Makesha Jones-Chambers talks about the early roots of mental health issues:

But really, it's the real desire to try to help people [that brought me into mental health]. People with true mental health needs are all over. Everyone has some kind of issue. That's what I love about being at this clinic and being in the field. People are coming with serious real problems. Whether or not they have been in the criminal justice system, they actually want to work on their problems. They don't like this feeling that they having inside.

There's just this stigma about it of being crazy. I've had people that have come to our door and say, “Someone told me to come here, but I'm not crazy.” They're really just serious about it. [We respond,] “No, this is not the crazy house, because I work here. So it's not the crazy house, [but] it is a place where we can help you.”

The problems can range from abandonment issues in the past – kids that were not taken care of [or helped to grow up] to the best of their abilities; and they just cope and try to deal with life and go through the motions. All of a sudden, at 21 or 25, it hits them and they are staying in their room, they are isolating from friends that they used to hang out with, they go into drugs. Those are the people that we really have to reach because they are just sheltered in the home and no one wants to talk to them at some point, because they are irritable or agitated. So it's really hard to get them the help they need at that point, which is why mental health is something that we have to do more advertising about, reducing the stigma at the child level in schools. Because [it’s] at that point where things are going on that kids don't feel comfortable with, talking about with their parents or family members. That’s the key.

It is definitely overwhelming and the problem is overwhelming, I think, for the community and the lack of resources that we have. But it has to start in the schools and it has to start in childhood. Kids have to talk about their feelings, not just allowing the behaviors to display [their feelings]. Teachers have to be trained in mental health to know when someone is just not playing the way they used to play, they are not socializing the way they used to, and noticing that change in behavior in order to get them help right then and there. I've had many, many clients that have said, “Wow, I wish I knew. I wish my mom [had] sent me to mental health way back then, when I was molested or when I got into that car accident. They assumed I was OK.”

We have a few that have a more recent job loss or divorce, more recent issues, but the majority have these childhood, teenage-year, issues that were unresolved. I've had clients that said, “Mental health, you don't say that word. You don't talk about being ill or crazy.” People in the family that were ill, they would just keep them in a room and give them their food and make sure they were OK [physically], but they didn't give them help. I’ve had people tell me, “if only somebody would have talked to me then, if only I could have told my teacher, or if I could have told my pastor, but everything was hush hush.” You just don't talk about those things in certain cultures.

READ THE FULL TRANSCRIPT BELOW.

Dr. Makesha Jones-Chambers, Psy.D., MH Clinical Program Head
Antelope Valley Mental Health and Wellness Center
interviewed by Jinah Kim, March 23, 2011

I was raised by a single mom who was an RN for Kaiser Permanente and for years, as an only child, I would always go to work with her. She worked in a teenage clinic where I would see varying ages of teenagers and what they were going through and what they were being seen for. I was just always very curious, even though I was young and didn't quite understand things. I was putting papers together [and] filing papers for the clinic after school.

And then, as I got older, I really started enjoying watching people. Being an only child in a single parent home, I was with adults a lot of the time and didn't have siblings or younger folks to play with. I would just sit and watch the adults, [whether] their conversations would be appropriate or not appropriate. I just really started to see that people were not always as happy as they appeared. You could see something deeper going on with them, [although] they would have the facade of "everything's great." Or they would drink or do things to make it appear that things were great. So that's what kind of sparked my interest in the field of mental health.

Then, during my second year of college, my mom had a mental breakdown. It was scary and surprising, because she was the oldest of seven children [and] she was the strength of the family. It was just difficult, seeing her going through this process. She was having psychotic episodes where she was talking to people that weren't there and was asking me if I saw the people there. "No, I'm not seeing what you see." So I had to go through the procedures to get her hospitalized. That was pretty sad and difficult to deal with, because she's looking at me – "We're supposed to be a team and you're my daughter and why are you doing this to me?" But it was the best thing I could have done for her, in retrospect.

She spent the three days there for hospitalization and came out and she was back to mom. She refused medications but she appeared to be better; and gradually, [over] the next four years that she lived, she did better. She was able to control whatever was going on internally with her, without treatment. But I wish so much that she had gotten treatment. She ended up passing from a heart attack. I wish that she had really gone through the therapy process and really addressed some of her depression that was still present, even through she was the strong person of the family trying to hold it all [together]. Sometimes it's just too much and I really wish that she would have gotten the additional help. Maybe she would have lived longer without the additional stresses. That's really what sparked my interest.

