

Carl McCraven talks about how the Hillview Mental Health Center developed housing sites....

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One of the programs [was] a mentally ill offender program; the Sheriffs Department discharges people at all hours of the night into the streets. We had this little program called the Mentally Ill Offender Program, which provided outpatient services, and we would find these people. We didn't have anywhere to house them and so we would use this house. Now, that was sort of bootlegging, I guess, but we would use the house that way. And then there is a giant in the history of the mentally ill offender program and the Jail Program, Roger Shock, and I was able to convince Roger to give us money for board and care. And so we ended up being able to take people out of the County Jail and put them in board and care, so that we could provide treatment. Every year the church would do an inventory – it was headquartered in Chicago and they would call all around and they would finally find me and then they would ask, "We have this item on our inventory, would you tell us what it is?" [He laughs] And after two or three years of that, someone said, "You know, maybe it would just be better if you bought the property." So they arranged for us to buy it, nothing down, book value, [and small and infrequent payments]

And we purchased it. We formed a corporation to purchase it [because our hospital financing prohibited it from incurring debt]; and we purchased it and it had on it an old farm house that was the first building for the church. [The property had two buildings on it when we purchased it. The two original buildings have been renovated and enlarged and we have added three new buildings.] One is this office building you're in. Then we have a tax credit project for permanent housing with fifty units next door and it's comprised of Buildings A and B; and then we have a building that has transitional housing. Transitional housing, what it really means is you have some rooms with various amenities and you could put it into use for whatever is in vogue at the time. So now we call it transitional housing. There's one big difference – it's not permanent housing like the other housing. Then we have a fifth building which we use as a licensed facility. Currently, it's being used as a board and care for urgent care. It's had various uses. Like I say, buildings, social workers, psychiatrists, all these people and facilities, make up the mental health system and it takes on different forms at different times depending on [what leaders in government think is best at a particular time].

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INTERVIEWEES: EVA and CARL McCRAVEN

INTERVIEWER: Marcia Meldrum

DATE: September 9, 2009

I. Carl's Story; The Pacoima Community Hospital; Mental Health and Housing Programs

MM: Good morning. It's the 9th of September and it's about 10 am in the morning and we're starting this interview with Dr. Eva McCraven and Mr. Carl McCraven at the Hillview Mental Health Center. Thank you very much, both of you, for giving us this time. So I wanted to start by asking you sort of the story of your life. Where you grew up, what your original training was and how you got into mental health services and what the factors were that led you there. So we'll start with you, Mr. Carl McCraven.

CM: Well, I was born in Des Moines, Iowa; and when I was about five years old, my mother sent me to Port Gibson, Mississippi to live with my aunt, her sister, and my grandmother and I went to school there until I was around seventeen, or sixteen. I joined my mother in Washington DC, where I attended high school. And then I was drafted into the army; and when I returned from the army; I entered Howard University in the School of Engineering and Architecture, where I studied Electrical Engineering in Washington for a number of years.

MM: Now was this in the 50's? The 1950's?

CM: I graduated in 1950 with a BS in Electrical Engineering, and I worked in Washington until 1955 at the National Bureau of Standards [the US government's measurement standards laboratory, today the National Institute of Standards and Technology, in Gaithersburg, Maryland].

MM: Oh, I know where that is.

CM: And then a gentleman asked a group of Howard University Engineering alumni to join him in a meeting. He was the Under Secretary of the Navy and he was telling us about the fact that the government had ordered military contractors to cease their discrimination against African-American engineers and that we should take advantage of that if we were interested. I interviewed at a number of engineering companies and I was offered a job, which I accepted, with Lockheed Aircraft in Burbank and I moved to California to accept that position. And I ended up in Pacoima, where all African Americans ended up in those days [he laughs], because that was the only place in the San Fernando Valley where we could live; and we formed a community in Pacoima. It was a concentration of African American professionals living in this very small community. And then some galvanizing events occurred – a plane crash [the collision of a USAF jet fighter and a commercial aircraft in 1957 that killed eight, including three schoolchildren, and injured 74 people in Pacoima] and the community became interested in building a hospital [because of the lack of facilities to take care of the injured children]; and one of the people that was a close friend of mine was involved with that and so he asked me to help.

MM: And was that the Reverend John G. Simmons?

CM: I beg your pardon.

MM: What was the name of the friend?

CM: Oh, the friend's name was Ben O'Brien.

MM: Ben O'Brien; okay.

CM: We belonged to the same church [St. Phillips Lutheran]. The effort to build the hospital was unsuccessful because some private individuals were doing this and it began to be rumored that they were really doing it for their own economic benefit.

MM: Yeah.

CM: And so [there were these rumors] to undermine our particular drive – there was an effort to also shift the money [to another community].

MM: Were you hoping to get money from like the state? Or the –

CM: State and Federal [hospital construction grants].

MM: Yeah, okay.

CM: [Hill-Burton] funds [Federal funds for hospital construction]. And the gentleman [Ben O'Brien] asked the minister of our church to see what he thought we should do. So then he talked to the Church leaders in the San Fernando Valley – this is the United Lutheran Church of America. The San Fernando Valley Lutheran Hospital Association was formed, and the Churches became involved. SFV Lutheran [now known as DMH Urgent Care] first met on this particular property. It was the house right over there; it's still there. From then on, the hospital project was taken on by the Lutheran Hospital Association. One of the other principal parties was the Reverend John G. Simmons [of St. Matthew's in North Hollywood]; and so it was pretty much the three of us, John Simmons, Ben O'Brien, and me; and the hospital was eventually built and operated with the help of many others, of course. [Ben O'Brien subsequently left the project and the community.]

MM: And this was like a general hospital that provided all services?

CM: Yes. And then there was an opportunity to apply for mental health grants [from the National Institute of Mental Health, for community mental health center construction and operation]. We were successful. A group of people were brought in to develop an application. We did it in conjunction with Hathaway Family Services in 1966. You had to have a children's provider, a general hospital, and an adult provider to meet the requirements; and so our hospital teamed up with Hathaway Family Services, which is now Hathaway-Sycamores [Child and Family Services; their headquarters are in Pasadena]. The grant was successful. We started the Center [in leased buildings]. We built our Center, including 26 hospital beds on the Pacoima Hospital site and Hathaway built their Center

MM: This is from NIMH?

CM: With NIMH, yeah. Hathaway built their Center up at the Cecil B. De Mille Ranch [in Lakeview Terrace] and we built our Center, [including 26 hospital beds,] near by, on the Pacoima Hospital site at Eldridge [Avenue].

EM: About a mile away.

MM: Okay.

CM: And so we began to operate as a community hospital with a Community Mental Health Center. At that time I had left Lockheed, and I was an engineer with TRW [an automotive and aerospace corporation] and I was chairman of the board of the hospital and a volunteer.

MM: A volunteer. Now, let me just ask you this, I mean, had engineering pretty much been your main interest? Obviously, you must have been interested in math and science to begin with or what exactly was the thinking that led you into that career?

CM: Into engineering?

MM: Yeah

CM: Well, I guess the idea of where employment opportunities may be. We're all guided by that – and an opportunity depends on a number of factors – where you live, your race and ethnicity. But also my brother had entered Howard as an electrical engineering student prior to that and that certainly had some influence; and my mother was very determined that both of us would attend Howard University.

MM: I see.

CM: That was her goal and it became our goal.

MM: Okay, so you had been an engineer all this time, but now you were involved in the hospital as well.

CM: In 1972, the hospital needed some additional administrative support and the administrator of the hospital, Reverend Simmons, invited me to join him as the associate administrator of the hospital. [I received a Master's in Health Services Administration in 1978.] My assignments included non-clinical departments of the hospital and the Mental Health Center; and as time passed, my focus became more and more [on] mental health and developing the center. Also at that time, we had an inpatient service, so our mental health program included inpatient services and day treatment and all of the outpatient and outreach services. Then the earthquake occurred in what?

EM: '71 [The Sylmar quake].

CM: 1971. That was devastating to the hospital. The hospital building was destroyed and we were successful, I say we – the board was successful in getting NIMH to approve the use of the mental health building for the acute hospital departments until the hospital was rebuilt. The hospital was rebuilt and then we had use of our building. We moved into it and continued our services. But in the process of rebuilding the hospital, the changing practices in health care, the hospital was too small to survive and it eventually went bankrupt and –

MM: It wasn't able to buy all the new technology or what?

