The Alchemy of Mental Health Policy: Homelessness and the Fourth Cycle of Reform

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Introduction

As noted in the literature[1–3] the history of public mental health policy is characterized by a cyclical pattern of institutional reforms. Each cycle was marked by public support for a new environmental approach to treatment and an innovative type of facility or locus of care. The first cycle of reform in the early 19th century introduced moral treatment and the asylum;[4–7] the second cycle in the early 20th century was associated with the mental hygiene movement and the psychopathic hospital;[8–12] and the third in the mid 20th century developed out of the community mental health movement and its support for community mental health centers.[13–16] Each of these reforms promised that early treatment of acute cases would prevent chronic mental illness. Each innovation proved successful with acute and milder—not chronic—forms of mental disorder, yet failed to eliminate chronicity or to fundamentally alter the care of the severely mentally ill. In each cycle, the optimism of reform gave way to pessimism and therapeutic nihilism toward the increasing numbers of incurable chronic mental patients. In the face of an expanding population of needy patients, public support turned to neglect.

The reform movements that stimulated these cycles often gained momentum by transforming social problems (e.g., dependency, senility, criminality, poverty, and racism) into mental health issues. Failure to address the basic social problems themselves has resulted in a repeating cycle of policies which only partly accomplish the goals of their activist proponents.

This paper examines a fourth cycle of reform emerging in the past decade in response to the failures of community mental health and deinstitutionalization. The new reform advocates creating community support systems, a broad network of mental health and social welfare services for care of the chronically mentally ill in noninstitutional settings. This reform movement is different becaue it directly addresses the needs of the chronically mentally ill rather than promising to prevent chronicity through the early treatment of acute cases and because it recognizes the problem of the chronically mentally ill as a public health and social welfare problem. The breadth of this mandate, however, is threatened by shrinking health and welfare resources and by a growing expectation that it will solve the problem of homelessness.[3]

The Community Mental Health Movement

World War II marked the turning point from the mental hygiene reform to the community mental health movement. In its return to advocacy for a new type of treatment facility—the community mental health center (CMHC)—the community mental health movement initiated a third cycle of reform devoted to the early treatment of acute cases and the hope that chronicity would be prevented.[13–16] Like mental hygiene, the main thrust of community mental health reform in America generally ignored chronic patients and embraced broader social issues.

Activitists became involved in civil libertarian reform, and the community mental health movement took on poverty, racism, civil unrest, violence, and criminality. Data on the relationship between mental illness and low social class and racial minority status[17,18] justified the involvement with the war on poverty and the civil rights movements. Decades of mental health study of violent and criminal behavior[19,20] seemed to justify community mental health practice with police and court agencies, in jails and prisons, and in the streets in times of civil disturbance.

Several models of community mental health centers emerged in the post-World War II era. Some, like Lindemann's original center, Human Relations Service in Wellesley, Massachusetts (1948) were devoted principally to consultation and education with community agencies.[21] Only later did the center offer outpatients services and develop inpatient agreements with community hospitals. Others, often sponsored by state mental hospitals (as early as the 1950s), focused on ambulatory services, especially "aftercare" and crisis intervention for a mix of disadvantaged acute and chronic patients in the public sector. The federal model of the community mental health center, which emerged in the 1960s and spread through the United States, was an anomalous combination of the two earlier models.[14,16]

In the late 1940s and early 1950s, psychiatrists like Erich Lindemann[23] and Gerald Caplan[24] adapted brief treatment methods and consultation techniques for use in outpatient settings and in community agencies. The first community mental health centers were developed, in part, to provide these services. Mental health professionals offered treatment to new populations of previously untreated, acutely ill, and emotionally troubled patients. Relatively few chronic patients were treated and public mental hospitals were largely ignored. Instead, these few early centers provided consultation to schools, religious organizations, police departments, welfare and other community agencies on specific mental health problems, environmental stress, and broader social issues.