My mom was into scary movies and she would always have me watch detective movies or investigative stories. So I thought, "Oh, I'm going to be a forensic psychologist," not just a psychologist, but a forensic psychologist. I really wanted to look at dead bodies and analyze what happened to the people. So I got my doctorate in forensic psychology and then I realized, in doing different practicums and internships, I don't want to work with this population.

I started working with children a little bit after that. It was a residential facility for children that were – either their behaviors led them to being in an inpatient-type treatment facility or it was their parents that [had given them up] because of drug use or abandonment. They were put in there by the foster care system. So that was a great experience, working with the children and really seeing how parents can impact their kids' lives, and how these folks will eventually be adults and we have to help them now, before they are at an age where they just don't care anymore.

I think there is a resilience factor that plays into [the lives of] African-American women and with probably all cultures. But my mom had always been the strength of the family. Everyone went to her if there was any kind of problem. She focused mainly on other people's issues, versus her own stuff. I think that was part of it. You just keep going regardless; you have a kid you have to take care of. You have other family members and their issues that you have to take care of. I don't have time for me, I have to focus on them. In the helping profession, as she was a nurse, she was just always busy. She would just do for others; that's just all she did. That's kind of what kept things suppressed for some time.

I don't really know what triggered [her breakdown], because I was at college. I didn't really know how things were going for her, because I was staying on campus. When I saw her, I think it was during Christmas break and I was with her for two weeks, I thought, "Oh, something's not right." That's when she started talking about the voices and things like that. So that's when I said, "OK, this is not normal. I know [from] what I'm learning in my psychology classes, that this is not my mom, number one, and this is not normal behavior." We call it psychotic processes.

When she actually went to Kaiser, they didn't have her [diagnosed] as schizophrenia [but] with bipolar disorder, which is the mood variations from depression to really being manic. When you're manic and high and feeling great, nothing can bother you. That's when some of the voices can come about. She was really into religion at that time. We've always had a religious focus, and at this point she was really extremely into religion. God was talking to her and she wanted me to hear what God was saying; and [she] would say my grandmother, her mother, who had passed when I was two years old, was in the room and talking to us. At that point, that's when I knew, "She's on the upswing." I had never seen her at a really low depressive swing. She was just my mom – kind of normal going through the motions – so I wasn't really understanding where she was at.

But really, it's the real desire to try to help people [that brought me into mental health]. People with true mental health needs are all over. Everyone has some kind of issue. That's what I love about being at this clinic and being in the field. People are coming with serious real problems. Whether or not they have been in the criminal justice system, they actually want to work on their problems. They don't like this feeling that they have inside.

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Kids have to talk about their feelings, not just allowing the behaviors to display [their feelings]. Teachers have to be trained in mental health to know when someone is just not playing the way they used to play, they are not socializing the way they used to, and noticing that change in behavior in order to get them help right then and there. I've had many, many clients that have said, “Wow, I wish I knew. I wish my mom [had] sent me to mental health way back then, when I was molested or when I got into that car accident. They assumed I was OK.”

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In most cultures, it seems like no one wants to be put in a category of being ill in any sort of way. People prefer to have a physical health diagnosis; they are more comfortable with that. Even with those diagnoses – diabetes, hypertension – there's a depression component within those. So people just try to cope and not deal with that side of things and get medications to cover things up and [don’t] really talk about what's going on.

I don’t think we’re there yet. I don't think we're close, as far as [helping all the] people that are really in need of help. Sometimes the resiliency of people gets them by, but if someone doesn't know that there's a place they can go to and actually talk to someone that's not going to be judgmental, who’s not going to criticize them for what they're feeling, they are going to keep that stuff inside.

I mean, there's only so much you can tell your spouse, there's only so much that you'll tell your best friend. There are limits to your comfort, in your comfort zone with folks. It's better for folks to obtain mental health services with a professional. It doesn’t have to be long-term treatment. I don't believe that someone should be in therapy for five years. It just doesn't make sense; you become a friend instead of a therapist. But the short-term interventions that we have available can really help someone get a different perspective, instead of the ruminations that go on in our mind over and over again all day long – “Oh, I should have, could have” – work that out with someone. Once you have that therapy, we don't want you to keep coming. We want to give you the tools and skills to do it for yourself. We're not born with those tools or skills, and so that's why it takes an outside person, and it really takes the interventions to happen early.

