was to have free medicine from the pharmaceutical company while we were working on benefits.

MM: To cover that.

SW: Yes. So here's this patient taking this med for free, and then, [once benefits were established for this client,] this pharmaceutical company has a paying customer for the rest of his life, so it behooved them to give [the clients] medication [while benefits were being established]. [The pharmaceutical companies] do it – I had to do that with my dad. He was on a medication, he had a low income. So Zeneca [Astra-Zeneca, a

pharmaceutical firm] at that time gave him free meds until the med was no longer experimental, I think, and then the insurance company paid for it. So I knew what the situation was.

I set up [the DMH Indigent Medication Program]. I developed a training program and slide show for all the clinics. I went to every clinic and showed them how to apply for the meds and why it was important that we do that. Because our costs – people who didn't have insurance, Medi-Cal, Medicare, anything, the money for their medicine came out of the County General Fund, and it was millions of dollars. I think that's still the same way today. Or there's no County General Fund now, so where does the money come from? But the big push was to establish benefits for these clients. Of course, they're eligible if they've been sick for a long time and they're on the streets, or whatever.

Then I had to set up a [Countywide] system of getting free meds from the pharmaceutical companies. Rather than go to individual clinics, we centralized it and [the medications] came to the [DMH] pharmacy. It had to be logged in and put into the IS so that when the patient went to the [provider], we actually wrote a prescription, the doc in the clinic wrote a prescription; the patient went to the [DMH-contracted] pharmacy, the pharmacy gave them the medicine, and then we mailed the free medicine to the pharmacy to replace [that]. It was a replacement program. That's how it worked. We had to set it up so that [the contract pharmacies] didn't bill us. They would go ahead and just give the medicine. That took a lot of work, with the pharmacies. Give away meds and not get any money for it. But [the pharmacy was] going to get the medication in its place.

I just did it for a couple of years; and the next person who came along really took it to a new level and they're saving millions and millions. We were happy; the first year I think we saved three hundred thousand dollars, which was small but over time, [adds up] to millions. So that's what I did for Dr. Shaner. I did, again, the leg work; [I was] the leg man and not the idea person. If I hear an idea, I can take it and expand it, but I don't always *get* the idea first. Somebody else gets it and I can operationalize. That's why I call myself a program developer, because I can take it from scratch where there's no program at all, and the next thing you know there's a program that actually works.

We had to hire staff – it was just me at first, and then we were saving enough money that we were able to bring in staff that went out to clinics one or two days a week and helped them apply [to the pharmaceutical companies for medication assistance]. We had a system set up, for how would the doctor even know to sign the application form. We set all of those things up and it's still going today.

MM: You did some work for Hawkins? They have had so many problems.

SW: [DMH] decided to do an Urgent Care Center [at Augustus Hawkins], a UCC, and I said, "I want to be in charge of that. I want to do that." I actually had to sell myself. Nobody thought of me. But I said, "Look. First of all, I have tons of inpatient experience, so I know how to work with hospitals. I have tons of outpatient experience. I know our system, I know how to bill; I know how to do assignments. And I have the rehab experience from the ABLE program, so I know how to try to connect people to the services that they need in the community." So they said, "Oh, OK, you can do it."

So I went over as the Director and I hired all the staff. They gave me two supervisors, a night and a day supervisor, and then the rest of the staff was hired [by me]. [The UCC was operational] twenty-four hours a day, seven days a week. We set it up. Hired a psychiatrist and a nurse practitioner, and together they did all the meds and med evals.

And [UCC staff] would communicate with the Psych ER in the hospital every day on [which clients] would be appropriate to send down to Urgent Care. Urgent Care was for twenty-three hours. You couldn't keep anybody longer. We had chairs, we didn't have beds. People would sit in the chairs. But we had showers and we had good food. We would order meals, breakfast, lunch, and dinner, and snacks. And [we had] case managers who could [send] people to shelters if they lived in – "Weren't you here yesterday? Where'd you stay last night?" "In the bushes right out there."

And [we] tried to find ways to keep – again, to relieve the burden of the Psych ER because, without outpatient services, that being cut, people would just get really sick. It happens in medicine, too. [Patients] just overflow the ERs. And the medical ERs are complaining because a lot of psych patients come in there and they have no place to send them.

MM: Sure. Where are they going to go?

SW: Where are they going to go? So there were resources in the community. The nurse practitioner went up to the [MLK] Women's clinic, and she formed relationships with them, so that when someone would come in [to the UCC] pregnant or with a women's problem, we'd take care of the mental health. Then that person, if they were referred by us, they would be seen right away [in the Women's Clinic] and be taken care of. We'd get a call, "Yeah, we saw her and this is what we did." So that there was some connection, some continuity, I should say.

