

INTERVIEW WITH CATHY WARNER

MM: OK. Good morning. It's March 11th, 2011, and we're here talking with Ms. Cathy Warner, who is the Deputy Director –

CW: That's correct.

MM: For ASOC [Adult System of Care]. And you probably have a couple of other titles?

CW: Good morning. I am the Deputy Director and a licensed clinical social worker, here in the Department of Mental Health, overseeing the activities of the Adult System of Care.

Actually, I grew up in Boston. My father was a physicist, my mother a schoolteacher. But my mother also had problems with depression, so there were times during my childhood where she would be hospitalized and disappear for a period of time. I found that confusing, frightening, and one of those experiences that makes you feel different from some of the other kids. So that was clearly an influence on me when I grew up. Remarkably, my mother was someone who continued to work full time as a teacher and was an amazing teacher, working with disabled children.

My family moved to California. My father started a company in San Diego, so we moved here my last year of high school.

MM: That's kind of traumatic.

CW: Yes, it was a little challenging. I wanted to stay back East with my friends, and had families that were willing to keep me there. But my father was very keen on the family staying together, so we moved to San Diego. I'm the second of four children, the only daughter. My older brother had just finished at Georgetown, which had been very expensive for my family. So my dad told me I would go to the little school on top of the hill, as he called it, which was UC San Diego.

I went there and got a bachelor's degree in psychology. It was experimental psychology at the time. And then I met my husband. We were married in August of that year when we graduated; then we headed back East, because I loved the East Coast. [After that,] I helped him apply to medical schools and worked to put him through medical school [at Dartmouth, in New Hampshire].

He matched here [to a medical residency] in California at UC Irvine, so then I began commuting to San Diego State, where I got my master's in social work. So we lived up here. I had a Volkswagen that had been rusted out after three winters in New Hampshire. No radio. No kids, luckily, yet. So I traveled down there.

I finished my master's degree and began working with the State Department of Mental Health. I started on the Inpatient Unit at Metropolitan State Hospital [in Norwalk, California, with 825 beds, the only state psychiatric facility in Los Angeles County as of 2011].

MM: You made a career change, though, here. You had been sort of headed towards medical school.

CW: No, no. My husband. Never me, no.

MM: But you were in experimental psychology.

CW: Absolutely, yes.

MM: So what motivated you to go into social work?

CW: Well, I'll tell you; that's a great question. When I was at Dartmouth, I was working to put my husband through medical school. I got to work at the Dartmouth-Hitchcock Mental Health Center [in Hanover, New Hampshire] as a secretary.

All of a sudden, I began meeting, not only the residents doing a specialty in psychiatry, but for the first time, I met a woman by the name of Anita McCafferty, from New Jersey, who was a social worker. I asked, "What's that?" And I saw she was doing therapy with children. I said, "This could be an opportunity for me." I was in my twenties by then, married, and [it was] only two more years. So when my husband did the [residency] match program, I was applying to graduate school. So I ended up going into social work school, thinking it would be a great degree. And it has been. It has been an amazing, door opening profession.

I worked at Metropolitan State Hospital [in Norwalk, CA]; and then in 1986, the State Department of Mental Health ended those programs. It was called the Office of Mental Health Social Services, or OMHSS. There's a few of us old-timers left.

I came over to the County [Los Angeles] then, and I've been here – in fact, Dr. Southard gave me my twenty-five year paperweight this week. [Dr. Marvin J. Southard was named Director of the Los Angeles County Department of Mental Health (LAC-DMH) in 1998 and continued to serve in that position as of the date of the interview in 2011]. So I've been with the Department now twenty-five years. I don't know if that answers the first question.

MM: OK. When you started working, you were in Mental Health Services, and you had had this earlier experience with your mother, but had you thought much about – I mean, did your perspective on working with people with mental health issues change as you began work?

CW: I think definitely it changed. When my family moved to California, my mother had another breakdown, and the San Diego School System, unlike Boston, did not let her go back and teach. So it was very traumatizing for her. At the same time, as I mentioned, I had two younger brothers, and Peter, my baby brother, was diagnosed, at first with depression, but it became bipolar illness [alternating episodes of depression and euphoric hyperactivity]. And he had terrible problems with substance abuse. So my mother was depressed; he became ill, and she spent most of her time trying to get him to accept treatment, and really struggled with that. It was very sad. My brother passed away. He really blew out his liver and died in his early thirties.

My mother never recovered from that and she became more and more really removed and – it was very tragic. Three to four years after he passed away, she passed away. She died way too young, in my opinion, as I approach her age that she passed away.

So I think early on, to be totally candid, when I saw mental health problems in my own family, I felt I needed to arm myself and get as much knowledge as I could so that I would maybe be cognizant for when I was going down the same road. So it's probably kind of selfish, or protective. I wanted to learn everything I could about mental health.

When I was working as a secretary and met a social worker, I began to love the work they were doing. I was the one who would type up their progress notes and their

case presentations, and I really began to value what good things could come in working with a family.

I had, truthfully, a sense of shame about who I was and where I came from for many years. So even though I was in mental health as a young social worker, I would not have talked as openly as I am today. I kept all of that buried and very close to my heart, but very unrevealed to people. I think, for me, I had a few trusted friends in the Department who knew [what was] going on. It was 1984 when my brother died. I was working here in the Department. Following his death, I got very involved with NAMI [The National Alliance for Mental Illness, a family-based advocacy and support group founded in 1979] and the Consumer Movement coming forward, and I slowly began to come out of the closet. I thought, "My goodness, here I am, I should be championing this cause." So now I share my story, probably quite openly.

So things have certainly changed, and those experiences really have, I think, been such a gift for my life, because, through having that in my personal family, I think I have always had a special relationship with our clients. I never lose that. I meet with them all the time. I value their contribution so much. So I think that's really been a sad but a good blessing in my life.

MM: OK. I know when you first started – Well, tell me if you thought about this. You started working for the state and then you moved to the County, so you were always working in the public sector. Did you think at all about looking – I mean, as a social worker, there are different options, but was that what you thought was the way to go, to work basically for the state?

CW: Well, it's funny you bring that up. It's a funny interview, because I'm thinking of things that I haven't thought about in a long time. I began to have a family back when I was working with the State. I left in, as I said, '86, so by then I'd had two children. I decided I should probably do a private practice, so I did spend a couple of years working evenings and weekends in Orange County with a group of other therapists, doing some family therapy. I found that work very isolating, to be candid, because you shared a space and you would come and go, but there was not the shared mission that we have in public community mental health. And I got quite lonely during that.

Also, my husband's a nephrologist [specialist in kidney medicine], so for a period of time I did medical social work at UC Irvine, part-time for awhile, when my children were young. That was rewarding in the sense that you were really helping people get benefits, get the quality of their life as good as it could be. But it wasn't my passion. So when the opportunity came to go full time again with the County, I was thrilled.

MM: You worked quite a bit with people with HIV as well.

CW: Yes.

MM: Can you tell me a little bit about that, about what kinds of services you were offering? I mean, HIV was a relatively new thing at that point.

CW: It was. And when it happened in the eighties, Elsie Go Lu, who was a former Deputy Director, submitted a grant proposal and got monies that came forward to do HIV mental health services. So it was in probably '96 to '98 [that I started]. She got this grant in the eighties, and it went forward. What she was doing at the time the grant started was a day treatment program for people living with HIV AIDS [AIDS, or Acquired Immunodeficiency Syndrome, first recognized in 1983, is the fully developed

autoimmune disease suffered by individuals who have been infected with HIV, Human Immunodeficiency Virus]. And people were really so different than today, so sick and dying. That day treatment program eventually morphed into providing not just day treatment, but case management and mental health services, and really, part of the grant was not just for the Department, but we had two subcontracts. So we had monies going to APLA [the AIDS Project Los Angeles, founded in 1982, provides prevention, advocacy, and patient support services] and the Gay and Lesbian Center Social Services Center [Los Angeles' Gay and Lesbian Center was founded as an advocacy group in 1971], which we still have to this day.

So when I was asked to take over that job, I think Ambrose Rodriguez was our Assistant [Director]. I think that was his title. Anyway, he asked me to come to Hollywood. Now, you know I live in Orange County. So I came to Hollywood. Hollywood Mental Health [Center] was a brand new building back then, and I had an empty office. The program had really shut down.

I got over there, and the former manager of the program had just decided to abruptly leave County service. So no staff, just some boxes in a room. I had a wonderful experience because I was reporting then, below Ambrose, to Dennis Murata [now Deputy Director of the Program Support Bureau], and he kind of just gave me carte blanche and said, "Do what you want. Create something meaningful." And it turned out to be terrific.

