INTERVIEWEE: JOHN SHEEHE

INTERVIEWER: MARCIA MELDRUM

DATE: February 15, 2011

MM: Good morning.

JS: Good morning.

MM: It's February the 9th, 2011 and we're here talking with John Sheehe, who is – Give me your title.

JS: I'm the COD [Co-Occurring Disorders] system-wide coordinator for the [Los Angeles County] Department of Mental Health [LAC-DMH].

MM: We're very glad to be here. Thank you for giving us this interview. So why don't you tell me a little bit about yourself to start with – where you grew up and what sort of led you into the field of social work to begin with.

JS: OK. I grew up in Fresno, California and I got my undergraduate degree at San Francisco State University and worked for several years for an airline that took me out to the East Coast and I wound up here in southern California in '84. And at the end of that career, [when] the airline went out of business, I went back to school and became a chemical dependency counselor, got my certification at Glendale College and worked for about a year as a chemical dependency counselor. I realized then, after doing an internship at the Gay and Lesbian Center, that I wanted to go on to get my Master's in Social Work, which I did at UCLA. I graduated in '95. [The Los Angeles Gay and Lesbian Center, located in Hollywood, provides an array of services for the gay community, including low-cost health and mental health care, AIDS testing, social, cultural and educational programs, and a shelter for transitional-age youth.]

And it was really during my first year internship at Olive View Medical Center [a UCLA-affiliated County hospital in the San Fernando Valley] where I was running groups for clients who were discharging from the hospital and we started talking about things that brought them into the hospital. I realized what a high prevalence of these individuals were dealing with substance-related issues, and coupled with the fact with that there was some concern at the hospital at that time about running groups on the psychiatric in-patient unit having to do with substance. I found that to be kind of odd and so that was kind of the beginning of my really realizing that there was a need in the mental health system to more fully embrace those issues.

MM: OK. So this was in the nineties. You'd had this training in chemical dependency. So you had this interest and that stemmed from –

JS: It really stemmed from my own recovery. I got sober in '89 and that was really kind of what precipitated my desire to go into the field.

MM: So you could help other people. And what was the situation like in the County then, in the mid-nineties? Do you think it was widely recognized? I mean, I had an idea that this idea about co-occurring disorders is relatively recent.

JS: Well, after I graduated, I went to work at a for-profit hospital, Ingleside Hospital, out in Rosemead. This is the kind of thing that would answer your question. Just with a minimal

amount of attention that I was giving to the in-patient units and doing groups for clients with substance-related issues, I kind of gained a name for myself. And I was responsible for representing the hospital in the probable cause hearings [that is, to determine if there is probable cause for involuntary commitment, as defined by the California Court of Appeals in *Doe v. Gallinot* in 1981] and at that time really all a patient's rights advocate had to do was say that the client had some issues relating to substance and the hearing officer would let them go.

And I began kind of saying, "Well, wait a minute, nobody, no one here in this hospital, knows what the presenting issues are for this client. No one can say that their issues are substance-related. We haven't had them here long enough and they need to stay for further treatment." The hearing officer started to hold clients that had substance-related issues, rather than just automatically let them go. So there was a lot of [change]. Then in '99, the County received SAMHSA funds [from the Federal Substance Abuse and Mental Health Services Administration] to do some work with dual diagnosis, [as] it was called back then, and the County was putting together a plan for each of the eight Service Areas and a COD coordinator was hired for each of the Service Areas to help kind of integrate services further. And that's when I was hired to work in Service Area 5 [West LA] by Robin Kay [then a Clinical Program head at Edelman Mental Health Center, now Chief Deputy Director of LAC-DMH]. I kind of had two roles, I did the service area co-occurring disorder piece and then I also was a supervisor at Edelman Mental Health [Center, at Olympic and Sepulveda Boulevards, named after former County Supervisor Edmund D. Edelman].

MM: So you were busy?

JS: I was busy.

MM: So tell me, when you started doing this, first of all, in moving to the County, did you have any concerns? Did you think the County was really the place to go if you were going to be able to help clients?

JS: Well, I did. It was a real struggle in that for-profit setting where you were dealing with, working with psychiatrists, many of whom didn't get this. And so you'd have clients in group [therapy], you'd be working with them putting treatment plans together, and then you'd look to see what medications were being given and benzodiazepines were being given [the benzodiazepine drugs, which include Librium and Valium, are anxiolytic sedatives that may cause dependence or exacerbated anxiety and depression with long-term use]. So I had at least enough experience so that when I went to interview with the County, in the County clinics, I knew what questions to ask.

At Edelman, Dr. [Kathleen] Daly [now LAC-DMH Deputy Director of Adult Justice, Housing, Employment and Education] was the medical director at that time, Robin Kay was the program head; and I asked the questions, 'Well, where's your psychiatrist at with the treatment of dual-diagnosis?" and they had the right answers. And there were other places that I interviewed where they either didn't know or they weren't sure. I knew that those were not clinics that I wanted to work at because, if the psychiatrist isn't on board, there's no hope, you can't do this work, [because] it has to be a team approach. And I think throughout my career that's been one of the things that's held me in good stead that it's not just one clinician, it has to be a team that does this work.

MM: So tell me a little about the particular challenges of managing people with co-occurring disorders?

JS: Well, when I went to work at Edelman, it was really my first experience working with clients in the outpatient setting. And I think one of the primary challenges is that people kind of come to a County mental health clinic to deal with what they consider to be their mental health issues. And so whatever problems they may have, associated to their substance [use], is not in the forefront of their thoughts when they come in the door. So we're often times dealing with individuals who are in what we call pre-contemplation. [In the transtheoretical model of behavioral change, developed by James Prochaska and colleagues about 1977, "precontemplation" is the stage where the individual is not planning to change his or her behavior and is probably unaware that a problem exists.] It's really kind of out of their awareness in terms of the fact that they either have a problem or need to do anything about their substance. So engaging clients in the outpatient setting is very challenging, particularly when there is an issue the clinician can [identify], [when] it's clear in the screening and assessment that there's some problem with a substance.