As early as the 1930s, depression-poor public mental hospitals considered reducing the patient population in an effort to save resources. According to Grob,[10] the term "deinstitutionalization" was used to describe this process in a 1934 report sponsored by the American Medical Association.[25] Abraham Myerson described his "total push" program for discharging chronic patients in 1939.[26] Throughout the 1930s, state hospital superintendents worked hard to reduce the length of stay of newly admitted patients.[27] The process did not gain momentum, however, until psychiatrists returning from World War II introduced rapid treatment techniques and an attitude of therapeutic optimism.[28] The resultant declines in length of stay were accelerated by

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the introduction of the antipsychotic and antidepressant medications in the 1950s. State mental hospitals developed ambulatory service departments, offering crisis intervention, partial hospitalization, and aftercare. Several state hospital systems had elaborate networks of decentralized services for acute and chronic patients by the early 1960s.[22] Not all states supported the decentralized service approach, a point of controversy among hospital superintendents since the mid-19th century.[1,4] Many hospital directors feared a loss of control over their fiefdoms. Other professional leaders mistrusted the state mental hospitals, often viewed as the root of the problem and an unseemly, unlikely change agent.

Indeed, by the late 1950s and 1960s, institutions and institutional care had become anathema to be avoided at all costs. Exposès,[29] sociological treatises,[30] public commissions,[13] and even organized psychiatry[31] deplored asylum conditions and advocated change. State mental hospitals were described as isolated, dehumanizing "warehouses"—"snake pits" where unfortunate deviants were sequestered, neglected, or abused. Mental institutions were transformed in the public's mind from medical treatment centers into factories for the manufacture of madness.[32] Clinical evidence of social and functional deterioration following long-term institutional care[33–35] reinforced the notion that institutions were the cause of chronic mental disorder. Community mental health reformers advocated for mental health centers to make institutions obsolete. *Action for Mental Health,* the final report of the Joint Commission on Mental Illness and Health,[13] called for federal support; President John F. Kennedy promised a "bold new approach," and the Congress passed the Community Mental Health Centers Act in 1963.

The federally funded community mental health centers merged the prevention ideology and acute treatment/-consultation philosophy of the early community-based centers with the service mix of the state hospital-based centers. The federal model required five essential services: inpatient, outpatient, partial hospitalization, emergency, and consultation-education services. The approach was predicated on an integrated services model, promoting continuity of care for patients throughout an episode of illness. There was no clear mandate, however, for the community mental health centers to coordinate their efforts with state mental hospitals or to care for chronic patients. In fact, federal policy makers intentionally created a program granting federal resources to local agencies, bypassing state mental health authorities.[36] As a result, mental health centers primarily served new populations in need of acute services and failed to meet the needs of acute and chronic patients discharged in increasing numbers from public hospitals. Furthermore, centers were not required to provide for housing or income support for discharged mental patients. Homelessness and indigency were predictable outcomes for many.

Deinstitutionalization and its Aftermath

Advocates of the federal community mental health center program often took credit for dramatic changes in the delivery of mental health services in the US. Data, however, do not support a direct relationship between the expansion of community mental health centers and deinstitutionalization. The decline in the resident census of many states preceded the community mental health center program by more than a decade, and catchment areas with community mental health centers did not uniformly experience decreased use of the state mental hospital.[36]

The community mental health movement, as a reform, did change the delivery of mental health services dramatically—for acute and chronic patients. Between 1950 and 1980, for example, the resident population of state mental hospitals was reduced from approximately 560,000 to less than 140,000; admissions to psychiatric inpatient facilities increased dramatically; and outpatient services expanded twelve-fold. Since the mid 1960s, more than 700 community mental health centers have been created, serving catchment areas representing 50 per cent of the US population.[37,38] Nursing homes became the residence and long-term care facility for approximately 700,000 chronically mentally ill Americans.[39,40] [Each year tens of thousands of elderly state mental hospital residents were transferred to nursing homes, reversing the aging trend in public psychiatric institutions that began at the turn of this century when the senile were transferred from local almshouses to state hospitals.[10] Hundreds of thousands of elderly and chronic mental patients were diverted from hospitals directly into nursing homes. As of 1977, about half of the 1.3 million nursing home residents had a mental disorder, especially organic mental disorder, making nursing homes the single most commonly used psychiatric long-term care facility.[39,40] As the population ages this phenomenon is expected to grow.] Changing the locus of care, however, did not solve the problem of chronic mental illness and, in fact, may have made matters worse.

Community mental health reform in America generally ignored chronic patients and embraced broader social issues.