Primarily because the clinic for so long had a criteria for persistent and severe mental illness – that was our criterion to get people in for many, many years – we've had a lot of people with significant diagnoses – major depression and schizophrenia, along with bipolar disorder. Those folks have been with us for several years - five, six, seven years. Some of them are at a point where they are just coming for medications. They don't need the therapy component, but just the medications; because there aren't other places in our community to obtain medications for a mental health diagnosis. So they still come to us for that.

Another group is our CalWORKS population where we are serving folks that have lost their jobs or have never had a job and need to find work at this point, but have a mental health barrier to finding work. They might have anxiety about interviewing. They might have lost their job in the past, or a supervisor has yelled at them and has created an anxiety for them to have a future

job. So we're working with that population. [CalWORKS (Work Opportunities and Responsibility to Kids) is a California state program providing temporary financial assistance and employment focused services to low-income families.]

We are addressing both those populations and really trying to do short term interventions. We're learning domestic violence treatments [and] substance abuse treatments for that population in order to get people to that point where they can work again, because we all have issues, but we have to work. I have to come to work every day, despite whatever I might be feeling inside, in order to really be a part of the community and be able to support my family.

So it's getting people to that point where they can support themselves and be self sufficient, because we don't know how long we'll have these programs for them, to get them the mental health treatment they need. Then we also have newly, in the last couple of years, the Prevention and Early Intervention Program [new evidence-based treatment programs created under the Mental Health Services Act of 2004]. We are addressing any kind of crisis that might be going on for the person. These people may not have any history of mental health problems; but maybe they lost their house, maybe they are getting a divorce. Some folks have lost their children to DCFS [Department of Children and Family Services] and they are having problems coping. So we're addressing those needs by providing short-term, crisis-related interventions, [for] six to eight weeks, sometimes 6 months.

Sometimes when we see these folks, they might end up needing more long-term services and medication services, because sometimes it's those folks that have been shoving things [inside] and really trying to cope on their own. All of a sudden, there's an issue with their job or their family and they have a total breakdown. DCFS – the Department of Children and Family Services – [stepped in because] they were abusing or neglecting their children. Someone saw them slap their child in the grocery store; anything like that could have happened. We don't do court-ordered treatment, but we will see them to address their mental health issues for crisis-related [problems].

The Wellness Center is for folks that have gotten to a point in their lives where they are stable on their medications. They don't need individual therapy. They've kind of graduated from our program here at the clinic and now they're at the Wellness Center which is peer-led. The services there are mostly groups, where our community workers are providing groups on depression and how to cope. But it's from a peer vs. a professional [group leader], which makes a difference, I think, in treatment – someone who's been there, done that, versus a professional that has the book knowledge [and] some prior experience too. But it just makes a difference where they can feel like they can talk to them and say, “OK, well, you've been through this, so tell me how you got through it.” And so that's where the program is really doing well. We have a psychiatrist stationed there too, just to keep the medications going.

The majority of the services are provided by the community workers and they go out into the homes if necessary. Some people become homebound, where they are scared to leave the house or something may have happened - a car accident or something – [and] they can't get in the car anymore. So [the community workers] will go out into the home and provide services in the home until the person is ready to come back to the Wellness Center.

We probably have about 1000 clients right now for this clinic and about 250 at the Wellness Center. There are two clinics that serve adults for mental health needs in the Antelope Valley itself. It's our clinic and the Palmdale Mental Health Clinic. Between the two of us, we have lines out the door. If we had a day when we had nobody coming, it would have to be a holiday,

because our doors are never closed, as far as the incoming of people. We have some clients that we might have to discharge at some point and we know that they can come right back in. They know they can come right back in and get the services that they need. Some people move away, but always want to come back and get their medication services from us. So [I ask them,] "You're going to commute from the [San Fernando] Valley? There are services in the Valley, but you want to come back to our clinic?" That says something about our staff and the services that we are providing for folks. People want to be here and like the services that they get.