So the challenge is really to be able to join with that client in a way that is going to be meaningful to them, when they first come in the door. And that often times has nothing to do with saying, "I think you've got a problem with substance and you need to quit." So really the goal is to get people to come back, to be able to have someone come back and continue in treatment and engage them. So it's a process. And for those clients that have a co-occurring disorder often times – we look back, and still to this day, some of the highest levels of care [utilization] and the worst outcomes are for those clients that have COD. It's still [a major problem]. So, if we can assist a client in staying out of the hospital for six or seven months, as opposed to going into the hospital every two or three months, it's kind of over the long term. So we really look at not isolated treatment episodes, but the whole full course of the client, in terms of their recovery.

MM: Did they present a challenge in terms of medication management?

JS: Well, I think that's one of the biggest challenges, medication management. And one of the things that's kind of exciting to me in terms of Health Care Reform [this interview took place shortly after the passage of the 2010 Health Care and Education Reconciliation Act, the Obama Health Care Reform plan] is that, in the context of health care, we hopefully will be able to provide the psychiatrists with a much clearer picture of what's happening with the client physically, so that the issue of treating while the client is still continuing to use becomes less problematic. Because that really is the issue, is what's going on with this client physically, how are the drugs interacting with them physically and how on earth can we ever treat them psychotropically [that is, with psychoactive drugs]? And the answer to that question is to have as much of a picture of that client's physical condition as possible to assist the psychiatrist in making those difficult kinds of decisions. And so there is always a need for further education and training. There also, I think, one of the largest challenges is that we do have clinicians in our system that are certainly capable of providing treatment to clients with co-occurring disorders and that what's missing is kind of an attitude shift, more than a learning of new information.

Because really, at the end of the day, what it really takes is a certain amount of humility and a need to really be able to set yourself at the feet of this person and really join with them in terms of what's going on in their life. And many of our clinicians have been inculturated to believe that substance-related issues are not part of their job and as a result they don't really join with clients around these issues. And so I think it's a challenge within the system, to invite people to kind of return to the values that brought them in to do this work and to kind of look at these folks with a different eye. And Dr. [Marvin] Southard [Director of the Los Angeles County Department of Mental Health from 1998 through the date of this interview in 2011] has been very supportive and has been very instrumental in bringing the system to where it is today,

insisting that we do treat clients with co-occurring disorders. It's in all of our policies certainly; you're not going to walk into a clinic and have someone tell you that you're not going to be treated because you're a substance abuser. But you might be told that you're not going to be treated psychiatrically if you don't get sober first. And that's something, that's a challenge that we're always faced with, that we want to provide our clinicians with the training and the support to be able to treat clients who are still actively using.

MM: And I could see that that could be very challenging.

JS: It is enormously, given all the constraints and the caseloads and the time involved in treating someone with a co-occurring disorder. It's not uncommon, or it wasn't in the past, to go into one of our clinics and meet with the staff and have someone raise their hand and say, "Well. [I'm] the COD person in the clinic." And that's as unrealistic as thinking that there's one person to take all [the responsibility] for the care of everyone's that bipolar [bipolar disorder describes the alternation of abnormally elevated energy and mood with abnormally depressed states]. That it really is something that we all have to be [involved in].

MM: So obviously it's different for every person, and every client has to be considered differently. But, in terms of the long term, you do want them to be weaned off whatever they're using. And are there particular strategies that are best for this?

JS: I think the principles behind Motivational Interviewing [are] kind of the cornerstone. [Motivational Interviewing is a client-centered, semi-directive counseling method developed by psychologists William R. Miller and Stephen Rollnick in the early 2000s.] And we, in revising our screening and assessment forms for clients' substance-related issues, we really took the principles of Motivational Interviewing and incorporated those into kind of the flow of those forms. So that what we're really doing is providing the clinician with an opportunity to really begin looking at the ambivalent issues related to the client's substance use. That we are asking clients, "What is it? What are the good things that you get from using substance?"

And for someone who's homeless on the street, there are many. And really, also in the screening process, [we're] kind of coming from this assumption that by and large everybody has been using or is using. So that the question we ask is not, "Have you ever?" but, "When was the last time?" So that we really kind of shift our thinking and kind of normalize the idea that people are using. And if they're not, we want to wonder why not, because for all of the clients that we see, there are going to be periods of time where they haven't used. We want to wonder with them what it was that was going on in their lives that helped support that and help maybe recreate those circumstances for them.

So being able to join with the client and really take a look at the pros and cons of their using and then also beginning to help them gain awareness of when it is they use, what are the triggers for their using, which are really – You and I may think, "Well, of course, anyone would know what it would be that would precipitate their using." But, if you're living in a world of using, it's something that you have to begin that slow process of regaining awareness. When is it that I use, who is it that I use with, what are the circumstances around that? And beginning to develop a plan for this person that will help them stay sober until the next time that they come to the clinic. So it really is about helping people who have little sense of control in their lives to develop an idea of, "Well, this is what I'm going to do at ten in the morning and this is what I'm doing at eleven." So we're not leaving people in the moment to make these decisions. Because what we know about addiction is that the addicted mind will always come back to [the idea that] the solution of the moment is to use. So it's very simple, but yet it's very painstaking in terms of that process.

MM: There's a lot of personal interaction with the client. So what you're saying here is – Sorry, I'm asking questions from a very naïve viewpoint so that we can get this all on tape. I think most people would think that the first thing, let's assume you have a substance abuser and you want to get them to stop abusing, the first thing you do is detoxify them, and get them to go cold turkey.

JS: Exactly. If we have someone who has reached the point in their using where they're addicted and they're exhibiting symptoms of tolerance and withdrawal, ideally our goal would be to get them into a program where they could detox. Again, that's easier said than done. And often times the client may be ready and come in and say, "OK, I'm ready to go into a treatment program;" but the beds are not available. So it's that frustration of helping the clinicians to get the client to the point where there are resources there when they're ready, and that window is sometimes very limited. But there are residential facilities available that will treat clients who have co-occurring [disorders] and there are more of them today than there were ten years ago. And we rely on our Substance Abuse Prevention and Control (SAPC, part of the County Public Health Department) residential services, often times, for that process for these clients. But again, getting people into detox is easier said than done. Often times we're going to work with them on an outpatient basis for quite some time before they get to the point where they're ready to do that.