CM: Well, it wasn't able to bring in the medical staff that would bring in the patients; and the deals you would have to strike to get support were not economically sound. [It is difficult to attract physicians to poor communities and to facilities that are paid primarily by MediCal.]

EM: This was always the ghetto community.

- CM: And this happens in small hospitals and particularly in minority hospitals. I imagine, if you took a look at Martin Luther King [King-Drew Medical Center in South Central Los Angeles, which was forced to close in 2007], you'd probably see some of the same events and some of the same issues. But as far as the mental health center was concerned, we were able to separate the mental health center from the hospital during the [Chapter 11] bankruptcy process. I was given the opportunity to develop a plan, which I did and presented it to the bankruptcy court; and everyone, including the creditors, approved it. The plan pretty much allowed us to leave with no assets and no liabilities. We got the approval of the [LA County] Department of Mental Health and so we had –
- MM: That's the County Department.
- CM: Yes, so we had the DMH mental health contract, the employees, the provider list, the contractors, and an arrangement for inpatient services. And on December 31st, 1984, we were Pacoima Memorial Hospital, Inc., doing business as Hillview Mental Health Center; and on the next business day, January 2, 1985, we were Hillview Mental Health Center Inc, [with the same staff, same patients, same policies and procedures]. [he laughs] And so that's the story of Hillview and then of course that meant we ultimately lost our inpatient program, [when the hospital filed for Chapter 7 and closed].
- MM: Okay, let me just stop you there. Okay, you clearly at this point, you made a career change.
- CM: Yes.
- MM: And became the associate administrator of the hospital and so what were your, I mean, this was a big – this is not something that many engineers do –
- CM: No.
- MM: Could you tell me a little bit about that? And then you also said that you became increasingly involved with mental health services and tell me a little bit about how your interest developed?
- CM: Well, like I told you, it had to do with the fact that I was a part of a small community and very active in the community and I was concerned about social issues. I became president of the San Fernando Valley branch of the NAACP [the National Association for the Advancement of Colored People, founded in 1909]. And early on, I saw the issues that were causing problems for people as being issues related to the ones that our hospital could address and so I began to push to get the hospital to move in that direction. I chose as a vehicle the Mental Health Center and the policies of the Mental Health Center were heavily influenced by the problems that the people had in this community. At that time, the majority of the people in this community were African American and the hospital and the Mental Health Center had programs to serve their interest and help the community. Many of the things that we're talking about today in mental health, I was trying to implement back in the 60s and 70s; and sometimes they worked and sometimes they didn't. But you know, what works – if it works once, then that's another person that has been helped and then maybe the person who was a failure before, second, or third, or fourth time, it may work with them. So in this arena, failures are not important, it's the successes that are [he laughs] important.
- MM: That's a good philosophy. So I mean, these were like housing and jobs programs?

CM: Well, we did all of that. We began to develop housing. One major assist that we got with our Mental Health Center is that it was a gift from the Church of which I was a member. The Church was formed to serve the ethnic group – I say ethnic group, to be very specific, the African American group and the white group, on either side of Van Nuys Boulevard. The church was formed with a pretty much an equal mix of both and the church was very successful. It was small and we developed an enviable relationship between each other and then the Black Power Movement came in and that had a devastating effect. You'll probably edit this out [he laughs]. I'd like to define it as an era when whites were afraid to be in black communities and blacks were ashamed to be in white communities [he laughs]. So the Church closed, but some of the leaders in the church were interested in what we were doing. They had assisted in the development of the hospital; and they admired the Mental Health Center and its social activities and they said, "Well, we'll [continue to support the community by allowing the Mental Health Center to use the buildings for its programs]."

One of the programs [was] a mentally ill offender program; the Sheriffs Department discharges people at all hours of the night into the streets. We had this little program called the Mentally Ill Offender Program, which provided outpatient services, and we would find these people. We didn't have anywhere to house them and so we would use this house. Now, that was sort of bootlegging, I guess, but we would use the house that way. And then there is a giant in the history of the mentally ill offender program and the Jail Program, Roger Shock, and I was able to convince Roger to give us money for board and care. And so we ended up being able to take people out of the County Jail and put them in board and care, so that we could provide treatment. Every year the church would do an inventory – it was headquartered in Chicago and they would call all around and they would finally find me and then they would ask, "We have this item on our inventory, would you tell us what it is?" [He laughs] And after two or three years of that, someone said, "You know, maybe it would just be better if you bought the property." So they arranged for us to buy it, nothing down, book value, [and small and infrequent payments]

MM: Good deal.

CM: And we purchased it. We formed a corporation to purchase it [because our hospital financing prohibited it from incurring debt]; and we purchased it and it had on it an old farm house that was the first building for the church. [The property had two buildings on it when we purchased it. The two original buildings have been renovated and enlarged and we have added three new buildings.]

MM: Wow.

CM: One is this office building you're in. Then we have a tax credit project for permanent housing with fifty units next door and it's comprised of Buildings A and B; and then we have a building that has transitional housing. Transitional housing, what it really means is you have some rooms with various amenities and you could put it into use for whatever is in vogue at the time. So now we call it transitional housing. There's one big difference – it's not permanent housing like the other housing. Then we have a fifth building which we use as a licensed facility. Currently, it's being used as a board and care for urgent care. It's had various uses. Like I say, buildings, social workers, psychiatrists, all these people and facilities, make up the mental health system and it takes on different forms at different times depending on [what leaders in government think is best at a particular time].

EM: The jargon of the time.

II. Eva's Story; The Mental Health Center as a Community Resource; Coping with Funding Cutbacks

MM: Yeah, the jargon of the time, that's great. Okay, I'm going to give you a little bit of a rest now, because we want to catch up with Dr. Eva McCraven. So same question to you, tell us about where you came from, what your plan was and how you wound up here.

EM: Well, I was born in Los Angeles, right downtown; and my parents followed the housing boom after WWII and bought a piece of orange grove in Granada Hills and my father built a house. He was a Los Angeles City fireman. But back then we had busing [to schools], because there weren't schools just everywhere. So that's why I went to San Fernando High School and became aware – at that time there was a lot of social unrest between Latinos and Whites; and the black community really hadn't formed. I'm talking 1948 and 50s now and the few African American people lived up by Hansen Dam, right there, in Quonset huts [temporary structures erected during World War II] that were moved there, leftover Quonset huts, because of segregation. So I had two girlfriends in junior high school who lived there.

In those days, everybody trained their children to grow up and get married and have children. I attended college for two years, but I didn't get a professional degree; and so then I was married and my husband struggled and lost his business and I had children and no means and no health insurance. As a matter of fact, I was one of the people interviewed by Senator Ted Kennedy, around when he was trying to get national health insurance, down at [the] big County Hospital. It was a huge gathering and he had all these horror stories. Because my husband lost his business, we lost our insurance; so everything fell apart and I was really on hard times.

My goal was to finish school; and in the process of all my adventures, I had to be hospitalized once for a medical procedure and I ended up in Olive View Hospital for a week. [Opened in 1920 as a tuberculosis sanitarium, Olive View was affiliated with UCLA in 1970; the hospital building was destroyed in the 1971 Sylmar earthquake and patients were housed in an interim facility until a smaller replacement hospital opened in 1987.] Boy, was that an education, because I was in a ward with all these ladies who were welfare mothers and people down the hall – [there was] one old man who'd spent ten years in there with tuberculosis of the spine, and people who didn't speak English; and I just felt I was so fortunate because I was able to get through the system, because I could navigate it. So I thought, I'm going to be a health educator; and so I went back to school and started. By that time I was divorced and just getting by; and then I approached the hospital to get a job, because I thought it would fit with what I was doing.

MM: The Lutheran Hospital.

EM: The Lutheran Hospital. So I met Reverend Simmons that way and he hired me.