We have telepsychiatry going on right now. One of our doctors is at his office in LA; the client comes here and watches him and talks to him through the computer screen. We have our RN write up the scrips [prescriptions] with the doctor's co-signature. That's where our need is really, getting the psychiatrists here and other clinical staff here, in order to provide the services necessary, because we can barely serve the thousand that we have and there's always more in line and waiting and waiting.

We've seen a gamut of cases. We've had a lot of people that are really in a lot of pain. Some of them have been discharged from the hospital, maybe not a hospital in our area, but they've been given our number, or have been referred to us to come in for treatment, because their medications will expire, or they won't be able to get a refill, at some point. So they come in here in crisis and they're demanding services today. Sometimes we don't have that availability [but] we've had clients that I feel have to get help. They're in need. I don't want to see them leave the clinic without us helping them.

There was one Monday, a client [who] had moved here from Georgia and had only been here a couple of months and didn't have her medications. [She] didn't have anything to support her mental health issue that she had long term care [for] in Georgia and decided to move here. On her way here, she drove here and had a major car accident where her arm was hurt; it wasn't broken, but it was bruised and she was just traumatized from that. She had gotten here, I think, in December and had been trying to get to our clinic since December, but couldn't get in the car and couldn't get here. She couldn't even sit in the car with her friend, because she was just so afraid of getting into another accident.

When she got here, I [said] "Whoa! Hi." The anxiety was ever present. She didn't want to come into the room and have the door open. She was afraid someone was going to hear what was going on with her or make judgments or criticize her. I told her [that] it's part of our program here. For safety reasons, we have to keep the door ajar, at least. It doesn't have to be wide open. She experienced so much anxiety from her past and then, on top of that, this car accident now, which is debilitating for her.

When I was a psychologist in the program, I would always incorporate spirituality in my treatment [and] care. But it's not something that we can promote necessarily unless the client comes to us with that. With this person, he's actually really interesting. He is a client that I had and he brought in this artwork for me [alluding to a painting on the wall]. He's diagnosed with schizoaffective disorder, which is a combination of schizophrenia and a mood disorder. He has the depression going, along with the voices and visual hallucinations. He is very religious. He brought in these pictures and said, "This is the kind of work I do and I spend two to three weeks doing this." I said, "OK," and I thought it was just a picture [an artwork]. I looked at it and there are words; there are writings in different languages. I said, "How do you know all these languages?" He said, "I don't;" but the voices told him what to write. I've asked other people, because I think there's some Chinese writing, there's Spanish writing. I said, "[Are these

phrases] really clear?" [They read them and said,] "Yes."

So it's just really amazing. He's an awesome client, he's great, and [has] sold his artwork in different places. He's done other kinds of images, but they're all words. So we've got to figure out how to use this artwork in a lucrative manner but not take you away from the family. Also, he would literally spend three to six weeks on this artwork, not caring about the family, being locked in a room - manic, not sleeping, not eating, but focusing on the artwork. "You've got to find a healthy balance."

The housing situation in the Antelope Valley is a crisis itself. There are a lot of people that have moved up here from LA in order to have an easier life where the housing costs are low. However, it's not low enough. We have some low income housing projects where the apartment buildings are subsidized by the government. People can get in for $500 a month but [for] someone that doesn't have an income, $500 a month is just too much and so [there are] a lot of homeless.

We only have one homeless shelter for the Antelope Valley, which is ridiculous. People have to line up by three o'clock in order to get in there. There's no limit to the number, but after three o'clock, you're not getting in. So, if you are out there job searching or trying to get things together, if you have kids in school and you have to pick them up and then get to the shelter, [and] if you're not there by 3, you're not getting in, so what do you do?

This is the desert. We have a chaotic climate. Right now it's been freezing and windy and people have to sleep outside in the desert. There aren't [any] other places. Many people tell me that they break into abandoned homes, places that are foreclosed, in order to just have shelter for the night.

There's also a domestic violence shelter, but you have to really have documentation that you were abused and have a police report to go with that in order to be a part of that shelter program. Everything is short-term. People are coming all the time with a housing need, but we don't have it. We want to help. We want to try to problem solve with them and figure out, "OK, we have a list of low-income housing, but they have waiting lists of two hundred people right now." It's this cycle that goes on where people lose their job, lose their home, become homeless, and the homeless shelters don't have much to offer them either.

END OF INTERVIEW