I worked very closely with APLA, really got to know the community, which was primarily still in the Hollywood area. We did some very exciting things. We began HIV testing in the [DMH mental health] clinics. I was really proud of that. I built a team of staff and we identified based on the demographics of the illness what our high need communities were. So we did a lot of education, a lot of staff training, so that in the assessments across the Department, people began asking about sexual things in a way they never had. It was like "don't ask, don't tell" back then. It really opened some doors. I was very proud of that work.

After two years, Mr. [James C.] Allen, who had stepped in and became my Deputy [Director], said, "I want you to decentralize this program." It was very small. We had about ten of us, and they would be co-located. They would come in at Hollywood, but then they'd go out across the community, and then come back to home base. So then we moved those staff to different parts of the County. We still have the grant. It's not a lot of money. We still have the subcontracts. David Martin is still involved over at Harbor-UCLA [David J. Martin, PhD, is Chief of Psychology and Director of HIV Mental Health Services at the Harbor-UCLA Medical Center in Torrance, California], and we're still working with APLA. But the staff themselves are now embedded in some of our directly operated adult programs. It was a very good experience, and it did change some protocols in the assessment process. And then the whole illness has so changed. Now it's more chronic illness.

MM: We've been talking a lot about the integration of physical and mental health care, but it seems to me that you sort of were having to do that, weren't you? Because these people had to have lots of physical health care as well.

CW: Absolutely. We were working with all their healthcare providers at the time, really being the go-between between their mental health and physical health needs. Back then, we were offering transportation, taking people to appointments. Some of the stuff we talk about now under Field Capable Clinical Services [FCCS; under the Mental Health Services Act of 2005 (MHSA), Field Capable Clinical Services are provided to mental health clients who are able to function to some degree in the community, but still

require ongoing clinical support] and the move that we're doing towards co-locating mental health staff in our health sites is exactly what we were doing. We had staff co-located at some of the foundations and some of the healthcare centers back then.

And then, like we're doing now, bringing the physical health, being able to test for HIV in our adult mental health clinics was totally new, and very exciting. I remember going for my HIV test; it was the [oral] swab. That had just happened, that we'd moved to the swab. And we took that on the road and had health providers coming to the Mental Health sites. That's kind of what we're trying to do now, as we move some of the Federally Qualified Healthcare Providers [FQHCs, community-based organizations that provide comprehensive primary care and quality for federal reimbursement] into some of our mental health clinics. It was kind of cutting edge, I guess. It was very cool.

MM: Exciting. OK. So talk a little bit about where you were going over the next few years, because for a while there you seemed to move to several clinics, one right after the other.

CW: I did.

MM: I don't know if that's unusual. It seems a little unusual.

CW: Yeah, yeah. I wonder why. I hope it was because I was doing a good job, but you never know. (laughs) I always tell people I think I have, truthfully, I'm been on almost every payroll title the Department of Mental Health has. I mean, I really have.

So I started as a social worker, and then I moved up. During the time I ran HIV, I wasn't the Program Manager, or Program Head as we call it, I was something called a Mental Health Education Consultant. I spent several years doing that. I ran day treatment programs. I ran Rio Hondo's Day Treatment Program. I was the Acting Manager at Rio Hondo [Mental Health Center in Cerritos, CA], I think prior to the HIV position.

And then after the HIV position, I was asked to go be the real Program Head at Rio Hondo, which I did for about two years. Then I got a phone call from Mr. Allen one day – I think it was a Friday, he was good at calling you on a Friday, to say, "You know Monday you're going to be doing something different." "Really? Oh, really?" So Rio Hondo actually, at the time, was under Dr. [Tony] Beliz [now Deputy Director for the Emergency Outreach Bureau]. So they called me downtown and said, "You know, we've got Steve Fishman retiring, who ran South Bay." Then they asked me to go over and run South Bay Mental Health [in Hawthorne, CA]. From there, I went to Long Beach Mental Health as the Program Head. By then I'd been promoted to Program Head.

And then from there, they promoted me to District Chief of Service Area 8. Then, for a brief period of time, [Chief Deputy Director] Robin [Kay] asked me to come down and be the Acting Older Adult Deputy [Director]. So I did that, and then I said, "Please send me back to the community." I loved the community. I really missed it.

So I went back to Service Area 8 as the District Chief, until about two years ago, when they asked me if I would interview for this job, and so I did. And here I've been ever since. I've been on this job for about two years. Anyway, I did move around a lot. I think that, actually, I'm quite fortunate, because if you look at those communities, I have worked with so many different populations. The clientele at South Bay Mental Health, for example, is so different from the clientele at Hollywood. I mean, really different.

I've been here so long, I've seen so many of the demographics change across the communities. Long Beach has changed tremendously. South Bay, which used to be largely an African American community, is now largely Hispanic. So you do see the new

groups moving in, others moving – and it's been fascinating, versus staying in one place. I think that was fortunate.

MM: So were there any particularly memorable experiences or programs during this period that you can remember?

CW: I absolutely loved running Rio Hondo, I have to tell you, because I had been a young professional there and one of the gang. It's unusual, I think, for someone then to come back and be the manager of the program. But I adored it.

We did some really, I think, amazing things during that time. One of the things I loved – it's a favorite memory of mine – is convincing the owner of the property that we wanted to plant a garden. We came on the weekend and he roto-tilled this yard and all the clients got involved in growing food. It was very cool. Then from growing the food to the harvest, and then to making zucchini bread and really sharing what we had grown with others. I thought that was a wonderful time.

MM: Wonderful. What a cool thing to do.

CW: It was, yeah, it was. A lot of my memories that I feel really good about, we started a program during that time at Cerritos College [a community college in Norwalk], at the Health Center. We were just starting to think about first breaks [initial psychotic episodes, usually occurring in adolescence] and young people that might have a mental health problem. And again, I went over and got to know the Health Director at the junior college pretty well. Mr. Charles Gale, I remember him. I said, "Well, they don't want to come to us, so we're going to come to you."

What we did is we co-located Mental Health staff in his Student Health Center, which was amazing. We would do some short-term therapies with them. And if and when we determined that they could use a psychiatric consultation, then they might come over and meet the psychiatrist. It was very cool and was considered the job everybody wanted, because it was so different, really, to work with that population than the typical chronically persistently mentally ill that we were primarily focused on.

The other thing I feel really amazingly good about is some of the work we did with our residential care facilities. I'm an old case manager, so my early days with the State [were] spent visiting clients in their homes, visiting clients at board and care facilities [small licensed residential facilities for 4-6 residents who require custodial care, but not skilled nursing]. Getting that system into our DMH system was a real goal for me, so I have terrific pride that I was able to move a few of the board and cares into becoming contracted providers with the County. And they still are.

I think some of the work they do – they are our unsung heroes. We've really moved away from what we used to have, in terms of really being out in our residential care communities, working with those staff and clients. We don't do that, and I think that's a terrible loss for us. As times changed – we used to have that program, the Supplemental Rate Program [terminated in 2004]. This was when Areta Crowell [Director of LAC-DMH 1992-98] was here. There had been a lot of family advocacy to give to our mental health consumers the same kinds of financial benefits that someone with what we call today intellectual disability would have, and they got more money. So the Supplemental Rate Program gave board and care providers, if they came under contract with us, additional money per month, to provide additional services to the clients.

So then my staff, people like me, people that were supervised by me then, would be out all the time working with the clients, making sure that people were really not living

their entire life in a board and care if they wanted to move on. So we had a couple of really good years with that. And when that funding ended – the State cut the funding – what happened is we utilized some County funds to keep a few of them with us and to make them legal entity providers. I feel really good about that.

That's the amazing thing about mental health. There's so many amazing things you can do. And probably the best thing about working for the County is that I have been so fortunate to do some creative things.

MM: Yes, it sounds like it.

CW: Yes. I've been very fortunate.

MM: Tell me a little bit about the housing. I've heard people speak very disparagingly of board and care homes.

CW: Yes.

MM: I'm sure, obviously, they probably differ a great deal. They aren't like cookie cutter facilities, but –

CW: Well, there are some that are truly [seen as] warehouses. [We still have some with] hundreds of people living there. It has an [83-bed] Intermediate Care Facility on the top floor. [Periodically, you will read in the newspapers about young residents placed in such programs who commit suicide; a recent example occurred in San Pedro where a young male jumped from the window of one of these programs] to his death.

But you're right. Board and care facilities – Well, first of all, we said back then they were places where everyone was bored and nobody cared. So there's a lot of truth in your thought that they are kind of warehouses, or places of last resort. But truthfully, as you know, it's sad but often true that many of our consumers end up in a board and care facility.

Even if you look at MHSA and the housing outcomes with this new funding, we still have too many people, in my view, living in board and cares, and without the supports in the facility – we used to train the board and care operators. We would put them through annual training on mental health to make sure their skills were kept informed. But we don't even see [such trainings provided any more]. [Yes, sadly,] we don't have very many housing options for people.