MM: And that was about 1960 –

EM: 1969. And I was in charge of the so called Health Education Department, although I wasn't really a health educator. But I was doing things like health screening fairs and running around trying to get the community to know [that] the hospital was there. Then MediCal reform started happening in Sacramento that the legislature was working on MediCal, I think to reduce benefits, and I got appointed to represent the community to lobby against it. I somehow was involved with the Law and Poverty Center at UCLA [the Western Center on Law and Poverty, formed in 1967, a joint legal clinic of UCLA, USC, and Loyola] and the labor unions. I don't know how all this – probably because Reverend Simmons was active and sophisticated with all of these social programs. So

he turned me loose. I became a lobbyist and I always liked to joke that I put on my little suit and got on the plane and went up there with my little portable typewriter and I didn't even know where the elevator was. But it's not too hard to access Sacramento, I found out; so I did a lot of testimony and I formed an organization of all the health agencies that I could organize, statewide. It was the most unlikely combination of board and cares and skilled nursing facilities and convalescents and hospitals and MDs, and I got Physicians for Social Responsibility involved.

MM: So it's like a lobbying organization?

EM: It was, only I was it, you know.

MM: Right, you were the lobbyist.

EM: I created a newsletter and I got everybody's input and so when I went to testify, I had creds. And so I take a lot of credit for stopping the legislature from reducing MediCal visits to less than two times a month, which they were trying to do, because that was my issue. Anyway, I did finish school and then I was appointed –

MM: So you were going to school at USC, or UCLA?

EM: No, I was going to Cal State Northridge. I lived near there and so I finished my Master's degree in 1976. And then the Mental Health Center needed a new director and they chose Carl. And so by that time we were put together, working together on all these community issues, and so he chose me to be the assistant executive director. They hired us as a team. I forget when that was.

CM: Probably around –

EM: 1976

CM: 1976, yeah.

EM: And so we took over the Community Mental Health Center. Our first assignment happened about a month and half later; we had a huge site visit from the National Institute of Mental Health and the State and about twenty five people showed up and we really got our feet wet in a hurry. And Carl was very well organized and was able to educate them about what our Center was about and what we were doing and issues that we knew we already had, because in those years, everything was controlled by a psychiatrist. Psychiatrists were not trained in the public health model for health care and they were probably all psychoanalysts and the system was kind of troubled, I think, around that. I think they [the site visitors] were terribly impressed by the public health approach that we were promoting and that we were seeing a lot of need to do more outreach in the community and to educate the professionals who were sitting around saying, "Hmm, the person didn't show up for their appointment; it must be resistance." They [the patients] were not compliant with [the doctors, so the psychiatrists assumed] they just don't want to do it.

A lot of the people in this community were very scary and because we were a licensed psychiatric facility, we had back and forth [admissions and discharges] with Olive View Hospital Psychiatric; so we were getting inpatients all the time or outpatients that just walked in the door. And they were poor, they were desperate, they were angry, they were even then using drugs and carrying weapons and we selected staff and got rid of those who would exclude them. We had an era when staff were openly trying not to

admit scary people and we thought, “Well, why are we here, folks?” So we got that all settled, but it took a while.

MM: Yeah, I can imagine. So your emphasis was on trying to essentially meet the needs of the community as it was?

EM: Yeah, I mean we did outreach. [We decided to focus on basic living needs, first, then the] psychiatric issues related to personal history and all of that. We hired social workers who would go out and find people. I remember one lady, her name was Connie Williams, a tall and imposing African American woman; and one time she just went out and knocked on the door of one of her clients, and said, “You’re in there, I know, and I think you have a gun and I want you to give it to me now.” So he said, “Yes Ms. Williams, yes, ma’am.” [she laughs]. So that’s the kind of people we hired and she helped us train [staff] as well.

So now everybody is talking about psychosocial rehabilitation and housing and employment and education and recovery like they invented it. But a lot of the people who are doing all this thinking now have no clue as to what we were doing forty-five years ago in the Community Mental Health Centers, because that’s what NIMH intended. We were well funded for a consultation and education program, which – That was my first responsibility because of my bent; and so we’re really proud of ourselves for having thought all these things through. That’s why we’re a little bit aggravated with all the new jargon and new people coming in here and auditing everything and acting like they – offering training to our staff and it’s so insulting [she laughs].

MM: You could be training them.

EM: Yeah, they should have been watching us for the last forty-five years.

MM: Okay, can you tell me just a little bit, I mean, clearly, I’m going to ask you the same question. Clearly you saw a need in the community. And so would you say you were [providing] some mental health services as a funded way to meet those needs or was there a particular, I mean, did mental health seem to be a crucial problem for many of the people you were seeing?

EM: Well, yeah, because people didn’t think about mental health in the same way in those days, I don’t think. People thought of it in terms of going to a private psychologist and having ongoing therapy. But I saw things really globally and when I learned – when I got the job at the hospital and then I had an opportunity to work in the Mental Health Center – I’d already come to the Mental Health Center as a student and learned what they were doing and sat in on meetings, and I was just thinking, wow, this is a better way, because it’s broader. I mean, if you’re doing what NIMH wants us to do, you’re looking at all aspects of health as well as mental. But, like I’ve said, [there were] all these people in the system who were thinking of themselves as psychoanalysts and therapists. And I just saw things differently, because of my broad experience out in the community and having grown up in San Fernando and Pacoima and my classmates, what their social needs were. I just thought that, because of the experience that I had in the welfare and the MediCal system, that I just fell into the most wonderful opportunity and Reverend Simmons was like my mentor. I mean, he trained me to work with all the different organizations and just kind of turned me loose. Then – but he’s still on our board, and very, very supportive, but it was just a golden opportunity where what I saw as what I wanted to do with my life come together with an opportunity in my own community.

CM: I’d like to address that also because at the time we thought of the hospital as being a community resource that could assist in various kinds of problem solving; and

sometimes it may have meant working with some union activities or other social groups, and then of course the mental health. And if there was a need, we would try to meet that need in some part of the hospital. Now, interestingly, over the years, I can think of at least five families that were social and community friends of mine that I socialized with and I learned thirty or forty years later there was mental illness in their family and their children showed up here because of the resources we have here. But I think that what we tried to do was to prevent services from being denied people by our staff, because they didn't fit the model that they wanted to serve and people would come into the Center and go right back out again. And it took us – Eva said that we resolved that, but it took a lot of hard work and it took several years to get that out of our Center. It's very difficult to redirect a facility.

MM: Sure, sure. I can imagine, especially with professionals.

EM: Well, they weren't very respectful of Carl because he came in with an engineering mind. Everything was logical and business oriented because we had to stay in business, especially when the hospital closed. I mean, it's a terrible shock there and he got so much resistance and subversion around that. But it's just taken all these years. Now we have a team that has nothing but respect. I got so ticked I went back to school and got my PhD in psychology.

MM: I was going to ask you about that. [she laughs]

EM: Yeah. We both had a Masters in Administration and then I kept going, because I've always – Well, the other thing I didn't say was when I was a little girl, I used to read my mother's *Ladies Home Journal* and it was Dr. Paul Popenoe [1888-1979], remember him? [Popenoe wrote the regular "Can This Marriage be Saved?" column in the *Journal*. He advocated traditional concepts of masculinity and heterosexuality.]

MM: Yes, I remember

EM: I thought, "Oh my God, I want to grow up and be a psychologist;" so that was in my head too. And so I got my doctorate and then I was qualified to develop clinical programs; and so that kind of bridged the gap, because people – as a matter of fact, in the old days, people used to say, "Well, you people, you administrators, you don't understand what the needs really are." And so then, after I got my PhD and started developing programs, I would come to Carl and say, "You administrators don't really know what you're talking about." [she laughs] So I got to advocate for things, so the staff felt quite comfortable that we were all on the same page.

MM: Did you change anything in particular in the center? I mean, what kind of programs did you develop?

EM: Well, the first thing I did was develop a long-term residential program for people who were in Camarillo State Hospital for an average of fifteen years; and the County was going up there and interviewing people [for discharge]. They granted us a contract for – It [their ward at the hospital] was very secure, [a grade below] a locked facility, but it was like a stepdown. And so we took people, put them in the van, brought them here. They were people I used to see [who were] like Rip Van Winkles. They hadn't seen supermarkets, automatic tellers, hadn't been to Bob's [hamburger restaurant] in years, if ever. So we put them – By that time the hospital had closed, so we had a unit that we could use for them. So I transformed it into something that looked more like a living unit. It was not locked, but we did have outside gates, because some of the people were really not well at all. I mean, they were so chronic and we had them. It was an intensive

long-term program, as I said, and I did my dissertation about it. 72% of them made it out in the community and never went back [to institutionalization].

