

In my view, Proposition 63 brought us a new kind of funding with a new set of responsibilities. Instead of being a government funded medical insurance plan for indigent people like MediCal requiring “medical necessity,” Mental Health Services Act (MHSA) funding comes from taxing millionaires and requires quality of life outcomes (like housing, employment, avoiding jailing, etc.). The MHSA grew, not out of “parity” efforts to treat mental illnesses like physical illnesses, but out of social responsibility efforts – finally keeping the “broken promise” of deinstitutionalization – to provide community support and care. The MHSA is more focused on helping people with serious mental illnesses live successfully in our community, than on treating their illnesses.

This article was my attempt to address the issue of social responsibility in very concrete ways.

Socially Responsible Mental Health Services

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Last week a confused fifty-year-old woman with no belongings or identification was picked up at the Los Angeles airport saying she was trying to get to Los Angeles. The police took her to the county psychiatric hospital. She told the hospital her name was Julia Smith, she was homeless and had a mental illness. Looking her up in the computer showed that she’d been seen by jail mental health four times and hospitalized five times in the last couple years, but no outpatient treatment. The hospital called us at the MHA Village to see if we would help her. We sent a staff to the hospital the next day to meet Julia and offered to help her out after she left the hospital. A few days later on a Friday afternoon, the hospital discharged her, penniless and without a plan. They had an ambulance drop her at our door.

We didn’t panic. We arranged to pay for a hotel for the weekend and gave her \$40 for food and cigarettes. I’m the psychiatrist and I talked with her that afternoon. She didn’t make much sense, was distant emotionally and couldn’t focus. I guessed Julia had schizophrenia, but there were no records. I checked that she did have a 2-week supply of pills and knew how to take them. She said she liked going to church so I started looking through the phonebook for a Baptist church nearby, but that was too confusing for her. We’d have to arrange for someone to go with her to church later on if she still wanted to go. We offered her a toiletry kit and a brush, but she wanted a comb instead. We didn’t have one. Out of our five engagement strategies—charity, medications, emotional connection, substance abuse empathy, and spiritual connection—only charity seemed to be working.

On Monday another one of our staff picked Julia up at the hotel. The manager reassured the staff that there had been no problems. She took Julia to the Social Security office and waited with her for three hours to be told that Julia had been cut off two years ago. Apparently Julia’s mother, who was her payee, died and then they made Julia her own payee. When she didn’t respond to their requests for medical re-evaluation they determined she was no longer ill. She’d been homeless ever since. They told us they couldn’t restart her benefits. They gave her an appointment in 2 weeks to begin the reapplication process, and told her to bring a birth certificate. She’s from Pittsburgh. She didn’t have money to request a birth certificate be sent to her and no address to send it to. Even if these obstacles

could be overcome, she would have no money to live on for the several months it takes to approve SSI benefits.

We didn't panic. We made up a budget and prepared to spend a few thousand dollars of our own to keep her housed and fed. Hopefully, we'll get most of it back from Social Security, but the two week delay in filing cost us about \$500 off the top. We sent the form and payment for the birth certificate. I checked in with Julia again. We still didn't have a comb. Later that afternoon another one of our staff saw her panhandling at the grocery store across the street from the Village. She told Julia very sternly that she shouldn't beg there. If she wanted to live in Long Beach she had to be a good neighbor. The store customers don't like begging and the police would be called on her again. We invited her back to the Village for lunch.

None of this is very dramatic. I didn't do any complicated diagnostic assessments, medication management, or insightful therapy. We just did a lot of practical, grunt work and spent some money. Socially responsible mental health services often look more like refugee services than treatment. It often includes welcoming, giving charity, re-documenting people, benefits assistance, good neighbor/citizenship training, helping to find a niche, and advocacy. Sometimes it seems like we're a lost and found for people ... except that no one ever comes to reclaim most of them.