MM: That's the main barrier. There's just not enough housing out there. It's not that people are not capable of moving.

CW: Absolutely. Right. The contract that I spoke about at one of these board and care facilities actually got an award for this. It was a NACO [National Association of Counties] award, I think. What we did – so they got a contract and then we said, "We're going to teach people independent skills, so they can leave the board and care." Then I got the owner to find an apartment building in Long Beach. So we [located] this apartment building; it's over by Wilson High School and its [residents represent a] heterogeneous [group of people]. So it's not just all Mental Health clients moving to an all Mental Health apartment building. It's got college kids in it. It's a very normalized apartment building.

[The board and care owner] leased sixteen apartments over there. And we would help people get on HUD [low-income housing assistance from the Federal

Department of Housing and Urban Development]. But in the meantime, she was just charging them – she still does today – what they would pay if they *were* on HUD. So a couple of the clients from the board and care may decide, “Well, let's try the apartments.” They would use their SSI [Social Security] check and one third of [the check would go to pay for] the apartment. Then the case managers, the staff from the [former] board and care [site set up] activities out in the community. They'd drop in and make sure medications and [clients' ongoing needs] were being monitored [and met].

It gave people the chance, which I really loved, to be part of a community, close to the high school, close to Long Beach State [California State University Long Beach]. Some of the clients re-connected [to loved ones]. There's one gentleman [I remember so well] who re-connected with his son, and his son moved back from Hawaii and moved in with him, and they shared the apartment. I thought that was really great work.

That's become kind of that idea of master leasing. You know, you hear about that now?

MM: Mm-hmm.

CW: I'm really showing my age, by the way. (laughs) But you're absolutely right, we still don't have the housing we need for our consumers today. The facilities do range in size. One of the things we tried to do was to move board and care operators to purchase smaller facilities [to create] more homelike [settings]. So four - and six-bed facilities became quite popular back then. And then we really [encouraged the smaller homes to take young, often] first break kids. [I did one of these programs with youth in Norwalk] – it became a great little project.

So [today,] some [facilities remain] huge, way too big; others are small [sites] where the owner may live with the clients in a more homelike setting. [Both types of board and care homes] come under community care licensing regulations, but those programs have really been [cut back]. They've really lost the monitoring that used to go on, because the state has really cut back on how often those programs get examined. It's really very unfortunate, since I think they're not getting the attention that they need, and I suspect bad things are probably happening in many places that we're not aware of.

MM: One of the things in the MHSA study that seemed to come up is that sometimes people that had been in a board and care and in an FSP [Full Service Partnership program, for clients who need intensive, individualized, services] and got to the point where they graduated and moved on, and they have an independent living situation. But then they sort of missed – Even if it was inadequate and poor, at least at the board and care they had people around them all the time. They had a sort of built-in support system. And putting them out on their own is not necessarily always the best thing for them?

CW: See, that's what I think is the beauty of the Wellness Centers [programs that provide ongoing social, counseling, and educational activities for clients who are functioning well in the community] and the client-run centers. Truthfully, at some of the places – [I could name several that remain] in the Long Beach [community], and if you saw how [the residents] spent their time, it would break your heart, because everyone smokes [and] drinks coffee all day long. It may be supportive, as they have peers with them, but it's not, in my view, healthy for people. I think what we're trying to do in LA with our Wellness Centers and client-run programs can really create that social network, that support [system] for people [living with mental illness who are striving for recovery and a better life].

The beauty I see in [what we are trying to build with some of our MHSA dollars allows us to enhance programs that really do help consumers. Before our interview today,] I was just upstairs talking to Dr. Southard about trying to get some [funding for adding] more Procovery training here [in Los Angeles]. I don't know if you know the work of Kathleen Crowley? [Kathleen Crowley introduced the concept of procovery, the realization of health and fulfillment despite an ongoing chronic illness, in an article, "Five Psychiatric Steps that Mattered," in *Psychiatric Rehabilitation Journal* (v. 19 (4), Spring 1996. Procovery differs from the original concept of mental health "recovery," in recognizing that many clients never fully recover from mental illness and need continuing treatment, but can nevertheless live active and productive lives. Crowley subsequently founded the Procovery Institute in North Hollywood and published *The Power of Procovery in Healing Mental Illness: Just Start Anywhere*, with psychiatrist and Recovery Movement pioneer William Anthony, in 2000.]

MM: A little.

CW: I have watched that group at South Bay a few times, led by one of our peer advocates, Gary Gougis, and they create a social network through that. People are on the phone going, "Hey, I saw you at the donut shop, you better be coming to Group today. We're going bowling this week." It's such a wonderful transition when it happens. They create friendships and relationships that I think are so much healthier than just sitting, smoking, drinking coffee in a board and care. I have great hopes that if we use this money in the right way, we can improve things.

But I totally agree – I think MHSA is wonderful, but we're struggling. I think it's going to take us ten or so years to figure things out. Full Service Partnerships. I think our view has so changed. When I was at Rio Hondo, we were beginning to hear of the ACT model, Assertive Community Treatment. I was able to bring out Debbie Allness. I don't know if you knew Debra Allness. She passed away in the last two years of cancer.

MM: I've heard the name.

CW: She did the ACT manual, called the PACT manual, Program of Assertive Community Treatment, which was the model [ACT is the individualized, intensive treatment model on which FSP programs are based. See Allness, D., & Knoedler, W. *The PACT Model of Community-Based Treatment for Persons with Severe and Persistent Mental Illness: A Manual for PACT Start-Up*. NAMI, 1999]. I mean, she was in Wisconsin, the whole state, and now many states use that model. Jim Allen, I'm sure it was him, said, "Sure, bring her out." So we started the first ACT team when I was at Rio Hondo. That [treatment model] led to [what later became] Full Service Partnerships and some of the things that we have today.

MM: Was this just something you'd heard about and it sounded appealing?

CW: Yes. I think we heard about it through Martha Long [Founder and long time Director of the Village, the integrated service agency program developed by the National Mental Health Association, now Mental Health America (MHA), in Long Beach in 1990]. I'm sure Martha was involved. And through, I believe, Rita Murray and Stella March [long-time leaders in Los Angeles NAMI]. So through NAMI, through MHA, [and] the Village as it was called at the time, she came out and trained us to develop this program, which is many years before MHSA, many years prior to that.

The thing with FSPs is that if you look at the ACT model, their belief is that the client could [remain] in the program for their lifetime. You move the inpatient team out to the community, wrap around those services [that is, ensure smooth coordination and transitions among various service providers], and I think that greatly influenced a lot of the thinking on [what full] Full Service Partnership [teams should be]. We clearly know that we have a small group of our clients who use most of the monies that are available.

But I [worry about giving] the message to people that you can stay [in a program] for life. I have a real concern about that, because I don't find it normalizing; [the real world isn't that way]. At first, when I was [newly] involved with ACT, I thought, "This is great. We're going to do so many things for these clients." But you also can foster a lot of dependency. So I've learned [and reflected a lot about this over the ensuing years.] I really believe that recovery [starts] Day One at the front door, that you say, "We're on this journey together, but you're not going to be with me for the rest of your life, because you won't want to be. You're going to be having such a better life. You're not going to need this program. You're going to get out there --"

That's why I'm so excited about some of the service extender work we're doing, the Wellness Outreach Worker (WOW) [trainings] that we're doing, the *Promotoras* efforts we've got underway [*promotoras de salud* are Latino community health workers], because I'm seeing great success with them. Not enough, but I know we can grow. You want to graduate people, but you introduce, I think, the very first day you meet a client, that "You *will* do better, you *can* recover."

But if you don't create that, then I think you have problems with flow. You have agencies, [where] many of our agencies don't like to let people go. Many of our staff don't like to say goodbye. "I've done really good work with you. You should stay here so I can feel good about myself." (chuckles) It's sort of that cultural change that needs to occur, and I think it will occur. I think the more we involve families and consumers in our day-to-day practices, it's going to change.

MM: Can you talk just a little bit more about that? I mean, the process of re-educating staff and families to sort of – on the one hand, the main person you're re-educating is the client, right?

CW: Right. And there are a lot of barriers to this transformation [now underway]; I think really we've all got so beleaguered by the [use of the] word "transformation." I like to think it's the best of times and the worst of times because, truthfully, we were so fortunate when Prop 63 [the 2004 ballot initiative] became MHSA, and we have funding now that I can only – I mean, I don't even like to think what our Department would be like had that not occurred. It would have been catastrophic. Catastrophic. So we were blessed with that; couldn't have come at a better time. But more and more, as we lost all our revenue, it was the only money in town, so we've pushed this transformation process, unfortunately, sometimes too quickly.