MM: You talked about how important it was to get the clinician on board and I think also you mentioned in your CV that you worked with a multidisciplinary treatment team. So can you tell me about the different roles that people played? We know what the clinicians did, at least we have a sense of what the clinician was doing, we have a sense of what you were doing, are there other roles that were important for people to play?

JS: Well, there's certainly an important role for the substance abuse counselor; that would ideally be running groups and assisting clients in that group dynamic. And the role of the supervisor is really important, I think, just in case consultation meetings, to be able to structure those meetings in such a way where it's routine for the clients' substance-related issues to be discussed, that it's not just an afterthought. And part of the supervision that's so important in the mental health system is to remember [that] we're first and foremost treating individuals with a primary Access I disorder [Access I diagnoses include schizophrenia, bipolar disorder, and schizoaffective disorder] and that the treatment that we provide for substance is in ameliorating those mental health symptoms. And so what may seem primary to the client in terms of their substance, in our charting and in our case notes, has to be secondary to the [primary diagnosis]. So to assist the clinician in being able to kind of make that funding piece is really important. And so you'll often hear, "No, we don't treat individuals with substance related issues only;" so we are treating people who have a mental health disorder and we're assisting them in treating that by ameliorating their substance-related issues. So it's complicated in the billing and the charting, not so much in the actual work that we do with the client.

MM: Is there a role for peers?

JS: Absolutely. I think it's an essential part of the recovery movement that there is something that a peer who is themselves in recovery can share with someone who's struggling with getting recovery or in early recovery that no social worker or psychiatrist can provide them. And there's a power and a strength in the group that is really important. Now, for a lot of the clients that we serve in our Full Service Partnerships that either are not to a place where they can tolerate being in a group or are working in a group setting, that really is, again, if we can have a peer work with them one-on-one that's in recovery themselves, it can be an invaluable experience for

them. [Full Service Partnerships are intensive, recovery-oriented, integrated care services provided to the severely mentally ill under the California Mental Health Services Act of 2004. "Recovery" in this context refers to the rehabilitation of persons with mental and/or substance abuse disorders and promoting their independence and active engagement in community life, in contrast to long-term or cyclical institutionalization.] And incorporating the peers into our community mental health settings is one of the biggest challenges that we face right now and one of the most important goals, I think, that we have as we look towards transformation [that is, transformation of the County mental health system to provide recovery-oriented care as mandated by the Mental Health Services Act (MHSA)] and getting ready for Health Care Reform.

MM: Well, I was going to get to that. So you were at Edelman for about ten years, is that correct?

JS: No, I was there from 1999 to 2006. And I managed one of the traditional in-clinic treatment teams for a while. I also managed the Full Service Partnership team when that first started and then I did more administrative work in the Geographic Initiative offices with the Service Area [the Geographic Initiatives involved administrative coordination of client services for all age groups with specific geographic areas – Hollywood, Santa Monica, and Long Beach] and also helped with the coordination and planning of the Co-Occurring Disorder Conference that happened yearly. [The First Annual Statewide Conference on Co-Occurring Disorders was in LA in 2002; although these are statewide, and often include national and international speakers, the conferences are usually held in the LA area.]

MM: That's right. When did those start?

JS: It's been about eight or nine years now that those [have been held]. It was really Vivian Brown [founder and recently retired Chief Executive Officer of PROTOTYPES, a multi-service health and social service agency based in California and Washington, DC, who] was the person who was kind of instrumental in helping to develop and further the conferences that ultimately became a statewide conference and that has been an important piece of the work that I've done.

MM: So what do you think is the most important thing you learned when you were at Edelman?

JS: The most important thing I learned when I was at Edelman?

MM: Or interesting thing.

JS: I think that one of the things that I learned was that it's very difficult to get everyone on board, in terms of doing co-occurring disorders. And I think that it's very easy or it's natural, in a community mental health setting, that, if there's a person or two or three people who kind of have a desire to work with this population, it's very easy for the rest of the staff to kind of say, "OK, well they're the folks that do this." And I think when the County first started, when we hired the Co-Occurring Disorder coordinators for all the Service Areas, and in those clinics where there were specialty programs set up, when we looked at the statistics, we saw that overall the clinic itself was not treating folks. So it's that refer-out kind of syndrome and what we learned was that doesn't just mean that we refer people down the street to the substance-abuse folks. It's referring people within the clinic.

And so [I've been] working with people around the referral process. "Who is the person that you are referring, why are you referring?" And really engaging that referring clinician into

the treatment is part of the challenge that I think we face. One of the other challenges, I think, is that you know, with the resources at hand in most clinics, if we can get one of two co-occurring groups going a week, that that's a lot. And yet what we know is for people in early recovery, that's not enough. So we really do have to either be providing more of that resource at the clinic or joining with other facilities in the community to assist in providing the kind of support that people in early recovery need.

MM: And what other facilities are there?

JS: Well, there might be substance-abuse related treatment facilities. And I think one of the great parts of the MHSA process has been the development of the Wellness Centers where we're really looking to do more of those kinds of groups at the Wellness Center sites. We're not quite there yet, but I think we're heading in that direction.

MM: What is the biggest challenge you faced while you were at Edelman? What's the biggest problem you had to solve? Maybe you've already told me what that was. Let me ask it a different way, was there something you couldn't solve, something that you just felt you were not getting done, no matter what happened?