MM: That's amazing.

EM: Some of them would scream all day. One was catatonic, but we managed to treat them. But then the County had a big shortfall in –

CM: '88, I think, '88 and '89 [1988-90 were the years when budget cuts forced the closure of many mental health clinics].

EM: '86. I forget. Anyway –

MM: We can check.

EM: Yeah, the County took the shortfall mostly on itself by not filling positions and I don't know what all they did. But then one day we were in Connecticut at a wedding, Carl's brother's son's wedding, and the newspapers came out and our staff called us and said we've just had a \$680,000 cut, which meant more than that because of the MediCal [match]. So we raced home and found out that [Supervisor Kenneth] Hahn said that, "Well, you got to find it somewhere," so the Director of Mental Health at the time just said, "Well, Hillview." He didn't like us anyway. [she laughs]. He sort of had feelings that – he saw this as an African-American agency. Well, for God's sake, the population changed from under us, but we have the most multicultural agency there is. But he was focused on Carl. So anyway –

MM: Even so – I mean that seems unfair.

EM: Yeah, but he just decided and then the County made us do all sorts of settlements with the past cost reports and everything. It nearly wiped us out; it was like a million and half, or something like that.

MM: Oh, my God.

EM: Two million, I forget, but it was really devastating. So we had to lay off many staff. But before that, the hospital had closed and we had to lay off all those people. And then we had a big – we laid off support staff, because we had to take care of the clients. And so we had a terrible time because we had to run everything ourselves, with about four people [she laughs], five of us, all of us [did the] support stuff. But we were able to pursue new opportunities in housing, like developing this property, because of the cooperation of the Lutheran church. And so we just kept going for new things, and that's what I was doing. I was developing all the new programs and whenever anything came along, I would be part of the team that wrote the proposal – the clinical part; and then I would plan the program and participate in hiring the staff and training the staff. So we just took whatever advantages came along.

MM: Okay, but so you took this major cut in funding and then you made that up through other sources, through grants?

EM: Oh no, we just shrank and stayed shrunk. We've never really been able to serve our unusual community since then, because the County took most of the general fund money. So [this became] my mission in life and anyone who knows Eva knows that every time I open my mouth, they're going to hear about the same thing. Decisions were never made with demographics in mind of the true makeup of the community, all of the morbidity and the morbidity statistics, and the lack of housing, and the poor education,

and the unemployment, none of that. And so we took that big wallop and [Supervisor] Mike Antonovich said, "Well, we're going to make it up to you when we have money." Again, well, yeah right, money has come and gone at least two or three times. I've been making this case for many, many years.

So in the last year or two, Dennis Murata [DMH Deputy Director for Program Support] is the name I come up with first; but I think he was in charge of it and the County hired a team of people to do a demographic study of Los Angeles County. They came up with a publication, which clearly shows where the poverty is and where the issues are; and much to their surprise, which they admitted, the San Fernando Valley, this half of the San Fernando Valley, is the largest poverty area in the entire County, because of both the population, this huge number of people, but the demographics are so devastating. And I've been yelling and whining and bellyaching for years about this. So now I got really involved, because the Prevention and Early Intervention funds are coming, if they ever survive [current budget cuts]. But now our Service Area got originally twenty million of the entire pot for Prevention and Early Education and a lot of people really raised Cain; and so it kind of shrank a little bit. It's still on the table, and so I feel like if I had any part to do with that, I would be happy.

MM: I hope so. Okay, but you said, I mean you were still developing residential programs and other programs despite having taken this huge budget cut, so where was the money coming from?

CM: Well, the residential program [the Long-Term Residential Program was started five years before the curtailment of our County funds, intended to eliminate our outpatient department] that she was so proud of, one evening with her, I said, "You know, I think for the betterment of Hillview, we should discontinue that program and ask the County to allow us to use that money to restart our outpatient program; because if you don't have an outpatient program, you will not very long be a Mental Health Center."

MM: Yeah.

EM: That's what they did, they said, we're going to take your outpatient program, so good-bye.

CM: So we discontinued our long-term residential program and restarted our outpatient program. One of the most shocking things that occurred to me – which I don't think other providers are aware of – in the process of closing down the outpatient program, some of the County staff came out to make arrangements because they had to figure out how to take care of the patients. So I said, "How do we transfer the medical records to you?" and they said, "No, you don't transfer the medical records. Those are yours." So, if you're out of business, you are legally responsible for maintaining medical records.

MM: Yeah, you have to keep them in your garage or something.

CM: [He laughs]

EM: He really made the case and they really couldn't say no. So we gave – why don't you tell them what you did for those patients we had?

CM: So now we're about to discontinue the long-term residential program; and a couple of the family members came to us and just pleaded with us to not discharge their children because they were afraid they might be placed in an unpleasant environment.

EM: They weren't children then, but they were children when they got ill.

MM: Right.

CM: Yeah. So we had a couple of houses we owned and we got one of them licensed; we conned Eva's daughter to look out after them [he laughs], if she could live next door [he laughs].

MM: I see [she laughs].

CM: And we did this very creative program.

EM: And then Carl persuaded one of our friends who was a waitress that we knew, and a psychiatrist and a board member –

CM: And others to –

EM: About five people?

CM: Yeah to invest money – to loan money for us to develop the property next door.

EM: No, well, we got houses - we bought one house up the street from Hillview.

CM: We had one of our psychiatrists – I made a deal with him, if you provide the money for the down payment and we will make the payments, then at the end of a period of time, we will either buy the house from you or sell it and pay you. So we had a psychiatrist to do that and then we had another guy, someone who was very –

EM: Oh, he was a big volunteer with the County.

CM: A big volunteer with the LA County DMH. I won't give his name, but he was very much interested in helping.

EM: He was wealthy.

CM: Well he had family wealth and he bought a house for us. We were operating all these board and care homes and so we were able to take care of the sicker people.

EM: So those people that were in my long-term program didn't have to go back [to the state hospital].

MM: I see. That's good.

EM: My daughter was working at Hathaway Children's Village, but she came to work for me in the long-term program. So she would get one of our vans and pick all these clients up [every morning and take them home in the late afternoon].

MM: Wow.

EM: From wherever they were and bring them back every day to our day treatment program so that they were safe, because these were not people that – they're kind of flatline. It was wonderful that they were not in the hospital anymore, but they were still psychotic and just couldn't –

MM: They couldn't just be wandering around.

EM: Yeah, and so we never – we didn't lose anybody over that. Well, actually we lost two, but it wasn't because of that, they just couldn't – one of them kept getting out and going into people's homes and terrorizing everybody and so he ended up in a locked facility; and another guy was just so psychotic we just could never get it under control. They still may live over there in Foothill, but so that was, I thought, a true act of compassion on Carl's part.

CM: I still think that housing and I expand the term housing – that includes hospitalizations as well. I think, what we've always guaranteed our staff – you'll never be stranded with a patient at five o'clock on Friday and nowhere to place them. We've always maintained resources so that staff would have a place [to house a client]. That's really the bottom line. You have to always be able to have the appropriate housing. It may be permanent housing, it may be transitional housing, and it may be [occasionally a] psychiatric hospital, but [having a continuum of] housing is critical.

MM: And you were just telling me about a couple of years you didn't even have – you didn't have any financial statements.

CM: [After our major budget cut,] we didn't have financial statements, we didn't have a financial department, and we didn't have a formal medical records [department], all those things were just done by one or two people, if they could find the time to do it.

MM: Wow.

CM: And we just struggled through that and everybody just left us alone and I guess if they had taken a look, they would have said, this organization can't make it, but we were able to. We decided that we needed X amount of dollars to pay staff and rent; and we asked everybody to take a day off. We reduced – we had a union at that time. The union cooperated with us.

EM: They bought off on it too.

MM: Very good, because unions don't always do that.