Change is hard for people. Family members are mixed, I think, in terms of how they look at their loved one. Some [parents] want [their son or daughter] to stay very dependent and medication compliant, and [they] talk about, "This is a brain disease and we're going to treat it as a disease." So there's that thinking. Then there's the other end. There's the Consumer Movement, [the group that says,] "I'm not a case and I don't want to be managed." There's that end.

And more and more, the value, with some of our new practices, of really not immediately putting someone on medication. What I see at the clinics – I go out, I visit all the clinics [regularly; it is one of the best aspects of my position as a Deputy]. I go to staff meetings. I think [because of] my upbringing in the department – I have that

passion, I love to do it. I love to feel the beat of what's going on at the clinic. And I have to tell you, I've been confronted many times. People get angry. People don't like how quickly change has come. The unions surely don't like it, [clearly a reflection on their role to represent our employees]. (laughs)

I do feel it's going to take a lot of communication, a lot of respect for all the different and diverse views that people have, so that we can come to some sort of shared consensus about, "OK, things are changing." I feel many of the changes are good, but we want to move thoughtfully and integrate the best of what was the medical model into the work of the recovery model.

So we have many clinics still – I was talking to one of my District Chiefs yesterday who had been out at her program, and with prevention/early intervention, our hope is that we do some work with the client, before we send them to the psychiatrist. But you have a whole culture at this clinic that has many psychiatrists who have been there many years. Then you also have the mentality of consumers who watch commercials [on TV] that say, "Hey, we got a pill to fix that!" So people come in with the expectation –

MM: They want their meds.

CW: Right. "I want meds." I like to think back to what we called the Access Improvement Project, and we were all committed at that point in time. I mean, the ideal clinic was able to see the client, do the assessment, open up their case [on the same] day, have them see their psychiatrist today, and get that prescription and walk out the door. And if we did it all in one day, we were given a pat on the back. [Staff were told,] "You did a good job!" That was Access Improvement. We got people in; they got their medication. So we have a lot of long-held views that are hard to change. I do feel – as these practices and evidence come forward – that there's other options, that we can [change] some of that. So I remain hopeful.

MM: Great. Talk a little bit more about this process of intake. What I hear, time and time again, is they come in, and usually we can do the intake within two weeks, and then two or three weeks after that they can see the psychiatrist, so there are five weeks in there when people are on the list, but not going anywhere.

CW: It's terrible.

MM: It sounds terrible.

CW: It's actually pretty good. I mean, I can tell you –

MM: You didn't tell me. You seem to think it is pretty good.

CW: We've got many places – I hate to tell you, Marcia, where it's not even that good. So as funding got more and more restricted, and then remember, MHSA says, "You're not doing business as usual. You're doing something different and new with the client." So we have those plans, and we're supposed to hold fidelity to the plan. And we've put our directly operated clinics through about three transformation efforts, where staff that were funded by County General funds are now funded by MHSA funds [MHSA provided for a dedicated funding stream for mental health services, generated by a high-income tax surcharge, that created a separate budget from the general County budget].

The way a client comes in now – In fact, I have a memo – Dr. Southard blessed it – and I'm trying to get Norma Fritsche's office to tell me I can release it. What we've seen recently, [since] we've got all that loss of funding –

MM: Norma?

CW: Norma Fritsche. She's the head of Standards and Records. So anything about documentation all goes through her shop. She's under Dennis Murata.

But anyway, our Department tends to – We're very process oriented, and when a bad thing happens, and we've had some very tragic things happen here over the years, we [process and] try to figure out a way to fix it so it will never happen again. A few years ago, we had a situation where one of our therapists was not opening cases, but would give a would-be client a letter saying, "Oh, yes, you do have a mental health [diagnosis] and you should be on benefits." Or something [to that effect]. Writing letters, sending out the information without having any paper trail or open case on the individual.

That led, [as I recall, to] a very adverse outcome, as they say, with one of the people that got such a letter. It led to a work group, and we tend to form a lot of work groups. We created what they call this Triage Form. Now we've got this new form, and it's supposed to direct people, based on the urgency of their need. Do they get help today? Are they eligible for help, but it's not urgent so I can have them come back? They could go on a waiting list. Or they really don't fit our criteria and we link them somewhere else.

With that document, that really only started getting used in the last – It's out now; it's no longer a draft. But what I started witnessing is that this piece of paper, in my view, became a barrier for access, because, as Dr. Southard and I share, our value is that if you came to see me today, you deserve to get something today. You really do. So if I say to you, "Gee, Marcia, yeah, you can benefit from some mental health treatment, but come back in July and we'll do your assessment." That's what I began seeing. All of a sudden, the backlog of people waiting to get into our system skyrocketed. It's funny that this intent to be helpful, and the creation of this form – that's what my memo is trying to talk to the programs about – can become, unintentionally, a barrier for people getting the help that they need.

Dr. Southard and I believe, and this memo reflects, that [if] you came to see me today, something drew you out of your home today, and you walked in seeking help, so I will decide with you today. Yes, your case is open today, not six weeks from today. So that's where we need to get.

Sadly, what's happened is – you know how MHSA works. You've got the CSS (Community Services and Supports) dollars, and then you've got your PEI [Prevention and Early Intervention] dollars [mandated programs under MHSA]. So we have used up our CSS dollars. So then we have – and we're at risk of having to give back to the State – PEI dollars. So we transformed staff in the last year, at the directly operated clinics, to begin to deliver PEI services.

Well, again, it's a very different client than what we were used to seeing. It's not a client that typically thinks of going to the County for service. More and more, with our economy, those people are coming in. They've lost their job, they have a crisis situation, they've lost their house. We didn't have training in place for the staff quickly enough to deliver these new kinds of services. And remember, we had no new staff. It's all the same staff. So you can see how the logjam starts occurring.

With the prudent reserve, Dr. Southard is very hopeful that after July 1st – right now there's a mandate that fifty-one percent of the money in it must be monies from CSS – so we have funded our prudent reserve. We have a lot of money in it that is CSS

funds. And really, if and when that ruling goes away, which he's hopeful about, we could not be as limited as to putting PEI money into that pot, drawing out some of the CSS money, and trying to take care of some of these huge holes that have happened in the system. So we're hopeful about that happening.

We have to be careful, I think. We want to stay true to what the intent of the legislation was, but at the same time, no one would have predicted what happened to the State's economy, or the world economy, for that matter. I don't know if that answered your question.

MM: Pretty much. I have a better sense of how we might look at it. So talk to me a little about PEI. I know what we needed to do here. You were involved in the selection process when they went to this fairly long stakeholder meeting?

CW: Yes, I was the Service Area District Chief for Service Area 8 at the time. What happened, as you probably well know, is that each Service Area picked, based on their community's needs and their demographics [and] populations, which plans became their Service Area plan. There's an array of Evidence-Based Practices. You've seen them all. None of us, I am sure, ever appreciated how arduous it would be to actually implement these. You would have to work with a developer, who may or may not want to work with you, who may or may not be available any time in the near future to bring the training to Los Angeles County. So it's really been hard [taking these practices to scale here in Los Angeles].

And that's what we talked about today, that if it's not on the plan, then you get that push back. I don't care if this is a good community defined practice, you don't have it on your plan, so you can't do it. You know what I mean? That's the clause I was talking about, that it should be "Service Area 8 is intending to do the following Evidence-Based Practices, and others to be determined." (laughs) That's the thing when you have something new. You do learn as you go.

Then, I guess truthfully, I have come to appreciate how politics drive so much of the work we're trying to do. As a naive young social worker, starting out, I never had any appreciation for that. But even in getting this Board letter [authorizing action from the Los Angeles County Board of Supervisors] passed for Prevention/Early Intervention. We finally just got it passed on Tuesday. The training dollars for our providers were in that Board letter. A hundred and forty-six new positions for our clinics were in that Board letter. Because of some of the struggles going on in LA County, we were questioned for weeks on this. So it got stalled, it really did, because we've had a lot of problems with the [Los Angeles County] Department of Children and Family Services [DCFS, which oversees children at risk and children in foster care], and this rash of suicides, or young children being killed, and what the interface between that Department and our Department is, or should be.

One of my District Chiefs, Ana Suarez, last Friday was asked to actually take some of the Health Deputies [for the County Supervisors] around and show them what the benefit of getting these new positions would be to our communities, but to the Health Deputies, so they could go back and support passing this with their Supervisors. So things move very slowly and very politically, I have found out.

MM: The idea of the PEI programs was that they were evidence-based. What exactly does that mean to you?

CW: Well, you know, they had to be evidence-based, or community-defined practices, or promising practices.

MM: There were three categories.