JS: We had one client that was in our Full Service Partnership that had spent quite a bit of time in locked facilities and who was on conservatorship [that is, had a court-appointed guardian overseeing his care and personal affairs]; he was now out and had actually gotten himself on the waiting list for an assisted living program downtown. And he wanted to do this and we felt that, because this was something that he wanted, that we would agree. So we made arrangements for him to go into the program, but came to find out it was not sanctioned by the Public Guardian's office. [The County Public Guardian serves as conservator for many disabled individuals if no appropriate family member can do so.] It didn't meet the criteria for what they felt was appropriate for someone. And so, in order for us to allow him to do this, we had to rescind his conservatorship. And once we did that, the client decompensated [deteriorated functionally] and it was a horrific situation of getting him from one facility to the next. That was about the time that I left Edelman. He's doing fine now. But I think, in those moments, here we have a program that's been set up to do whatever it takes to help someone and yet there are still bureaucratic constraints that we have to work with that at the time were inflexible. And it can be very challenging.

And then I think, with any system, there were clients that had co-occurring disorders that were people who were very adept at talking to the [Los Angeles County] Board of Supervisors and the Governor's office. And I spent a fair amount of time with a couple of clients that we were really not providing treatment to. We were unable to provide really even any [treatment], but we were trying to contain [them]; and that was part of the job that could be really exhausting. Where it was really a situation where] we were kind of held hostage. One of the really good things that happened while I was at Edelman was that the County, under the direction of [LAC-DMH Medical Director] Dr. [Roderick] Shaner and Dr. Southard, really pulled back from the formulary [list of drugs approved for prescription in County facilities], the dispensing of benzodiazepines, that we really took a hard line with that and that was to the benefit of a lot of our clients.

MM: And what proportion of the clients – I mean, it seems to me a lot of them must have been in and out of the criminal justice system as well. Yes or is that not true?

JS: Not so many clients out on the Westside, I don't think, but that was not the population that we saw. There were a lot of clients who were homeless, who were coming to the clinic for

services and on a waiting list to get housing. That was kind of like the carrot that we used to engage them in treatment. But we didn't see that [forensic] population so much at that particular clinic, which is not the case obviously at many.

MM: A lot of what you've been talking about sounds very much like recovery. I mean, working with the client where they are and providing a sort of multi-faceted approach. Again, was recovery something that was very much in the air when you were working at Edelman? Is it something that people talked about as the Edelman goal or was it something that developed during the time you were there?

JS: Really the transformation started just before I kind of left there, so it really was not something that was talked about. The whole idea of peer support, I think, is still something that we're negotiating. I think if you walk into a clinic and if there are still separate bathrooms for the staff, that's kind of like a bench mark to me, in terms of whether or not we have really integrated and do we really honor what happening in terms of the peer piece. And it's a paradox because we expect the peer advocate, the peer support worker, to share their own story and be supportive in that way with a client; and clinically speaking, that's one of the hardest issues to deal with, the issue of self-disclosure. And so we're expecting someone with the least amount of education to deal with a very sensitive issue in terms of boundaries. So there's really need for support and supervision for our peers, so that what they do is done appropriately and effectively.

MM: And do you think that in many cases they don't get enough of that?

JS: I think that we're working towards that, but I think that in many places it's a challenge, especially when the resources have been pulled so thin already. Supervision time is really precious [for] the Clinic Directors and the supervisors. So in their mind, their thinking, "Well, here's one more, this is one more issue that I have to give time to;" when in reality, it really is an investment in the development of the program.

MM: So tell me about how you made the move from Edelman to this office?

JS: Well I was the coordinator out in Service Area 5 and *Roberta Bradley retired; a vacancy became available and I interviewed for the position. And I'd actually – about a year or two before then, [then LAC-DMH Deputy Director of Adult Systems of Care] Jim Allen was spearheading an institute for co-occurring disorders that they were going to put together at Augustus Hawkins [the County Comprehensive Mental Health Center in South Central LA, affiliated with the King/Drew Medical Center] and I was provisionally offered a position there to help with the training and education component. That all fell apart. I was still at Edelman and he [Jim Allen] was one of the people who was on the interview panel. So I knew Jim and I had worked with Dr. Shaner as well. It was really at a time where the Department was [thinking], "Well, we've sunk all this money into hiring coordinators and we've done all this preliminary work and we don't have much to show for it."

So I think at that time, we kind of shifted to more of a central approach to issues related to COD. That was when we looked at redesigning the assessment and screening tools and started our work with UCLA's Integrated Substance Abuse Programs [ISAP, a research and training center within the UCLA Semel Institute for Neuroscience and Human Behavior] to provide some system-wide trainings, some basic trainings in co-occurring treatment, and we're kind of still in that process today. Part of the stats process [is] that every month we take a look at clinical, or really more administrative indicators, business indicators, lag time for billing and such; and the administrators added a clinical component looking at co-occurring [disorders],

about the time that we started these trainings. So it was a good tool for us to be able to get into the clinics and provide more training. If the secondary Access I diagnosis and what we call the *30X code were not in concordance – those were the two indicators for COD – then there was the assumption that the screening and assessment were not being done properly and we were able to go in and do trainings to that. So that has been a big in for co-occurring [training] in the Department.

MM: So one of your goals is to improve the level of COD assessment and management throughout the County, County wide. So I actually had two questions. One is, when you took this job, you sort of moved in a sense from being on the front lines into a more administrative job. Did you see that as something that you brought special strengths to? What was your thinking in terms of making that move? I mean, obviously you saw that there was a system-wide, County-wide problem that really needed to be addressed. And did you think that, is there a particular reason that you thought *you* were the person to do that? I'm sorry, that sounds like a very job interview question. Maybe, though, you have an answer. And then the second part of the question is, could you sort of talk about what your goals were when you started doing this, when you moved into the position?

JS: OK. Well, I knew I didn't have any magic wand. And I think that I brought the experience of working with the clinicians and [that] being in the front line was really invaluable to my ability to move into more of an administrative role. Because I think sometimes we get caught up in moving past kind of what are the constraints that people are working with in the clinics and how can we best support them. And I think that, throughout my time in this job, I have been able to kind of hold on to that idea that we really want to come from a place that people are doing the best that they can and that we want to support them in doing more versus they're not doing it right. Because, when I was at Edelman and we first started the transformation process, there were some initial folks that came in to talk to the clinicians and the message was loud and clear. What the people were saying was one thing and what the clinicians heard was something very different. And it took a long time for us to kind of regroup and kind of say, "OK, we can do this;" because by and large I think people need to be acknowledged for the work that they do and that's where, in any of the trainings that we've done, we start from that place.