What happened was that [the AFH-UCC] didn't get enough patients. And we were limited. At first, we could only take patients from the Psych ER, and sometimes those patients were just too sick for only twenty-three hours more of care. So then, finally, we were allowed to take patients from the PET teams, the PMRT [Psychiatric Mobile Response Teams], and from the local clinics. When I left, I retired, that was just starting to happen. So the numbers were coming up, but apparently they weren't up high enough, so it's not there. I mean, there's a program there, but it's not a UCC. They're setting [a UCC] up at Olive View [Medical Center in Sylmar, CA].

I'm going to pull all my stuff from the [AFH-UCC], because I have tons of material just like this that I can send to the new director at Olive View; and she can delete it or she, or he, can use it. How to schedule your staff, and how to cover the weekends, policies on keeping the medicine room locked, and things that hospitals know, but outpatient clinics don't always know. That was it. We had to integrate an outpatient service in an inpatient setting.

MM: Again, that has advantages, because they can provide the physical healthcare as well.

SW: Right.

MM: Which is such a big problem.

SW: Those [AFH-UCC] patients were really sick. Those patients were the sickest, I think. More homeless than I'd ever seen, even when I worked on Skid Row [in downtown Los Angeles, a center for the city's homeless]. I thought the patients were sicker at Hawkins than at Skid Row. And everybody [that we saw was] homeless, most everybody. Still, on Skid Row, there are tons of services down there so they can access services. There are some services out in the Willowbrook area [in South Central LA], but I guess not as many. That was a great job.

MM: It sounds like it. You kind of miss doing all this, don't you?

SW: I really miss it, yes. I had a hard time retiring. I would not be retired if my husband hadn't said, "You *will* retire. We *will* move to the desert." OK. I want to live with him, so I guess I'd better go. But, no, in fact, I'm not retired. When this job ends, [training the] nurse practitioners, I have another job [as a Clinical Nurse-Specialist at San Geronio Hospital in Banning, CA]. I'm working every Monday. I'm doing psychotherapy, which I said isn't as useful [for people with severe mental illness]. But I'm identifying clients that I think could work, so we've got to find grant money to hire somebody to do some job development for these people. I mean, psychotherapy is good; it structures clients' days and it helps them think. And it keeps them out of the hospital. That's all they get is psychotherapy and they stay out of the hospital.

But there's a big connection between that program and [the] board-and-care and the doctor and the medicine and the physical health care, which is what I want to do, is do a family – what's it called? Health Home or Medical Home [the concept of a primary care base for every patient to access comprehensive services, first introduced in 1967, but given new currency by the AMA, American College of Physicians, National Committee for Quality Assurance, and other major professional organizations in the 2000s], the new –

MM: Oh, yes, Medical Home.

SW: The government. Let's do a Medical Home here [in Banning] for these clients, and that way you'll have that; because of John Cheng [the Family Medicine Fellow] and the ABLE clinic and the psychiatrist working together, [the clients] just had better care. We can repeat that. So we'll see.

MM: So has your thinking about mental health clients changed at all over this interesting and long career? Do you see them as more able to live in the community than you did before, or have they surprised you in any way?

SW: I wasn't totally surprised because I knew that the Village was putting people to work, and that was the first time I'd heard that concept. I'd always worked in outpatient clinics that just did mental health services. [The ABLE Program] also actually had a connection with the [State] Department of Rehabilitation. I got an establishment grant, and somewhere in there is that proposal. So they sent [State] Rehab [staff] to the ABLE Program to interview clients and [connect] them with the Department of Rehab and help them find jobs that way. That wasn't as successful as I would like either, but at least we did it. I was a little bit surprised.

But actually, I think Dr. Elpers was an inspiration to me because he never felt that anybody couldn't do something. If they say they want to do it, then we ought to just help them to find the way to do it and not think about, "Oh, they're so sick." Sick people will get better if – I mean, if you have a class on how to interview for a job and you have a psychotherapy group, which one is the client going to pick? They're probably going to pick this [the job group], because that's what they want. Even though psychotherapy can help them become stable enough to get a job, they're going to pick the rehab group that puts them in touch with employers.

Like I started to say, [ABLE staff] did speeches with the Chamber of Commerce, Lions Clubs, and asked for jobs. We actually said, "Here's our phone number. If you need somebody, just call us." That was kind of a bust, too. The private sector was, "Oh,

too much liability. We don't want those mentally ill people." But I think if we had kept at it longer, we might have gotten more jobs [for the members].