Deinstitutionalization, the policy of releasing mental patients into the community, often without adequate mental health and social welfare supports, was reinforced by the expectation that communities and their community mental health centers could handle the problem. It was believed, naively, that chronicity was a function of institutional care and that release from the hospital would eliminate the problem. Institutions were regarded as harmful, or at least undesirable, and they were a major item in state budgets. To sustain the movement, the civil libertarian/community mental health reformers joined forces with fiscal conservatives, who viewed deinstitutionalization as a way to save state resources and shift fiscal responsibility onto federal programs. [i.e., CMHCs, Medicare, Medicaid, Supplemental Security Income (SSI), and Social Security Disability Insurance (SSDI)]. Together, they propelled the community mental health reform into serious trouble.[41–53]

By the mid 1970s, the policy of deinstitutionalization was being criticized for its neglect of the chronically mentally ill. Eloquent criticism came from professional journals,[41–43] government publications,[44–46] political white papers,[47–49] newspapers,[50–52] and popular literature.[53] The zeal of the community mental health activists for trying to solve social problems without also focusing on the need for the humane care of the chronically mentally ill had, in part, contributed to the new set of social problems associated with deinstitutionalization. Even the 1975 revisions of the Community Mental Health Centers Act, which mandated cooperation with state mental hospitals and encouraged care for chronic patients, did not address the social welfare and housing needs of the mentally disabled. The expansion of

Social Security disability to the indigent (Supplemental Security Income) provided some assistance but was not equal to the growing problems of deinstitutionalization. The over-promise of community mental health to relieve widespread social distress and disenfranchisement and to prevent chronicity, in fact, left thousands of former patients homeless or living in substandard housing, often without treatment, supervision, or social support. By the late 1970s, the General Accounting Office[46] deplored the lack of federal support for a rational deinstitutionalization policy, and the President's Commission on Mental Health[49] called for a national mental health policy focused on the chronically mentally ill.

The Community Support Movement

The Community Support Program was the National Institute of Mental Health (NIMH) response to the criticism of the federal role in deinstitutionalization.[54,55] A total of $3.5 million was allocated annually for contracts with 19 states for three-year pilot demonstration programs designed "to provide services for one particularly vulnerable population—adult psychiatric patients whose disabilities are severe and persistent but for whom long-termed skilled or semi-skilled nursing care is inappropriate."[54] The Community Support Program responded to "a much needed social reform" by championing "community support systems"—a community network of crises care services, psychosocial rehabilitation services, supportive living and working arrangements, medical and mental health care, and case management for the chronically mentally ill.[54] The federal program became a model for states throughout the United States.[55]

Mental health centers failed to meet the needs of acute and chronic patients discharged in increasing numbers from public hospitals. Homelessness and indigency were predictable outcomes for many.

In some respects, the community support movement has been only a mid-course correction in the community mental health movement, an adminstrative fix for the problems of deinstitutionalization.[56] However, the community support movement may be viewed as a fourth cycle of reform in that it advocates a new approach to treatment, in this case, a whole system of care.[3,55] It also proposes a fundamental change in attitude and approach to the chronically mentally ill. Rather than prevent chronicity, the community support reformers offer direct care and rehabilitation for the chronic mentally ill.

The systemic approach to the care of the chronic mentally ill also marks a shift in the tendency to transform social problems into mental health policies and to ignore the chronic mentally ill. In a sense, the advocates of community suports have recognized that the problem of chronic mental illness is first and foremost a social welfare problem. They do not recommend mental health solutions to social problems; instead, they propose social welfare solutions to mental health problems. A community support system includes health and mental health services but also recognizes entitlement programs, income supports, transportation, and housing as critical elements.

Recent fiscal policy and resource constraints have threatened the community support reform movement: the repeal of the Mental Health Systems Act, the termination of disability benefits to tens of thousands of mentally ill beneficiaries of SSI and SSDI, and prospective payments systems that may increase admissions to state mental hospitals have all compromised the care of the chronic mentally ill in the community.[3] In addition, the Community Support Program, each year, struggles to maintain its appropriation.

Homelessness: A New Social Problem Beckons

Community mental health brought mental patients "home"; deinstitutionalization left them homeless.

Deinstitutionalization without community support and adequate housing has contributed to the problem of homelessness in America[57–59] but it is not the whole story. Although studies demonstrate that there are mentally ill individuals among the homeless, not all (or even most) of the homeless are chronically mentally ill. Those who are mentally ill focus on their housing and welfare needs rather than on mental health treatment needs.[60] Do the homeless mentally ill need more mental health treatment or a return to the asylum, as some have suggested?[61] Or is the problem more fundamental, a lack of adequate community-based housing, jobs, and other services?[62]

At this critical juncture in its short history, the community support reform is faced with a sensitive issue: How to handle its involvement and define a role for mental health in the national problem of homelessness? Having declared chronic mental illness in the community as a social welfare problem and advocated for housing reform for deinstitutionalized mental patients, mental health advocates now find themselves once again confronted with the dangers and opportunities associated with offering a mental health solution to a larger social problem.