So [I was] really kind of able to design the trainings in a way that the clinicians understood that the people who were training them really got what they were doing. And that's really been part of the success, the value that I've brought to our system-wide efforts, was that there's never been a time where we put a trainer in front of the clinicians that they don't understand the population that they're training to. And in some of the early years, back when we first had Motivational Interviewing, one of the big complaints was that trainers would come in to talk about Motivational Interviewing as if we were working with people in a 60-minute hour on the Westside [that is, the standard psychiatric visit]. And it was an insult to the clinicians and it was not to the betterment of the client. So one of the first things we did in our first round of trainings with UCLA, was [that] the *Substance Abuse and Mentally Ill Task Force had put together a wonderful DVD of clients who [were] talking about their journeys of recovery from co-occurring and we showed clips of those clients talking about recovery. And it wasn't so much for the clinicians to see, but it was for them to see the trainer see, so that we really, really got that they understood who it was that they were treating.

And the other piece that I think we've done that's been successful – there's this push, there's an initial inclination to put trainings together and get them out there and get people going. But there has to be a buy-in. And so [for] all of the trainings that we do for all of the systems of care, we've taken the time to really go into the clinics and into the programs and talk to the clinicians and the supervisors and the managers about where they're at and what they feel they need, so that we can bring to them what they feel is important. They really have an

ownership in the trainings versus something that's just being forced on them, because it really is the bottom line at the end of the day, it's all about engagement. If we can't mirror for the clinicians the kind of engagement that we want them to have with clients, then we're not doing our job. So it's been a great experience, working with the folks from UCLA in setting up the trainings and stuff because they really get it. And I think we can be proud of that piece.

One of the other things that I think has been hard, that has been a challenge, is moving away from this idea that we're putting together specialty programs in clinics and training everyone. We have to acknowledge that everybody is at a different place. Everybody is at a different place in terms of dealing with COD; and we have to engage the clinicians where they're at, with being able to do this work. And the more we can bring it back to developing personal relationships and honoring the people that we see, I think the better off we are [and] the more chance we have of successfully integrating these services. So I think that's my overarching kind of goal. When I first took the job, Dr. Shaner, my boss, said to me, "We'll know when we're successful when everybody is wanting to taking credit for what it is that we're doing and we'll be happy to let them take it." That's his attitude and his philosophy and it's been really a privilege to work with him because he really understands. He understands what it takes, and we've really been given that opportunity, through the support of Dr. Southard, to provide these trainings and move this forward in a way that I hope has been helpful to the clinicians.

MM: So when the MHSA came along, I guess, was this a positive step? Did you see this as helping what you were trying to do?

JS: I saw MHSA as [providing] more resources for the client. But, in the setting up of the Full Service Partnerships, [there is] the issue of how do we deal with a client who's actively using. And there is no amount of wraparound service that is going to assist someone who is actively addicted. And the question then becomes where does a client like this [fit]? Where can we put them, where can we treat them, how can we help them? And it's about residential services. So yeah, I think that MHSA has been responsive to this. In that instance, we're able to treat a client residentially for their substance-related issues with a Full Service Partnership team, with the understanding that they're going to transition back out and be case managed by the team.

So there are some allowances. But, on the whole, I think we still are struggling to provide our clinicians with the resources and the training that they need to feel confident, in terms of working with clients with co-occurring. We work in a voluntary system; so again it's about engagement and those things are very difficult. I think that, without MHSA, we'd be in a world of hurt today. The trainings that we've done, all of the work that I've been able to assist with, has been directly funded through MHSA. I think that the transformation of a lot of the lives of the clients that we work with is directly tied to the services that they received through the Mental Health Services Act. So I think that it's been invaluable, but change is always hard. I think that it's taken our system a while to really get [where we should be, but] we're certainly there now. The change is here and we're not going to be going back to the way things were. Now, with Health Care Reform, it's been even more magnified. We're headed in another direction.

MM: So what are you thinking about doing in the next few years to help meet that challenge?

JS: Well, we're just now trying to figure out what that is and what is Mental Health's role in the primary health care sites. I think really these are the issues that are being grappled with right now. But there are definitely evidence-based practices [that is, practices that have been validated by research evidence of efficacy in the designated population] [and] models of care that can be incorporated into these settings. So that there's going to be an enormous amount of training that's going to be needed.

MM: So it all seems to come down to training more and more.

JS: It does. It does, I think. As we embrace evidence-based practices, it is something that we've just begun really, I think. And in looking at Health Care Reform, there will be different models of care. Do we work as a consultant? When the primary health care person says, there's a problem with someone in a behavioral sense, are we equipped to go in and screen and assess for both substance [use] as well as mental health [disorders]? I mean, these are the kinds of challenges that we have, because it's not about having the mental health person and the substance abuse person, it's about having the behavioral health person, as far as primary health care.

So really seeing our role through this different lens, [in] that we are now really being forced to see ourselves as part of a larger team. And how do we ensure that we have a place at that table is something that is really kind of being mapped out right now through the demonstration projects [and] the 1115 waiver [a program that enables managed care programs for low-income individuals under MediCal (California's Medicaid program), by allowing preferential MediCal referrals to selected facilities who contract for discounted payment rates]; and things are changing so rapidly. The training project that we have with UCLA, as I think it is today, may change. Talk to me in three months [and] it'll probably be something very different. Maybe our focus will be much more towards Health Care Reform and preparing our clinicians for treating clients in that role, in that capacity. But that shift from just treating clients who are acutely mentally ill to providing more Prevention and Early Intervention services to a larger population in a primary health care site, I think, is kind of the focus. That's kind of where we're headed.

MM: Does that make sense within your context? This is probably a question I should have asked earlier. In terms of individuals with co-occurring disorders, would it be correct to say [that the] individuals have a mental health disorder which is not getting adequately treated and therefore they essentially start using substances to sort of self-manage the disorder. Would that be a true statement or would it be the sort of other way around?