CW: Right, three categories. For example, One of the community-defined evidence approaches that we're using in the Adult System of Care is what we call here in DMH, PEI Crisis Oriented Recovery Services, or PEI CORS. That is adapted from Didi Hirsch [Community Mental Health Center, a contract provider in West Los Angeles] and what they call the *Benjamin Rush model [the Didi Hirsch model for crisis intervention is named after 18th century physician Benjamin Rush, a pioneer in understanding mental disturbances as diseases]. As I understand it, it hasn't had [ongoing] research backing it up, i.e., reliability studies, validity studies, those kinds of things. To me, that's what an evidence-based practice is. It's got the research behind it. You can say, yes, this practice [is known, tested, and] will work and achieve these [expected] outcomes.

[PEI-CORS, though, falls into] this community-defined [model or approach, so], it has allowed us to train a very large number of our clinicians quickly, and allow us to provide – and it's very good for this new population. [For] Crisis Recovery Services, [the training is] six weeks, that's it. You miss some sessions, you don't extend it to eight weeks. It's six sessions, the module is done. So you've got all sorts of people like we talked about who may have lost a job, or they're going through divorce, or they've [lost their home] – you know what I mean. People can come in, we try [the intervention]. The intent is [not to place them immediately on] medication. You give them this module. We're having a hard time, I'll be candid with you, in some of the clinics, because the doctors are like, "Oh, no, no, no. I still want to give them meds." "No, we're going to do it this way."

As I have said before, many of the [actual EBPs] – ones that are well borne out by the research – many [of their developers reside] on the East Coast. Many of them are very busy.

MM: So it's hard to get people to come out and do the training for that.

CW: Right. And truthfully, a lot of them have technological supports that need to be in place. One of the first ones we did – I'm overseeing the initiation of Veterans Services in the Department. So we just started doing that in the last year, less than a year, actually. For years, veterans would come to our clinics and be told, "Oh, go to the VA." So now with PEI, we set aside money for veterans and their families.

One of the EBPs is called Prolonged Exposure [a treatment protocol for post-traumatic stress disorder]. And again, the woman that does that, *Dr. Fao, I believe, had to come out from Ohio. (laughs) But anyway, not only did we have to have the developer of these models come out and train staff, but then there's ongoing consultation. In this model, they wanted our staff who had been trained, before they utilized the model, to do a video taping of themselves with a client, and then to send that to the doctor to be evaluated. Well, our Department, we're kind of technologically impaired. (laughs) So a lot of time is spent on – "Oh, my God, we've got it set up this video," and getting the money [and needed technology, along with protecting confidential client information,] to do it. So that took us a while.

Many of the EBPs are like that, the ongoing consultation and support that is needed. Then what does that work out to be? Is it the person coming back repeatedly to work with the staff who have been trained? Is it using video conferencing? Right now, we're just finally setting up video conferencing in our programs so we can do this. But we didn't have it. And we passed the Plan, saying, "OK, we're going to do this list of EBPs." (laughs) It gets messy. I guess that's what I'm trying to say.

MM: So are some staff enthusiastic about this, and others not so much? What would you say?

CW: I would say, "Yes." I think that's the nice thing about being an old-timer. We have a lot of clinicians who are, truthfully, set in their ways. They've been very close to their caseload of clients for many years. They don't want to say goodbye. I mentioned that before. But then we have – I think a growing group, truthfully – especially with the new people that we hire, they're so excited and really feel, "Wow, I'm going to actually [do a recognized therapeutic intervention] – this is why I went to social work school. This is why I became a psychologist."

I think the preponderance of staff feel the "new" way. They just want the skills, the tools to do it. And I'm sure they feel frustrated that, "Jeez, you've got me on this PEI item now, but I haven't been trained to do the PEI interventions." I think we have a mixture of staff, but I do think more and more, I'm sure – we're going to do a Job Fair for this. We have like sixty-six social workers that we're going to be hiring for this. I am thrilled.

We're going to have a Job Fair in April. We'll be hiring new young blood, which is very exciting. [Social workers] and a whole bunch of psychologists, too. I think we can tip the balance of programs. And there are people that are negative. I won't kid you. I'm sure if you travel around, you'll meet them. Because change is hard. I think if you give people the skills and say, "Now you've been trained. Here are the skills," maybe slowly their attitudes toward their jobs will become more positive. I hope that [will happen as we move forward].

MM: OK. We sort of went in through MHSA without stopping and looking – What we usually ask is, When the MHSA passed, what were your expectations? Aside from the financial thing, whoopee, isn't this wonderful, here's money. And you had worked with the ACT Program previously. But what were you thinking might happen, and how did you see *you* in particular being able to contribute to this?

CW: It's a funny story. Full Service Partnerships was the first piece of the act, and at the time that came forward, must have been 2004, somewhere back then. I think I was at South Bay Mental Health. Some of the things that were going on back then [were interesting and a bit funny, as I look back.] So we got this money, and we got this plan; the Department decided that the directly operated programs would do a proposal, would reply to a request for services, just as our contractors had done. That was the first and only time we've ever done that. (laughs) So each of us, as a Program Head, were charged with writing a proposal, a statement of work.

[recorder off, then resumes] XX

MM: OK. Coming back. We were talking about when this RFP [Request for Proposals] was issued and the directly operated clinics were invited to apply.

CW: Oh, right. It was kind of funny because – Debbie Innes-Gomberg was starting to implement MHSA, and I think we had what we called the Big Six Clinics at the time [originally, six LAC-DMH clinics selected to take the lead in MHSA implementation – these included Arcadia, Compton, Edelman, Hollywood, South Bay, and San Fernando Valley]. Then we were tasked with writing an RFP. That was a unique experience. I think they [DMH HQ] learned from it. Well, it was kind of funny. We acted out a little bit. (laughs) It was due by five o'clock, so we were all on a conference phone call, and it

was 4:59 and it was, “OK, who's going to press the send button on this?” But we did send it in on time, and it must have been terrible, whatever we wrote, because I think it convinced them never to have RFPs again for the directly operated programs. But it was an interesting process. Why were we talking about that? What was your question?

MM: I was asking about how when MHSA first started, what your expectations were of it, and sort of how you thought this might work out, and how things changed.

CW: Right. I think probably, as someone who had done the ACT model, I was very excited and hopeful that this would allow us to have money to keep that model and to expand it. Our ACT team covered South Bay and Rio Hondo, so it was very small. So I was very optimistic about that. I guess, clearly, things didn't work out as optimistically as we had wanted, in terms of having our regular money, plus new money.

MM: But, outside of the financial issue, were there any particular roadblocks that you foresaw or that occurred that you didn't foresee?

CW: (pauses) I think the roadblocks were first of all, just the delays and finding staff, identifying people who wanted to do this. This was a new model for us. This 24/7 approach was not something our clinical people had done before. Based on each community, we identified how many high-need utilizing clients should be in each Service Area, and then that trickled down to how many would go to the directly operated programs, and how many programs would be contracted out.

We did not have, and to this date we still do not have, Full Service Partnerships in each of our clinical programs, so in many places, you either have too few FSP slots, or you have programs without any program at all. So if you look at a continuum of care, which I've tried to develop, where we have five levels of service now in the Adult Programs, we have some people who don't have all the “rooms” in their house [clinic]. So that's been a challenge.

People saw the Full Service Partnership program – Many of the old-time clinicians, I think, saw it as work beneath them to do. It was a case management driven program. It utilized community workers. We began to talk about bringing in consumers. So we still had a lot of top-down [processes out there, i.e.], “I'm better than you” kind of feeling, “I'm not going to apply for this job.” I think we've worked through that. Our Full Service Partnership programs went through several years of enrolling clients, that whole process. Today, we seem to stay about 90% enrolled. I keep wondering why we can never hit a hundred percent enrolled.

One of the things I've thought about recently is, “How do we, as times get better, create that element so that every program could have a Full Service Partnership team?” For many of the programs, there weren't enough dollars. Long Beach Mental Health, which is a huge adult directly operated clinic, only has opportunities for fifty clients in their Full Service Partnership. And you've got San Fernando Valley that has 210. You know what I mean? So there's great disparity.

MM: Why is that? Because of staffing?

CW: Yeah. The way it just – it depended – so you had an allocation for each service area, and there was an [allocation/] dollar amount tied to [each specific Service Area]. So then it depended on how many contractors came forward, I suppose, and were successful when they bid. It got very complicated. I'm a big believer in having both

contracted and directly operated programs in the System of Care. I think it serves us both well. So, if and when we can fairly distribute resources, that's always best.

I came to recognize how hard this was going to be. Plans can look beautiful. You plan for your wedding, and it's going to be magnificent. On the morning of my wedding, the cake fell. There's always something along the way that will give God's little message to you, "Don't think this is going to go without flaw." I think we continue to look at what could have been done differently? Hindsight's 20-20. But Rio Hondo has no Full Service Partnership Program. That's another one of [my programs]. We've got 2500 open cases there, so to not have that element in our continuum is a disservice to people who need it [and to Rio Hondo's clinicians who assess clients to need this level of care. Clients may enter one program, then based on their needs be re-directed elsewhere. Sometimes that is hard – for the client as well as the clinician].

