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Tell me about how you got into this field, and how you got where you are?

Well, I actually started off as a pre-med major. I'd always wanted to be a doctor and then [to] be part of Doctors Without Borders and work in Third World countries. I always had a strong sense that I wanted to work with underserved populations, in areas of high need. As I was a pre-med major, I kind of discovered that everything is memorization after a while. At first, biology is exciting and everything is new. But everything becomes a lot of rote memorization.

And then I had my first psychology course. We were studying schizophrenia and it was like a revelation to me. Like wow, this is just amazing. It was such an interesting, fascinating condition and also you got a sense of the suffering that went along with it. I felt very compelled to go into that direction.

Intellectually, it's a fascinating disease and there's so much unknown and there was a lot of mystery involved and a lot of questions still being asked. But what struck me even more was a real sense of suffering for the people who had schizophrenia. To me, that was very compelling. It really drew me in. It made me want to find out more and learn more; get involved and see what I could do to have some kind of effect in this area.

I don't think I had any concept of what mental health was at that time, as opposed to now. It's so hard to say, because it just seems like almost a lifetime ago. At that time, it was really about just the disease state and about mental illness and studying psychopathology. It wasn't until I actually got into a clinic and worked with clients that I had a real understanding of what mental health was versus mental illness.

Can you explain that to us?

Well, mental illness is really a focus on disease states and on deficits and on suffering and symptoms, whereas mental health has more of a concept of what it means to have a sense of health, to have a sense of wellness, to go beyond the symptoms, to go beyond the illness, which, I think, especially for our clients, is so important. That their identity isn't tied just to the symptoms that they experience.

Yes, [I mean] quality of life, because even somebody with a serious mental illness is more than the illness itself. It's like somebody with cancer. They're defined by more than their cancer.

What's changed at Downtown Mental Health since you started working here?

Well, this place has gone through a lot of transformation. I've been here a little over twenty-two years. I started actually as a practicum student doing my bachelor's practicum and I just kind of fell in love with Skid Row, and with the clients of this clinic and I stayed through my Master's practicum, my pre-doctoral hours. I came on as a consultant, [became] a therapist, [and then] a program coordinator. Then, a little under four years ago, I became Clinical Program Head over our Wellness Programs and our Cal Works Homeless Families Programs; and now [the] upcoming PEI, Prevention and

Early Intervention Programs. And the clinic has really changed in response to how the community around it has changed.

When I first started, the average age of people in the Skid Row community was probably like in the late forties. A lot of alcohol abuse, almost exclusively men. Through the years, you've seen a change, where the average age has dropped down. Alcohol has really been replaced by different kinds of drugs, mostly crack and some other drugs. A lot more women now and in fact the fastest growing segment of the homeless population nationally, as well as in the Skid Row area, is families. Right now about 25 percent of the homeless population in Skid Row is comprised of families.

What do you try to do for people here at the Downtown Mental Health Center?

Well, here, hopefully, the general sense we want to give people is: this is a place of respite. This is a place where you can walk in and you can get a break from your life in Skid Row. Hopefully it's a place where it's a safe haven. It's a place where people can come and know that they're cared for and also have a different sense of community. A safe sense of community within the walls.

Well, the first step, when the client enters into Downtown Mental Health Center, is entering into our Crisis Resolution Service [CRS]. That program, which is not under me, but is under Stacy Williams, deals with the initial crisis stabilization of clients. So they may come in off the street and they don't have a place to stay. They don't have any medications. They may not have been seen by a mental health professional for a very long time.

They come in and Stacy's staff kind of tries to see where they're at, [to] see first of all if they meet target population criteria, meaning, do they have a severe or persistent mental illness? And if they do, then an intake is provided for them. First, a medication appointment is scheduled. We try to look at, do they need a shelter bed? Do they need help with benefits establishment? Do they have medical needs that have been unmet? So we kind of just try to provide everything at that very basic level.

People can stay in that program for up to sixty days. And, at the end of sixty days, they're evaluated for where's the next best step for this program? For some folks who come in very, very stable, they've been taking medications for ten years [and] they have family outside of the area, what we try to do, after initial crisis stabilization, is reconnect them with their community of origin. And honestly, that doesn't happen a lot in Skid Row. 'Cause by the time they get to Skid Row, most family ties are really broken and the bridges are burnt crispy.

And what happens after the 60 days?

