A five stage public advocacy agenda to attempt to deal with violence prevention, mental illness, and social isolation collaboratively as a community.

An Anti-Violence Mental Health Plan

2014

It seems almost every week now that we hear of a mass murder / shooting in the media. By now the pattern is too familiar to be as frightening as it once was: An isolated young man, with some ongoing mental illness that isn't being actively treated, is resentful of his world, buys guns and lot of ammunition, and kills people until someone kills him. The response has also become reflexive: Guns should be less available, especially to people with mental illnesses, and potentially dangerous people should be treated for their mental illnesses, involuntarily if necessary, so they can live safely in our community. Yet, nothing much changes, outraging the next set of victim's families and communities.

I would like to propose a different long term, proactive strategy on the mental health side of the problem.

From a mental health point of view these young men, have two relevant characteristics – their mental illness and their social isolation. We've focused much more attention on their illnesses than on their social isolation. I believe this is because we have a lot more faith in doctors, medications, and treatment than we have faith in relationships and community. Never mind that these people seem to have a variety of conditions (though it's hard to make diagnosis on dead people from media reports). Often they seem psychotic, probably from schizophrenia. Sometimes they seem socially impaired from childhood, even dramatically so, perhaps with some variant of autism. Occasionally PTSD seems to be part of the problem. Even though they all seem to have very longstanding problems, we seem to have the belief that if only someone would have gotten them some treatment, especially into a hospital, their tragedy could've been averted. There are plenty of expert psychiatrists willing to tell the media about how effective our treatments are if only we'd be given the power to force more people to receive them. It's unclear if that's actually true. Some of these young men have received treatment, and seem to mostly have been antagonized by it and further isolated and stigmatized in the process. Don't get me wrong. Treatment, including medications, can be a very powerful tool to achieve recovery, but it will never be "the answer".

Psychiatrists don't publically share that our treatments mostly only work when we can engage the person themselves in their own treatment and recovery, when they collaborate in the hard work of recovery and that recovery needs to be an ongoing effort. (When was the last commercial you saw that said, "If your antidepressant isn't working, maybe you need to be more involved in your recovery"?). Maybe mental health workers need to do better at engaging people and collaborating with them and working on goals they think are important.

One of the main reason we're reluctant to share our limitations is that we don't want society demanding that more and more people with mental illnesses, who are uncooperative, be locked up indefinitely in mental hospitals again. Despite some vocal counterexamples, most mental health professionals have neither the stomach nor the budget for locking up lots of people. The main reason we're locking up more people in jails instead of hospitals isn't because anyone thinks it's better for them; it's because most judges were prosecutors and they don't' have any budgetary constraints on them. They have society's permission to be extravagantly coercive. Psychiatrists don't have that permission and we're not likely to ever have it again. The judges don't get blamed for overcrowded, budget busting, inhumane prisons. Psychiatrists did get blamed for overcrowded, budget busting, inhumane hospitals.

What if instead of heading down this dead-end again, we focus on the "socially isolated" part of the equation? Could we find ways together focused not as much on how to help get people into treatment, but how to help get them into life? (Notice before we start down this road, that most of the recommended treatments further isolate, shame, and stigmatize the person as a not insignificant side effect. For example, colleges are busy hiring psychiatrists so they'll know which students to get rid of to "make sure no one gets hurt".)

Here's my five step plan for reducing social isolation:

1) **Outreach**

Our mental health systems say we're too overwhelmed with the people showing up to our programs every day to go out and look for more people in trouble. Therefore, we only allocate resources to share the burden with police of responding to dangerous situations. (Note that many people think this is a legal requirement - "We can only do something if they're dangerous to themselves or others." I don't think any state has a law against involuntary outreach, wellness checks, or listening to concerned families.)

There are a number of ways of being alerted to who might be in trouble and isolated. Usually their family knows. We could answer the phone when they call and actually go out and meet their family member. We could use data bases (for example, people withdrawing from college, signing up for unemployment, cancelled weddings, evictions, bankruptcy, loan defaults, jail

releases, even gun purchases) to reach out and offer human contact. We could have "social isolation" outreach teams instead of "call the police".

2) Engagement

Depending on how the outreach went, we could triage people who are actually socially isolated and at risk into a variety of paths of engagement. Some would require mental health professionals, but not all. Programs like Emotional CPR, Mental Health First Aid, and What a Difference a Friend Makes train the general public to engage people with mental illnesses. Peer outreach workers, who are in recovery from mental health conditions themselves can do outreach. Sometimes the most pressing need might be for some other specific non-mental illness social engagement – unemployment benefits and a job developer, an educational counselor, a financial counselor, meals-on-wheels, clergy, etc. If we worked together we could form a sizable engagement team.

3) Inclusion

These young men have been socially excluded for a reason. They have serious problems. They've all experienced far more rejection and bullying than acceptance and inclusion during their lives. We live in a community that is not accepting and inclusive of people with mental illnesses in the same way we are with physical illnesses. For them to be included, individuals, whether mental health professionals or not, will have to be part of a "counterculture of acceptance". Examples of disability-based inclusion programs are: Compeer, Cornell's practices of reintegrating students after mental health crisis, 12 step programs, impaired physician programs, Yolo county and other NAMI programs, Project Return self help clubs, etc. Probably more important, however, would be non-disability based inclusion (The movie "Lars and the Real Girl" is a great example, so are "midnight basketball" and Big Brother/Big Sister programs). The engagement worker would have to be willing to include these people in other parts of their lives and in other roles besides disabled person receiving help.

4) Protection

Risk factors for dangerousness are only predictive in the absence of protective factors (when they're predictive at all). Common protective factors include having an income, having a reasonably secure place to live (an actual "home" is best), having a family (it doesn't have to be a "perfect family"), having other adults in life (romantic partners are probably the most impactful), having a role besides "outcast" or "mentally ill", and having some active spiritual faith and connection. Thinks of how few protective factors these mass murderers had. Once we've engaged with people we can work with them on building protective factors. Mental health professionals can be one of their protective factors, but we shouldn't be all they have.

5) Strengths- Based Growth

Every person, even these mass murderers with mental illnesses and social isolation, has strengths, talents, and personal gifts. We can help people reclaim and develop their strengths and enrich all of us. (A social worker once told me that her job is to "help people remember what made their heart sing and find a way for them to do it again.") The difference between a contributing, valuable person and a frustrated mass murderer may be more in their opportunities, how they look at themselves, and how we react to them, than in their diagnoses. And that's a difference worth making.

There's good news and bad news in this strategy.

The good news is that even if we can't identify the needle in the haystack to find that rare socially isolated, armed, mentally ill person who will actually commit murder, those people accidently included in this strategy are likely to be benefitted anyway (unlike the likely inadvertent consequences of being locked up, involuntarily medicated, terrified, and traumatized). We'd likely prevent some suicides with this strategy too.

The bad news (besides the problem that I can't think of a clever acronym for these five steps) is that all of us have to get involved. We have to be a community that cares about each other. We can't just put all the responsibility on the mental health system (no matter how well funded, which it rarely is) to keep us safe. We can't say that's someone else's kids or "No one is that crazy in my family…or my neighborhood, or school , or work, or church." We're in this together. We can't just change the channel and see what else is on tonight. It's not happening to someone else. It's happening to all of us.