Then what moved forward was our whole thinking. I've only been at this desk for two years, but we were very fortunate that, in Los Angeles County, when we put in our CSS plan, that we came up with Field Capable Clinical Services based on the Genesis Program for Older Adults. [Genesis (Geriatric Evaluation Networks Encompassing Services, Information and Support) provides mobile health services to homebound adults over the age of 60.] Because that has been a godsend that we have now utilized, because it was in the plan to put across all age groups. Because, as we lost County General funds, the other elements of the CSS became [what we used for] many of our [basic] "bread-and-butter" clients, clients we had worked with, that needed not as much as an FSP, but they still need services [and the ability to make home visits, help them navigate community needs/resources, etc. And then we also developed our Wellness Center operations.]

Our thinking on Wellness Centers has really changed over the last few years. We started with a perspective that [only] our very healthy clients, those about ready to terminate services, would be the ones to be in our Wellness Centers. And today, that's totally different. But I'm very OK with that. I think that was actually a good outcome. Unfortunately, we rented buildings that are not conducive to providing a Wellness environment, because they're so small, some of them have no room to even gather a group of people together.

That's OK, because I think what we're learning is what didn't work. If I have a leased building that's on a lease for three years, but it's not working for the Wellness Center, do I have another program I could put over there, and move the Wellness Center back to what was the traditional outpatient program? Whereas [at the main clinic] we have many, usually, group rooms for different client-run groups and other activities that can go on, that are really part of the Wellness community.

We're kind of – What does Robin [Kay] always say? "We're building the plane as we fly it."

MM: Okay. So tell me then about the patient who is in this Wellness Center now, not the fully healthy client.

CW: Right. Well, a lot of work had gone on with CiMH [The California Institute for Mental Health was founded in 1993 by the California Mental Health Directors Association to provide training, technical assistance, research and policy development in the field] and with Mental Health America, and Dr. David Pilon [President and Chief Executive Officer of MHA as of 2010, and developer of the Milestones of Recovery Scale (MORS)]. So we began to look at this idea of tracking where people were in their recovery and using this Milestones of Recovery Scale to set a number to a client and say, "You're a six. A six would put you at a Wellness Center." I'm probably not a six!

But early on, that was our thinking. So this tool became available, and I think I was probably [managing] South Bay or Long Beach at the time. We started scoring everybody, to try to figure out where does our caseload of clients fall? The thinking early on was that someone with a six, seven, or eight would go to a Wellness Center, and the clients that are in the FSP are down there at a one or a two, or something like that.

With the economy then, and with the reality being that most clients that are doing that well, they don't want to come and see us. I don't know how we got into that concept as deeply as we did, but we started seeing that, like I said early on, that really the idea of Recovery and Wellness should happen on Day One, and that a score on a scale does not totally define you. We started seeing people that were fours and fives being actually really good candidates to be part of the Wellness community.

That tool today – and I know there's a lot of work going on. Dr. Pilon has what's called the MORS generator. There's work at CIMH. I think Debbie's got some Counties looking at that Scale and how to use it. I have found it helpful to use periodically, just to get a snapshot of where people are. That's how I use it. I'm sure others would want me to be using it differently.

What we try to do instead is to really – I'm very proud of what I do in ASOC. We run a lot of data here, and when I visit a program, I bring out to them these pie charts that I think are terrific. It shows [the staff] where their clients are currently, how many are you actually seeing [for services] under PEI, what percent are in your Wellness? And then break down [those percentages even more, i.e.], What kinds of services are you giving the client in Wellness? Are you doing any group modalities? If not, why not? So I'm a real hands-on kind of manager. I think I would call it that. Probably not as analytical as someone who comes from maybe a psychology background, [although I did have my BA, as I told you, in experimental psychology]. I do find [these are often] helpful tools, but [I don't use them to direct] everything we do with the clients.

Our Wellness Centers have really changed. I think we've got some really exciting things going on. I was just telling Dr. Southard in supervision this morning that we've got to get some additional positions. Across the whole Department, we only were able to fund thirty-four Peer Advocate/Community Worker positions, so I've got Wellness Centers that have sixty volunteers in them now. They would all like to be at the table, but we don't have enough to offer them. [Dr. Southard is] very supportive of that, he really is, and we just have to find a way to make it happen, and then to concurrently create a career ladder for individuals [peer workers]. I think I shared with you, I've been on almost every item in the Department [that is, every job line item in County Civil Service]. I wasn't told, "This is all you can be. You can only be a PSW-1 for your entire career." So we have to give the same opportunities to [our consumers].

We have some amazing stuff going on that I'm very proud about. We've done, recently, some great trainings. We just had thirty-eight consumers graduate from our Wellness Outreach Worker training, so they're all certified now to be WOW (Wellness Outreach Workers). They're going to get [paid for their work] – even though they're on SSI, they can earn up to 240 [dollars] a month. So if they get a small stipend, I think it's going to make them feel so good about themselves. I told Dr. Southard today, "You know, I'm going to spend that money by June 30th, and I'm going to be back and I'm going to need some more money [from you] (laughs) to do [even more]."

With the healthcare reform underway, we're really busy right now. We're starting the PEI piece, and we've got the Innovation and the WET [Workplace Education and Training] pieces moving forward. [And we still plan to move to] the integrated plan. But now, with health reform – they're telling us we should call it "health reform," because, if you use the word "care," then everyone talks about ObamaCare. (laughs) So "health reform". There's a huge role for Adult System of Care in there, and what we'll be doing –

probably about half of the clients in any Adult program are either undocumented or indigent, and the indigent ones will be eligible, many of them, for this program. So we've been looking at that next piece of the work before us.

I think there's an incredible role for people with lived experience, for our peer advocates, to play in helping us identify and enroll people who are eligible for this healthcare plan. I've been helping to put together the information. It's going to be a packet for each client, because you have to have proof of income, you have to be below 133% of the poverty [line determined by the Federal Department of Health and Human Services; as of 2011, \$22,350, for a family of 4], you've got to be a U.S. citizen, and you have to have a birth certificate that demonstrates that, plus a photo ID.

We're not going to actually implement Healthy Way LA [which will expand health care coverage for low-income uninsured adults] until July 1st now. We thought it would be sooner than that, but it'll be July 1st. We're looking at data now that tells us how many of our clients in the clinics are already enrolled in Healthy Way LA, and then how many potential clients in our clinics *should be* enrolled. At first, we didn't think the Department was going to be able to enroll people, to increase the numbers, because [the County Department of] Health Services has so many – they've got, I think, forty-seven thousand already enrolled. So we need to know, if our clients are enrolled with them, who they are, first of all.

Now that window has opened, so we're going to be able to look at people with high need. Many of [the potential enrollees may be in some of our most intensive level of care – like a Full Service Partnership Program. Now they will potentially have coverage under HWLA.] The nice thing about FSP is [that with] most of those clients, unless they're undocumented, we're really good at getting them quickly on benefits. They get Medi-Cal. But we do have a lot of people that have high needs that are not in Full Service Partnerships, that we'll be able now to have health coverage for.

MM: That's cool.

CW: It's very cool. I do think that, [with] the packets, we can have consumers help putting that together [and specifically speak to other peer consumers about the benefits of enrollment into HWLA]. Another new job for them, to be more valued for what they can provide.

MM: Thinking about consumer workers, because this isn't new, it's something we've been thinking about a lot and which we're trying to find out more about. Certainly, I mean, this is a logical role for them to play in terms of being peer advocates and offering support services. What kind of career paths can you develop for them out of that?

CW: Well, I think we talked earlier about John Chernak, the community worker at Long Beach who [came into the Department as a peer advocate, but has moved up to become a community worker? The Community Worker is a position where the employee, once appropriately trained on billing guidelines,] under the Rehabilitation option, [can provide billable services]. So, as the peer advocate moves to become a community worker, [he or she may be given a large caseload of clients to serve. With John, he was given about 65 cases. Taking on a large caseload is a big challenge for anyone. We want to support our peers as they move progressively into these larger roles.] But then the next position [for John and others is up to a higher position, maybe to a] senior community worker.

What's really valued by me is supporting people going back to further their education. So [with] Workforce Education and Training, we have some really exciting

opportunities with those funds. One of the things we're doing right now that I'm very pleased about, it's not just with the consumers; but it's with our clinical social work staff, who in the Department are given nine years, Marcia, to become licensed. Human Resources knew people were falling [through the cracks] and not getting licensed.