So no, my thinking in terms of their ability has changed, because I've actually seen them, in the later part of my career, do more than I saw [them do] in the beginning. But my love for them has never changed. I feel corny saying that on the tape, but just recently someone from my husband's high school days was out for lunch and he was asking me about my work, and he said, "Don't you ever get sick of working with those people?" And I said, "Never. Never." And he was like taken aback, but that's just what came out of me. I feel like they need us, they really need [us]. When you look at need, they're the most in need, so they should have the most services to get them to being less in need.

MM: Good for you.

SW: So I shall continue until I can't do it anymore.

MM: Do you think there's anything – I mean, stigma persists. We've made big steps forward, but it's still there. I mean, what would you recommend if someone said to you, "OK. Here's some money. Design a stigma reduction program."

SW: Well, I've been thinking about that. I think that the way that the State of California addressed the smoking problem, they put big commercials on TV and they showed people with tracheotomies [airway incisions] and we really have brought down smoking in the state of California. I'm no writer, but there should be some public service announcement way of showing mentally ill people at work. I've seen this in films, but I don't know if the public has seen it. Or you've got to educate people because they don't – I think the average person doesn't want to be stigmatizing, they just are.

I mean, my eleven-year-old grandson came home from junior high and he was taking about, "Oh, there's a 'retard' in my class." "Well, now, let's talk about that." When he was little, he had a G.I. Joe that the arm broke off and he says, "I'm going to throw this away and get a new one." I said, "No. This is a disabled toy. He has only one arm and he can do more with his [remaining] arm." And that kid kept that doll for a long time. "This is my disabled toy." But even though I did that, I still hear him saying things that his peers say about other kids. So it's not going to be easy.

Dr. Miller had the vision of building a psych building on the grounds at Harbor, and he had architects come in and interview all the staff. And I said, "When we build this building, there's gotta be a little café, and the clients have to run it and work in it, and then we can have lunch there." One of the architects said, "You don't want to eat with your patients," and [had] this real look of disdain on her face. "Why not? I do it every day." We had a big lunch table [in the ABLE Program] and I'd bring my lunch over [from the cafeteria]. You learn more about [members while] having lunch, and you can do teaching, like Bob Liberman at UCLA [Professor of Psychiatry, who teaches courses in Independent Living Skills Training and Psychiatric Rehabilitation]. If you see somebody chewing with their mouth open and food falling out, [you say privately,] "Hey, you gotta close your mouth when you eat."

So you can teach social skills and all kinds of things while eating with clients, which I do. In my new job, all the staff sits at one table and the clients sit at another table in the lunchroom. I said, "I'm going to go sit with the clients." Well, there's this boundary thing. When you do psychotherapy you have boundary issues, so they don't let me do that. We should all be sitting at the table with them. Maybe one day. Introduce the idea, plant the seed.

But that's what I think would work on stigma. I think that would be a good thing. Public service announcements [on television]. Education about what people do, what they can do, and how they feel. One time I said, "Oh, that poor family." How they must feel. All [of their] successful sons and daughters were doctors and really prominent people, and they have this mentally ill son who's really, really sick and disheveled and dirty all the time. I said, "Those poor people. How they must feel." And Dr. Elpers said, "Think about how [the client] feels, being a member of that family." So he really helped me with my thinking. And he didn't do it in a formal way. It's just kind of being around him and hearing him say things about the way he thought, that people could reach their full potential, that I have to give him that credit. He inspired me in that way, and taught me.

MM: So one thing that we frequently ask about is the difference between contract programs and directly operated programs [that is, non-profit clinics that provide care under contract to the County versus those operated by the County directly and staffed by County employees]. I mean, you've been working for the County all this time. What is it the County can do that the contract providers can't do?

SW: I'm not sure, actually. I've thought about it and I've always thought we shouldn't have contractors that aren't County employees. You hire the best people and then you provide the services under the County umbrella. But I do admire a lot of the contractors. My issue was always that they were more free to let people go [fire staff]. Your whole program depends on the heart and the goodness and the work habits of your people, and if somebody's not making it, the County can't [fire them] – you can try. Whereas, Martha Long, somebody would say something disparaging about a patient, the next day they're gone. She was firm about that and taught her people to be open-minded and not express things that were negative about a client. Or they had [better not] come to work.

I was lucky because the people who came to work for ABLE were all people who really wanted to do it, because they were subject to this kind of negative thought about the ABLE program, and they came anyway. So we didn't have any turnover for eight years.

I'm not a good person to ask about what the County can do better than the contractors. The point of contracting is to save money. You contract out services. And that goes for dietary, whatever. But then you run the risk of not having control over that program, and you hope – Luckily, the [contractors that joined] PARTNERS all have really great leaders that were believing in the philosophy and set up the PARTNERS programs.