So I was telling you about the services here and what happens when somebody comes through CRS. Some of the clients who come in maybe are really bad off and really not doing well and require a lot of individual attention. Either they're chronically homeless, very resistant symptoms, chronically in and out of jail. Those people we refer to our FSP program, the Full Service Partnership. That's a really low staff to client ratio, and a lot of one-on-one kind of work.

The majority of the clients though come to our Wellness Center. They are transferred over after sixty days. And what our Wellness Center is, it's focused not just on traditional mental health care, but really helping clients see their lives move from point A

to point B. What we emphasize in that program is the concept of wellness, and that whether you're symptomatic or asymptomatic, taking meds, not taking meds – whatever background you've come from, you deserve a shot at wellness, and having more of a life.

So quality of life is really a big emphasis there. We have medication provided for people, medication evaluations. We also have case management, individual therapy, a lot of group psychotherapy. We have like twenty-six different groups. We have a five-day-a-week co-occurring disorders program. So a lot of things are offered to clients at that level to really help them kind of rebuild their lives.

They find, not just a place in the group therapies, but a place with each other, because, as they participate in the groups that we offer, the biggest part of the groups is being with peers. They're able to get to know other people who have been through what they've been through. And a lot of times, that carries more weight than what a therapist might have to say. Because I haven't been through homelessness. I haven't been through a lot of things that they've been through.

In fact, a lot of times when I used to see clients here at the clinic, I would have to start off by telling them, "Look, I know, your depression right now is really, really bad. I know this is all you've known for years now and you don't see a way out of this. You're going to have to take my word for it at first. I've worked with hundreds of clients. I've seen people really get better, even when they felt they couldn't. So you're just going to have to trust me to start."

And for a lot of our clients, because they are cut off from their friends, from their families, they are able to find sort of a surrogate family here.

Can you give us an example?

I can think of one client in particular. She grew up in foster care. I think at the age of 12, her mother passed away; and her mother had been schizophrenic and alcoholic. When her mother passed away, her father took her and her siblings to drop them off at the police station, and said, "I can't take care of you." And she grew up, from 12 to 17, in foster care. I think she had over ten different foster care homes in that period.

From foster care, she emancipated into Job Corps. And from Job Corps, she went into homelessness and pregnancy. When she came to us, she was very skeptical at first. It was very difficult for her to establish a relationship, because everybody disappointed her in her life. Not only was she struggling with serious mental health issues, but she was struggling with trust issues, and the ability just to trust in relationships.

But after she began to see us, she started to do really, really well. She was able to keep custody of her baby. She went back to school. She started working full time. But not only that, one day she stopped me and just said, "I want you to know this is the longest relationship I've ever had."

So stories like that. When you go through those sorts of experiences, when you can have the honor of being with somebody on their wellness journey, it's hard to leave a place like this, which is probably why I've been here this many years.

What kind of diagnoses do your clients have?

Well, our core services here have a target population of people who are seriously, persistently mentally ill. So we're talking almost 100 percent of our population here has a diagnosis of schizophrenia, bipolar disorder, major depressive disorder that's recurrent and severe, or recurrent and severe with psychotic features. [That's] the bulk of everybody that comes here. And combined, all of our programs together, we have almost three thousand clients just in this clinic. Yes.

What is your biggest challenge?

Probably the most frustrating thing, [which] is probably pretty obvious to most people, would be resources. There just aren't enough resources to go around as it is. And I warn my staff when they come on board, that we're working with people who are seriously mentally ill and homeless and substance abusing. Society's never going to throw money at us. They're never going to throw resources our way. I want [them] to have a realistic outlook and get used to this fact. Because when you have that acceptance, then you start to work creatively with what we do have.

And I think the biggest frustration is to routinely see that our clients don't get a lot of resources, because really they don't have a voice in society. They don't have family they're connected to, to advocate for them. They don't really have much of a political voice. They're not a big voting block that politicians go after. But despite that, they're able to do amazing things. Despite the challenges, despite the frustrations, there are so many things that can pull you through whatever is frustrating.

Like for instance, we may not have a lot of resources. We may be much shorter in staff than some other clinics. Our staff though is super dedicated. Let's face it, whether you're a social worker here or a social worker on the West Side, you're getting paid the same amount of money. So social workers here really generally really want to be here. They have a sense of mission, a sense of purpose. And same thing with our clients. Our clients, unfortunately, are used to getting by on very little. They tend to be more creative, more resourceful. They really persevere through almost everything.

Do you do much outreach to bring clients here?