CM: No, that was unusual, but the times we went through are unbelievable. But we had some key people including professionals, psychiatrists and social workers, who have stayed – administrators who stayed with us through that time.

EM: They're still here.

CM: They said, "Well, don't pay me this week," [he laughs] whatever.

EM: We did go for funding from Los Angeles Housing Services Authority, LAHSA and HUD [Federal Housing and Urban Development] money. We started a homeless program over there and we started a transitional youth program in whatever space we had. Some of them needed a place to live and so we just kind of unofficially rented them apartments and the program manager moved in. So we were the first adult-only provider to start providing transition age youth services and those programs have been exciting and interesting and scary, because the population is so needy.

MM: Yeah, these are kids who are basically out of school right?

EM: Well, they're out of school, they're out of the foster system, they're emancipated by the courts. And, until recent years, they would just be shown the door when they turned eighteen and they were emancipated. A lot of them have gang affiliations. But across

the board, they're all so damaged from their childhood. [Many of the] parents were in jail or doing drugs and there was physical abuse and sexual abuse and some of them just don't really have the will to live. They don't care about anything. It has really been a challenge [to encourage them to be motivated to improve their lives].

MM: This is probably a really, really dumb question; but I mean, obviously, when they get to the transitional stage, it sounds like they've been damaged for a number of years and yet probably mental health services are not routinely provided to them, kids in the foster care system..

EM: Well, no, because they don't present as mental health clients. They present as having behavioral problems.

CM: Bad acting people.

EM: Bad acting people and the prevailing wisdom is like, "Well, tough, they sink or swim, they-learn-the-hard-way, kind of thing." There *is* now a lot more attention being paid to screening and a lot of the kids are symptomatic, but they deny it because they know what that means. They are so horrified by the stigma. And you can't always tell because of drug abuse and behavior and so, because we are a Mental Health Center, we end up getting the ones who are suspected or known to have an Axis I adult diagnosis. They live right next door. We have a certified clinic in that building now, so the staff can see them right there on site. Some of them just get more and more symptomatic and the hard thing is to get them to understand what's happening to them, so they can cooperate with the doctor and be willing to take the medications, which aren't always very pleasant.

So we've had a lot of kids hang in a while, then disappear, then come back, and take off and get pregnant and go somewhere and then come back; and our goal is to keep them hooked into outpatient services no matter where they live, if we can get them to accept it. But we have to support them in whatever they're trying to do; because, if you could put a lid on it and say, "You've got to stay here and be safe and take your meds," we're never going to find out whether they can function independently. In the early years we were a hospital and we had mentally ill offenders and we had this feeling that we had to keep people kind of under control. But we've come to know by experience that you cannot put limitations on what people can do, but somehow you have to keep them safe while they're experimenting.

III. Working with LAC-DMH; Impact of MHSA; Stigma and Concepts of Mental Illness; Cultural Competence

MM: True enough. So I've got a whole batch of questions. To begin with, let's just – since you became a Mental Health Center back in the 80s and you had this period of budget cuts, since that time, what's your relationship been like with DMH?

CM: Well, we believe that we have maintained a certain competitiveness and so, whenever there is an opportunity for new programs, we have been successful. I guess the first one was the – which came first?

EM: I think the ACT first.

CM: ACT first, yeah.

EM: It was called PARTNERS at the time.

MM: Right, that was Dr. Crowell's program.

EM: Yeah, we were one of the first groups that got the first contract and we took to that – that was, I mean, I could have just written the book on that, from our experience. That was such a successful program and many of those people are still floating around here [in the community and living independently, with supportive services as needed].

CM: And the AB Program.

EM: Then we started the AB 2034 Program which was also amazing and that worked especially well, because we had the housing capacity to help people released from jail establish themselves in the community

CM: And then after that, the MHSA.

EM: I wanted to add something.

MM: Sure.

EM: From the NIMH beginnings of Community Mental Health Centers, there has been so much growth and I have nothing but respect for what our California Plan was. The MHSA thing is something new, but I really was proud of the whole system, because our planners incorporated the public health concepts, as well as the psychosocial rehabilitation. The Plan met the needs that we foresaw from the beginning, from our experience in Pacoima. This is the only copy of the Plan I have, but I'll let you have it, if you remember that it belongs to me.

MM: Okay, well, what we'll do is scan it and we'll send it back to you, because I'm glad to have this.

EM: Yeah, okay, and this is much earlier. You can keep this one, and this has Areta Crowell's name on it.

MM: I have this one already.

EM: I'm sure you do.

MM: I mean, we've seen this one, but I don't think I've got a copy of it.

EM: So I just have to say that California really grew up with respect to mental health care and the broad spectrum of things and then we saw "Achieving the Promise," the Federal Plan. I was so disappointed, because what they said in the beginning when [George W.] Bush got elected and what they tried to do to the mental health system was –

MM: Appalling

EM: A tragedy and if it weren't for our National Council of Community Mental Health Centers, they would have done us in. So we've all struggled, DMH included. We have a lot of respect for each other. We really work together very well with LAC-DMH and we've come to feel really good about their orientation to mental health care in the public health mode.

MM: Okay.

EM: I messed up your thinking.

MM: No, no. Now I think I should have asked this question before, but okay, this community though, I mean we've talked about this several times. This community has kind of evolved. You said when you came here originally, it was a group of African American professionals and clearly the demographics have changed. It's become more mixed. Can you talk a little bit about that and what's been going on here?

CM: Well, it's hard for me to know exactly what's going on here. I have always suspected that San Fernando and Pacoima were gateways for Hispanics coming into the country; and so I suspect that we have a lot of people here that are not registered, which makes it very difficult to provide them services, because no one wants to address that.

EM: But the County is faced with all these ill people, and we can't treat them because we don't have any County money; so they – we're on this street, lined with this low-cost housing and people walk around here with all these problems, but we have to send them over to Granada Hills, [to the County-operated clinic].

MM: Oh, for heaven's sake.

EM: Because we don't have any indigent money.

CM: So that's an issue. Maybe Prevention [and Early Intervention funds] will try to address that, because I think the people that need the help are not interested in a long-term relationship because that just causes them trouble.

MM: No, so you have to try to give them sort of short-term services?

EM: We can't.

CM: We can't. I just think they go unserved.

EM: Well, if they walk in here, what we do is we hook them up with the directly operated [clinics], but other than that we just –

CM: You have a program that you're being measured by outcome, [including employment]. Well, if you get someone who is not here legally, you cannot do the outcome. You can't get them a job. It's crazy.

MM: That is crazy.

EM: Some of our transition age youth are in that category. They're looking at outcomes related to employment and education and we tell them – One of our program directors told DCFS, "You people have had them for eighteen years and you haven't done anything for them, what do you expect us to do? They don't have papers even; we can't get them a job." [she laughs].

MM: So they've been in the system for all this time.

EM: Yeah.

MM: And nothing's been done.

EM: But it's just the frustration of my life. We're a formerly federally funded Comprehensive Community Mental Health Center mandated to serve our own geographic area in our own catchment area, and we don't have any money to do it.

MM: God, how frustrating.

EM: It really is. There's nobody to be mad at, it's just the way it is. But I was so hoping that the [Prevention and] Early Intervention money would focus not – Prevention is all well and good but being trained as a health educator, I know how long term that is and how hard that is to measure the effects of what you do. And so I was hoping, and I know Dr. Southard said this one time, I heard him, that we need early intervention and intensive services for people having their first break, at whatever age, and that's the only way – I mean, you can't know who's going to get mentally ill. You can spend all your resources talking to the PTA, etc., like I did. But if we could – regardless of whether they have funding or not, get them in here with focused [services] for a year or two, or whatever it is, get them educated [about mental illness], get them on a medication regime, try to stabilize their life, we would [have a chance at preventing so much of the mental illness we see in people on the streets].

I mean, it's just ridiculous, we don't seem to be making any progress; and the Mental Health Services Act got all caught up in complicated issues and specialized programs for this, that, and the other thing and the bureaucracy to run it all and I don't see anybody paying attention to the kind of people that we can't even treat. I'm sure we're not the only Center in that situation and so where is the focus on early treatment? No matter who they are or whether they have money, they're still going to be clogging up the emergency room and the jails.

MM: And ultimately costing money one way or another.

