THE
OPEN
DOOR

Homelessness and Severe Mental Illness
in the Era of Community Treatment

Carol L. M. Caton

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PREFACE

Among the throngs of homeless people in the streets and shelters across America, the severely mentally ill are arguably the most vulnerable. One in every three homeless people suffers from a mental disorder that is both severe and disabling. People in this group are more likely to remain homeless on the streets and in shelters for longer periods and suffer from multiple health problems that incur high social and economic costs to society. While it is widely acknowledged that the decline of the mental asylum led to the emergence of homelessness in this subgroup, there has been significant progress in finding solutions that warrants greater recognition at the public policy level.

I have been both an observer of the events that have given rise to homelessness and a participant in the quest for solutions that would bring greater stability to the lives of people with severe mental illness. Over the past 35 years, I have worked among clinicians, researchers, and advocates who have been inspired by the challenges imposed by homelessness to devise innovative service and policy interventions and creative housing initiatives. This collective body of work has advanced the evidence base in the care and treatment of the homeless mentally ill, paving the way for continued advances toward ending this American tragedy.

This ten-chapter book is a chronicle that begins with an account of the unintentional rise of homelessness following the far-reaching reforms in post–World War II mental health care, followed by descriptions of the key role of advocacy in spurring a governmental response to homelessness, the characteristics of homeless people with severe mental illness and issues related to their care, the quality of evidence for treatment and housing approaches tailored to the severely mentally ill, the challenge of bringing evidence-based interventions to scale, homeless prevention efforts, and the expanding emphasis on a recovery orientation and early enriched treatment to facilitate social inclusion. Homelessness and severe mental illness are issues that have, over the decades, aroused strong opinions and

opposing views in both lay and professional circles, threatening a clear focus on the search for workable solutions. I have striven to bring objectivity to a review of the "state of the science." Guided by the available evidence, my goal has been to identify what we know about what works for preventing and ending homelessness, and where unanswered questions suggest that greater effort is necessary. Despite significant progress, the lack of evidence in some areas indicates the need to continue an aggressive research agenda. Future progress will require increased public funding and support for mental health services and research, areas that have suffered from changing priorities and persistent budget cuts at all levels of government, particularly after the 2008 recession.

Ending homelessness requires a multidimensional effort that begins with the early, consumer-focused treatment of psychotic disorders in concert with continuing treatment, rehabilitation, and housing support for as long as it may be needed. The idealists of the community psychiatry movement in mid–twentieth century America envisioned that a change in the locus of care from the mental institution to the community would enable people with severe mental illness to achieve a more lasting recovery and live meaningful, productive lives outside the walls of the mental asylum. I hope that greater understanding of homelessness, severe mental illness, and the advances in treatment and housing initiatives can strengthen the public will to ensure that people with mental disabilities have access to the interventions that could help them live successfully in the community, diminishing the chance that they will ever experience shelter or street living.

ACKNOWLEDGMENTS

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CHAPTER 1

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The Open Door

The Mental Health System Transformed

In twenty-first-century America, about one in every three homeless peo-
ple suffers from severe mental illness. The rise of homelessness among
those suffering from severe psychiatric disorders paralleled the decline
of the state-funded mental institution and the creation of the system of
mental health care that replaced it, a process that began slowly in the mid-
1950s, accelerated in the late 1970s, and continues to the present. In the
period from 1955 to 1975, the resident population of state mental hospi-
tals dropped by 66 percent (Bachrach, 1978). By 1998, the patient caseload
of state mental institutions dropped 90 percent from the 1955 peak of over
a half million patients (Lamb & Bachrach, 2001).

THE DECLINE OF THE STATE MENTAL ASYLUM

For nearly one hundred years, from the mid–nineteenth century to the end
of World War II, public mental health care for people with severe mental
illness took place in state funded and operated mental hospitals (Caplan &
Caplan, 1969; Rothman, 1971). Often located far from population centers,
these institutions provided all of an individual's treatment and support
needs. Publicly funded care was available to all who needed it, regardless of
their ability to pay or the length of their stay in the hospital (Grob, 1991).
By the twentieth century, mental hospital caseloads consisted mostly of

people with chronic conditions, sometimes associated with aging or underlying somatic disorders (Grob, 1991). Many hospital admissions occurred through a process of compulsory commitment (*Duke Law Journal*, 1969). Treatment options were limited, and custodial care predominated. Patients lacked the opportunity to play an active role in their care and treatment, typically accepting whatever treatment was recommended. It was not uncommon for the more disabled individuals to live out their lives under asylum care.