So I really have no complaints about them, except I have to complain that they didn't really do twenty-four hour services. The PET team saw their clients at night, whereas we [saw our own]. If you see somebody [in an emergency situation] at night that you've been working with all week, it doesn't matter how sick they look, you may be able to get them home instead of hospitalizing, and [if] they see somebody they know, that makes a difference. But a stranger comes to do an evaluation and – I've been that stranger. I've done a lot of PMRT. You do the best you can, but you don't know this person and they don't know you. So you do the best you can. But [ABLE staff prevented] a lot of hospitalizations by doing our own after-hours [crisis services]. That's a minor thing. I think they did a good job overall.

MM: You've mentioned Dr. Elpers several times. Is there anyone else you would want to mention as being particularly influential or having taught you something that you consider important?

SW: Paul Arns. He's another one. He already had the rehab philosophy down pat. He didn't have to learn anything. He came, knowing all of that. And he's a genuinely good person. I learned a lot from him about treating people just as naturally as the day is long. You don't act like you're better than them, or you have a PhD, so you're smarter, or any of that, because you're not. His "way of being" influenced me, I think, and he's really – I always say I'm the president of his fan club because he's a good person, and he won the National John Beard award, from the Psychosocial Rehab Organization, [for] Young Researcher of the Year. [From] the whole country, they picked him.

And he really worked on the tool kit, the assessment tools to determine social connections and – there are so many categories, I wish I could remember, but it was a tool kit to assess people in real time, [and] their progress as they got better and better. We borrowed it from IAPSRS, International Association of Psychosocial Rehab Services. They've changed their name now to USPRA [United States Psychiatric Rehabilitation Association], but it used to be IAPSRS. He was on the committee to develop the tool kit, and he never said this, but my guess is that he probably did it himself. I'm sure he had a lot of input, but I think he was the driving force. We were using it at Augustus Hawkins when I left, so it's the tool kit, the assessment [Caminar, available now through Behavioral Health Services, Inc.].

[Another important colleague was Dr. Karl Burgoyne, the first Medical Director of AMI/ABLE. We worked together daily for four years before he transferred to a leadership role in the DMH Adult Outpatient Program at Harbor. He came to ABLE straight out of his Residency at USC, and actively campaigned for the job. Karl had a genuine concern for the difficulties faced by the members, and that concern came through in a very healing way. Karl was one-of-a-kind, in that he saw members in their homes, board-and-cares, or anywhere they were in the community. In good weather, we would take everyone to Cabrillo Beach in San Pedro on a Friday afternoon, where the members and staff played volleyball. Dr. Burgoyne would see members individually, doing med evaluations and writing prescriptions as needed. He also went out on some emergency calls in the evenings with staff, and was available to the on-call staff by phone at night for emergencies. The members, especially the young men, confided in him and he was able to help them with their most private concerns. He attended our social functions with the members and holiday dinners on the holidays. Karl often joked that he was writing a training manual for community psychiatrists on working with people in unconventional ways. I often wish that he had actually written the book, but he did influence every psychiatry resident that came through Harbor's program.]

MM: And you worked a lot with people from NAMI.

SW: Talk about inspiration. I wasn't going to forget this. Richard and Teal Dennen, Sandy Sternquist, Monty Sternquist, [members of the NAMI South Bay Chapter that worked with us to establish the ABLE program and continue to work with ABLE to this day,] all those parents that had been dealing with a mentally ill son or daughter for twenty years, thirty years, on and on, and just never saying, "Oh, I can't be with this son anymore. He's not my son anymore." They just kept on. During the worst times and the best times, they were the parents, they were trying their best. They would go to any lengths within their means to help. Those NAMI people were not only inspiring, but they were so supportive. They were very comforting people.

My son had cancer during that period. He's better now. But they just flocked to me and said, "How are you doing?" and, "Are you OK?" "I cooked a dinner, here's extra for your family while you're going through this." It was amazing. They were just – but



they knew what it was like to have an ill son or daughter, so they just made me always feel like I was really important. I like people like that, who make me feel important. (chuckles)

MM: That's great. That's really nice to hear. So what else would you like to tell me about? Is there something else that we've missed?

SW: I don't think so. I've rambled in some ways, on and on.

MM: Everybody rambles.

SW: I'm so enthusiastic about it, and I've loved that piece of my career. I can't think of anything specific. If I think of anything, I'll just send an email and you can use it.

MM: You can also add it to the transcript. We can incorporate it.