EM: So now the Mental Health Services Act has come along, same thing, but all new words and all new bureaucracy to support it, and I'm just increasingly concerned that –

CM: I think that problem is bigger than – it's a bigger problem than the Department of Mental Health.

EM: Oh it's not us-

CM: And California and Los Angeles.

MM: Right, right.

EM: The whole thing has just gotten – they're missing the point.

MM: You think they're concentrating on Wellness for a relatively small group of people in the system; meanwhile, there's all these other people outside of the system who you don't have a good way of reaching out to.

EM: Well, I think the Wellness part is fine. It's just that there's a piece missing in the whole expenditure of money that would keep people from getting chronically ill before they can get service, because they have to get chronically ill and get through the Department of Social Services and SSI and all of that and get on MediCal before we can see them, the way the thing is set up. There's just a big gap and I sat on the steering committee for Service Area 2 and the state – no –

CM: CIMH?

EM: Yeah

CM: CIMH.

EM: CIMH [California Institute for Mental Health] was in charge of providing “best practices” [and “promising practices”, between which we were to choose for our Service Area. We had a huge number of choices and a very short amount of time to rate them and vote on them. The committee was comprised of stakeholders representing all ages and included the police, schools, rape treatment programs, substance abuse, but not many mental health agencies who treat mentally ill adults. When we completed the process, there were no programs on our list that will provide early intervention and treatment for adults experiencing early symptoms of mental illness.

I was very disappointed that the process was so cumbersome and so competitive between community agencies that we ended up with a plan that completely overlooks the problem of chronic mental illness that causes people to wander the streets and fill our jails and hospitals.]

MM: Gosh. We can't argue with that.

EM: Yeah.

MM: Okay, so a couple questions about stigma. One is, have you had opposition or support from the community here as a group?

EM: The neighborhood really was pleased when they saw we were developing this property. They sat out there on their porches and applauded, because it provided more security, more light, made the neighborhood look nice.

CM: Yeah, we're very sensitive to the neighborhood. We try to run our programs so that people are not hanging out on the streets.

EM: One time we went – we were getting ready for a fair or something and we started knocking on doors around the neighborhood. [People asked,] “What Mental Health Center?” [She laughs] Is that good or bad? I wasn't sure. But yes, well, you know what stigma is – it's something that makes it so hard to get to the families and to the youth, especially.

MM: Yeah, that was my other question.

EM: Yeah, it's so painful for them, and they're so ashamed and a lot of families blame themselves for doing wrong by their children or they blame their children for not trying hard enough. And one of the things [was that] I was pleased because I had a health education background, that I was sensitive to that; and, in the long term residential program, I would work with families for two years sometimes before I could get them to accept it, stop blaming, support the successes, quit trying to micromanage and back off and take pleasure in whatever they do that's an accomplishment. And I've seen that that really works, because if clients can understand exactly what's happening to them biologically, it's easier to accept. They know that it's a no-fault thing and it's nothing to be ashamed of anymore than if it's appendicitis.

MM: It's hard.

EM: Yeah, but the reality – I just finished reading a book by Kay [Redfield Jamison], at UCLA [Jamison, a psychiatrist, suffers from bipolar disorder; her book, *An Unquiet Mind* (1997) describes her adjustment to life with her illness]. I read that book and I've never seen a more poetic description of how it feels to be bipolar and how she grieved and mourned for that high because there's apparently nothing like it. I mean that's not the same as schizophrenia but –

MM: No, but it is. I think it's –

EM: Medication especially in the early years just made you a dead person, in some cases, and that's a terrible loss and so you can't fault people. We just try to go with it and try to encourage them, but you can't fault them or make them do what they don't want to do.

MM: No. Do you think – do you think African Americans in particular have certain conceptions about mental illness, about seeking help at a Mental Health Center, which is – I'm just asking this because this grew out of interest in your community in particular.

CM: I said earlier I had these friends of mine who had children in their family and we learned about them, later on, by – I think only one person did talk to us in an abstract way about his child, about the services that are available, but didn't just come out and say –

EM: It's a significant number of people that you knew, and I knew in the early years that we had their children and grandchildren, but we never knew [at the time]. But the Latino culture has the same issues.

CM: Oh yeah.

EM: Every culture does, really. I don't know if it's more so for African Americans or not.

CM: I guess I don't either, but I just know that among my friends, I never knew. And then the people that you see – the people who come to us through the jails and homeless shelters have gone through a whole process of being – getting to where they were. So you don't know what they were like, when they were a bright looking young man or woman.

EM: Yeah, but it's a biological illness, and it affects everybody across the world, uniformly, no matter what country. But just certain cultures are more sensitive and more private and more tending to keep things in their families. The Asians are that way. But when things get bad enough, I mean, by the time they get to us [she laughs], usually it's like a "Well, help!" kind of thing, because that's always been the kind of population we treated, people who were severely mentally ill.

MM: Right, so obviously that prevention step is still not getting done.

EM: No, that's so far in the future. We should have done it a long time ago and it's never too late. But I still worry about the mess right now in front of us that we haven't figured out what to do with and it's just getting worse, because of the financial situation everywhere.

MM: All the way around, yeah.

EM: Yeah.

MM: Has your idea of mental illness changed over the years that you've been working here? Working on this? I mean, my thinking on mental illness has changed like 180 degrees in the last few months because previous to this, I would have thought [that] a person who is

mentally ill is basically mentally ill. We need to give them care, but they don't – normal life will never be possible for them and now my thinking has changed dramatically. So, I mean, what have you learned from doing this, I guess, is the question.

CM: I guess what I've learned is that there are a wide variety of illnesses and some will respond to treatment and some will make recoveries and I guess sometimes I've seen recovery that I didn't expect, or anticipate. But so that's what I've learned, but I think we still have a lot to learn as to what to expect and in terms of numbers and all of that.

EM: I still like [psychiatrist] E. Fuller Torrey's model in which he says where he says, there's a spectrum and everybody is somewhere [on the spectrum], at all times emotionally. But, among the people who have mental illness, a third you probably never hear from that much, maybe they might have an episode and not again; and then there's another third who are probably amenable to medications and I mean, I'm surprised about all the people I hear about just casually out in the community, on medication, that other people don't even know about; and then the other third is the people who come here. But, among *them*, we've seen some quite miraculous functional improvements. They still have mental illness, but they've learned how to manage the symptoms and develop whatever talents they had or capacities or propensities, even going to school and working, and we've seen some young people from our TAY [Transitional Age Youth] Program out working and doing good things. It is good to be in a field that enables us to make a difference.

MM: Yeah, yeah. That must be very satisfying.

EM: Yeah, it is. Nothing better than seeing the people you know would be somewhere homeless, drifting; because we have fifty units over there, they have permanent housing. It's theirs.

MM: That's great.

EM: It's their own, it's HUD Section 8 [a Federal program for low-income housing].

MM: Because housing is really – obviously it's really been a major problem, and it's something you've taken significant steps to address.

EM: Oh yeah, that was something, as he said, we learned thirty years ago. The folks who live over there come over here when they feel like it. Most of them are taking medication. Some of them are very disabled and some of them we hardly see. When we opened it fifteen years ago, it was kind of a zoo. People moved in there and swiped the microwaves and the toasters and did whatever they wanted. I had town meetings and they would all say things like, "Well, my faucet leaks," and there were all kinds of demands and entitlements. But we had staff that were tuned into the idea of helping people learn how to do basic living skills and take responsibility for themselves and not demand everything.

So it took a few years, but now they're very prideful. They help each other. When one runs out of money, somebody else helps them. They tell us when there's any kind of problem over there. It's their community. They own it. We had a celebration and Carl got these beautiful cups and handed them out and wrote letters to everybody and we got some wonderful responses back.

CM: The tax credit period is fifteen years. You have to operate them for fifty years, but on December the 31st, we will have completed our fifteenth year so I bought cups, commemorative cups.

EM: So the tax credit people walk away, turn it over to us. Now, we have thirty-five years of housing that we're obligated to provide; and so it belongs to the community.

MM: That's great. Good for you. So okay, what else would you like to tell me? I still have a batch of questions.

EM: I can't think of anything, so maybe just keep on asking questions.