JS: Well, it could be both. It could be either.

MM: OK. There's no single prevailing model?

JS: No. The issue of trauma is one that we are looking and screening for. In this larger population, it may be that this individual suffered early childhood trauma which precipitated the substance use that now has exacerbated an underlying pre-existing mental health condition. So again, I think that screening and assessment is really essential for us to understand where it is that we need to be treating this person. Short-term models of treatment are going to do very well for clients who have maybe secondary mental health issues related to their substance abuse. There's always going to be a place for the Department of Mental Health in treating clients with chronic and persistent mental illness that are the Full Service Partnership kind of population that are not going to be served in a primary health care setting. That piece I don't think will ever change. So the Department is really defining, what are those basic roles that we have that are mandated by law that no other entity is going to be able to probably provide? And then, aside from that, how do we address the issues of this larger population who may or may not have a primary Access I disorder? It's very challenging.

MM: It is very challenging. In a sense, we don't really know the size of that population or the parameters, do we? Because they haven't come to the clinics.

JS: One of our demonstration projects is an enrollment [project], to enroll clients and so through that process, we'll gain a better understanding of who it is we're going to be treating. But we're really moving away from a fee for service system to a capitated system [where services are funded by set amounts per client enrolled] and so it's not about providing more services. The system is predicated on providing better services and less service versus more and so it is a whole gear shift.

MM: Quality versus quantity.

JS: Exactly. So if you look at the substance abuse folks, they have an enormous amount of transformation ahead of them. Their primary lead task [has been] treating clients who are addicted to substances. In the health care setting, in Health Care Reform, there's a need to, as I said before, screen a larger population of individuals, ferreting out those folks who may be having some problem with substances and provide them with some short-term therapy, or treatment rather, in relation to where they're at with their substances. It's very different than working with someone who's been addicted for years. So those are some of the challenges that we're facing.

MM: Do you want to talk a little bit about the demonstration projects? Outline each one of them for me?

JS: I don't know that I'm really equipped to do that. Dr. Shaner would probably be a better person to talk to on that.

MM: Is there one in particular that you feel particularly involved with or that you've had a lot of experience with?

JS: Well, we do have a – it's kind of the demonstration project of the demonstration project. There's a co-located project that we're now working on with DHS [the County Department of Health Services] to co-locate mental health staff in various primary care settings. And so screening and assessment protocols are being set up and that project is just now kind of coming together. We'll probably be doing some training, we'll be diverting some of our UCLA resources into the training of the medical staff, providing training on the ASBI [Alcohol Screening and Brief Intervention] model, screening, brief intervention, treatment and referral, which is kind of a basic component to a primary care setting with regards to substance [use]. So we will be working on that.

MM: And then the goal would be to screen those people and give them some sort of brief intervention. And then give them what, any kind of resources in the long run? Just tell them to come back?

JS: Well that, and then also make sure that the clients who have a diagnosable mental illness [are] seen by the psychiatrist. So it's all of those different factors.

MM: Sure. All of the pieces. What am I going to ask you? I have more questions but is there something you want to talk about that I'm not talking about?

JS: No, I don't think so.

MM: Well, here's a question. This one is particularly because part of my project is to visit programs as well and so I need to ask you if there are particular programs in the County that would be interesting to visit. In particular, we have some money to do some video documentaries and we would very much like to feature a co-occurring disorder program as one of those.

JS: OK. I think that the Downtown Mental Health [Center, a DMH Center in the Skid Row area of Los Angeles] would be an excellent place to visit. *Dr. Cavanaugh and their Full Service Partnership team is very much a co-occurring project. Rio Hondo Mental Health [in Cerritos, in East Los Angeles] has a very active COD program. And on the substance abuse side, the River Community is really the only blended funding residential treatment facility in the County for co-occurring [disorders]. It's up in the Angel Crest Mountains and it's run by Social Model of Recovery; that would be a great place to see. [Social Model of Recovery is a contract provider of mental health and substance abuse treatment services. River Community is a residential rehab treatment program in Azusa, California.]

And I think it would be good to go to just one of our [directly operated clinics] – Hollywood Mental Health, and probably to see Edelman would be good too, and kind of contrast these clinics with their corresponding Wellness Centers and what the Wellness Centers are doing. The Wellness Center down at Harbor USC would be a good place to visit.

MM: In terms of wellness, how do I ask this? The long-term goal, right, is a client that's in recovery, functioning in the community and is basically off substances, is sober. But you would want to continue that person in a wellness program. Certainly, if they still have the mental health disorder, that would be appropriate, and then do the wellness programs incorporate then some kind of maintenance for –

JS: For substance, yes, ideally. Are they now? Some of them do. In the transformation process that created the Wellness Centers, what you just described is ideally what their genesis was. The reality is that many clients may have landed in the Wellness Center where the screening and assessment process was such that their COD piece may have been missed. So the reality is that we may have people in the Wellness Centers that are still actively using [and] that we need to assist in the initial steps towards recovery. So the reality is again that no program can – people can't be turned away because they're using, so it presents a kind of a quandary for the Wellness Centers. You're supposed to have this certain level of functionality to be in the Wellness Centers, so does using substances precipitate your dismissal from the program? Well, the policy says no. So how do we grapple with this issue? Again, I think it's important, this is a great place for our peer advocates to be working in. I think there's been a lot of resources put towards ensuring that we have peers in the Wellness Centers and that they can run groups and assist with some of the support.

MM: You've spoken about working on the County-Wide Task Force on the methamphetamine epidemic. Is that sort of an extracurricular activity or what is that? I mean, I know what the methamphetamine epidemic is. [The manufacture and sale of crystal methamphetamines, which can be synthesized from pseudophedrine, the active ingredient in many non-prescription cold medications, became a virtual home industry across the US in the 2000s, resulting in high overdose and death rates.]