Years ago, if people with mental illnesses couldn't function in society or behaved badly, they weren't held responsible. They were given asylum in institutions away from society's demands. There are no more asylums. Now they are held responsible and often evicted, jailed, or just plain rejected because of the things they do. Similarly, mental health workers were sheltered away in the institutions. So long as there were no severe scandals, we could do as we pleased. Mental health workers continue to hide behind a wall of confidentiality and a maze of psychiatric jargon. We want to be funded and left alone. We know what's best. We're the experts. It's time for us to be held responsible by society too.

No more saying we'll only treat certain types of Axis 1 diagnosis, when it's obvious we're turning away people that are disabled. No more saying, "I'm sorry you're homeless, but our next appointment is in six weeks. How would January 8th at 1:30 be?" No more telling distraught families we can't do anything if your brother won't come in to see us unless he's dangerous. There is no law against outreach. Instead of coming with an ambulance and restraints, we can come with a lot of listening, some resources, and a willingness to meet people where they're at.

At the MHA Village, we can, and do, show up to the library when the librarian calls concerned about a homeless man pacing around talking to himself upsetting everyone. We can, and do, show up to jail to meet people before they're released, to pick them up and pay for a room. Similarly, when the police get a call at night about a young woman wandering around confused they can take her to a hotel for the night at our expense and leave us a message so we'll pick her up the next morning and work out a plan. If we expect our communities to fight NIMBY and accept us, we have to be part of the solution, not part of the problem.

When I drive to work, I often pass the crossing guard with her yellow vest and hand held stop sign helping the kids get safely to school to learn and grow. Often I smile and wave at her. Sometimes I think our job is to be crossing guards for people with mental illnesses. We help them get around safely so they can learn and grow too. Often we go with them to social security, the welfare office, court, medical doctors' offices and hospitals, the housing office, vocational rehabilitation, the college's disabled students' office, and to church. None of these places are easy for people with mental illnesses – or even “normal” people – to navigate. They often need someone to help them get what they need safely. We don't wear yellow vests, but it would be nice if you'd smile and wave at us instead of telling us to get out of here with “those people”.

Socially responsible mental health services can go even further. We can be the social security payee for people. We can do employment training and job development, apartment finding and support, substance abuse treatment, even parenting support. In each of these cases we need to be careful we're creating a support for the mentally ill to be part of the community, not a protected alternative to the community. In each of these cases we're helping someone recover their place in the world and we should be held accountable for achieving that goal. We can, and should, report how many people we helped get off the street, out of jail, living in safe housing, working, and caring for their children. These are the core of socially responsible outcome measures.

There are many obstacles to creating socially responsible mental health services: Staff don't want to do this kind of work. We haven't been trained to do it and it's not what we expected our jobs to be. Our program designs support our refusal; “that's not our job”. The other agencies, and the community at large, don't want us there. They want us to protect and remove people with mental illness. Stay in your clinics and hospitals far from sight. Our major funding source, MediCal, is a “medically necessary” system and simply won't pay for socially responsible services if they're not medically based. San Francisco seems to have a new mantra, “We don't do social admissions to psychiatric hospitals.”

It's clear to everyone by now this just isn't working. We need to integrate medically responsible and socially responsible services to have an effective mental health system. The recovery model has given us a vision of how to do this. Proposition 63 has given us the opportunity to build it. We now have the opportunity to hire and train new staff and retrain old staff. We can redesign our programs. We have funding available that can be separated from medical necessity. We have new resources in a time when other agencies do not. We can help them save a lot of money, so we should be a more desirable partner now. We can create a record of effectiveness and showcase it to fight stigma and build inclusiveness. We can build a socially responsible mental health system, helpful to those that need it and accountable to those who are paying for it.

Even two years later, I rarely hear discussion of the change in responsibility I believe the MHSA has brought with it. We're far more likely to focus on clinical or programmatic issues than meeting our social responsibilities.

The mental health field is sharply divided on this issue. Especially people trained as medically responsible professionals aren't happy becoming socially responsible. The two sets of responsibilities aren't mutually

exclusive. In fact they're usually synergistic. But they're not identical either. MHSA money shouldn't be used just to leverage more MediCal money. That would be abdicating our social responsibilities by pretending they're the same as our medical responsibilities. The social consequences of our programs need to be well thought out distinct from the medical consequences.