Anyway, as a social worker, as does the Marriage Family and Child Therapist, gets nine years [to get licensed]. We used to have, years ago, a really dedicated effort to help people become licensed. That kind of went away, so we're bringing it back. I recently hired a wonderful woman that used to be my program head at Harbor-UCLA, and then had left and moved to Colorado. I was able to reinstate her, and she came back. And that's what she's doing now. We've identified, in a few of the Service Areas, the clinicians under me, who are vulnerable [to not becoming licensed within the allowable time frame]. We've sort of assessed with them [their commitment to becoming licensed.] There are some staff who kind of give up hope that they can ever pass. Maybe they've tried and failed many times. Many of them have this fallacy that, "Well, I'll still have a County job, I'll just get demoted." So we're trying to hit them much earlier in that nine-year process. I'm really excited about that. We're doing that.

Really, [with] the Workforce Education and Training [(WET) dollars], we have several opportunities for people to go back to school, someone like John Chernak. You don't make much money as a community worker. You make maybe two hundred dollars more a month as a senior community worker. So how do we help [someone like John] finish that bachelor's degree that he's got partially completed, perhaps, and then [work to] move him into [a higher-paid position with the County]? We have this Civil Service stuff going on, so the next option for him would be [a position] we call a Medical Case Worker.

Now, Dr. Southard is very excited about the idea of what our peer advocates [can help us with in respect to] Healthcare [Reform]. I would see us looking at that and saying, OK, so what skill set [would a "health care worker"] need? And maybe the goal for them [in our Civil Service/DMH world] would be a Medical Case Worker position. [It may be the job that best] describes the work that we will want [our health care workers] to do. So then how do we support the group [of consumers and peer advocates moving] forward to [acquire a] degree [and move into upper jobs within our system]?

MM: OK. This seems to somehow follow along. We still have problems with stigma, certainly out in the community, but in the Department as well. How has that changed since you've been in the field? Are there things that we could do to make it change more quickly?

CW: I think we have to be so eternally thankful to these grass roots organizations that really said, "I'm mad as hell and I'm not going to take it anymore, and you're going to start listening to me." I really value their voices. There is stigma in our Department, there still is. But I think because of those voices coming forward, it's slowly improving. I really feel that way. I think I was telling you before about that Security Committee I'm on, and I've got three consumers that are part of that Committee. Hearing their perception of how we welcome, or don't welcome, people into our programs, hearing their perception about what it feels like to try to seek help and the first thing you see is an armed guard at the door, and if you're like many of our homeless mentally ill people, that doesn't invite you in.

I think they're here to stay, and I think, truthfully, we've probably had a lot of clinicians and Program Heads, and others, who thought, "This too shall pass." But I don't think it is going to pass. I think, rightfully, it's exactly where they need to be. They

have found their voice, we're listening, and we need to work together in a meaningful way.

I, for one, learn something every day in talking to someone who's a client. As Program Manager, I used to like just to sit in the waiting room and talk to people. I think leadership is so essential and that if and when employees, be they the clerical staff behind the window who are watching a room full of people wanting to get help, see their manager go out there and really sit down and engage somebody, I think that helps everyone value that these people are no different than anybody else. We don't call them "these people" or "those people." We're all people. I remember when I put coffee out – it was decaf – in the waiting room at Rio Hondo to welcome people. No one had ever done that. We would have food, and I would always take it out, or we would have extra pizza and put it out for people to enjoy.

You've got to break barriers, these long held barriers, that people really still have a lot of fear of those living with mental illness, even though the research shows there really is no correlation between having a mental health diagnosis and being more violent. Yet, you see it every day of the week in the paper, and on TV, and in movies. We have a lot of work before us to do. So if and when people can do well, who have been a consumer, and who can rally the troops, so to speak, I think it's exactly what we need to do. It doesn't change overnight. It doesn't change overnight.

I don't know. I mean, it's like I talked to you about earlier, I was able to come out of my private shell and just say, "Yeah, this is my family. They're just as lovable as any other family, and just as important."

MM: But I think it's very hard for many people to do that. And it is a matter of perspective. I mean, you talk about the clinic and you walk in the clinic and you see the barrier and the guard and you have to walk through a metal detector. I never have any problem with that, because I don't feel that that barrier is there for me. It might as well be invisible, as far as I'm concerned, because it doesn't seem directed at me. But it seems to me, for people with mental illness, or people coming seeking help, it's very intimidating, and the reverse of welcoming. I don't suppose there's anything that can be done about that. We have to have those guards there.

CW: No, I don't know if we do. I think we're going to change some of that. I don't believe we need those glass partitions between the waiting room and the people behind. I want to pull those down. I have to tell you, though, I have a program head who wanted to put – She's not mine, but she works for the Department – who was requesting to put glass between the front and back seats of all the cars. So we've got a long way to go.

And you don't want to humiliate people for their beliefs, but I think part of what I try to do at *ROAR – Every month, they have breakout groups. We spent a year looking at the five levels of care, and what do we want to really have happening in our Wellness Centers. Welcoming is a big piece of every element of the program.

So you have to believe, I guess, to stay hopeful in a group discussion like that, and by sharing and people learning other ideas. I learned other ideas this week in having Mollie Lowery come down and talk about them never having an armed guard at LAMP, on Skid Row. [The LAMP Community was founded by Mollie Lowery in 1985 as a drop-in center (the Los Angeles Men's Place) for homeless, mentally ill men and expanded within a few years to provide permanent housing and supportive services, including advocacy, life skills training, and recovery support, for both men and women.] Now, that, I think everyone would agree, is a much more dangerous environment, with unknown people walking in, than what we typically face.

So, I don't know what to tell you. It's very hard to change those attitudes. I think what's really good is that you can look at Stigma Busters [a NAMI program to advocate against the dissemination of mental health stigma through the press and popular media] and all these efforts that are underway and say, "Now people are aware of that." We applaud and celebrate many celebrities who have come out recently and shared their own [mental health issues], because they're often held in high esteem by lay people, and they think, "Well, gee, he seems OK. She seems like a reasonable human being. Maybe someone living with depression, or whatever, is [OK]." Then you find out – I mean, there's not a family in America that doesn't have mental health problems in their family. (laughs)

I'm sure I haven't answered your question. There probably isn't a real answer.

MM: I imagine there's an answer, and we're working towards it. OK. Are there any particular things you've learned from clients, besides what we've just talked about?

CW: I think stigma's a part of it. I've learned from clients how hard many of their lives have been, how fortunate I've been, and how much so many of them struggle. They *have* lost their way many times, and they don't feel a sense of hope.

I think the most essential thing is the relationship that you create between yourself and the client. That is it. It's that moment between you and that person, sitting across the table from each other. Every time you have someone with you, you have that opportunity, to use that time in the best way. And shame on us if and when we don't.

I had a manager recently who did a really great thing, I thought. It was kind of a guilt trip, but I thought it was kind of cool. We're really pushed by our department to be productive these days, and to reach these benchmarks, and these stats outcomes, and all of that. This manager said, "Well, one of the things I found really worked with my staff was to really sit down with them and say, 'OK, so you worked forty hours this week, and the entire month you worked a hundred and sixty hours. And then, if I show you here's what you did for those a hundred and sixty hours, you ended up with a week and a half that you didn't do any direct service with a client. A week and a half. We know the clients want service, so how do you understand that? How could that happen? You're a social worker. A week and a half out of four weeks in the month, and you didn't sit and have that opportunity to work with someone.'" That's the cool thing about some of the data that we now look at, that you can have those – you can't deny the data, it's right here. Either you saw a lot of people and you didn't put in the data or the data says you're not seeing people.

I thought that was a powerful story, because when you're faced with that, you have that moment that [you realize that] I need to change, I need to do some self-reflection and remember why I work for the County. I think working with the Department of Mental Health, truthfully, is the best job anybody could have. I just think there are so many doors that we can open and work with people in so many ways. It is. It's the best job. I swear to God, it really is. I could have made a lot more money doing something else, but I could never have felt as rewarded as I have.

MM: That's important. That's cool. So we always ask everyone to talk a little bit – you alluded to this a little bit earlier, about the differences between the directly operated and the contract clinics, and the advantages of each. You said it was really important to have both of those in the system.

CW: I believe it is. But that doesn't mean that they don't each point the finger at the other side and say, "You lousy so-and-so." (laughs) The way we set it up, I think

truthfully, we fund positions, so people are given money [and] the money is tied to a funding stream. And then the contractors, they have been very successful at leveraging the County General [Fund] dollars that they get. They work very well, I believe, at taking a little bit of money, and if it's EPSDT with a child [the Federal Early Periodic Screening Diagnosis and Treatment health program for low-income children], almost every child in America can get on that if they're within the criteria. So they're able to draw down a lot of revenue. A little bit of money brings them a lot more. I think we have a lot of very good contracted children's providers in our system, and they are generating a lot of revenue.