-

JS: There was a task force that was put together. It's now the Methamphetamine Workgroup and I'm not sure, they haven't met for a while. But it was initially tasked by the [Los Angeles County] Board of Supervisors. There were community groups that came together, really with the cry that something has to be done about the meth epidemic. And all of the Departments

involved were charged with coming together to deal with this issue. SAPC was the lead agency and actually the money was given to them and with that money –

MM: I'm sorry, SAPC?

JS: It used to be ADPA [Alcohol and Drug Program Administration]. [SAPC is the County agency for] Substance Abuse Prevention and Control. With those funds, they were able to fund additional beds, I think at Tarzana [Treatment Centers], Rainbow Bridge [Community Services], and at the Venice Recovery House [all contract service providers], for people who had [substance abuse], specifically with crystal [methampethamine]. And as an offshoot of that, some of the work from UCLA's research arm was working with meth users in the gay community to ensure that they were not seroconverted [that there were no HIV antibodies in their bloodstream]. And so there were various community groups, as well as these research and funded programs, that came together to talk about this issue.

It was a lesson for me in how completely different the geneses [origins] were; all of the HIV and AIDS programs [that] were instituted and predicated on their ability to generate statistics. And the Department of Mental Health is still struggling to put together a computerized medical record.

So when you sit with researchers who are saying, "Well, why haven't you collected copious amounts of data on transgendered individuals and their sexual practices?" It is absolutely unconscionable to them and yet we're two years away from the medical record. So it was really challenging to us; and part of what we are doing is response to that is we are providing more training. Back to the training. We have a small contract with the [County] Office of AIDS where we see clients. Specifically, [they are seen] by case managers at Harbor and at Hollywood Mental Health, as well as at Long Beach. The clinicians that are involved with those programs are also doing some more outreach and education in the larger system about screening and assessment. And the main issue with clients with substance is high risk behavior screening, to kind of understand where they are with their sexual behavior, and the need to have ongoing medical treatment and support for that and that's a piece [where] we're not there yet. So yes, the Crystal Meth Task Force.

MM: OK. Somehow this brings me into something I wanted to ask you about earlier. You mentioned the importance, in terms of prevention and early intervention, of providing support for young kids and kids who had experienced trauma. One group which seems to me to be in considerable need of support is the TAY [Transitional Age Youth, ages 16-23] group, particularly kids who are coming out of the foster system. Tell me what you think. It seems to me that this group is just – we're just sort of looking at a disaster waiting to happen unless there's some sort of support in place.

JS: Absolutely; and I think that's why, if you look at the Transitional Age Youth services, the bulk of those services are outreach workers, out in the streets, really in the community to interface with these kids where they are at. It's not about funding clinics. It really is about outreach support and to that end, there's a real need in that population too. How do we deal with the substance piece? And that's the great thing about my job, because part of this training project will interface with the Transitional Age Youth and, once we're finished just working with the Older Adult population around all the challenges that they have, we'll be then working with the Transitional Age Youth. Then we'll bring together what we've learned from those two populations and we'll do more trainings with our Adult Systems of Care.

But there is definitely a need for the outreach workers and peer support in the TAY population as well. When I worked at Ingleside Hospital all those years ago, it was not uncommon to see kids admitted to the psych unit just before their eighteenth birthday. They'd

turn eighteen in the hospital and then it would be my responsibility to find them somewhere to go because they'd aged out of the foster care system or the group home that they were in. I think it's safe to say we've moved past that. I don't think that's the discharge plan. But still there is this struggle to deal with kids who are aging out of the system and what resources are there for them? The Transitional Age Youth system of care is definitely one that is a viable component to assisting those young people as they transition out of that system.

MM: So what have you learned? You have the conferences every year, are there new things have happened in the last two years which has sort of helped you to do your work better? Is there new research going on that's telling you new stuff? Or what's changed about what you're doing in the last five years?

JS: Well, I think that the research that has come out around stimulant abuse and the work that's been done through UCLA and some of, just in general, the work nationally, I think two things. One, the focus on trauma and the need to address that and understand that, at least in the screening and assessment process, as a component of what we're looking at in a clinical picture that we're seeing. And I think in terms of the treatment of substance use, that there are some very simple and basic skills that we can provide our clients. This is not rocket science we're talking about. This is, I think, the idea of being able to demystify treatment of clients with COD for our clinicians. That it really is no different dealing with someone who's struggling with schizophrenia and not wanting to get on their medication. Well, what are the triggers for relapse there? I mean, there are parallels to the treatment of substance, but that we really are being able to – How do we join together with our clients effectively in assisting them with putting together a program of recovery that's going to work for them?

For some of our clients, that might be going to Twelve Step [the twelve-step program towards achieving sobriety, with a significant emphasis on putting one's trust in a higher power, developed and championed by Alcoholics Anonymous since the 1930s]. I think one of the challenges that we face is providing our clinicians with some basic knowledge about the Twelve Step process: What are the Twelve Steps, what is a sponsor, how can we assist clients in engaging successfully in that community-based setting? Because it's a huge resource that we've as yet been kind of unable to tap. And so I think that's definitely one of the challenges that we face, because we were talking about peer support. There's the peer movement and then there's also the Twelve Step recovery movement. I think there's a place for many of our clients in those meetings and being able to use our peers to help them bridge that, to be bridgers into those meetings is a part of what where we're headed.

MM: What's the most frustrating thing for you on a daily basis?

JS: Well, I think just dealing with the bureaucracy. We spend an enormous amount of our time – There's the MHSA, there's these dollars that are there for us to be used and accessed and then there's the funding mechanisms that we have to set up by which they're accessed. And an enormous amount of our time is spent dealing with the Board of Supervisors, creating Board letters and contracts and that kind of stuff, to enable us to access the funds that are available. If anything, that is probably the most frustrating piece of the work.

MM: I can definitely sympathize with that. But yes, go ahead.

JS: Making that work and being able to utilize those funds in a way that's going to be responsive to a system that is changing very rapidly. I think the most successful MHSA programs are the ones that have been set up that have flexibility. I mean just in general, because we can't foresee what's going to happen; but what we can do is to allow for as much

flexibility and adaptation as possible, because that's kind of the name of the game in this really rapidly changing time.
MM: Have you dealt much with stigma issues? I mean, it seems to me that your clients, the COD clients, are likely to be doubly stigmatized?