MM: [She laughs] Okay. Well, I wanted to go back sort of to this issue of cultural competence. I read the very nice piece you wrote on the culture of Hillview.

EM: Oh, I did?

MM: Yes you did [she laughs]; and what exactly that means, though, in practice? I mean you work with a fairly diverse community here.

EM: Well, being sensitive to special mores or attitudes, like we mentioned.

MM: Such as?

EM: The shame of admitting mental illness and things that might be going on in the home that are culturally affected, like the role of male and female, domestic violence, that's in the picture; and nuances of language, people having trouble spilling out their hearts to somebody that's not speaking their language or their dialect, or something. And that's such a challenge, although we have done a good job of that, but there are never enough bicultural people at the professional level, particularly. Our staff come from all cultures and they seem to be united in doing good. We don't really think of it; it's such a cliché to say we are color blind, but it doesn't seem to be any kind of issue here, as far as the workers are concerned and I can't think of anything smart to say about that really.

CM: I think that – there's no answer to this, but you send someone out who is 25 years old and they're going to go to this person's house who is 80 and start telling them what they should do and what they should not do [he laughs] and the reason why is – The payoff is, you're going to get to be 80 [if you take this advice]. "But I'm already 80!" [he laughs]. I often think about that and that always amuses me, I guess it's because of my own age. But we hire staff and send them out to do that.

EM: We provide - we get whatever trainings we can send them to and we have a unit in our in-service training, a young Vietnamese psychologist is specializes in cultural competence. But on top of that, I think you just have to have folks on your staff who accept people for who they are, inside of themselves and just don't worry about anything, except for what they think that person is feeling and just try to go there. And of course, we're so challenged by documentation and billing and productivity. We try to train our people to keep refocusing folks on "What do you want to do? What's the problem? What do you want to do with yourself? What are the steps?" Treatment planning is so crucial. The biggest challenge is to get people to focus on the real needs and cut the extraneous stuff out and not go on side trips. And the case managers are not trained clinicians, we have to train them [to do their work].

I try to hire, as much as I can, everybody who works here. So you can sort of tell when people have a kind heart, to be corny. Sometimes I hire people who are so kind that we have to help them set limits on what they can do, because you can also create dependency and get people into a state of helplessness by doing everything for them. We've had that too, especially with the ACT Program. We had such disabled people

and we hired staff that just loved to do for them, and I can see the handwriting on the walls so I'm trying to reeducate the staff to pull back from that and focus on the strengths. It's a real kind of a relearning thing, because our approach has always been so kind and compassionate. It's so hard to have a balance.

IV. Contract Clinics and County Clinics; Measuring Outcomes; Advisory Board; Closing Comments

MM: I see. Yeah, it is. I can see that that would be a challenge. Okay, so we usually ask people in the clinics, do you see that your clinic, a contract operation in this particular community, is more effective here than a DMH directly operated clinic would be? Would it be helpful if there was a directly operated clinic nearby where you could send some of these other people, or do you see yourself as – You tell me.

EM: I think we are more effective and operate at a very much lower cost. I think the directly operated clinics have a different environment, because so many people [without resources] walk in there all day long. I don't know what they're doing now, with the crunch. For years we were providing case management services for every single person and I don't think – I think the County kind of separated out things and they had people just doing medication and no case management service. And now they have incorporated the Mental Health Services Act, so they have [all the new MHSA programs]. But I just wish that there was more money for the contract agencies, because we started out with a certain mandate by the way we were structured by the Federal requirements and we've stuck to that; at least this agency has. [We are skilled in community mental health care.]

My idea was to do the Assertive Community Treatment Model on every single client who walked in the door; and the psychiatrists were part of the treatment team, the support staff, and even the drivers were part of the treatment team, everybody shared what they knew in the case conference. Of course, that's kind of impossible when you have a huge caseload in outpatient, but we did it as much as we could. Even today, the social workers confer, or the clinicians confer with psychiatrists, and they bring the information to the team and they make group problem solving sessions out of it, and they [the clients] just get a broad interdisciplinary attention. But, with this latest cutback we just had this month, what we had to do was stop that and so now we have referred all the people we could into the MHSA funded programs, where they will still get more care. Then we have approximately 100, I think it's 140 maybe now, but people in medication only and crisis intervention as needed, and the rest of them –

MM: Because that's all you can afford.

EM: Yeah, and then we had to go through our caseloads. We have – it's complicated keeping your caseloads current because a lot of people kind of drift off for a while, and [then come back]. Or you'll close a case, but the process takes a while to get them closed in the County and get them closed here and so we've cleaned up our caseload a lot. So now we still have about 1400-1500 clients, but we're just shuffling them around. And when we did this, we took the trouble to address each client personally, and I wrote a script to remind them of their strengths and reassure them that their team is still here; you're just going to go here on this day instead of there. And so [Carl and I] were on vacation for three weeks; and when we came back, it was done and everyone's just going along like nothing ever happened.

MM: That's good.

CM: One of the things that I observed is that a lot of our clients came here under not the best circumstances in the world. They came here as MIO clients [Mentally Ill Offenders] thirty years ago and then they came here as homeless clients off the street and all of that, then more recently, ACT clients, and so they come into our program and they receive these very intense services. Then they end up in our outpatient program and so they know our Center and they know our people and so it's a little bit different than just someone going to an outpatient clinic to get their medication. They have the history of the place [and feel some ownership].

EM: We just got a new MIO client back the other day.

CM: Yeah and it's not too uncommon [that] sometimes I could just walk into the lobby and someone will buttonhole me and he'll say, "You know, doctor so and so and so is a very good professional," and he'll start talking about how his situation was corrected over years; or sometimes they'll come in and thank me for the Center.

MM: That's great.

CM: We're here to provide the services. But I do think that we have a lot of people here who have a long time relationship with us, because they had intensive services and subsequently they're now just getting medication only.

EM: One thing I think we are is leaner and meaner, because we learned how to be. We have requirements for things that are not reimbursed, like quality monitoring, quality improvement, and all the in-service training that goes with that. And gradually I've sort of built up an infrastructure over the years, which keeps us [on top of things]. I mean, we have State auditors, County auditors and potentially Federal auditors coming in here [and we need to stay in compliance].

MM: I've heard about these, yes.

EM: And we don't have all this bureaucracy. I mean, there's Carl and me and our little team of about seven managers and a minimal support staff doing all this focused work to keep us on target and measure what we're doing and design in-service trainings where we think we're weak, but we do it *so efficiently*. Government, bureaucracy, has not always been that way, not news. But I have to tell you about this – our adventures with our MHSA programming. We have every single new program that you could have for all adult and older adults, field capable. We have full-service partnership for adults, for TAY, for older-adults, field capable for adults and older adults and Wellness Center. What else?

CM: I don't know.

EM: The contract agencies, as an organization, negotiated with LAC-DMH to have "legal entity contracts," which allowed us to manage our allocations for services according to the needs of the people who presented for service. The Mental Health Services Act created "silos" or program divisions for funding category purposes. Each of our MHSA programs has a specific population with a funding allocation that cannot easily be shifted if not used for that program. This arrangement, plus curtailment of traditional outpatient programs, has limited the contract agencies to treating people who fall into a specific category. Moreover, the treatment of each client is monitored by DMH for frequency of service, type of service, appropriateness of service with respect to the treatment plan, the clinical appropriateness of the treatment plan, and, in short, the clinical judgment of the staff.

County staff are here about once a month from Central office and the District office. Each visit requires staff to stop seeing clients (and producing revenue) and the preparation time of support staff whose time is not billable. The cost to the County for this micromanagement must be enormous. In addition to this on-site monitoring, our staff are required to attend weekly "impact" meetings for each program, the cost of which also was not anticipated in our contract negotiations.

The Federal Government, which is us taxpayers, invested billions of dollars in the community mental health system, and research and training. We have consistently delivered high quality care at a cost far lower than government agencies can operate. I fear sometimes that the depth and scope of our experience and our consistency of operation during the almost fifty years of our experience is overlooked during this period of change brought about by the Mental Health Services Act. My attitude is leaking out.

MM: Yeah. That's okay. That's okay! That's what we wanted to find out. So, aside from this monitoring, has the way you operate with clients changed substantially?

