

*When the Village first opened, one of my jobs was to go down the street to MHA's Homeless Assistance Program and try to recruit new members for the Village. I noticed that although the vast majority of people hanging around there weren't willing to go to the clinic a few miles away to get medications, they were willing to talk with me. I told the administrators of MHA that I thought that most of these people weren't really medication resistant, they were clinic resistant. I'd been able to get people like them to take medications if I brought them to them at LAMP in Skid Row and I predicted that if we could get some money to pay for me to hang out there one morning a week, some money to pay for pills so I could avoid clinic intake assessments to authorize them, and a few lab tests, I could probably get a lot of them to take medications. They got the approval and a small contract from the county and I was right. Within a year there was a line of people wanting to see me all of whom who had refused medications in the past.*

*We used that experience to build in psychiatric services to all of our HUD contracts instead of separating the. Eventually, this practice led to fully integrating psychiatric and homeless services in the AB2034 programs.*

*Throughout the 1990s I continued to work about one or two mornings a week in the Homeless Assistance Program which had been moved into the basement of the Village. It made me feel cool and gave me a good way to introduce myself to friends and at parties. (Take my word for it, it's much better to say you help homeless people than that you're a psychiatrist.) When we redesigned the Village in 2003, I volunteered to work full time in the basement. But I wasn't really sure I could handle it. It's one thing to slum on occasion to impress my friends. It's quite another to work with homeless people full time. The personal challenge I set for myself, was to see if I could keep my heart open to these people and their tragedies and avoid shutting down and distancing myself from them to protect myself emotionally. Looking back now, I think I was successful.*

*The surprising outcome of opening myself to them was that they opened themselves to me. They told me very different stories than they did when I was an outsider. Those stories are the basis for the next two articles. The first one was intended for a professional audience. The second one was intended for a public audience.*

## **Who Are the Mentally Ill Homeless?**

**(2003)**

Over the past several years, California has targeted millions of dollars to provide intensive, integrated mental health services to people who are either homeless or being released from jail. As we've become heavily involved in their lives, and built close trusting relationships with them, we've been surprised by who they really are. There

are numerous people, with severe mental illnesses, who are on the streets and in jails but they are not who we thought they were.

For decades, we've been told that after California closed the vast majority of its state mental hospitals, tragically, tens of thousands of people, who would've been taken care of, were neglected on the streets and incarcerated. We've been told that so many times we just assumed it must be true.

Maybe we should've wondered when Courtney Harding and NIMH published their longitudinal studies of the last, most hopeless people released from the state hospitals in Maine and Vermont and they found that the majority of them were not wandering lost and neglected. The majority of them were recovered.

Even still our belief has been bolstered by two ongoing sources of information.

One is the ongoing stream of tragic stories from the growing and highly vocal AMI groups. Parents lash out at us with stories of their adult mentally ill children, usually suffering from schizophrenia, who after numerous treatment referrals became homeless and incarcerated. *Although AMI represents the families of people with severe mental illnesses, they are not representative of them.* Only one of the last 200 people I evaluated in our Homeless Assistance Program had a family member in AMI and very few could be described as having a supportive family at all. To the contrary, the vast majority described their families as abusive, neglectful or lost to them entirely in childhood. While there certainly are successful children whose lives are ruined by neurochemical mental illness and end up homeless or incarcerated, they seem to be a very small percentage of the overall group.

The other set of information is the ongoing reports of surveys of structured diagnostic interviews of people on the streets or in jail. Repeatedly these have reported large numbers, 30%-70%, of mental illness. Further, they report diagnoses of major neurochemical mental illnesses, schizophrenia, manic depression, schizoaffective disorder and major depression. Two serious problems exist with this data set. First, many of these people probably weren't telling the truth to these surveyors. In particular I find that over time, as people trust me, they reveal much more information about substance abuse, child abuse and neglect, school failure and special education than they reported initially. These things are generally shameful to them and likely stay hidden from a symptom checklist interviewer. Secondly, there are internal biases within our diagnostic system. In other words, if you give someone a structured diagnostic interview, you are likely to come away with a structured syndromic diagnosis, but you may not realize its not really what's wrong with the person.