I think we've become a little more savvy in terms of expecting – beyond generating revenue now, to really look at, "What is that child getting?" So if you just keep a child in the System of Care for Children for years on end, we don't want to do that. We're looking more closely at providers who are billing huge amounts to EPSDT and Medi-Cal, or whatever the payer source is. So that's something that we need to scrutinize, I think. It gives the wrong message in terms of any family. I mean, to be told your child has to spend its entire childhood in therapy, I don't want people to have to hold on to such a belief. And at the same time, yes, you're generating a lot of revenue, but are you helping people recover?

I think, as we move more and more to managed care, I think a lot of that's going to change. Right now, there are no regulations that say you can't see that child twenty-seven times and bill forty hours a week. We haven't put any of those in play. They're very good at maximizing their revenue, because you can take a little County General Fund [money] and get a lot more with EPSDT. Many of the providers are seeing more children than they are adult populations, where it's fifty cents on the dollar to draw down the Medi-Cal match, so your dollars don't stretch as far. From a business perspective –

MM: Children are more profitable.

CW: Right. I understand that. Then they tend to use up their County General Fund dollars, and then they direct people to the directly operated clinics. So then if you talk to the directly operated staff, it's like, "Oh, those damn contractors. They're not seeing the indigents. They're dumping them all on us." So there is this – I guess it's a rivalry, a sibling rivalry. I don't know what it is between the two of us.

But I think that's good. I think it's good. I think we have the opportunity to go back and say, "Wait a minute. This client was being well served by your program; he has a relationship with people there. I'm sorry you don't have money, but what else can you do? It isn't fair to send him across town to a totally near environment, not near his home." I think, as a directly operated manager, you should hold yourself accountable to make those kinds of phone calls and to be candid with your staff about, "Well, you know what, you're absolutely right, what you brought to my attention. Let's get on the phone and let's see what we can do about it."

We are, truthfully, the place of last resort. We are the safety net in the directly operated [system]. I think we're going to move – to survive, they [the directly operated clinics] have to become able to compete, because there will be many healthcare providers who want to be at the table now and provide behavioral health services with parity, with the things that are happening. We are being wooed right now because of our expertise in working with SPMI [severely and persistently mentally ill] populations. We are known as probably not just the place of last resort, but the environment that really works successfully many times with that population.

We're getting a lot of interest in wanting to partner with us, which is kind of interesting. Some of the big health groups have been approaching Dr. [Roderick]

Shaner [Medical Director of LAC-DMH]. I've sat in a couple of those meetings. So tremendous change is before us. I thought MHSA would be the last thing that I would work on in my career, and now it's going to be healthcare reform. (both laugh)

MM: And who knows what will come next?

CW: We don't know. Well, hopefully, I'll be retired by then.

MM: I wanted to ask you a little bit about the Service Area Advisory Committee.

CW: Oh, OK.

MM: You work with that?

CW: Sure.

MM: I'm not exactly sure what that is. Maybe you can explain a little bit what that is, and then we'll do two final questions and wrap it up.

CW: OK. All right. Well, in Los Angeles County, we have eight Service Areas, and you know them, I'm sure; you've seen them on the map.

MM: Yes. I know those by heart.

CW: All right. Very good. So what happens in the Service Area Advisory Committee, or SAAC as it's called, is that's really a forum, and it's held monthly in each planning area. It brings together – I was just at SAAC 8 last Friday – all of our providers. They come together monthly; we share with them whatever's happening in the Department, but it's a planning body. For example, when you had the PEI plan, they had that plan come forward through the SAAC planning process. Unlike FSP and some of the CSS programs, where we did it here at St. Anne's [conference center, run by St. Anne's Social Service Agency for women and children], in a central venue, we came to appreciate, I think increasingly, the value that each Service Area provides us in terms of their uniqueness, and that my community in Service Area 8 may be very different than the Antelope Valley [Service Area 1, in northern LA County]. So our planning process needs to engage the voices that are in the community.

We have contracted and directly operated providers there, across age groups. We bring in people who are not just in the Department, so you'll have – law enforcement is often there, you'll have colleges, the regional centers. So a broad canvas of community stakeholders, family members, NAMI groups, they all participate in that. Those meetings are led, usually, by the District Chief, the Service Area District Chief, and often come forward with a recommendation to upper management.

The other thing they do is, any time a new provider wants to come into town – It could be a provider who's worked in Service Area 2 who wants to open up shop in Service Area 8 – that approval process goes through the SAAC. We look at, "OK, we've already got a lot of providers doing children's services. Why do you want to come here? What are you hoping to do? Is it going to be different? Is it going to take funds that really need to be in Service Area 6 with that population and move them to Service Area 8, and is that needed?" When that happens, the two Service Area District Chiefs will be saying that. We don't like to take money out of a Service Area, truthfully.

So we look at that, and then a recommendation would come forward. The SAAC has two co-chairs, usually, and they would send a letter to Dr. Southard in terms of, We've reviewed this, thumbs up, thumbs down, kind of thing.

I think that can play a very valuable role. The SAACs, I think they need to be looked at again. We used to have a process in terms of membership, who should be on the voting? Who should vote? Can everyone vote? We used to have different categories. You're a consumer. We'd have X number of consumers that would vote, we'd have X number of agency representatives, county employees. We've kind of moved away from that. I think there was interest – probably sometime during the MHSA planning process – that we really need to go back and work with our SAACs, but no one's really taken that on and led the charge for that. I think you see them probably – when you travel around, Marcia, you'd probably see [that] some are really highly organized, functioning very well. They've got rules and all of that. And others have probably floundered.

MM: Okay. These are our last questions. First of all, what have you done in your career that was most valuable or most important, that really gives you the most pleasure to think about? And what have you not done – What have you maybe tried to achieve and not been able to do? What do you still think you would like to do?

CW: So what have I done that I feel really good about, and what have I not been able to do or would still like to do? OK. Hmm. I don't mean to brag.

MM: That's OK. (both laugh) You're allowed to brag.

CW: Oh, really? Because one of the things I probably feel the very best about, people talk a lot about having an open door. You'll go and visit a program and the manager will say, "I have an open door policy;" but people don't come in. I think one of the things I feel the proudest about is I do have an open door policy, and that door has opened to a much larger audience over the years of my career. If I compare the opportunities I had when, let's say, I ran the HIV program, that door is not nearly as wide as the door I have open today, to really influence what we're doing as a system for our adult clients. I feel really good about that.

I feel really good that I have kept my roots with the clients and with the programs. I am not a "sit at headquarters" kind of Deputy. That's not who I am. And I get, every day, calls from clients, calls from staff, which I really value. Because I told you, to me, it's all about the relationship with people.

One thing since I've been down here that I feel particularly proud about is my ability to – I've gone from having probably a hundred vacant [job line] items to none. I helped identify and move good people into good jobs. I kind of feel I've got one of the -- sometimes I feel like my little team were the heartbeat of the Department, because people know if they're being maligned or turned away, or not respected, or if they just feel they would like a new job. I feel like *Ghostbusters*, "Who you gonna call?" [a popular 1984 science fiction comedy starring Bill Murray] I do.

I mean, that sounds kind of braggy, but I see it across all levels, and I so value that. I think it's really important in an organization to have a place where you can go and you know it will stay confidential, and yet, someone will get back to you and believes in your concern or what you're trying to bring forward. I feel really good about that.

In terms of what I tried but failed at? Is that one of them? Tried and failed.
(laughs)

MM: Or tried and it didn't happen.

CW: Oh, God. Oh, probably a lot of things. Tried and failed at. Hmm. You know, I struggle with feeling I'm bright enough to do this job. I'm very hardworking, but there are a lot of people that are much smarter than I am, so I continue to struggle with that. Sometimes you will voice what you think is a really good idea, and everybody's like, "No. (laughs) No, we're not going down that road."

I think what I'd like to do better is become better at math. If I could become better at math in my final years in the Department, I would understand these budgets a whole lot better. I'm so fortunate to work with Robin Kay, because she's got a compassionate side, she really does, as well as this amazing analytical ability. I want to do social work, in large part, for everything I shared with you. [But] I really struggled. UC San Diego was a hard school, and I was very fortunate, when I had a year of statistics, that I could go home at lunchtime, because I only lived two miles away, and see my father the physicist and have him help me with the math classes. That was a godsend.

I never thought, when I became a social worker, that I'd have to do math. I thought, "Oh, thank God, I found a place where I won't [need math]." But now, so much of what we do is really around money and finance, so that's probably the thing I wish I could do better. Truthfully, in the few years I have left with the Department, I probably won't get that. But I think I will appreciate and go to the people here and feel more comfortable in going to them and saying, "I'll do that now. Can you run that by me again? Can you explain those numbers? I don't get it." And I think that's the heart of what social workers do; they network with people.

MM: Good. OK.

CW: Thank you. I enjoyed this.

MM: I did too, very much.

CW: It was just good to have it, so thank you. I haven't thought about these things in a long time.

MM: It was a pleasure. Thank you.

END OF INTERVIEW