Changing the locus of care did not solve the problem of chronic mental illness and, in fact, may have made matters worse.

The problem of the homeless mentally ill is complex and may be defined from two perspectives: Who among the homeless are mentally ill, and who among the mentally ill are homeless?[63] Both are important questions relevant to mental health policy. Mental health activitists, however, must protect against offering a mental health solution to the problem of all of the homeless, but also must not allow social welfare activists to forget the psychopathology of the homeless mentally ill. Bachrach[65] recalls Susan Sontag's description of illness as a metaphor[66] in her warning not to blame the homeless victims of deinstitutionalization by ignoring their mental illness. Bachrach and Sontag suggest that mental illness may serve as a metaphor for personal failings. We suggest that labeling problems as "mental" may also be used metaphorically to avoid having to deal fundamentally with social problems. A recent American Psychiatric Association Task Force on the homeless mentally ill[64] recognizes these problems and points a middle course for mental health policy, recognizing the mental health *and* social welfare needs of the chronic mentally ill homeless.

The community support activists may have found a balance between specialized mental health and basic social welfare needs of chronic patients. They have learned the importance of caring as well as curing but their reform is frail and in danger of failing, due to resource limitations, frustration dealing with chronic patients, and exaggerated expectations. They must resist the temptation of the alchemy of past reforms for fear of turning the base metals of social welfare into the fool's gold of overly optimistic mental health policy. The base metals are dull and heavy but solid and dependable; fool's gold glitters but serves no useful purpose.

Beyond Alchemy in Mental Health Policy

Hopefully, this community support reform will avoid fiscal threats to its existence and will not be diluted by the expectations that community support systems will solve the generic problem of homelessness in America. For the reform to persist, however, will take more than sailing the narrow course between this Scylla and Charybdis. The dichotomy between caring and curing, between chronic and acute patients, that evolved over the four cycles of reform is deeply rooted in the ideology of the mental health professionals who practice in community settings. A new professional, a nonclinician case manager has been offered as a partial solution to the problem of prevailing professional attitude. This approach, however, may create new problems related to nonclinicians' insensitivity to psychopathology and their inability to provide needed treatment.

Changes in the diagnostic nomenclature in psychiatry, reflected in the advent of the Third Edition of the Diagnostic and Statistical Manual (DSM-III) of the American Psychiatric Association,[67] narrow the focus of psychopathology to more reliably defined disorders with specific criteria. This marks a change away from a broad labeling of distress and deviance as pathology that was common from the 1950s into the 1970s. It reinforces the more biomedical aspects of mental disorder, de-emphasizing individual moral and psychosocial responsibility. Hopefully, DSM-III will reduce confusion between the disorders and their social context without ignoring either one. Although potentially destigmatizing, this approach must also be accompanied by acceptance of the social welfare needs of chronic mental patients, if it is to contribute to better care. Disorders need treatment and medical intervention; social dependence and homelessness demand social welfare solutions. Both are required for the chronically mentally ill.

Community support advocates recognize that chronic mental illness is first and foremost a social welfare problem.

Public attitudes, too, must change if there is to be progress. Recent advances in biological psychiatry offer a redefinition of mental illness as "an illness like any other"—not a moral issue. However, the psychoactive drug "revolution" that accompanied the third cycle of community mental health reform did not succeed in overcoming the stigma of mental illness.

Another hopeful sign in the process of changing attitudes is the current reintroduction of lay leadership into mental health activism, not seen since Clifford Beers in mental hygiene and Horace Mann and Dorothea Dix in the moral treatment era. Self-help and family groups are growing. A new, popular movement may revitalize the fledgling community support reform, if it can gain political strength. Such a movement would be new in the sense of being led by patients and their families rather than by professionals. It would be a democratic movement rather than a social reform fueled by guilt and noblesse oblige.

The history of public policy on behalf of the mentally ill has been a search for the proper balance between professionalism and lay leadership, between caring and curing, and between social welfare and mental health needs and services. The next decade will tell us if the fourth cycle of reform is more successful in achieving this balance than its predecessors.

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Preliminary Program for APHA Meeting to Appear in August Journal

The preliminary program for the 113th annual meeting of the American Public Health Association to be held November 17–21, 1985 in Washington, DC will appear in next month's issue of the Journal. The theme for the convention is: "Government's Responsibility and the People's Health."