Well, there aren't very many people who don't know about this place now. But, back in the early days, when our population was a little bit different, when there was less substance abuse, we would have to do a lot of outreach. I remember, when I was an intern, one of the big activities of the day for me would be to go into alleys and down different deserted streets, looking for clients. And I remember we always used to have this policy where [you would] keep the engine running and keep the doors open, in case you had to run.

Nowadays, though, we don't have to do outreach in the same way, because this clinic is so well established in this community. So it's known not just by the residents of this community, but by all the service agencies in the community. So really we get a lot of our referrals from either word of mouth or from other agencies. We still do outreach though, in that we make ourselves known to other community agencies. We go to various missions to let people know what we do here. We have a small satellite team out at the Center for Community Health which is an integrated health care setting.

But honestly, one of the ways that word spreads about Downtown Mental Health is by word of mouth of the clients. We have one former client, who I remember, when she first

came to us, she told us, "I'm never going to work and you can't make me." And now she's working full time, aside from being mother of five children. She's working full time, doing really well, has her own place. And she works at a place where she constantly refers people to us. She's sort of like our single source referral agency.

Substance is a big issue among your clients.

Yes. Officially on paper we have about 50% of our population [that] has some kind of substance abuse issue. But we think, realistically, it's more like 75%. And that's part of the reason why we have a five-days-a-week co-occurring disorders program. Yes, it's not just mental illness that people are dealing with but there's substance abuse on top of it, substance abuse issues. For some people, the mental health issues came first, and for some people, the substance abuse issues came first.

Or like some folks – I can think of one client in particular who's schizophrenic. He actually came to us from another country, like, kind of very innocent, very naïve, and ended up in Skid Row because [his] family couldn't handle him, couldn't handle his symptoms, and he started staying in one of the hotels down here. And, as he was in Skid Row longer, he became addicted to crack.

A lot of times, the dealers down here prey on our clients. They know that they get an SSI check or they have some source of income. They'll come in and do the typical thing where they offer them something for free, and then soon hook them in. And then, the next thing you know, our client is dealing with not just his schizophrenia, but also with an addiction to crack.

How do you deal with these patients?

Well, we rarely get a person on the first go-through. I have to say that. Usually what we try to do is engage with the client, as best as we can, just on a person to person basis. And if he or she is not willing to address the substance abuse issue, that's OK. We let them know however they want to come, they're welcome here, they're accepted.

And what happens is, as they're exposed to other clients in the clinic, they see what their life stories have been. They see that, "Oh, this person struggled with what I struggled with. I don't have to be ashamed of admitting that I was hearing voices. I got scared. I started using crack." Or "I was so depressed I started drinking everyday." They see that what they went through, they're not alone in it. It helps them then to be able to let some of their story out.

Or, for some of our clients, they might never participate in a group. And their only shot is with individual therapy. And as they build that relationship, that rapport with their therapist, they're able to open up their lives a little more and a little more. For some people it might take a couple of weeks of getting to know their therapist, a couple of months of getting to know their therapist.

Or, there was one gentleman I worked with, it probably took about ten years. Where I started with him and it was just a matter of showing him at first unconditional positive regard, that we were there for him no matter what. I'd get him a pair of shoes and by the time I turned around, he would have sold them for some crack. And then I'd get him something to wear and same thing, turn around, it's gone.

But he kept coming back, kept coming back and kept coming back. And he saw that no matter what he did, we still cared about him. We were still interested in him. Then soon he started coming in to the clinic, because he was kind of curious. What are these people about? Then he started participating a little bit; and he started taking medication.

Then he started talking with us on a regular basis. Then, several, several, several years later, he'd reduced what he uses, and was sober for a long time and then rebuilt connections with his family. Then a couple of years ago, he was so proud, he showed me he got his first credit card. I don't know if that's a good thing, but it really showed the journey that he took in kind of rejoining life.

What do your clients get out of the groups?

I think there are many reasons why group therapy means a lot to our clients. I think, number one and probably one of the more superficial but basic things, is that it helps with their sense of isolation. A lot of times, the clients at our clinic, they've expected – Well, they've experienced a lot of rejection. They've experienced a lot of doors closing on them and they've come to expect it and they tend to isolate after a while. They don't really trust other people or other relationships. And what group therapy does is it helps number one just get them out of their room or wherever they're staying, get them to a place where other people are and kind of start that initial socialization.