An example: A young woman came to our program one day with a boyfriend she was flirting with. She said she'd been diagnosed as having manic-depression in the jail and

given Depakote. She'd run out months ago and wanted more. She clearly met all the diagnostic criteria for mania – she was pressured, silly, laughing, and a little euphoric, disinhibited, sleeping poorly, and couldn't focus. She even heard a few voices at night. And, like most people with mania, she made us laugh. It wasn't until months later that I learned her whole story. She was very slow in school, never learned to read or write, and was in special education classes by 2<sup>nd</sup> grade. Her mother described her as having "scrambled brains" almost from birth. She dropped out of school at 16 unable to support herself and unconnected to government benefits. Mostly she lived off her mother. When she wanted extra money she stole, but she wasn't very good at that either. She usually stole used clothes and sold them to thrift stores. She was caught numerous times and jailed repeatedly in Chicago. She was able to function in jail until the day when she was told her mother died. When they wouldn't let her go to the funeral she exploded. That was the day she was sent to a psychiatrist for the first time, diagnosed with manic-depression and medicated. When she was eventually released from jail, she came to Long Beach to live with her sister and discovered crack, thanks to her new boyfriend. That's why she was hearing voices and couldn't sleep now.

*Her structured interview diagnosis is manic-depression, but that's not what's really wrong with her.*

This year I changed job assignments. Now I do all the initial psychiatric assessments of people in our homeless drop in center and from our street outreach workers. I've spoken with over 200 people so far. I've taken it as a personal challenge to try to connect with each one. I try to create space in myself to feel their stories and to help them feel understood by me. I've been stunned by what they've shared with me. The majority of them were severely traumatized as children and they are still reliving those traumas.

I've started wondering about new questions: How many homeless mothers with small children were sexually molested as kids? How many aggressive, drug abusing homeless men had drug addict mothers, brain damage, and frequent beatings as a kid? How many second grade special education students become illiterate dropouts unable to get a job or benefits? How many people became homeless after their children were removed and they couldn't handle the pain? How many people's voices began in early childhood while they were being severely abused and is that really schizophrenia? These aren't the kind of questions we're asking about the homeless mentally ill.

When I tried to divide these people into four groups, neurochemical major mental illnesses, severe childhood trauma victims, developmental/learning disabilities and severe substance abuse, I found two things. First, almost everyone is in more than one category. Second, the neurochemical major mental illness category is often the smallest of the four. Why, then, are we so exclusively focused on this group? I believe a good deal of the answer lies in how we use DSM III and IV.

About 15 years ago DSM III began being used nationwide as a tool to ration public mental health resources. There clearly were not enough mental health services for those who want them and the perception was that clinics were seeing cooperative, “worried well” people instead of focusing on truly needy people with severe mental illnesses. It was decided, that some diagnosis –schizophrenia, schizoaffective disorder, manic-depression, major depression and psychosis not otherwise specified, were in fact “major mental illnesses” and deserving of public funded treatment. All other diagnosis – including personality disorders, anxiety disorders, posttraumatic stress disorders, substance abuse disorders and developmental disorders were “minor mental illnesses” and not deserving of public funded treatment. We also set up computer monitored standards of care that required people have a major mental illness diagnosis to be prescribed medications.

When this division was made many people were discharged and left to manage on their own. However, many others were re-diagnosed into one of the major mental illness categories to ensure ongoing needed assistance. No conscientious clinician will make a principal diagnosis that isn't a major mental illness if they want to help that person. Therefore, our present records show that the vast majority of people in the public mental health system are diagnosed with a major mental illness, whether they really have one or not. By now this has gone on so long that we've all but forgotten that it was an “ends justifies the means” deception and not reality and we've trained a new generation in this diagnostic approach without explaining the intentional deception we were practicing. Many patients are now savvy enough to present their stories in a way to assist their clinicians in making a major mental illness diagnosis so they can get services and medications.

The initial rationing assertion that all those other diagnoses are “worried well” was probably wrong. More likely is that most of the people with other diagnoses who came to our clinics cooperatively and regularly, for individual and group psychotherapy, were “worried well”. There were probably always large numbers of the most impaired versions of those diagnoses not in treatment and not in our awareness. It is only as we are aggressively pursuing homeless and jail diversion people that we are meeting many of these people and they aren't “worried well”. They are every bit as impaired and therefore every bit of deserving of treatment as people with “major mental illnesses”.

It seems likely to me that the people who created DSM III and DSM IV rarely met people with these severe versions of personality disorders, anxiety disorders, posttraumatic stress disorders, substance abuse disorders and developmental disorders. The descriptions in the manual do not adequately describe these severely impaired people making it even more likely they'll be diagnosed with a major mental illness instead. For instance, I was taught that trauma could induce anxiety, depression or personality disorders, but not true psychosis. Now I've met many people who began

hearing voices while being severely traumatized as young children. We found them in the streets and in jail, not in mental health clinics. I don't think they really have schizophrenia, but there is no category for "chronic hallucinations, childhood-onset, trauma induced" in DSM IV.