During the 1930s and early 1940s, the focus on the Great Depression and World War II upstaged concern for the aging and deteriorating physical plants and chronic staff shortages of state mental hospitals. Despite these problems and efforts to reduce hospital stays (Goldman & Morrissey, 1985), the growth in the population of state mental hospitals continued to accelerate (Grob, 1991). As hospital staff members were drawn into the war effort, the shortage of trained and qualified personnel grew more acute.

It was during this time that reports of the abuse and neglect of patients and the deplorable conditions in mental asylums surfaced in the lay press. Publications in the popular press, such as Albert Q. Maisel's "Bedlam 1946" article in *Life* magazine, Mary Jane Ward's novel *The Snake Pit*, and Albert Deutsch's "The Shame of the States" exposed to the general public the conditions of state mental asylum care (Grob, 1991). Torrey (2014) notes how negative appraisals of mental asylums were also apparent within the mental health professions; and Rochefort (1984) details how scientific studies of the mental hospital (Belknap, 1956; Caudill, 1958; Goffman, 1961; Stanton & Schwartz, 1954) reinforced the conclusion that "mental hospitals were making worse the very problems they were intended to remedy."

In the early years following the end of World War II, the mounting criticism of state mental institutions in governmental, medical, and lay circles created a context for change. In the second half of the twentieth century, mental health care in the United States evolved in response to advances within the psychiatric professions, a more prominent role of the federal government in mental health policy, funding, and entitlement reform, and the expansion of civil liberties for the mentally disabled.

The Coming of Age of Psychiatry

The end of World War II ushered in changing views of the nature of mental health and illness and the care and treatment of the mentally ill.

The war effort revealed that mental illness was a greater problem than anticipated in men screened for induction to the armed forces and those discharged with a disability (Rochefort, 1984). Military psychiatrists observed that environmental stress, such as that experienced in combat, could precipitate mental maladjustment in otherwise healthy individuals (Grob, 1991). The military experience broadened the focus from hospital-ized patients with serious mental illness to the potential to effectively treat high-risk and early-onset conditions in community-based inpatient and outpatient settings (Grob, 1991). Moreover, the war exposed a new generation of young physicians to the discipline of psychiatry and pro-vided psychiatrists with opportunities to advance new approaches for the treatment of mental illness that did not require long-term hospitaliza-tion (Grob, 1991).

The successful treatment of war neuroses enhanced the public's esti-mation of psychiatry and its role in addressing the mental health of the nation (Grob, 1991). The importance of psychiatry's role in the prevention and treatment of mental illness was acknowledged with the passage of the National Mental Health Act of 1946. The legislation led to the establish-ment of the National Institute of Mental Health (NIMH) in 1949, which would eventually provide funding for professional training, research, and preventive services. Robert Felix, the first NIMH director, initiated a shift in the locus of mental health care with funding to the states for the devel-opment of community mental health services (Torrey, 2014).

The ensuing decade witnessed advances in psychiatric theory and prac-tice, as psychoanalysis and dynamic approaches challenged the status quo and emphasized early treatment of acutely ill patients as a way to prevent chronicity (Goldman & Morrissey, 1985; Grob, 1991). With their focus on epidemiology and the impact of the environment, social scientists con-tributed to a greater understanding of the prevalence of the untreated psychiatric disorders in the community (Hollingshead & Redlich, 1958; Srole, 1962) helping to fuel the nascent community mental health move-ment and the development of new psychosocial therapies (Klerman, 1977). Early efforts to reform mental hospital care, inspired by the devel-opment of milieu therapy (Cumming & Cumming, 1962) and therapeu-tic communities (Jones, 1953), led to open-door policies and decreasing use of restraints, accompanied by staff training and the creation of new professional roles.

Importantly, it was the discovery in the early 1950s of the antipsy-chotic effects of chlorpromazine (Ban, 2007; Lehmann & Hanrahan, 1954; Lieberman et al., 2000, 2005) that catalyzed the demise of long-term institutional care. In widespread use by the middle of the decade, the new

medication could, it was believed, control the florid symptoms that characterize severe mental illness, easing the return of hospitalized patients to a productive life in the community. By the mid-1950s, the shift from hospital- to community-based care was emerging, with innovative efforts to develop general hospital inpatient units, day hospitals, halfway houses, and social clubs for discharged patients (Geller, 2000).