SW: Yes. It's been a great career. The Department has been a good place to work. Some of the best people in the country, I think, work for the Department of Mental Health. And all that talk about County employees, it's just not true. But I was lucky to be at Harbor, which *is* an academic institution, and the setting was very academic, and that was inspiring. I did a lot of literature reviews before I wrote the [ABLE] Program description. I learned about literature review. Even though I [studied] it in my master's program, I re-learned about it.

MM: But you really learn about it when you're doing it.

SW: Yes. And then being able to travel around and present [papers]. We took two clients one time – Dr. [Karl] Burgoyne [LAC-DMH Director of Critical Care at the time of the interview] and myself, Ken Miya [former Director of Development at Telecare, and before that, the Director of the DMH Intensive Case Management Program], and then two clients, to Texas to a NAMI national conference. NAMI paid [the expenses] for one of them and somebody else paid for the other client [to go to the conference], and Dr. Miller found a way to pay for [me to go]. We went out to dinner at a regular restaurant. We're all sitting there and one of the clients says, "I'm going to have a Margarita," and someone (who was a friend) who was there, said, [whispers] "Are you going to let her drink?" I said, "She's an adult." Any adult that I'm with who over-serves themselves, I'll be talking to them about it, but as long as – She just said, "I'm having a glass of wine."

So we had a chance to do a lot of normalizing kinds of things. One of the clients brought a clock radio [on that trip], because he didn't know that hotels had clock radios. He'd never flown on a plane before. Frank Compton [former client of the DMH Intensive Case Management Program and later an employee of the ICM] wrote part of our article in there [the CAMI (California Alliance for the Mentally Ill) *Journal*], so you'll get to know him. Fabulous guy.

[I also wanted to highlight the fact that we developed relationships with Board and Care operators that were in our South Bay area. I particularly remember Homes for Life, directed by Carol Liess [Homes for Life is a non-profit foundation founded by Liess in 1985 to build a network of permanent, affordable housing for the mentally disabled in LA County]. Some of the ABLE members and I appeared before the Los Angeles City Council to speak on behalf of Homes for Life when a neighborhood protested the development of housing for people with mental illnesses.

Because we had so many of our members in each [local board-and-care home], we were able to find homes for members that did not have favorable histories, e.g., a history of violence or jail. In other words, the [board-and-care home] operators appreciated our business, and accepted clients that other B&Cs would reject. We kept their beds full and provided 24 hour availability of crisis services for our members. We cannot underestimate the importance of the 24 hour access to services that was provided for ABLE members. That program component helped the members to remain in the community.]

MM: That's cool. Amazing. We usually ask people at the end, What is your vision for mental health in California? What would you like to see happen?

SW: Well, I'd like to see more programs like this. This program required years of expense [as an enrollment criterion]. I think if they did it with First Break clients [that is, clients experiencing their first episode of mental illness], that you might shorten the course, or at least ameliorate the course of their illness. I talked about this with NAMI and they said no, because parents at the beginning never want to believe that their son or daughter is going to be in the system for very long. "Oh, this is just a temporary thing."

But if there were some way to do it – and I think there have been some programs with First Break [clients], but I don't know if they were as intense, with all the services and the community reintegration. We helped people go to college, we helped them apply and sign up at the Disabled Students office, and take courses. And I think one of all those clients ever graduated from college. But we went to her graduation.

So I think the younger you intervene, the better. I think that. Having more programs like this earlier, and then the integration of physical and mental health. [A client is] a whole person, so people have to look at their physical health. And if you intervene early – again, with diabetes and all those things, we give them diabetes with the medications that we prescribe. So therefore, shouldn't we be addressing that? So I'd like to see that.

And more education. More slots for nurses, nurse practitioners. It's very expensive to become a nurse practitioner, I found. When we discontinued the tuition reimbursement, we lost a lot of nurses [in the PMHNP programs at the local universities]. But the State has done some grants, and I hope they're going to do another one. But then, those nurses have to find jobs within three years, I think, in a public agency. And we're out of jobs. We filled all our [PMHNP] spots. So, as our people go through these programs, they'll probably have to go to northern California [in order to find PMHNP jobs].

MM: They have to leave the area.

SW: The areas that are under-served [are in Northern California]. So, yes, I'd like to see more money spent on educating people in the rehab piece, but also in the integration of physical and mental health. I'm not a politician. I have pipe dreams. I don't know if I'll ever see a commercial or public service announcement about people with mental illness that are just like you and me. Their goals are the same.

MM: OK. On that note, we're going to conclude this interview. Thank you very, very much.

SW: You're welcome. I enjoyed it.

END OF INTERVIEW