When the DSM III was created, major changes were made in our diagnostic perspectives. Perhaps most importantly, causes were removed. Since it was very hard to get anyone to agree on what caused someone's mental illness, it was only thought possible to get replicable diagnosis by virtually eliminating causes and relying on what symptoms regularly clustered together to define syndromes instead. Gone were the old "schizophrenic reaction" and "depressive reaction". Gone were "pseudoneurotic schizophrenia" and "schizophrenia, obsessive type" with their implications that weak mental structures could be broken down into psychosis under stress. It's not that people stopped having these conditions. We relabeled them all as causeless syndromes and forgot how to make the old diagnosis. Even when clear correlations are well known, like that the majority of women with borderline personality disorder were victims of childhood sexual abuse, causal linkages were left out of the manual. This has created the mistaken impression that all the DSM diagnoses are best understood and treated neurochemically.

Another other change in perspective that was included in DSM III was that the diagnoses of adults are separate from diagnoses of children and adolescents, with a few exceptions. It is not considered relevant if an adult diagnosed as manic depression had a childhood diagnosis of conduct disorder or attention deficit disorder or no childhood diagnosis at all. Indeed the transitions between childhood diagnoses and adult diagnoses are so few that one could be excused for thinking that all major mental illnesses emerge in late adolescence or adulthood. The pendulum swung radically from all mental illnesses being rooted in childhood issues to virtually none. This perspective makes it particular hard for us to successfully diagnosis homeless and jail diversion people since the vast majority of them were already seriously impaired in childhood.

Our training in childhood and adult conditions is also separate, along with almost all treatment settings for adults and children. Besides creating an enormous crack for them to fall through - I've heard it cited that 50% of foster children with mental illnesses end up homeless in the first year after they turn 18 - this creates an enormous psychological divide. Childhood clinics don't perceive themselves as preparing people to deal with their mental illnesses in adulthood and adult clinics don't perceive themselves as continuing childhood care.

If we try to build a bridge across that divide, a shocking reality appears. The vast majority of mentally ill homeless and jail diversion people are not previously well adjusted people tragically struck down by neurochemical major mental illnesses who

years ago would've been cared for in mental hospitals. They are largely severely impaired children grown up. The political implications are stunning...

*LA County Jail is not the largest defacto mental hospital in the country. It is the largest display case of the results of child abuse, neglect and traumatization, the failures of special education programs and foster care, and the failures of childhood substance abuse prevention and juvenile justice rehabilitation (Or more accurately, the failures of those programs in the past. We won't know our present failures until they grow up). Disabled and outcast children become adult homeless people and jail inmates.*

It's not as simple as that though. As my children have pointed out to me, blind children and seriously physically disabled children don't become homeless. But mentally ill people do. Overall, I believe homeless people are people with highly stigmatized conditions, who do not have family support available, and who do socially unacceptable things. For example, people who drop out of school, abuse drugs, are violent, are convicted of crimes, become single mothers, have their children taken away, are abandoned by their husbands, or are prostitutes often become homeless. We have a variety of policies that restrict these "undeserving" people from employment, housing, disability benefits, mental health services, etc. In effect, our society has intentionally excluded almost all the homeless people. They have become refugees in their own country. Strangely enough, it would seem that the vast majority of people with schizophrenia are not homeless because they aren't very uncooperative and disruptive, and because most of them have not lost their families, even though they are highly stigmatized.

The bottom line is that a medical treatment system designed to reduce the symptoms of neurochemical major mental illnesses will have very little impact on the vast majority of homeless mentally ill people *even if it is given increased coercive powers.*

I believe our Homeless Assistance Program is effective because we've used what we have learned about who these people really are. Now we're able to serve the major needs of our homeless mentally ill people:

- 1) We are a refugee center, an Ellis Island, for these people. We welcome them in, provide a sanctuary from the rejecting community around us, get them documentation and benefits to return to the community, help with legal sanctions against them (e.g. warrants, probation and parole conditions, and immigration issues) and actively develop community niches for them to settle into (especially employment and housing).
- 2) We actively work with them to stop their socially unacceptable behaviors, especially disruptive substance abuse, without rejecting them. We are part of an extensive, community based, substance abuse treatment network. Many of our staff are role models and guides to substance abuse recovery.
- 3) We assist with emotionally healing from the severe traumas they have been scarred by. We have close emotional relationships as adults with them, rather

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- than keeping them behind professional barriers and boundaries, or treating them like misbehaved children. We truly like them, care about them, believe in them, and are willing to share their suffering with them. We can do that because we actively support each other and work as a team.
- 4) We help them with psychiatric medications although there is no body of research or accepted practice standards for medicating most of their conditions. When they feel better they are often able to take more responsibility for their lives and accomplish more.
  - 5) We help people reconnect to whatever reasonably supportive roots they had, including family, home and spirituality, and we help them build new roots.
  - 6) We fight stigma and discrimination in our community alongside them as they face it.

There are now hundreds of mentally ill people reclaimed from the streets and jails that are reconnected to our community with our assistance. I think California is getting its money's worth.