Over time, the public perception of psychiatry grew increasingly positive. The language and principles of psychodynamic psychiatry would come to have a notable influence on art, literature, and film (Bell, 1999; Grob, 1991, p. 271; Kandel, 2012). However, the metamorphosis in psychiatric theory and practice that occurred in the post–World War II years did not occur without internal struggle. Early on, those with a psychodynamic orientation, a focus on treatment in outpatient settings, and a concern for poverty, discrimination, and social justice, clashed with the more tradition-oriented psychiatrists who emphasized somatic etiology and therapeutic procedures and were skeptical of social activism (Grob, 1991, p. 24). Others attacked the very foundations of the discipline. Psychiatrist Thomas Szasz (Szasz, 1961) contended that psychiatry was a pseudo-science that lacked reliability and validity, and he asserted that psychiatric diagnoses were based on value judgments reflective of the larger society that functioned as a form of social control for people who did not conform to society's standards of behavior. Sharing Szasz's criticism of the inadequate scientific base of psychiatry, sociologist Thomas Scheff popularized "labeling theory" in a sociological model of mental illness that challenged the prevailing medical model (Scheff, 1966). Scheff's work on labeling theory sparked a lively dialogue within the social sciences (Link et al., 1989) that has influenced the study of the effects of stigma and discrimination on people with mental illness. Elaborated to encompass the terms and conditions of the traditional doctor–patient relationship, criticism of the medical model of mental illness and treatment has persisted into the current-day recovery movement (see Chapter 10).

Mental Health Becomes a Federal Priority

In a quest to better understand the status of mental health care in the United States, Congress adopted the Mental Health Study Act of 1955 (Public Law 84-182) to conduct a comprehensive nationwide analysis of mental health needs, both human and economic. Led by psychiatrists Kenneth Appel and Leo Bartemeier, the Joint Commission on Mental Illness and Health was made up of 36 organizations representing many

disciplines and areas of professional interest (Ewalt, 1957). During its three-year mandate, the Joint Commission conducted a broad set of inquiries ranging from the nature and prevalence of mental disorders, mental health promotion in the community, and importantly, detailed study of private and public mental hospitals that included personnel issues, organization, administration, available treatments, and patient outcomes. A final report, *Action for Mental Health* (Joint Commission on Mental Illness and Health, 1961) assessed the scope of mental health conditions and resources nationwide. Highly critical of state mental institutions for having "defaulted on adequate care for the mentally ill" (Torrey, 2014), the Joint Commission recommended that community mental health centers should be established to coordinate future mental health care, and advocated for greater federal involvement in the care of people with mental illness. The Kennedy administration established a Cabinet-level interagency committee to determine an appropriate federal response to the report (www.nih.gov/about/almanac/organization/NIMH.htm).

The Community Mental Health Centers Act of 1963

In October 1963, President Kennedy signed into law the Community Mental Health Centers Act (PL 88-164), which authorized federal grants for the construction of public or nonprofit community mental health centers to provide inpatient, outpatient, partial hospitalization, emergency care, and consultation and education services. Grants were awarded to the states, with the stipulation that funds could not be used for existing state mental institutions. The program was administered by the NIMH, signaling the greater involvement of the federal government in determining mental health policy and the delivery of mental health services.

In creating a new type of mental health treatment facility, the landmark Act fueled the community mental health movement with its emphasis on prevention and early treatment (Caplan, 1964). Scant attention was paid to the fate of the severely mentally ill, however, who were discharged from state mental asylums in increasingly greater numbers throughout the 1960s and 1970s. Few received care in the new community mental health centers, as mental health professionals turned their attention to acutely ill patients with mild to moderate psychiatric conditions and limited treatment histories. In the context of the civil rights movement and the social change sweeping the nation in the 1960s, the community mental health movement embraced civil libertarian reform, focusing not just on psychiatric disorder, but on larger social issues like "poverty, racism, civil

unrest, violence, and criminality" (Goldman & Morrissey, 1985). Although patients continued to suffer from chronic mental illness, access to the services they needed to live successfully in community settings grew increasingly limited (Cutler et al., 2003). By the end of the 1970s, only about half of planned community mental health centers were ever built, none were fully funded, and the legislation did not provide for long-term funding. In the early months of the Reagan administration, funds remaining from the Community Mental Health Centers Act were diverted into block grants to the states.

Federal Health Insurance and Income Entitlements for the Disabled Poor

Federal support for community mental health services was further advanced in 1965 with the passage of Medicaid and Medicare legislation, which provided coverage for a range of mental health services apart from state mental institutions. The new legislation prevented state mental hospital patients under age 65 from receiving Medicaid benefits. Medicaid funding for mental health services facilitated the expansion of general hospital psychiatric units, offering patients the opportunity to receive care in their local communities. The availability of federal health insurance for nursing home care provided a vehicle for the transfer of chronic patients from state-funded mental hospitals to nursing homes, allowing states to markedly reduce the cost of caring for the mentally ill and hastening the process of deinstitutionalization (Koyanagi, 2007). The cost for the shift in the locus of care from the state mental asylum to community services came from the federal purse, estimated at $2 billon by 1977, and a large measure of the treatment and support burden fell on nursing homes. By 1980, nearly half of the nursing home population consisted of the chronically mentally ill (Solomon et al., 1984).