EM: Not a whit [she laughs].

MM: So you were pretty much doing this Recovery stuff before.

EM: Yeah, we're doing everything we ever did, [but we also] have definitely formally incorporated the levels of care concept. Right now we're doing the MORS [Milestones of Recovery] Model. Those are useful tools.

CM: Yeah, we got the –

EM: We try more and more to measure what we're doing and we're fine with outcomes [requirements]. I mean, what's the point of all this, if you don't know why you did what?

CM: We get reports of our staff's productivity and we get reports of how many services each client is receiving. And, if we find that a staff member is spending an unusual amount of time with a client, the supervisor will investigate and find out whether the client has real problems, or is this a client taking advantage of the system, or is this a staff member who [finds it easier to spend more time with fewer clients].

EM: That can happen.

CM: And so that's being done twice now. We're doing it and then someone [at the County] gets a report in addition to the one we have. And they see that and then they say, "Are you spending too much time with this client?" and if you say, "No," then they say, "Well, tell me why." And so then you have to go – the staff member has to go back into the records and pull up this information to convince this person of what's going on and so there's lots of [redundancy].

EM: In the Quality Improvement Department, I have a person who analyzes productivity reports against the logs that we ask the staff to turn in every week and against vacation and sick time and we try to keep it at 70%. We have to or we won't survive; and so the staff - Last year I put a lot of pressure on people, met with them to ask, "What are you doing, why are you doing it?" One person thought she had to spend two hours with every client, and she was seeing [stable, long-term] clients that I had known 25 years. So we tried to restructure her, having her set limits without rejecting the clients and finally she quit. She went somewhere else because it was too much. I've had two or three people just voluntarily say, "I've got to find a less stressful thing," and that's so sad,

because they were kind and reasonably effective, but the County probably can't do that. They can't; they have other issues, like the Union [County clinic staff are unionized].

MM: You seem to have gotten your Union sort of under control.

EM: Well, they went away.

MM: Oh, okay [she laughs].

EM: [She laughs] They decided they wanted a closed shop and I think there was a mole [employee] here because she showed up on the team with the Union and said lies about administration, about me, about Carl, they were ugly, they were mean, they tried to split our staff all up. But they didn't care anything about [what was in] their contract. The only thing they wanted was a closed shop, which we didn't have; and they got so frustrated because the staff just shined them on. We got this letter, this angry letter that the Union wrote to our employees, that's faulting them for not –

CM: They were angry with – the Union management was angry with the employees because they would not vote for a strike.

EM: A closed shop or a strike? Was it was a strike?

CM: I beg your pardon?

EM: Was it a strike or –

CM: Oh, a strike.

EM: After [this latest curtailment], I met with the whole staff and all the program directors and the financial people. We came up with a plan to reduce the support staff and then to reduce salaries of everybody by five percent, except for people who make forty thousand or less, they were two percent. And we took a lot of other measures, mostly related to transferring clients out of outpatient, because that's where the loss is. So we moved those who qualified into all the other programs within the limits, you know every program has its limits to how many transfers you could make within house and [to the] Wellness Center. We discharged a lot of people, and transferred staff from one program to another.

And so it went off without a hitch and when [we finished], I felt so bad. One of the staff members said we showed that our compassion was for the clients and that we were doing everything to save the clinical services and to keep going and save the clinical jobs. After [we met with the whole staff], they applauded me and this person said, "Well, this is the first time I've heard of somebody getting a pay cut and applauding the Director." [she laughs] So we feel really good to know we have a solid [group of] people, all united on the mission.

MM: And do you have a Board?

EM: Yes.

MM: And this Board is community people, consumers?

EM: We used to have consumers, but they kind of faded out. [shows a photograph]

MM: Oh, okay.

EM: Yeah, a lot of them are long time supporters. We chose – some of them are from the original NIMH Board, because we just went to the community and [found] people who had the same idea of service to the community. We asked [them] and they trust us. They've stuck with us.

MM: Okay, and so they advise you? How active are they?

CM: We meet about six times a year, but we have other events that bring us together.

EM: Dinners and things.

CM: And then telephones and dropins and stuff.

EM: We've brought – they know all about our cuts and our financial structure and our different programs, they're interested in all that. It's small and kind of been around for a long time, but they ask intelligent questions. They're school teachers and a former council member, Ann Finn, who figures large in Los Angeles politics. Reverend Simmons is still on the board and we took one of them out to dinner last night, John Alexander. The tall gentleman in the middle [showing photo] passed away very suddenly of a heart attack. Before that, he was on our staff as a psychologist and there's another couple, the Enzers that have been community advocates, I think you knew them before I did, didn't you? David and Rosemary Enzer?

CM: Yeah.

EM: She's a school principal and he's in the primary care industry.

MM: So a community group, for the most part.

EM: It's all community. It's a little different in adult services and it's a little different being in this community. I mean, we're so identified with this community so we wanted our board to be from here.

MM: That's great. Well, I've certainly learned a lot about Pacoima. So one of thing we sort of slid over earlier was, so how did you two decide to get married?

EM: Working together for so long, we were both divorced and I think I started it.

CM: [He laughs].

EM: You've taken up all my time, damn it, [I said,]; and my whole family loved him, even my ex-husband and my children, I mean, he's just the leader of our clan.

CM: We have a nice family. I have one son and Eva has three – two sons and a daughter.

EM: You'll get it right [she laughs].

CM: Eva has two sons and a daughter; and I have a son and then we have a granddaughter.

EM: We raised her.

CM: And the granddaughter is sort of different because we raised her, and that's our family.

EM: She's half Chinese, which has been very interesting for her.

MM: So one of your sons' children?

EM: One of my sons had a child, without benefit of marriage, and the mother is around here, but she just couldn't – I mean, she's a very successful business woman now, she's bought her daughter a house in Long Beach. She's an importer of items from Beijing, but she just couldn't do the daily stuff. So one day she called us up and said, "I can't do this any more! They kicked my daughter out of school, because they found out I don't live in Arcadia, and I don't know what I'm going to do." Carl just said, "Go get her," so we got her. Her mother would never let us be the guardian, so that was kind of a sticky wicket.

MM: Yeah, well that seems unfair.

EM: Yeah, but I didn't want to lose her. She's just a magnificent human being. But we got her into Cleveland Magnet School. Cleveland is a humanities program, started by a very famous, internationally known scholar. The school is international in its population. So you have all these kids dealing with cultural issues, with their immigrant parents from all different countries. I tried to send her to Chinese school [to enhance her Chinese origins], but she just wouldn't go. [The school was an interesting cultural experience for all of us. We learned a lot and she was able to comfortably integrate into her Chinese culture, African-American and Caucasian cultures. She finished UCLA and plans to stay in the business world, where she now works.]

MM: Oh, wow, good for her.

CM: One of the things that I'm now concerned with has been to make sure that Hillview is financially stable and so we run a pretty tight ship. We don't usually have excessive losses. [DMH requires us to spend exactly the allotted amount for each specialty program and, if you exceed that amount, you have a loss. But the cost of one program affects the others.]

And that's becoming more and more difficult to do because of those silos, but we have fully developed our properties. Hillview built this building and about 34% of it is leased, so Hillview has rental income that it expects to continue for the future and that will help take care of the problems that we have. We have been very successful in doing solid financing. The other buildings give us some resources to build programs around and we don't have to go out and expend lots of money trying to find places. So I feel very good about our future and we have a very good core staff. We have psychiatrists [and other key staff] who have been with us [25 and 30] years. So we have this core that we never have trouble expanding, because we always have that strong core to build around.

MM: That's great. Okay, well, that's kind of a nice summary statement; actually; do you want to add something?

EM: Well, I'm glad that somebody is documenting this long journey we've all been on. I still remain proud of the state of California for what it's done, and I just hope that we can continue to progress and learn new things and make the most out of the Mental Health Services Act. I'm going to be there to nudge on my areas of concern, but you know, we have a lot of brilliant leaders that put AB2034 together and now, this Mental Health Services Act. I think we probably stand out in the whole United States for having an enlightened approach to mental illness.

MM: Okay, thank you very much.

CM: Thank you.

MM: We'll conclude this interview now.

END OF INTERVIEW