I presented several papers at the World Mental Health Conference in Vancouver in 2001. While I was there I also attended several presentations including an impressive workshop about working with refugee. The workshop panel consisted of someone from Australia working with refugees being forced out from their homes in East Timor, someone from Sweden working with people fleeing the war in Yugoslavia, and someone from Chicago working with people escaping for the ex-Soviet Union. As I listened to them, I realized that their work was not that different from mine. Most of the homeless people I've worked with are also refugees forced out, fleeing, or escaping from something back home. They are, in effect, refugees in their own country.

Notice how this is an idea I wouldn't have been able to see from an illness centered perspective because it's only visible from a person centered perspective. Once I could see it, I was led in several unexpected directions I discuss here and in the hospital letter later on. It also helped me better understand what we were really trying to accomplish in our Homeless Assistance Program.

American Refugees: The Village as Ellis Island

(2002)

When I was in India, I learned that there was a difference between homelessness and houselessness. Many people in India have no house. They live by roadsides, in shacks, under bridges. To me, this is tragic. But, most of these people are not homeless. They have families, social networks, some work, and spiritual lives. In contrast, most of the houseless people I meet in America, especially those with mental illnesses, are also homeless. They have lost their families and communities. They have become refugees in their own country.

Sometimes when the Village houses these people, it fails because they are still homeless. On the other hand, there are some people who we don't house who have clearly found a home with us. "I didn't come to the Village to find a family, but that's what I found."

I was recently asked to refill medications for a man in our homeless/jail diversion program while his psychiatrist was on vacation. I asked him how his life was going and he said, "Better than ever before." In the four months since he'd been released from jail, he'd really gotten his life together. He'd stopped using drugs, was taking medication regularly, had an apartment, was employed at our Deli, and working on reuniting with his ex-wife and daughter. I asked him what had made the difference this time. In the past he'd always just gone back to drugs and been rearrested. He said, "Every time before I was just dumped back onto the streets with nothing. This time someone from the Village came and picked me up. They got me a hotel room and eventually a Section 8 apartment. They supported my sobriety and took me to meetings. They got me a job at the Deli. I had a reason to change my life and a reason to stay clean. They made me feel like I mattered and I could have a real life again."

When the Village first began, our members were a cross section of people living in Long Beach with disabling mental illnesses. When our funding changed from the State Department of Mental Health to

the County Department of Mental Health, they took control of our admissions criteria. Now we focus on "revolving door" people, state hospital, and locked nursing home patients who are willing to relocate to Long Beach. The passage of AB34 added groups of homeless, jail diversion people and "aged-out" 18 year olds from the foster care and group home system. Almost all of these new people are refugees, lost and alone. It's rare now days to admit a "treatment resistant schizophrenic" being pushed by their involved, advocating, AMI family. It's unclear to me if our funding bureaucracies intended to change our business, but they did.

We now see a much broader array of overlapping diagnosis (childhood trauma, developmental disorders, severe misery, "attention deficit disorder", substance abuse, personality disorders, PTSD, etc., etc.) – all, of course, years ago carefully packaged as Major Mental Illnesses so they can get services and SSI. The list goes on and on, I believe, because the list of ways to be rejected by American society goes on and on.

The common analysis that our jails are filled with deinstitutionalized mentally ill people is missing the point. Our jails are filled with rejected American refugees, many of whom can be diagnosed with a mental illness. (Maybe that was true of the old mental institutions, too. I don't know.)

The Village's main job, at this point, is to be a point of re-entry for all of these people —an Ellis Island for American mentally ill refugees.

Effective refugee services around the world generally contain three elements:

(1) Charity: They give people practical things like food, shelter, clothes, jobs, transportation, money, etc.
(2) Treatment: They try to diagnose and treat both mental and physical illnesses to improve people's ability to function, and
(3) Political Advocacy: They help them form a new political identity to redress the causes of their rejection and fight for a place in their new community.

Most mental health programs do only the treatment element and, as a result, fail miserably. The Village does both charity and treatment and does much better. We probably could do even better if we did more catalyzing of political advocacy. The most obvious place to work is in mental health advocacy and MHA, Project Return and the California Network of Mental Health Consumers all are working in this area. Their presence could be more prominent within our "refugee center" at the Village.

However, many people at the Village became outcasts for other reasons than inadequate mental health treatment – child abuse, school dropouts, substance abuse, lack of job or housing opportunities, foster care failures, domestic violence, prostitution, physical disabilities, illiteracy, etc – that are excellent political advocacy areas. Perhaps we should also be more actively involving people in these causes.

Refugee centers tend to be very unpopular with the communities they are trying to integrate people into. It's no accident that Ellis Island and Angel Island (for Asian immigrants in San Francisco) are on islands. Our recent forceful rejection when we tried to open up a new homeless program shows to me

that Long Beach would prefer us to be on an island as well. Often the only ones who reach out to refugees are those seeking to prey on them.

Within refugee centers problems often emerge as well. Overcrowding in substandard settings breeds tension and conflict. Internal "black market" economies and drug abuse can flourish. Older members can exploit newer ones. It can be difficult for staff to continue to treat people humanely, who are so clearly devalued by our community. Yet humanizing respect may be the most healing thing we can offer to them. Internal cultures that demean, or build dependency on charity, or reduce hope must be guarded against as well.

Even the best of refugee centers can't integrate everyone into a normal community. How do we know when to give up? A good argument could be made for giving up on nearly every Village member. In fact, the "normal" mental health system has either intentionally or just neglectfully, given up on virtually all of them. Who is just too dangerous, or self-destructive, or regressed, or unbearable to be a part of our community? At any given time every Village team has a few people that are locked away either in mental institutions or jails.

This "refugee model" can also offer a new perspective to the involuntary treatment debate. When our homeless outreach worker brings a sandwich every few days to a homeless psychotic man laying on a bus bench talking to voices only he can hear and wearing plastic wrap to keep gamma rays away, he is beginning the process of reintegration. He is breaking into the man's invisibility and welcoming him back to our world. The man may begin to accept other assistance; a blanket, a shower, a bandage for his leg. Ultimately he may even accept medications, housing, benefits, or employment and become one of us again. If instead of reaching out to him slowly, we call the police or the Psychiatric Emergency Team and have him put on a psychiatric hold, tied into an ambulance to be taken to a hospital, and perhaps forcibly medicated, we are certainly not welcoming him back to our world. Even if his illness is effectively treated in the hospital, it's unlikely he'll have a home to go to, and he'll be once again rejected and abandoned.

Involuntary treatment may be useful to treat some people who have homes, who are not refugees, so they can function in them. It may also be useful to lockup people we've given up on. But, it's not a useful refugee reintegration tool.

Over the past couple months I've been helping out with our homeless/jail diversion teams, while we've been recruiting a new psychiatrist. A number of the people I've seen reminded me that I've met them before, often several years ago, in our drop-in center. "You were the one who first got me on medications and getting my life together." I'll look back and find a long forgotten hieroglyphic note I'd written. I don't think I'll ever know how many people over the years we've helped bring back into our world. It's probably hundreds. I've always been proud of what we do.

Recently, I've returned as a consultant to Skid Row. It seems that with the soaring price of real estate, the loft developers are redeveloping the area. They want to change the name and get rid of all the "refugees" there. The problem is that most of them have no where to go back to and nowhere to go

forwards to either. Many of them have been there for a very long time. It's only place that hasn't rejected them and after a while they've learned to fit in somehow. No other community wants them, so we haven't been very successful at reintegrating them anywhere else. Over the years it's become more like a Palestinian refugee camp than an Ellis Island. If it's closed down, where will they flee to next?