Additional federal legislation, Supplemental Security Income for the Aged, Blind, and Disabled (Title XIV), enacted in 1972, provided income support for people who could not engage in gainful employment due to physical or mental impairment. Eligibility, based on need, was tied to an assessment of the person's source of support and available resources. Amendments enacted in 1972 extended Medicaid and Medicare protection to all Social Security Disability Income (SSDI) recipients. Entitlement income supported the ability of the severely mentally ill to live independently in the community.

The Expansion of Civil Liberties for the Mentally Ill: Actions of the Courts Facilitate the Transition from Institutional to Community-Based Care

Involuntary Commitment

Shortly after the passage of the Community Mental Health Centers Act of 1963, a series of state and federal court decisions broadened the civil liberties of people with mental illness admitted to psychiatric hospitals. These decisions have had a marked effect on both patients' rights and mental health services (Geller, 2000). Since mental hospitalization, particularly when it is of an involuntary nature, involves limitations on liberty, legislation was developed early on to clarify protections against inappropriate commitment (*Duke Law Journal*, 1969). The District of Columbia Hospitalization of the Mentally Ill Act of 1964 addressed the right of voluntary patients to seek hospital discharge within 48 hours of filing a written request. In so doing, the Act set forth a criterion for compulsory hospitalization based on the likelihood of self-injury or injury to others, established procedures of emergency hospitalization, court-mandated hospitalization, and the rights of involuntary patients to a periodic examination and release when the patient has recovered (Columbia Law Review Association, 1965).

In 1975, the United States Supreme Court ruled that states cannot constitutionally confine a non-dangerous individual who is capable of living safely in the community alone or with the willing assistance of responsible family or friends (O'Connor v. Donaldson, 422 U.S. 563, 1975).

The Right to Refuse Treatment

Later court decisions increased individual civil liberties concerning mental health treatment, challenging precedents that hospitalized patients had no role in treatment decisions, and that medication and physical methods of behavior control could be used without the consent of patients or their families (Melton et al., 1997). Addington v. Texas (77-5992), Supreme Court of the United States (441 U.S. 418.99 S. Ct. 1804; April 30, 1979) set a standard for involuntary treatment by raising the burden of proof required to commit persons for psychiatric treatment from the usual civil burden of proof of "preponderance of evidence" to "clear and convincing" evidence as required by the Fourteenth Amendment.

Rogers v. Okin (1975), a class action lawsuit brought by patients at Boston State Hospital, challenged the hospital's policies on the use of

restraint, seclusion, and involuntary treatment that resulted in medi-
cating people against their will and isolating them in forced seclusion.
It was one of the first cases that led to the recognition that compe-
tent mental patients have the right to refuse treatment (Monahan &
Steadman, 1983). The Federal District Court ruled that committed (and
voluntary) patients must be assumed to be competent until proven oth-
erwise, and as such, are capable of making non-emergency treatment
decisions. Forced medication could be justified only in emergency situ-
ations where the evaluating physician determined that there was a risk
of harm to the patient or another person. The court decision required
that the determination of whether to treat an incompetent patient must
be made in a full evidentiary hearing with counsel representing both
plaintiff and defendant and expert witnesses representing both sides.
The decision in Rogers *v.* Okin served as a model for other states grap-
pling with the same issues.

Community Treatment in Integrated Settings

Two court decisions stand out in their support of community care for
people with mental illness. A class action lawsuit brought by District of
Columbia patients at St. Elizabeth's Hospital (Dixon *v.* Weinberger; 405
F. Supp. 974; U.S. District Court, District of Columbia, 1975) asserted that
the 1964 Hospitalization of the Mentally Ill Act granted the right to care
in community-based alternative settings for those unnecessarily confined
to institutional care. The court ruled that treatment in community-based
alternatives should be made available for those who do not meet crite-
ria for mandatory hospitalization. Years later, in Olmstead *v.* L.C. (527
U.S. 581; 1999), the United States Supreme Court held that under the
Americans with Disabilities Act, people with mental disabilities have the
right to live and receive services in the most integrated settings appropri-
ate to their needs.

The Right to Quality of Care

Finally, the decision in Wyatt *v.* Stickney (325 F. Supp 781 M.D. Alabama,
1971) is important because it helped to accelerate the emptying of state
mental institutions. Wyatt *v.* Stickney was an action brought by the
Department of Psychology at Alabama's Bryce State Hospital to reverse job
loss for over 100 employees, including professional staff, that occurred fol-
lowing a state budget deficit. The action alleged that the layoffs impaired