Most importantly, what it does is helps them to see that other people can understand what they've been through and accept them for who they are. And I think that's something valuable that we see with all of our groups. I mean, look at any of the research on group therapy or self help, mutual help, and they show that, not to get too technical in terms, but part of the value of being in a group is having opportunities for what's called lateral social comparison, upward social comparison and downward social comparison. Meaning it gives you a chance to compare yourself to other people you feel are doing as well as you or better than you. And when you compare yourself to people who are doing better than you, it inspires you to be better. And when you compare yourself to people maybe not doing as well as you, it helps you to boost your self-esteem a little. So the group kind of provides a mini-contact with society in that way.

Do you work with youth at all?

We don't get a lot of TAY population per se. We have some folks who come to us [who are] Transitional Age Youth, so people who are eighteen to twenty-five. And I think partly that's because Skid Row is the roughest place you can be. So thankfully, we don't have a lot of TAY, but we do see some.

What kind of changes would make things better for your clients?

The possibilities are endless. What I would really like to see is I'd like to see more peer support and the spread of that. We have such potential here in terms of the life experiences of our clients. I think the most amazing things about our clients are the stories that they have to share with others. And there are so many people out there who might be locked behind their hotel room, because they really don't think that it can get any better than this.

They think, they feel like, "This is as good as it can get. At least I'm off the street." But they don't know that's just the start of it. And I think that our clients carry a message of hope that can't be conveyed any other way. We need to get that to other people in the

community to let them know, “Look, you can have more. Everybody else in your life has told you that you can’t, but you can.”

I think one of the most valuable things we do here at the clinic, especially being in Skid Row, is we still have hope in people who everybody else gave up on.

Do you do home visits?

Not usually. But what we will do is we send people to outreach. Like sometimes we’ll get a call from an apartment manager or a hotel manager down here and they’ll say, “You know, I have this guy. He doesn’t want to come into mental health; but we thought maybe if he met you, he’d be a little more open to it.” So sometimes we’ll do a house call like that and try to be friendly and bring them some extra socks or snacks or something.

Do you ever get overwhelmed?

No. I don’t think I’ve ever felt that way. I mean there have certainly been days where I felt really discouraged or like we were really fighting an uphill battle. There are days where I feel like Sisyphus. I’m just rolling that big boulder up the hill to watch it roll back down. But when you meet clients who defy all odds, you can’t help but have hope.

One mom I worked with, she was down here with her two young kids in Skid Row. They lived down here for a year, living in one of the shelters. And it’s not even a nice shelter, it’s like a really not nice shelter. And her kids were, I would say, three and four or four and five around that time.

We really tried hard to help her with her mental health issues. We talked to the kids. We helped her get into permanent housing. We stayed in touch with her and she continued to see us for treatment through the years.

One day, she came in and she brought a video camcorder with her, with a videotape. She said her daughter “wanted me to show this to you.” It was a tape of her daughter as valedictorian of her graduating class. Her daughter got a full scholarship to a major university. And this is a girl who was in Skid Row. So when you see things like that happen, you can’t not have hope for people.

A lot of times, we get people who are very well intended and they’ll put 110 percent into what they do here and then they burn out. Unfortunately, that happens like around three years [after they start work]. And part of the reason for that, I think, is that you have [to keep your perspective.]

[She mentions another client.] He went back to school and he’s getting like a 3.75 GPA, after ten years under a freeway. And when you hear their stories, you know, it could be anybody.

It really defies the stereotype that people have of people who are homeless and on Skid Row. We get all kinds of people down here. It’s not just people who are non-intelligent and from lower SES and whatever else. Anybody could end up on Skid Row.

What would you like to tell people about this community?

I think just first of all, the diversity of people here. In terms of educational background, socioeconomic backgrounds, family backgrounds, it's just such a variety. We have everybody here from somebody who never finished third grade to somebody who graduated from Yale. I've had attorneys who have been clients here who had passed the bar. And I've also had people who've come from other countries who have never had any kind of education. I've had people who've come from very wealthy families, to people who were orphaned and put into foster care from a very young age. So it really defies the stereotype. There is no stereotype of who is homeless or mentally ill on Skid Row.

Oh, definitely, I see people – I had one client who had a trust fund and I had his mother calling me asking if $100 would be enough to buy him a pair of tennis shoes. So from that to somebody who has no friend or relative that we can find anywhere. Yes, it runs the gamut. We have people who graduated from Yale, as well as people who haven't finished elementary school.

END OF INTERVIEW