JS: Absolutely. I think – when I worked at Edelman, Dr. [Kathleen] Daly instituted a medication refill. Some of our clients [who] missed their appointment with their doctor could come and get their medications refilled on a one-time basis. The psychiatrist that was running this would be doing this with a social worker. I helped do that for a long time and it took me a while to really realize that we had a significant portion of clients that would come to the medication refill group who were working, who were very high functioning. They would have been in the Wellness Center if we had it back then

They had missed their appointments, and when you started talking to them to really understand that one of the reasons why they missed their appointment was they just didn't want to come back to the clinic one more time, to walk through the door and admit that they were someone who has a mental illness that's being treated at County Mental Health. And I really remembered that, because it takes an enormous amount of courage for people to walk through the doors and just to be able to be there. And so I think that – I kind of get simplistic with this but to really be able to greet our clients and be able to welcome them into the clinics each and every time that they come, it's a big deal. It's a big deal that we say, "Hey, we're glad that you're here, we're glad that you showed up;" and to just acknowledge that and start from *that* place, rather than the long laundry list of the things that we see that they either need or are lacking. Kind of that strength- based approach, I think, is really important.

MM: If you have a client who clearly will not stop using, what – Are there some who will not, who just won't stop? I would assume so.

JS: Many. So it's kind of adapting that approach that anything that we can do to minimize the negative consequences of their using or to decrease their using in some way. That maybe they were using seven days a week, that we really understand how much they were using and now they're using six days a week. So that there's some [progress] towards the goal of abstinence [and] that we are doing some harm reduction for this client. [interruption].

MM: We were talking about goals, about cutting back [use] rather than trying to stop people all together.

JS: Utilizing a harm reduction approach for clients and I think the basic understanding that if the client is at the clinic, they're not using. So what are the activities that we can engage clients in and assist them in participating in, that will be something that will bring them back to the clinic on a daily basis versus once a week or twice a week? That alone is a huge support, I think.

MM: We have a question we usually ask. Is there anyone who you can tell me about that you've learned something specific, either someone at DMH or a peer, or someone who's taught you something you haven't thought about before?

JS: That's hard. I think, with understanding the brain chemistry through all the research that's been done and the understanding the basic component that we're really assisting people in, who have poor impulse control with heightened emotionality and poor decision making, to help them create a life. And the way that we do that is by assisting them in setting up some kind of a schedule for themselves. It seems so simple, but yet it's such a powerful thing. And so to move people away from this idea of making a decision here and now that I'm not going to use drugs,

versus I'm going to adhere to this schedule that I've set up for myself. That was one of the basic from research to practice kind of concepts that I think has been most powerful with our clients. How do you help a client ensure that they get back to the clinic for their next appointment? Just really that simple piece is just a great example of what we know, what we've learned from research, and how we can apply that to the work that we do with our clients.

MM: Do you find it still kind of frustrating that co-occurring disorders still need this sort of separate piece, [and think] that they should be more integrated into the whole of the program?

JS: Well, that's the goal. The goal is that it be integrated and even, in hearing you, you said that you want to go and see a program that has a special program.

Human nature is an amazing thing and we're trained in our professional schools to delineate and separate. And it assists us in communicating more effectively with our colleagues and it does not however assist us very much in terms of interacting with our clients. Sometimes I think – and Dr. Daly was one that really used to talk about that – just that idea that we can refer people out in our own clinic and how do we [address] the challenges of shifting that [approach]. That it's about being able to sit with someone and ask them what it's like to get high and kind of sit with [them while] they're wondering about what it is that brings them to that.

That's really important and I think, I had this clinician that works at the [LA County] Jail, a young woman who has been able to engage clients there to the point where they'll talk about their substance use; but then they'll ask her, "Do you use substances?" And she says, "I don't know what to say, 'cause I haven't done that so I can't connect with them." So we really have to find in ourselves what are those areas where we've been challenged and we've really struggled that we can bring to the table, [so] that we can join with people with substance, because really it's just an extreme. It really is just an extreme form of the human condition and I think our reluctance to be able to sit with that is directly proportional to our own stuff. To be able to get people to do that is a challenge and it happens through modeling and it also happens through support from above as well as below. It takes the peer advocates and it takes the Dr. Southards, and everything in between. And everybody has their limitations, as well as their gifts, that they bring to the table and we have to be able to honor all of those.

MM: So what do you feel most proud of having accomplished?

JS: What do I feel most proud of accomplishing?

MM: Or what has been the most rewarding for you?

JS: I think being involved with the training projects has been really amazing. I'm most proud of that and the fact that the training has dovetailed into the system in a way that's been meaningful, I think, and has helped further our ability to screen and assess. There's tons of more work to be done.

Well, one area, one thing, completely unrelated to what I'm doing right now, [happened] when I was working at Edelman, [when] Dr. Daly was the Medical Director. After [the World Trade Center and Pentagon attacks on] 9-11, the airlines were contacting the Department because they had flight attendants [at] American and United Airlines [that] were really traumatized, the American crews, and so she set it up for me to go to the airport. I met with the flight attendants as they were showing up for their first flights.

So I was able to do some crisis intervention work because I had done that, I was in that field before, [and] I kind of had an understanding of where they were at. And that was kind of a really cool kind of merger of my two careers. I didn't have to share with them that I had worked with an airline; they just knew that somebody was there and got what they were going through

and with all the people whom I saw, it was really easy. They had a choice, they either got on the plane and flew or they got in their car and went home. And of course, as with everything in life, for the people that needed to get on that plane, it was the hardest choice that they had to make; and for the people that needed to get in their car and go home, that was the hardest choice. And just to sit with people as they made that decision and there were some people that were able to do what they really needed to do and there were others that couldn't. And just to be there and witness that was really a great moment in my career.

MM: OK. I think on this note, we'll conclude this interview for now. I want to thank you very much for your time. It was great. Fascinating.

JS: Thank you so much.

END OF INTERVIEW